DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00421025 Complaint IN00421025 - Federal/state deficiencies related to the allegations are cited at F660. Survey date: November 6, 2023 Facility number: 008505 Provider number: 155590 AIM number: 200064830 Census Bed Type: SNF/NF: 139 Total: 139 Census Payor Type: Medicare: 11 Medicaid: 124 Other: 4 Total: 139 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/9/23.	F 0000	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **The facility respectfully requests a desk review for these alleged deficient practices.**	
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Attinger	RVP of Operations	12/07/2023

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

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	The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.			

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	(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on record review and interview, the facility failed to ensure a resident was discharged in a safe manner and the facility completed guardianship papers timely for 1 of 3 residents reviewed for discharge. (Resident B) Finding includes: The record for Resident B was reviewed on 11/6/23 at 9:35 a.m. The resident was admitted to	F 0660	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B currently resides at the facility and has had no adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the	12/08/2023

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	the facility on 8/22/23 and, per facility documentation, was discharged Against Medical Advice (AMA) from the facility on 10/29/23. Diagnoses included, but were not limited to, COPD, vascular dementia with behavioral disturbances, osteoarthritis, cognitive communication, and cerebrovascular disease. The Admission Minimum Data Set (MDS) assessment, dated 8/25/23, indicated the resident was not cognitively intact and needed supervision with most of her activities of daily living. The hospital History and Physical Notes, dated 8/16/23, indicated a social service consult would be needed for placement for suspected elder abuse. The resident had not seen a physician in 4 years and had minimal past history, but appeared to have cerebrovascular disease and vascular dementia. The patient's son indicated his ex-wife, with whom the patient had been living, had been abusive to her. The son reported his mom had chest pain and some shortness of breath, but was not on any medications. "The patient was also reported elderly abuse by her son." A Psychiatric evaluation was completed in the hospital on 8/22/23. The consult was recommended by Adult Protective Services (APS). The assessment indicated the resident had dementia and the plan was for extended care placement. The patient was recently living with her son's ex-wife who reportedly was abusive to her, striking her in the head and hurting her wrist. She was not sure when these things happened and did not know if she has medical problems, but indicated she had not seen a doctor in 4 years because she was not allowed to see a one. She did		same deficient practice will be identified and what corrective action(s) will be taken; Any resident with a cognitive impairment has the potential to be affected by the alleged deficient practice. A full house audit will be completed to ensure any resident with a cognitive impairment has a guardian/POA in place, or is referred to the MD to determine the need for a guardian/POA. All discharges were reviewed from the last 30 days to ensure a safe discharge occurred. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; SSD/DON educated on the process to follow if a resident is admitted with a cognitive impairment, to include holding care plan meetings with family and obtaining a guardian/POA if applicable. The IDT was reeducated on the discharge process. The facility will start discharge planning upon admission and complete a discharge care plan meeting with the IDT, resident and care givers ,when applicable, to ensure the residents needs are able to be meet after discharge. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;	

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	not take any prescription medications, but had reported having urinary frequency. Her son recently removed her from this home when he found out about the concern for abuse, however, he lived at a halfway house and was unable to take care of his mother and was requesting placement. All of the information was provided by the patient and her son. The patient was assessed at that time, and was asked how she was feeling regarding not being able to return to her previous place of residence. "The lady there was mean to me. She would slap me and push me down. I didn't know what to do or say. If I say the wrong thing she would come back and slap my face and ask me why did I say that. But she never told me what she wanted me to do. Sometimes she would push my back and tell me to go wash the dishes. I was just so scared because I didn't know what to do. I'm ok with going to the new house because I won't have to be scared there. I just want to see and talk to my son." She continuously mentioned how she was physically attacked by "the woman." The patient indicated "When I'm with her and I'm not sure what's go [sic] happen I feel scared" Physician's Orders, dated 8/22/23, indicated the following medications: Donepezil 5 milligrams (mg) 1 tablet every evening for dementia. Atorvastatin (used to lower cholesterol) 20 mg 1 tablet by mouth every day. Cholecalciferol 1000 units, 1 tablet by mouth every day for vitamin D deficiency Melatonin 3 mg 1 tablet by mouth at bedtime for sleeping difficulty. There were no Power of Attorney (POA) or guardianship papers on file for the resident. A Social Service Progress Note, dated 8/22/23, at		Administrator/designee will audit any new admission with a dx of a cognitive impairment to ensure the proper procedure has been followed related to obtaining a POA/guardian. Audits will be completed on 5 admissions a week x 4 weeks, 3 admissions a week x 4 weeks, 1 admission a week x 4 weeks then 1 admission a month x 3 months. Administrator or designee will audit all discharges weekly x 4 weeks and then 3 discharges weekly x 5 months to ensure a safe discharge occurred The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	3:25 p.m., indicated she met with the resident to obtain a social history and cognition assessment. The resident was alert and oriented to self and surroundings. The resident lived with her ex-daughter in law prior to her hospitalization and was apparently being abused, therefore, the resident will be staying long term. A Nurses' Note, dated 8/22/23 at 3:38 p.m., indicated "the resident's son/POA" was notified of the resident's arrival. The resident signed all the admission paperwork on 8/25/23. There was no evidence the facility had a care planning conference with the resident and her family regarding any type of discharge, guardianship, or how long the resident would be staying, and there was no documentation the resident had seen outside or contracted behavioral health services while at the facility. A Social Service Progress Notes, dated 10/29/23 at 12:58 p.m., indicated "Resident's son came into facility stating he want to discharge his mother, writer expressed concern due to this being so abrupt. Writer explained that resident has not been properly discharged by her physician, and writer made him aware of the consequences of taking her without setting up some of the things she may need at home. Son voiced understanding of writer's concern and stated that she was only here because she was homeless but now she is going to live with her granddaughter, son was given AMA form to sign resident discharged." A Nurses' Notes, dated 10/29/23 at 1:25 p.m., indicated the resident left AMA with son and AMA paperwork was signed.			

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A Social Service Progress Note, dated 10/30/23 at 3:50 p.m., indicated staff called APS as well as the Ombudsman and there was no answer, therefore a message was left for both of them.

A Social Service Progress Note, dated 11/1/23 at 2:48 p.m., indicated the resident discharged with her son AMA on 10/30/23, and he took her to her granddaughter's home. The granddaughter called and indicated she could not take care of her and wanted to bring her back to the facility. The granddaughter was asked if she wanted to get temporary guardianship so the son did not continue to take the resident and she did not want to deal with her uncle, therefore, was not going to get guardianship. The facility will initiate a guardianship for resident.

On 11/1/23 at 3:36 p.m., the resident arrived back to the facility and was admitted.

An APS letter, dated 8/23/23, indicated their office had a report of a concern for Resident B. It was reported there were definite concerns regarding her ability to care for herself, and for her well being and safety. It was also alleged she was being financially exploited and neglected by her ex-daughter in law. Her son was incarcerated for a few years and was a convicted felon and was currently living in a halfway house. He found out that his mother had not been in the hospital for a few years or seen a dentist or doctor. The patient was eating cereal because she lost her teeth and it was reported the daughter in law would push her to make her do the dishes and do stuff around the house. In order to address this report appropriately, the office needed to determine whether or not the patient was capable of making her own decisions and have to assume she can,

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unless otherwise noted by a physician.

Interview with the Social Service Director (SSD) on 11/6/23 at 10:44 a.m., indicated the resident was admitted to the facility from the hospital in 8/2023. The resident had moderate impairment for cognition and her son was the person who signed her into the facility. She was not aware if the son had POA papers. The son did visit the resident periodically, however she was unaware of the son's background, and that he had recently gotten out of prison and was living in a halfway house. She was aware the resident was an APS case because her son's ex-wife was accused of elder abuse. She was informed the son went to see his mom and took her hospital to get care and to be evaluated, and as far as she knew, the resident was going to be long term placement at the facility. On 10/29/23 she was the manager on duty and the nurse came down to her office and told her the resident's son was here to discharge his mother and take her to his niece's house. She walked down to the room and asked the son why he wanted to take her out now, he indicated she was only supposed to be short term and wanted to take her to live with her granddaughter. She informed the son if he left with his mom AMA she would not get any services, he indicated he did not care and did not need anything. She had the son sign the AMA paper and he left with his mother. She indicated she called APS and left them a voice message.

Telephone interview with the resident's granddaughter on 11/6/23 at 11:15 a.m., indicated she had driven her uncle to the facility to get her grandmother that day. Once they were in the car, she dropped him off at his men's shelter where he was living and drove her grandmother to her house. Her sister lived with her, so the both of

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them took care of her. She indicated her uncle told her nothing was wrong with her grandma, but when she found out she was taking "all these medications" and had health issues, that was too much for her and she called the facility to ask if they would take her back. She brought her back to the facility on 11/1/23.

Interview with Director of Nursing (DON) on 11/6/23 at 11:25 a.m., indicated she was made aware the resident's son came into the facility to get his mom and she knew she was APS case, however, she was informed by other facility staff that the son signed her into the facility and he was the next of kin so he could come and take her out.

Interview with the Business Office Manager on 11/6/23 at 11:25 a.m., indicated they had received a fax from APS regarding guardianship for the resident upon admission and all they had to do was to have a Physician complete the Physician's report and return the paper work. She had faxed the Physician to complete and sign the paper and send it back to her, however, it had not been done and she had not followed up on the situation. She has now reached out to the Medical Director and they were going to complete the paper, sign it and send it back to the facility.

Telephone interview with the Regional Vice President of Operations on 11/6/23 at 11:35 a.m., indicated the discharge was fine due to the fact the son was the next of kin, he had signed her in and he was the person signing her out and indicated where he was taking her. He was unaware the facility did not follow up on the guardianship paper work.

Telephone interview with APS on 11/6/23 at 11:51

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	a.m., indicated she received a voice message from the facility on Sunday 10/29/23 indicating the resident was discharged with her son and she was supposedly going to be living with her granddaughter. She had sent a detailed letter at the time the resident was admitted on 8/23/23 regarding guardianship and about the resident's son and how he had just been released from prison and was living in a halfway house and her ex-daughter in law was accused of elder abuse as well as exploiting her. She sent over paper work to be completed by the resident's Physician to see if she was able to make her own decisions, however her office had still not received any of that information back as of today. Interview with the SSD on 11/6/23 at 2 p.m., indicated there was no care planning conference where they had sat down and met with the family and the resident regarding discharge or long term care placement and the resident had not seen any outside source for psychiatric care while in the facility from 8/22-10/29/23. This citation relates to Complaint IN00421025. 3.1-12(a)(21)			