

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/04/2016
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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00196279.</p> <p>Complaint IN00196279 - Substantiated. Federal/State deficiency related to the allegations is cited at F465.</p> <p>Survey dates: March 28, 29, 30, 31, April 1, 2, 3, &amp; 4, 2016</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type: SNF/NF: 106 Total: 106</p> <p>Census payor type: Medicare: 11 Medicaid: 83 Private: 4 Other: 8 Total: 106</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. <i>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.</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 0246 SS=D Bldg. 00	<p>Quaity review completed by 32883 on 4/6/16.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview, the facility failed to ensure a resident's call light was within reach for 1 of 1 random observations on the PCU unit. (Resident #168)</p> <p>Finding includes:  On 4/3/16 at 9:35 a.m., Resident #168 was observed in his room in bed. He was yelling out for staff requesting to be bathed. The resident's call light was observed on the floor tangled in the oxygen tubing on the side of the bed. Interview with the resident at the time, indicated he was unaware of where his call light was located. He further indicated that if the call light would have been in reach, he would have been able to</p>	F 0246	<p><b>F246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts</i></p>	04/22/2016

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	<p>press the call button for assistance. Observation at the time indicated the resident was able to press the call button for assistance.</p> <p>Interview with LPN #1 on 4/4/16 at 10:20 a.m., indicated the resident was alert and oriented and required assistance from staff with activities of daily living. The LPN also indicated the resident was able to use his call light for assistance.</p> <p>3.1-3(v)(1)</p>		<p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #168'S call light was untangled and placed within reach.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Facility verified that all call light were within the residents reach immediately.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Staff will be re-educated on proper placement of call lights by the DON/designee by 4/22/16. Call light placement will be checked during rounds by the Charge Nurses and Managers daily. Manager findings will be documented on the Daily Manager Rounds sheet and reviewed at the morning and afternoon</p>	

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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure follow up was completed for dental recommendations related to oral surgery for 1 of 3 residents reviewed for dental services of the 9 residents who met the criteria for dental services. (Resident #129)</p> <p>Finding includes:</p> <p>On 3/29/16 at 11:32 a.m., Resident #129 was observed propelling herself down the</p>	F 0250	<p>meetings.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The DON/designee will perform random audits for call light placement at least 3 times a week for 4 weeks and weekly thereafter to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p><b>F250 PROVISION OF MEDICALLY RALTED SOCIAL SERVICE</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	04/22/2016	

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	<p>hallway in her wheelchair. The resident was observed to have missing teeth on both the top and bottom of her mouth.</p> <p>The record for Resident #129 was reviewed on 3/31/16 at 11:13 a.m. A dental exam dated 7/8/15 indicated the resident was edentulous (having no teeth) on the top and had 4 teeth left on the bottom. The Doctor of Dental Surgery (DDS) recommendation indicated extraction of the remaining teeth and for the teeth to be replaced with dentures. The resident agreed.</p> <p>A dental referral dated 7/8/15 indicated, extraction of all remaining teeth. Continued review indicated the resident received an Oral Surgery exam on 7/22/15 and was to be sedated for the extractions.</p> <p>There was no documentation in the Progress Notes indicating the resident was scheduled for or received Oral Surgery as recommended.</p> <p>Interview with Social Service Employee #1 on 3/31/16 at 2:21 p.m., indicated the resident had not received Oral Surgery as recommended.</p> <p>3.1-34(a)</p>		<p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>An appointment with an oral surgeon was setup for Resident #129 on 4/21/16.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents who reside in the facility and utilize dental services have the potential to be affected by the alleged deficient practice. Dental recommendations were reviewed for the past 6 months to ensure recommendations were followed.</p> <p><b>3) Measures put into place/ System</b></p>	

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F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.		<p><b>changes:</b></p> <p>The Social Service Department/Unit Managers will be re-educated on following dental recommendations by the DON/designee by 4/22/16. All dental recommendations will be logged on the Dental Recommendations Log. The Dental Recommendations Log will be reviewed by the Social Service Director weekly to ensure timely follow with dental recommendations.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The Social Service Director/designee will complete the "Dental Services" CQI audit tools weekly x 4 weeks, the monthly ongoing thereafter for at least 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p>	

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	<p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded related to the use of antidepressants and episodes of wandering for 2 of 25 MDS assessments reviewed. (Residents #26 and #78)</p> <p>Findings include:</p> <p>1. The record for Resident #26 was reviewed on 3/30/16 at 9:04 a.m. The resident's diagnoses included, but were not limited to, major depressive disorder.</p> <p>A Physician's order dated 7/9/15 and listed on the March 2016 Physician's</p>	F 0278	<p><b>F278 ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute</i></p>	04/22/2016

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	<p>Order Summary (POS), indicated the resident was to receive Zoloft (an antidepressant) 50 milligrams (mg) daily.</p> <p>The March 2016 Medication Administration Record (MAR), indicated the resident received the Zoloft daily from 3/1-3/29/16.</p> <p>A Quarterly Minimum Data Set (MDS) assessment was completed on 3/7/16. Review of Section N - Medications, indicated the resident had not received an antidepressant within the past seven days.</p> <p>Interview with the MDS Coordinator on 4/4/16 at 1:50 p.m., indicated the resident's MDS was not coded correctly related to the use of the antidepressant.</p> <p>2. The record for Resident #78 was reviewed on 3/31/16 at 2:24 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance and psychosis.</p> <p>An Annual Minimum Data Set (MDS) assessment was dated 12/28/15. Review of Section E - Behaviors, indicated the resident had episodes of wandering for 1-3 days and wandering placed the resident at significant risk of getting to a potentially dangerous place.</p>		<p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #26 and #78 – Modification of MDS has been completed.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Most recent MDS completed in the last 30 days will be reviewed to ensure accurate documentation was completed. If any discrepancies are noted an MDS modification will be submitted as indicated.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>The DON/designee will audit at least 3 MDS per week completed in the prior 7 days to ensure accurate</p>				

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F 0280 SS=D Bldg. 00	<p>Interview with the Social Service Employee #1 on 4/4/16 at 9:45 a.m., indicated the resident had episodes of wandering on the midnight shift on 12/25/15 and 12/29/15. Continued interview at the time, indicated the MDS was coded incorrectly related to wandering to a potentially dangerous place.</p> <p>3.1-31(i)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>		<p>documentation prior to submission. Results of the audit will be documented on the Quality Assurance Worksheet – MDS Accuracy form. If any discrepancies are noted corrections will be made prior to submission.</p> <p><b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months</p>	

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	<p>Based on interview and record review, the facility failed to ensure the resident and/or the resident's responsible party were invited to care plan conferences for 1 of 3 residents reviewed for participation in care planning of the 5 residents who met the criteria for participation in care planning. (Resident #25)</p> <p>Finding includes:</p> <p>Interview with Resident #25 on 3/29/16 at 9:33 a.m., indicated that she was not invited to her care plan conference.</p> <p>The record for Resident #25 was reviewed on 3/31/16 at 10:19 a.m. The resident had a Quarterly Minimum Data Set (MDS) assessment which was completed on 3/7/16.</p> <p>There was no documentation in the Social Service or Nursing progress notes to indicate the resident or Responsible Party was invited to her care plan meeting after the completion of the Quarterly MDS assessment.</p> <p>Review of the resident's profile sheet indicated a cousin was listed as the resident's Emergency Contact.</p> <p>Interview with the Social Service Assistant on 4/4/16 at 12:50 p.m.,</p>	F 0280	<p><b>F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>The facility will initiate a Care Plan meeting for Resident #25.</p> <p><b>2) How the facility identified other residents:</b></p>	04/22/2016	

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	<p>indicated resident families were notified of care plan meetings by letter. They were given a seven day window and they could pick a date that worked best for them. If the resident was alert and oriented and their own responsible party, then Social Service staff would personally invite the resident.</p> <p>Further interview with the Social Service Employee #1 at 1:45 p.m., indicated the resident and/or her responsible party were not notified of the care plan meeting that was scheduled in March.</p> <p>3.1-3(n)(3) 3.1-35(c)(2)(C)</p>		<p>All residents who reside at the facility have the potential to be affected by the same alleged deficient practice. The facility has reviewed the care plan conference schedule to ensure that the resident/family was invited to the conference with no negative findings.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>The facility is providing Care Plan Invitations to the resident/responsible party two weeks prior to the care plan conference. A copy of the invitation is kept on file with the date mailed. Social Services/designee will follow up with the resident/responsible party when a care plan meeting is not scheduled. Documentation of the follow up with will entered in the medical record.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The Plan of Care Notification Quality Assurance Worksheet will be completed weekly x 4 weeks, the monthly ongoing thereafter for at least 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p>		

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure pain medications were available for a resident with a history of pain for 1 of 3 residents reviewed for pain recognition and management of the 3 residents who met the criteria for pain recognition and management. (Resident #102)</p> <p>Finding includes:</p> <p>Interview with Resident #102 on 3/29/16 at 11:06 a.m., indicated that he was in pain and that he had not had any pain medication since Friday (3/25/16). The resident was observed to grimace when he repositioned himself in his chair.</p> <p>The record for Resident #102 was reviewed on 3/30/16 at 11:23 a.m. The resident's diagnoses included, but were not limited to, osteoporosis, muscle weakness and neuropathy.</p> <p>A Physician's order dated 2/23/16,</p>	F 0309	<p><b>F309 PROVE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p>	04/22/2016			

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	<p>indicated the resident was to receive Norco (a pain medication) 5-325 milligrams (mg) one tablet every 4 hours for pain.</p> <p>An entry in the Nursing progress notes dated 3/24/16 at 5:49 p.m., indicated a prescription was needed for the Norco.</p> <p>On 3/25/16 at 4:21 a.m., documentation in the Nursing progress notes indicated the Norco could not be given because staff were waiting for it to be delivered. At 8:37 a.m. and 12:19 p.m., documentation indicated a prescription was needed for the Norco. At 8:33 p.m., documentation indicated the medication was on order. At 8:37 p.m., documentation in the Nursing progress notes indicated the resident was upset because he was not receiving his Norco medication as ordered. The Pharmacy was called and indicated the resident needed a script from the doctor, the resident was informed.</p> <p>Documentation in the Nursing progress notes on 3/26/16 at 1:33 a.m. and 3:22 a.m., indicated the medication was on back order. At 8:23 p.m., documentation indicated the facility was waiting for Pharmacy to deliver the medication.</p> <p>On 3/27/16 at 12:14 a.m., 6:25 a.m. and</p>		<p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #102 was assessed for pain and was received and given as ordered.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents who reside at the facility and receive pain medications have the potential to be affected by the same alleged deficient practice. An audit was completed on all residents who receive a narcotic medication to ensure their medications were available with no negative findings.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Nurses will be reeducated on Addressing Pain/Pain Medication Availability by the DON/designee by 4/22/16. The DON/designee will complete the Medical Available/Administered as Ordered Quality Assurance Worksheet 5 x a week 8 weeks and then weekly thereafter.</p> <p><b>4) How the corrective actions will be monitored:</b></p>	

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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
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	<p>12:09 p.m., documentation in the Nursing progress notes indicated the Pharmacy needed a prescription from the Physician for the Norco.</p> <p>On 3/28/16 (four days later) at 1:24 p.m., the Physician was contacted to fax a signed prescription to the Pharmacy. The resident was notified at this time.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated 2/15/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact for decision making. The assessment indicated the resident was on a scheduled pain medication regimen, had pain in the last five days that was almost constant and made it hard for him to sleep at night. The resident's pain scale was coded as a "10."</p> <p>Interview with the Director of Nursing on 4/4/16 at 12:54 p.m., indicated the resident's Physician had not been contacted until 3/28/16 in relation to getting the resident something for pain. She also indicated the Physician should have been contacted in a more timely manner.</p> <p>3.1-37(a)</p>		<p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p>		

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F 0356 SS=C Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the</p>	F 0356	<b>F356 POSTED NURSE STAFFING INFORMATION</b>	04/22/2016
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	<p>daily staffing pattern was posted at the Main Entrance at the beginning of the shift.</p> <p>Finding includes:</p> <p>On 3/28/16 at 7:46 a.m., the facility staffing sign posted at the Main Entrance was dated for Saturday 3/26/16.</p> <p>On 4/1/16 at 8:35 a.m., the facility staffing sheet located at the Main Entrance was dated 3/31/16.</p> <p>On 4/3/16 at 12:05 p.m., the facility staffing sheet located at the Main Entrance was dated 4/2/16.</p> <p>Interview with the Administrator on 4/4/16 at 8:00 a.m., indicated the day shift started at 6:00 a.m., and the facility staffing sheet should be posted at that time and be current.</p> <p>3.1-17(a)</p>		<p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>No residents were identified as affected. The staffing sheet was posted past the desired time.</p> <p><b>2) How the facility identified other residents:</b></p> <p>No residents were affected by the</p>		

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F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug		alleged deficient practice. Staffing sheets are posted daily.  <b>3) Measures put into place/ System changes:</b>  The Nursing Scheduler/Nurses will be re-educated on the posting procedure by the DON/designee by 4/22/16. The night nurse will post the Staffing Sheet at the end of the night shift daily.  <b>4) How the corrective actions will be monitored:</b>  The DON/designee will audit the staffing sheets posted at least 5 x weekly to ensure that the staffing sheet is posted and reflects any changes as indicated. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.		

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	<p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure multi-dose vials of medication were dated when opened on 1 of 3 units. (The PCU Unit)</p> <p>Finding includes:</p> <p>On 3/29/16 at 1:29 p.m., a vial of Influenza vaccination was opened and not dated. A vial of Lantus insulin was also</p>	F 0431	<p><b>F 431 DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of</i></p>	04/22/2016

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	<p>observed to be opened and not dated. Both medications were observed in the Medication refrigerator in the PCU Unit Medication Room.</p> <p>Interview with LPN #2 at that time, indicated the multi-dose vials should be dated after opening.</p> <p>The current Medication Storage, Labeling and Expiration Dates policy was provided by the Director of Nursing (DON) on 3/29/16 at 2:46 p.m. The policy indicated, facility staff should record the date opened on the medication container when the medication had a shortened expiration date once opened.</p> <p>Interview with the DON on 3/29/16 at 3:38 p.m., indicated the multi-dose vial of insulin and the influenza should have been dated after opening.</p> <p>3.1-25(j)</p>		<p><i>compliance.</i></p> <p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>The bottle of Flu Vaccine was discarded immediately. The opened and not dated bottle of Lantus was labeled for the date it was delivered to the facility which was 3/28/16.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents who receive insulin have the potential to be affected by the alleged deficient practice. All medication carts were checked to verify that all insulins were dated and current.</p> <p><b>3) Measures put into place/</b></p>		

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F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program		<b>System changes:</b>  Nurses were re-educated regarding proper labeling and storage of multi dose vials of medications by the DON/designee. System in place for night nurse to check insulin dates daily.  <b>4) How the corrective actions will be monitored:</b>  The DON/designee will perform random audit of medication carts at least 2x/week x 30 days, then weekly thereafter to ensure compliance. Findings will be documented on the Medication Labeling/Expiration Audit Quality Assurance Worksheet. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.		

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	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview the facility failed to ensure residents' clothing and linens were stored properly related to clothing and linens being stored on the floor of the residents' bedroom closet for 1 of 16 rooms observed on the North Hall. (Room #124)</p> <p>Finding includes:  On 3/29/16 at 2:02 p.m., Room #124 was</p>	F 0441	<p><b>F441 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of</i></p>	04/22/2016

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	<p>observed, the closet was in disarray and there was clothing and linen stored on the bedroom closet floor. Two residents shared this closet.</p> <p>On 3/31/16 at 4:00 p.m., Room #124 was observed, the closet was in disarray and there was clothing and linen stored on the bedroom closet floor. Two residents shared this closet.</p> <p>On 4/4/16 at 2:00 p.m., Room #124 was observed, the closet was in disarray and there was clothing and linen stored on the bedroom closet floor. Two residents shared this closet.</p> <p>Interview with the Director of Nursing on 4/4/16 at 2:07 p.m., indicated she was aware there was a concern related to resident's bedroom closets being overfilled with clothing and other items. Observation at the time indicated the residents' closet was in disarray. There was clothing and linen stored, stacked, and piled high on the floor. The Director of Nursing (DON) indicated she would have the closet cleaned by Housekeeping.</p> <p>3.1-19(g)(4)</p>		<p><i>compliance.</i></p> <p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Room 124's closet was cleaned immediately.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents that reside in the facility have the potential to be affected by the alleged deficient practice. Managers assigned to Angel Rounds completed rounds and checked closets throughout the facility.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>All staff will be re-educated on the</p>		

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F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred and gouged walls, cracked, discolored, and scuffed floor tile, a cracked face plate, a broken vent register, garbage and trash on floors, and garbage cans without any garbage bags, on 4 of 4 units	F 0465	facility Infection Control Program by the DON/designee by 4/22/16. C.N.A.'s and Laundry staff will check closets daily for infection control issues.  <b>4) How the corrective actions will be monitored:</b>  Managers make Angel Rounds twice daily and will check the closets and will document findings on the Daily Manager Rounds checklist. The checklists will be reviewed and negative findings will be corrected. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.  <b>F465 SAFE/FUNCTIONAL/SANITARY /CONFORTABLE ENVIRONMENT</b>  <b>The facility requests paper</b>	04/22/2016

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	<p>throughout the facility. (North Unit, Secure Care Unit, South Unit, PCU Unit)</p> <p>Findings include:</p> <p>An Environmental Tour was completed on 4/4/16 at 8:20 a.m. with the Environmental Supervisor, the Director of Maintenance, and the Administrator. The following was observed:</p> <p>1. North Unit:</p> <p>a. Room 104: On 3/28/16 at 10:07 a.m., garbage was observed on the room floor. There was no garbage bag in the garbage can. There was garbage on the floor at the time of the tour. Two residents resided in this room.</p> <p>b. Room 123: The electrical outlet face plate was cracked. Two residents resided in this room.</p> <p>c. Room 124: The wall behind bed 2 was marred. Two residents resided in this room.</p> <p>d. Room 125: There was a purple sticky substance observed on the floor on 3/28/16 at 10:32 a.m. and at the time of the tour. Two residents resided in this room.</p> <p>e. Room 127: On 3/29/16 at 9:51 a.m.</p>		<p><b>compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Garbage cans were placed in Room 104.</p> <p>The electrical outlet face place in Room 123 was replaced immediately.</p> <p>The marred wall in Room 124 was repaired.</p> <p>The floor in Room 125 was cleaned.</p> <p>The floor in Room 127 was cleaned.</p> <p>The care plan for this resident was updated to reflect the resident's</p>		

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	<p>and again at the time of the tour, trash was observed on the floor around the resident's bed. One resident resided in this room.</p> <p>f. Room 131: The bathroom wall was scratched and marred. The right arm of the wheelchair, belonging to the resident in bed 1, was frayed and cracked. Two residents resided in this room.</p> <p>2. Secure Care Unit:</p> <p>a. Room 204: The bathroom floor tile was discolored and lifting around and near the toilet. Two residents resided in this room.</p> <p>3. South Unit:</p> <p>a. Room 213: The bathroom wall was marred and the tile was discolored. One resident resided in this room.</p> <p>b. Room 216: The bathroom floor tile was discolored and scuffed. Two residents resided in this room.</p> <p>c. Room 219: The bathroom wall was marred and the floor tile was discolored and scuffed. Two residents resided in this room.</p> <p>d. Room 221: The bathroom floor tile was cracked, discolored, and scuffed. Two residents resided in this room.</p>		<p>non-compliance with disposing of her trash.</p> <p>The bathroom wall and the wheelchair arm in Room 131 was repaired.</p> <p>The bathroom floor tile was repaired in Room 204.</p> <p>The bathroom was and floor tile was repaired in Room 213.</p> <p>The bathroom floor tile was repaired in Rooms 216, 219, 221 and 222.</p> <p>The register vent was replaced in Room 301.</p> <p>The wall behind the bed in Room 307-1 was repaired.</p> <p>The floor was cleaned in Room 308 and trash liners were added to the trash can.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Managers assigned to Angel Rounds completed rounds on their room and noted any negative findings on the Daily Manager Rounds Checklist.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/04/2016
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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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	<p>e. Room 222: The bathroom floor tile was discolored. Two residents resided in this room.</p> <p>3. PCU Unit:</p> <p>a. Room 301: The register vent was broken. The bathroom wall was marred. Two residents resided in this room.</p> <p>b. Room 307: The wall behind bed 1 was gouged. Two residents resided in this room.</p> <p>c. Room 308: On 3/29/16 at 10:32 a.m., 3/29/16 at 1:25 p.m., and at the time of the tour, garbage was overflowing and there were not any garbage bags in the trash can. Two residents resided in this room.</p> <p>At the time of the tour, the Environmental Supervisor, the Director of Maintenance, and the Administrator all agreed all areas were in need of repair or replacement.</p> <p>This Federal tag relates to Complaint IN00196279.</p> <p>3.1-19(f)</p>		<p><b>3) Measures put into place/ System changes:</b></p> <p>All staff will be educated on the use of the Maintenance Request Form by the DON/designee by 4/22/16. Angel Rounds will be completed by managers and they will document on the Daily Manager Rounds Checklist daily areas needing repairs. The sheets will be reviewed daily in the morning and afternoon meetings and Maintenance Requests will be completed. The Administrator will review the Maintenance Requests daily with the Maintenance Department to ensure repairs are completed.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The Administrator/designee will complete the Environment Quality Assurance Worksheet on 5 rooms weekly x 8 weeks and monthly ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p>	

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

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