PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL OF CORRECTION IDENTIFICATION NUMBER 155469	IA (X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/16/2024	
	PROVIDER OR SUPPLIER F HOBART	4410 W	ADDRESS, CITY, STATE, ZIP COD 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
F 0000	REGOLITORY OR ESC IDENTIFY THE INVOICEMENT	mort mo		DATE	
Bldg. 00	This visit was for the Investigation of Complai IN00442760.	F 0000			
	Complaint IN00442760 - Federal/state deficier related to the allegations are cited at F622.	ncies			
	Survey date: September 16, 2024				
	Facility number: 000366 Provider number: 155469 AIM number: 100288900				
	Census Bed Type: SNF/NF: 91 Total: 91				
	Census Payor Type: Medicare: 8 Medicaid: 69 Other: 14 Total: 91				
	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.				
	Quality review completed on 9/23/24.				
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements				
. J.ag. 00	Based on record review and interview, the faci failed to ensure a resident-initiated discharge w documented in the resident's medical record an appropriate information was given to the reside for continuation of care, related to a list of medications the resident received at the facility not sent with a resident and no documentation	vas id ent	CASA of Hobart Complaint Survey 9/16/2024 Plan of Correction Please accept the following as	10/02/2024 the	
LABORATOR	I RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTA	ATIVE'S SIGNATURE	TITLE	(X6) DATE	
Dilane D Knights Administrator					

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/16/2024 155469 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART **HOBART. IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE the resident's status at the time of discharge. facility's credible allegation of compliance. This plan of Finding includes: correction does not constitute an admission of guilt or liability by the Resident B's record was reviewed on 9/16/24 at facility and is submitted only in 9:12 a.m. The diagnoses included, but were not response to the regulatory limited to, anterior cervical discectomy and fusion requirement. of the cervical 5-6 and 6-7 discs. The facility F622 - Transfer and Discharge admission date was 8/28/24. Requirements A Social Service Assessment, dated 8/29/24. It is the policy of Casa of Hobart to indicated an intact cognitive status. ensure that resident-initiated discharges are documented in the A "Release of Responsibility for Discharge resident's medical record and Against Advice" form, signed by the resident on appropriate information given to 9/5/24, indicated the resident assumed full the resident for continuation of responsibility for being discharged against the care. advice of the Attending Physician and Facility Administration. The resident was informed of the What corrective action(s) will be risks involved in discharging AMA. The signed accomplished for those residents form released the Attending Physician and the found to have been affected by the facility from all responsibility. The Social Service deficient practice Director (SSD) witnessed the resident signing the Rb - No longer resides in the form. facility How the facility will identify other There was no documentation that indicated the residents having the potential to physician had been notified of the resident's be affected by the same deficient request for the AMA discharge. There was no practice and what corrective action documentation that indicated the resident had will be taken. All residents residing in the facility discharged from the facility, with whom the resident left the facility, and if current medication have the potential to be affected orders were provided to the resident for by these alleged deficient practice continuation of care. What measures will be put into During an interview on 9/16/24 at 10:53 a.m., the place or what systemic changes Director of Nursing (DON) indicated there was no will be made to ensure that the documentation of the resident's AMA request deficient practice does not recur. and status of the resident upon leaving the facility All nursing staff have been in the Progress Notes. The Physician had not in-serviced on the process been notified of the impending AMA and no receiving, managing, documenting

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLII		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICAT		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
	155469		B. W	B. WING		09/16/	2024
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					/ 49TH AVE		
CASA OF HOBART					RT, IN 46342		
	T	OTA TEMENT OF DEPLOYENCE	1		· I		OV.5
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)			(X5)
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL					TE	COMPLETION
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION Physician's Orders or other information had been		1	TAG	and following through with a		DATE
	1	t. The resident requested the					
	_	-			resident /Family request to		
	AMA on 9/5/24 and had discharged from the facility on 9/6/24. The DON indicated she spoke				discharge Against medical Ad		
	1	rse on duty at the time of the			1. Documentation of Attempts to		
		informed Unit Manager (UM)		establish traditional discharge plan			
	_	would document the		2. Documentation of notification of			
		would document the			Md of request for AMA	n of	
	discharge.				3. Documentation of notification		
	D :				Family/ Responsible party of A		
	During an interview on 9/16/24 at 11:30 a.m., UM 2 indicated she had "no interaction" with the				4. Documentation of presental	liOΠ	
		ver said she would document			of AMA Form for signing	··	
		ver said she would document		5. Documentation of presentation			
	the discharge.				of current medication list and	any	
	D	0/16/24 + 11 41			appointments		
	During an interview on 9/16/24 at 11:41 a.m., LPN 1				6. Documentation in the reside		
	indicated she was not informed of the AMA				record the current status at the		
	discharge until 9/6/24 and UM 2 had indicated she				time of discharge and with wh		
	would "take care of everything." When a resident				any and how the resident left	ne	
	requested to leave AMA, no paperwork or				facility.		
	medications were usually sent with them. The				How the corrective action(s) will be		
	Physician had not been notified of the impending			monitored to ensure the deficient			
	AMA discharge nor asked if the Physician would				practice will not recur, i.e., what		
	give a discharge order.				quality assurance programs w	ili be	
	Duning on intermi	on 0/16/24 at 12:00 the			put into place.		
	During an interview on 9/16/24 at 12:00 p.m., the DON indicated she remembered the Physician had				DON/Designes will review all		
come into the facility on 9/6/24 and was informed				DON/Designee will review all	v		
of the AMA discharge. The Physician was unable				non-traditional discharges dail	-		
				2 weeks then 3x week X 6 mo	ntΠ		
to recall what was said to him and the response he				Confirming that any residents	•		
gave. There was no documentation that indicated he was notified or the response after the			discharging AMA have done so				
	ne was notified or u	ne response arter the			per facility Policy and procedu		
	nouncauon.				The Administrator/designee w		
	The "Discharge Ac	ainst Medical Advise" policy			present a summary of the aud	11.5	
The "Discharge Against Medical Advice" policy, dated 9/14/20 and received from the Administrator				to the Quality Assurance	he		
				committee monthly for 6 mont			
as current, indicated the resident had a right to				Thereafter, if determined by the			
sign themselves out of the facility without the consent or order from the physician and would be				Quality Assurance committee,			
					auditing and monitoring will be	;	
discharged AMA. An AMA form must be signed. Once the resident has left the facility AMA, the				done quarterly and present			
				quarterly.			

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

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155469	B. WING		09/16/2024		
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART			STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		TE	COMPLETION
TAG	REGULATORY OR	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	facility is under no further obligation to the resident. All medications were to be returned to the pharmacy.						
					Date of Compliance 10/2/2024		
	This citation relates 3.1-12(a)(3)	to Complaint IN00442760.					

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