| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155469 | A. BUILDING 00<br>B. WING | 10/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CASA OF HOBART | 4410 W 49TH AVE<br>HOBART, IN 46342 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00391530, IN00391678 and IN00392052.<br><br>This visit was done in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 9/27/22 and the PSR to the Investigation of Complaints IN00387879 and IN00390783 completed on 9/27/22.<br><br>Complaint IN00391530 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00391678 - Substantiated. Federal/state deficiencies related to the allegations are cited at F624.<br><br>Complaint IN00392052 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00387879 - Corrected.<br><br>Complaint IN00390783 - Corrected.<br><br>Survey dates: October 27 and 28, 2022<br><br>Facility number: 000366<br>Provider number: 155469<br>AIM number: 100288900<br><br>Census Bed Type:<br>SNF/NF: 90<br>Total: 90<br><br>Census Payor Type:<br>Medicare: 7<br>Medicaid: 72<br>Other: 11 | F 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Katherine Bakrevski | Administrator | 11/11/2022 |

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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| | Total: 90<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 11/1/22. | | | |
| F 0624<br>SS=D<br>Bldg. 00 | 483.15(c)(7)<br>Preparation for Safe/Orderly Transfer/Dschrg<br>§483.15(c)(7) Orientation for transfer or discharge.<br>A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.<br>Based on record review and interview, the facility failed to provide a safe discharge for a resident who was deemed not capable of decision making and had a court appointed Guardian for 1 of 3 residents reviewed for discharge. (Resident D)<br><br>Finding includes:<br><br>The closed record for Resident D was reviewed on 10/27/22 at 1:03 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, psychotic disorder, bipolar disorder, pulmonary edema, stroke, high blood pressure, edema, heart failure, dementia with behaviors, delusional disorder, and suicidal ideation. The resident was admitted to the hospital on 9/9/22 and returned to the facility on 9/13/22. She had another hospital admission on 9/23/22 and returned to the facility on 9/29/22.<br><br>The resident had a court appointed Guardian as of 9/27/21. The Guardianship papers indicated "[Resident name] by reason of her incapacity is | F 0624 | **F624 Preparation for Safe/Orderly Transfer/Discharge**<br><br>The facility requests paper compliance for this citation.<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.* | 10/31/2022 |

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| | unable to care for her person and estate and is therefore adjudicated to be an incapacitated person, and the appointment of a guardian is necessary. [Nephew name] is the most qualified and suitable entity available to serve as guardian and is hereby appointed as the permanent guardian of the person and estate of [Resident name]."<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 7/27/22, indicated the resident was cognitively intact.<br><br>A Care Plan, dated 3/16/22, indicated the resident demonstrated cognitive impairment related to schizoaffective disorder and delusions. The resident will have a responsible person assigned decision-making responsibilities either through guardianship or surrogacy in compliance with state law.<br><br>A Nurses' Note, dated 8/4/22 at 10:15 a.m., indicated "Writer spoke with the doctor at this time resident is not safe to discharge unless she has 24 hour care and guardian is in agreement of discharge. SS [Social Service] aware and to follow up with resident." (sic)<br><br>A Nurses' Note, dated 9/7/22 at 7:57 a.m., indicated the nurse was called to the room due to the resident throwing things all over the room. There was food all over the floor, walls, and dresser, including broken glass on the floor. Staff attempted to speak with the resident to get a better understanding of the behavior and the resident started yelling about her recliner and wanting the recliner back. Staff attempted to calm the resident but she was not receptive to communicating with staff. | | **1) Immediate actions taken for those residents identified:**<br><br>Social service director was immediately in serviced by the Administrator on the process of preparations of safe transfers and procedures.<br><br>**2) How the facility identified other residents:**<br><br>All residents discharging from the facility have the potential to be affected by this alleged deficient practice.<br><br>**3) Measures put into place/ System changes:**<br>All anticipated discharges will have a discharge summary and post discharge plan completed and discussed with the resident and the responsible party within 24 hours prior to discharge.<br><br>Current staff to include, Licensed nursing and interdisciplinary team were re-educated on ensuring the proper procedure with safely preparing a discharge or transfer. This education has been added to the new hire orientation.<br><br>A discharge log will be maintained by social services to include the completion of the discharge summary, post discharge plan and meeting with | |

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| | Nurses' Notes, dated 9/7/22 at 9:30 a.m., indicated the resident had fresh grapes scattered on the floor with a broken old vase. There was liquid makeup on the blinds and purple nail polish on the over bed table and floor. Garbage was also noted on the floor. The resident indicated she belonged at home and not at the nursing home.<br><br>A Social Service (SS) Note, dated 97/22 at 3:59 p.m., indicated the hospital was unable to admit the resident for an evaluation due to her past psychiatric history with them. SS was seeking alternate placement for an evaluation. The physician was notified of the same.<br><br>An SS Note, dated 9/8/22 at 9:06 a.m., indicated a referral was made to the Neuropsychiatry Hospital on behalf of the resident. The behavior health agency indicated based on the history between the resident and the agency, they would not admit the resident into their services.<br><br>Nurses' Notes, dated 9/8/22 at 11:54 p.m., indicated the resident called 911 and complained of difficulty breathing. The Guardian was notified and gave permission for the resident to be transferred to the hospital.<br><br>Nurses' Notes, dated 9/16/22 at 3:00 p.m., indicated the resident was alert to name and verbal.<br><br>An SS Note, dated 9/21/22 at 1:21 p.m., indicated the guardian had been contacted in regards scheduling a Care Plan meeting to discuss possible discharge plans.<br><br>Nurses' Notes, dated 9/23/22 at 7:25 p.m., indicated the resident had refused all treatments from facility nurses on multiple occasions during | | responsible party and resident.<br><br>**4) How the corrective actions will be monitored:**<br>The administrator will audit the discharge log weekly for 12 weeks to ensure that all discharges have been prepared for a safe discharge. The log will have documentation that a discharge summary, post discharge plan and meeting with the responsible party and resident have been completed.<br><br>The administrator will be responsible for the compliance of this corrective action.<br><br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**<br><br>**5) Date of compliance: 10/31/2022** | |

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| | the 3-11 shift on 9/22/22. Eventually the local EMS arrived and the resident elected to be transported to the emergency room. The Guardian was notified.<br><br>Nurses' Notes, dated 9/29/22 at 2:20 p.m., indicated the resident had arrived to the facility by an ambulance. The resident was combative, uncooperative and shouting profanity at staff. The resident did not allow the writer to perform a full body assessment or take vital signs. The resident scratched the CNA and yelled "You have no right to touch me, I'm Jewish, you're going to jail!"<br><br>Nurses' Notes, dated 9/30/22 at 6:36 a.m., indicated the resident was sitting up in a chair throughout the shift. Many attempts were made by staff throughout the shift to care for the resident, but she continued to refuse to be assessed and have her vital signs checked. The resident believed that she was supposed to be in Israel and the facility had all of her information wrong.<br><br>An SS Note, dated 9/30/22 at 10:03 a.m., indicated "SSD [Social Service Director] spoke with resident responsible party [Guardian Name] to inform him that at this time the resident is very determined to leave the facility on her own. Resident has contacted her own transportation. SSD was informed by the resident that she is trying to get to Westville. SSD at that time made contact with [Guardian Name] to inform him of what the resident was trying to do and the destination the resident provided to the IDT. [Guardian Name] asked if she was safe at the facility and if we could stop her from leaving. SSD informed him that she is safe here however, our IDT cannot restrain the resident to keep the resident from leaving. SSD informed [Guardian Name] that multiple attempts | | | |

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| | to redirect the resident was made by staff. [Guardian Name] stated that 'he does not know what to do'. SSD informed [Guardian Name] that he needs to come to the facility to assist with managing the resident's behaviors and that a placement a psych facility may be more appropriate for the resident at this time. [Name] stated that he would not be here in time and SSD informed [Guardian Name] that we won't be able to keep her against her will or restrain her to restrict her from leaving. SSD also informed [Guardian Name] that she was physically combative upon being readmitted to the facility from the hospital on 9-29-22 and that the resident was not receptive to any redirection attempts that were made. Resident and Guardian were both informed that AMA [Against Medical Advice] paperwork would be completed if the resident left the facility against medical advice at this time. AMA paperwork was completed. All parties were notified. Resident is no longer in the building." (sic)<br><br>A Nurses' Note, dated 9/30/22 at 11:03 a.m., indicated "Upon approaching resident in hallway, resident is seen walking with walker dressed appropriate with footwear on. Writer approached resident asked where you are going? resident states 'home to Westville. I have been married for 40 years, my husband is waiting for me and I'm going by my Hebrew name Sarah.' Resident states her ride is up front waiting. SS went up front to check, and it is a Taxi waiting. SS called [Guardian Name] he states I thought she was secure at the facility. SS did make him aware she is safe, but we cannot restrain her, and she is combating. Writer attempted to stand in front of walker and educate that this not the way to leave. You need O2 [oxygen] resident states [Medical Doctor] MD discharge it. Resident is seen huffing and puffing | | | |

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| | taking rest periods. Writer explained to resident that she needs her O2 on. Resident begins to state 'No I don't and leave me alone. I am going home.' Writer attempted to educate the resident this is not how you leave let me call MD and get an order and order you supplies. Resident states ' I was not discharged from [hospital name] I did not sign any paperwork.' Writer explained you were discharge yesterday back to the facility. Resident ignores writer and continues to walk towards the door. At this time writer explained the AMA paperwork and can she sign it. Resident states I will if you give me a wheelchair. Writer explained I can't assist you to leave due to you are going AMA. Resident continues to walk and says move then. SS again is contacting guardian to let him know we cannot stop resident. Resident gets to the door tells the driver can you get this. Resident hands her walking stick to him. SS reads the AMA paperwork to resident. Resident states, 'I am not signing that. That not my name, my name is Sarah.' SS changes the name and resident signs it. Resident then continues to the door and sits in the SUV. SS is on the phone with guardian at this time. Resident left in black Dodge SUV with no c/o [complaints of] pain or in respiratory distress no open areas noted that we saw." (sic)<br><br>Nurses' Note, dated 9/30/22 at 1:29 p.m., indicated the Physician was notified of the situation.<br><br>An SS Note, dated 9/30/22 at 1:33 p.m., indicated AMA paperwork was explained to all parties. Resident and responsible party were aware the resident was discharged from the facility.<br><br>There was no documentation the police or EMS were notified of the situation in any attempt to try and help to stop the resident from leaving the | | | |

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| | facility.<br><br>Interview with the SSD on 10/28/22 at 9:04 a.m., indicated she was notified by the Assistant Director of Nursing (ADON) on 9/30/22 the resident was adamant about leaving the facility. She had never seen the resident get up and physically walk before. The staff tried to stop the resident and she was always told she could not physically restrain a resident. The resident became very aggressive with staff when they tried to stop her, and the Guardian was called. Everything was explained to him regarding the situation and they could not restrain her to stay. The Guardian asked her if she was safe and secure and he was told that she was safe but she called a taxi and was going to get into the car and leave. She was in contact with the ADON the entire time who was calling the MD. The Director of Nursing (DON) and Administrator were not in building at the time.<br><br>Interview with the ADON on 10/28/22 at 9:21 a.m., indicated she saw the resident walking out of her room fully dressed and telling everyone she was leaving. She immediately got a hold of the SSD and told her to call the Guardian. She was on the phone with the Doctor and the told him what was going on. The doctor told her to document everything, but did not give orders to send her to the hospital or for an needed medication. The DON was notified per phone of the incident while the resident was in the building. The resident was fighting staff and was very combative with the cane she was walking with. The SSD told her the Guardian could not come to the facility at that time. They also told the Guardian they could not physically restrain the resident or hold her there. The resident called a taxi, and was calling the driver by his name. She kept telling staff she was | | | |

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| | leaving and continued to be combative. The taxi driver told the facility where the resident was going and they told the Guardian. The facility did not call 911, EMS or the police.<br><br>Interview with the Administrative Consultant on 10/28/22 at 9:48 a.m., indicated the facility had notified her and she was aware of the situation. The Guardian was aware the resident was going to leave AMA, where she was going and agreed to meet her there. She indicated they were not going to restrain the resident.<br><br>Interview with the resident's Legal Guardian on 10/28/22 at 12:00 p.m., indicated he was notified and on the phone with the SSD at the facility during the entire event. He asked the facility if they could secure her there at the facility and they told him "No", they could not restrain her. He asked the SSD if they knew where she was going and or if they could give him the description of the car or the license plate of the vehicle, they told him they could not give the license plate number because there was a resident blocking the view. He was told by the SSD if the resident left AMA then she would not be allowed to return. The Guardian indicated her "MO" (modus operandi, meaning mode of operating or working) was to go back to her trailer in Westville so he knew where she was going. He called the judge and within 6 or 7 hours he had EMS and the police out at the trailer and they detained her and took her to the hospital in Michigan City. He indicated the resident did not go willingly.<br><br>This Federal tag relates to Complaint IN00391678.<br><br>3.1-12(a)(3)<br>3.1-12(a)(21) | | | |