STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 00 B. WING	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00287410. Complaint IN00287410 - Substantiated. Federal/State deficiencies related to the allegations are cited at F660 and F846. Survey date: February 19, 2019 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census Bed Type: SNF/NF: 0 Total: 0 Census payor type: Medicare: 0 Medicaid: 0 Other: 0 Total: 0 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/22/19.	F 0000		
F 0660 SS=F 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			

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

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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	factors leading to preventable readmissions. 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			

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	agencies or other appropriate entities. (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 the discharge needs of each resident included identification of needs, the development of post-discharge care plans with the involvement of the Inter Disciplinary Team (IDT) and the resident and/or Responsible Parties, and lack of a discharge plan for each resident at the time of the facility closure for 4 of 4 residents reviewed for discharge planning (residents B,C,D	F 0660	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident discharged from the facility the receiving facility has details of the resident. how other residents having the	03/08/2019

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	and E). This deficient practice had the potential to affect the 76 of 76 residents discharged from the facility in a period of (7) days and resulted in psychosocial and emotional upset to residents and families. Finding includes: 1. The closed record for Resident B was reviewed on 2/19/19 at 9:12 a.m. Diagnoses included, but were not limited to, dementia, depressive episodes, high blood pressure, repeated falls, and osteoarthritis. The resident was discharged to another Long Term Care facility on 2/15/19. Resident B resided on a secured Dementia Unit at the time of discharge. A "Notice of Transfer or Discharge" notice for Resident B was reviewed. The notice was issued on 2/13/19. The transfer was to be effective on 2/15/19. The reason for the transfer/discharge was checked as "The facility ceases to operate." A "Summarization of Episode Note" was created on 2/15/19. The section for "Responsible Party" listed the resident's Physician's name. The "Next of Kin" section indicated "No Contacts Found." Family and/or Responsible Party names and numbers were noted in the medical record. There were no Discharge Planning Care Plans initiated. No Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge was to occur. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility was completed. There was no documentation of IDT		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents discharged from the facility have the potential to be affected what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Discharge checklist developed and policy reviewed and updated. See attachment 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; If a resident discharges the facility will utilize the discharge checklist and document IDT meeting and transfer details in the record. All discharges will be audited utlizing the checklist and discussed in QA for 6 months or until 90% compliance is reached by what date the systemic changes occur: 3/8/19	

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	involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. 2. The closed record for Resident C was reviewed on 2/19/19 at 10:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and insomnia. The resident was discharged to another Long Term Care facility on 2/14/19. Resident C resided on a secured Dementia Unit at the time of discharge. No Physician orders for Discharge were provided. A "Notice of Transfer or Discharge" paper for Resident C indicated the notice was issued on 2/13/19. The transfer was to be effective on 2/14/19. The reason for the transfer/discharge was checked as "The facility ceases to operate." There were no Discharge Planning Care Plans initiated. No Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge to occur. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility on 2/14/19 was completed. No documentation of IDT involvement in discharge planning or emotional support was present. No documentation of IDT involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. 3. The closed record for Resident D was reviewed on 2/19/19 at 10:37 a.m. Diagnoses included, but were not limited to, traumatic brain injury, intellectual disabilities, depressive disorder, anxiety, and aphasia (inability to speak). The resident as discharged to another Long Term Care			

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	facility on 2/12/19. Contact information was noted in the record. Contact and Responsible Party phone numbers were available in the record. No Physician orders for Discharge were provided. A "Notice of Transfer or Discharge" paper for Resident D indicated the notice was issued on 2/08/19. The transfer was to be effective on 2/12/19. The reason for the transfer/discharge was checked as "The facility ceases to operate." A Nursing Progress Note, dated 2/12/19 at 10:32 a.m., indicated the Resident and the Resident's Son were made aware of resident to be transferred to another Long Term Care facility. No Physician orders for Discharge were provided. There were no Discharge Planning Care Plans initiated. Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge to occur until 2/12/19. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility was completed. No documentation of IDT involvement in discharge planning or emotional support was present. No documentation of IDT involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. A "Summarization of Episode Note" was created on 2/12/19. The section for "Responsible Party" listed the resident's Physician's name. The "Next of Kin" section indicated "No Contacts Found." Contact information was available in the chart. 4. The closed record for Resident E was reviewed			

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	on 2/19/19 at 11:48 a.m. Diagnoses included, but were not limited to, anxiety disorder, left femur fracture, history of falling, convulsions, and high blood pressure. The resident was discharged home on 2/15/19. No Physician orders for Discharge were provided. There were no Discharge Planning Care Plans initiated. Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge to occur until 2/15/19. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility was completed. No documentation of IDT involvement in discharge planning or emotional support was present. No documentation of IDT involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. 5. Confidential interview with a family member of a discharged resident indicated they received a written letter in the mail on 2/11/19 or 2/12/19 indicating the facility would be contacting them for the purpose of discharge planning and notification that the facility would be closing 4/15/19. "We had just been told in the letter the date would be 4/15/19. No staff contacted us to ask our opinions. Upon arrival to visit on 2/15/19, staff informed us that the resident was supposed to be gone already and we were just in time because the bus was late. There were barely any staff to help. Residents were being moved by bus." Their family member had a diagnosis of dementia, never liked change, and was currently not handling the change very well at all.			

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	6. Confidential interview with a family member of a discharged resident indicated they received a "courtesy call" from the facility on Friday 2/8/19 indicating they had 2 months and "we sure didn't get that. We received that letter 2-3 days later and facility staff said all were being discharged." 7. Confidential interview with staff from one LTC (Long Term Care) facility which received some of the transferred residents indicated they were told to take the residents "as soon as you can" as it was on a "first come first serve basis." Discharging facility staff also informed them to bring enough staff to pack up the residents. "Our facility came to (Discharging Facility) a few days later per their request that we pick them up. We agreed to admit three residents to our facility. One other resident that we did not originally agree to pick up was present with the other three residents we had arranged to pick up. They requested that our staff take him also at that time. We agreed to accept the resident and made arrangements to have a CNA at our facility stay with him 1:1 upon his arrival, as he was very anxious and upset. He did seem to adjust after that, as our CNA was able to figure out some measures to comfort him. Medication orders were not sent for the residents. Our Medical Director was able to make emergency arrangements for the medications to be filled for these residents." 8. Confidential interview with LTC staff of a second receiving facility indicated the residents arrived in wheel chairs off the van with their items stuffed in plastic garbage bags. Some of these residents were scheduled to be admitted to the facility's locked Memory Care Unit. 9. Confidential interview with staff from a third LTC facility which received some of the			

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	transferred residents indicated the facility gave them referrals for residents. The discharging facility asked them if they could take the residents the next day. One female resident received was "upset" as she was told residents had up to 30 days, and that ended up being two days. The residents were missing items. The Staff member was not aware of any Inventory lists being sent. One family member indicated they were not aware of the transfer. 10. Confidential interview with staff from a fourth LTC facility which received some of the transferred residents indicated their facility offered to go the discharging facility to talk with residents and families to answer any questions they had. The discharging facility never responded. They also offered to come and make copies of records to have the resident information. They were told the charts would just be sent with the residents. Residents arrived on the discharging facility van with torn garbage bags of belongings. Resident medications were all together in one big cardboard box. Some of the medications were unusable and expired since 2017. One alert and orientated resident had a partially filled drink container get tossed in a bag with other things. It leaked all over and ruined some of his belongings. No clinical staff accompanied the residents, only the one male driver. A family member of a resident who had been discharged called this facility to see if his brother was there because he did not know where he went since he was discharged and the facility closed. This facility had also received many referral phone calls directly from and also made their own calls to other area facilities in attempts to assist families and residents in finding placement with adequate services to meet needs.			

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	11. Confidential interview with staff from a fifth LTC facility who received residents indicated their staff had gone to that facility to address intent to help with accepting residents if able. They spoke with residents and spoke with the family of a resident who expressed consent for their family member to be transferred to their facility. The discharging facility was aware of the above and transferred the resident to a different facility. The family member confirmed he had not been informed the resident was transferred to the other facility and was upset. The resident and Son requested transfer out of that facility to the facility she is currently residing. 12. Confidential interview with a 6th facility receiving staff indicated, when she spoke with the Social Services Director (SSD) from the discharging facility regarding referrals on 2/13/19, the SSD indicated the residents would not be discharged gradually before the 4/15/19 closing date, as Corporate had mandated the residents be gone by the end of the week. The receiving staff visited on 2/14/19 and assessed referred residents. The family of one of these residents had just toured & chosen this facility, however, staff at the discharging facility indicated, "we have picked another facility for her and don't want her coming to your facility," even though they were made aware the resident & family had already chosen. The residents were transported to the receiving facility on 2/15/19 by the discharging facility. No staff except the driver accompanied the residents or transferred their medications. Belongings were also brought in garbage bags & miscellaneous boxes by a U-Haul. This Federal tag relates to Complaint IN00287410. 3.1-12(a)(18)			

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F 0846 SS=F Bldg. 00	483.70(m) Facility Closure §483.70(m) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (l) of this section. Based on record review and interview, the facility failed to implement provisions to prepare residents to ensure a safe and orderly transfer from the facility related to not interviewing each resident and responsible party to determine discharge goals and needs, not offering each resident and responsible party adequate opportunity to obtain information regarding their community options including setting and location, not providing residents and responsible parties information pertaining to the quality of the providers and services available, and not making reasonable effort to accommodate residents goals, preferences and needs for discharge for 4 of 4 residents reviewed for discharge due to facility closure. (Residents B, C, D, and E) This deficient practice had the potential to affect the 76 of 76 residents discharged from the facility in a period of (7) days and resulted in psychosocial and emotional upset to residents and families. Findings includes: 1. The facility provided a Closure Plan to the Indiana State Department of Health via email on 2/8/19 at 3:37 p.m. The Closure Plan was to be effective as of 4/15/19. The final revised version was approved by ISDH on 2/18/19. The Administrator's duties and responsibility were to remain unchanged. The Administrator was responsible for providing all required notices of	F 0846	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident discharged from the facility recieving facility has recieved information to care for the resident. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents discharged from the facility have the potential to be affected what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Discharge checklist developed and policy reviewed and updated. See attachments how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	03/08/2019

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	the facility close and to ensure the Closure Plan was adhered to. Social Services or designee were required to identify possible settings that matched each resident's choice and ability to meet the individual's needs through conversations with residents and residents' legal guardians or responsible parties. Residents were to be discharged or relocated in a safe and orderly manner to the most appropriate settings. Written notices of the facility closure were sent out to residents and resident representatives via mail on February 8, 2019. An IDT meeting would be held with each resident and the resident's legal/responsible party to determined resident goals, preferences, and need for services, location and setting from which they could choose. The facility was to make a reasonable effort to accommodate each resident's goals, preferences, and needs regarding receipt of service, locations, and settings by following the Closure Plan. Upon entrance to the facility on 2/19/19 at 8:15 a.m., the Administrator informed the ISDH surveyor the last resident had been discharged from the facility on the previous day and the facility no longer had residents residing there. This was confirmed by the DON during the Entrance Conference. 2. The closed record for Resident B was reviewed on 2/19/19 at 9:12 a.m. Diagnoses included, but were not limited to, dementia, depressive episodes, high blood pressure, repeated falls and osteoarthritis. The resident was discharged to another Long Term Care facility on 2/15/19. Resident B resided on a secured Dementia Unit at the time of discharge. A "Notice of Transfer or Discharge" notice for		quality assurance program will be put into place; All discharges will have the discharge checklist utilized and all actions and IDT meeting will be documented in the record along with events of discharge. All discharges will be audited using the checklist and details will be discussed in the QA meeting for 6 months or until 90% compliance is reached by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not	

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	Resident B was reviewed. The notice was issued on 2/13/19. The transfer was to be effective on 2/15/19. The reason for the transfer/discharge was checked as "The facility ceases to operate." There were no Discharge Planning Care Plans initiated. Responsible Party/POA (Power of Attorney) contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge to occur. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility was completed. No documentation of Interdisciplinary Team (IDT) involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. 3. The closed record for Resident C was reviewed on 2/19/19 at 10:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and insomnia. The resident was discharged to another Long Term Care facility on 2/14/19. Resident C resided on a secured Dementia Unit at the time of discharge. No Physician orders for Discharge were provided. A "Notice of Transfer or Discharge" notice for Resident C was reviewed. The notice was issued on 2/13/19. The transfer was to be effective on 2/14/19. The reason for the transfer/discharge was checked as "The facility ceases to operate." There were no Discharge Planning Care Plans initiated. Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 00 B. WING	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

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	to occur. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility on 2/14/19 was completed. No documentation of IDT involvement in discharge planning or emotional support was present. No documentation of IDT involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. 4. The closed record for Resident D was reviewed on 2/19/19 at 10:37 a.m. Diagnoses included, but were not limited to, traumatic brain injury, intellectual disabilities, depressive disorder, anxiety, and aphasia(inability to speak). The resident was discharged to another Long Term Care facility on 2/12/19. Contact information was noted in the record. No Physician orders for Discharge were provided. A "Notice of Transfer or Discharge" notice for Resident C was reviewed. The notice was issued on 2/08/19. The transfer was to be effective on 2/12/19. The reason for the transfer/discharge was checked as "The facility ceases to operate." A Nursing Progress Note, dated 2/12/19 at 10:32 a.m., indicated the Resident and the Resident's Son were made aware of resident to be transferred to another Long Term Care facility. No Physician orders for Discharge were provided. There were no Discharge Planning Care Plans initiated. Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge to occur until 2/12/19. There was no documentation of the actual event of the discharge from the facility. No Nursing			

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	Assessment of the resident's condition at time of discharge out of the facility was completed. No documentation of IDT involvement in discharge planning or emotional support was present. No documentation of IDT involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. 4. The closed record for Resident E was reviewed on 2/19/19 at 11:48 a.m. Diagnoses included, but were not limited to, anxiety disorder, left femur fracture, history of falling, convulsions, and high blood pressure. The resident was discharged home on 2/15/19. No Physician orders for Discharge were provided. There were no Discharge Planning Care Plans initiated. Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge to occur until 2/15/19. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility was completed. No documentation of IDT involvement in discharge planning or emotional support was present. No documentation of IDT involvement in discharge planning to ensure discharge goals and needs or emotional support was rendered. 5. The closed record for Resident E was reviewed on 2/19/19 at 11:48 a.m. Diagnoses included, but were not limited to, anxiety disorder, left femur fracture, history of falling, convulsions, and high blood pressure. The resident was discharged home on 2/15/19. No Physician orders for Discharge were provided.			

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	There were no Discharge Planning Care Plans initiated. Responsible Party/POA contact information was noted in the record. No Nursing or Social Service progress notes were in place related to discharge information of date discharge to occur until 2/15/19. There was no documentation of the actual event of the discharge from the facility. No Nursing Assessment of the resident's condition at time of discharge out of the facility was completed. No documentation of IDT involvement in discharge planning or emotional support was present. No documentation of IDT involvement in discharge planning to ensure discharge goals, needs, and emotional support was rendered. The facility Closure Plan was sent to the Indiana State Department of Health on 2/8/19 at 3:37 p.m. A revised version was approved on 2/18/19. When interviewed on 2/19/19, the Director of Nursing indicated the notification of closure letters were mailed on 2/8/19 and the facility began a phone call list the same day. Several resident families/Responsible Party individuals wanted to be transferred right away as they feared other facilities in the city would fill up fast. The Director of Nursing indicated the last resident was transferred out yesterday. This Federal tag relates to Complaint IN00287410.			