STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155166		05/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE & REHABILITATION	606 WALL ST VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00199596 and IN00200104. Complaint IN00199596 - Substantiated. Federal/State deficiency related to the allegations is cited at F282. Complaint IN00200104 - Substantiated. Federal/State deficiency related to the allegations is cited at F323. Survey Dates: May 11, 12, and 13, 2016. Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census bed type: SNF/NF: 127 Total: 127 Census payor type: Medicare: 13 Medicaid: 102 Other: 12 Total: 127 Sample: 6 These deficiencies reflect State findings	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.**	

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 determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 5/16/16.			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow Physician's Orders and care plans, related to blood sugar monitoring and insulin administration, for 1 of 6 residents reviewed for Physician's Orders and care plans in a total sample of 6. (Resident #G) Finding includes: Resident #G's record was reviewed on	F 0282	**F282 – Services by Qualified Persons/Per Care Plan** It is the practice of this provider that all services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those**	06/03/2016

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	5/13/16 at 11:25 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. A care plan, dated 1/14/16, indicated the resident was at risk for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) related to the use of glucose lowering medication. The approaches included, labs as ordered, medications as ordered, and observe blood sugars as ordered. A Physician's Order, dated 4/16/16, indicated to administer Novolog (insulin) by sliding scale (units given by blood sugar levels) every six hours. The order indicated no insulin was to be administered if the resident's blood sugar was 150 or less and blood sugar monitoring was to be done at 12 p.m., 6 p.m., 12 a.m., and 6 a.m. A Medication Administration Record (MAR), dated 4/2016, indicated on 4/20/16 at 12 p.m. the MAR was left blank, which indicated no blood sugar was obtained and no insulin was given and 4/27/16 at 12 a.m., the resident's blood sugar was 142 and 2 units of Novolog was administered. A MAR, dated 5/2016, indicated on 5/3/16 at 12 a.m., the resident's blood		**residents found to have been affected by the deficient practice:** Resident #G's physician and family have been updated regarding his blood sugar results and insulin administration. This resident has been receiving medications, accuchecks and insulin administration per physician's order. **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 with orders for and care plans related to blood sugar monitoring and insulin administration have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team to identify all residents with orders for and care plans related to blood sugar monitoring/accuchecks, routine insulin administration and sliding scale insulin administration. Physician Orders will be reviewed to ensure that all orders related to blood sugar monitoring and insulin administration have been transcribed correctly. All Medication Administration Records will be reviewed to ensure that all ordered blood sugar monitoring/accuchecks, insulin administration and sliding	

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	sugar was 150 and 2 units of Novolog was administered. During an interview on 5/13/16 at 12:25 p.m., the Director of Nursing indicated the wrong dose of insulin was administered on 4/27/16 and 5/3/16 and the blood sugar was not obtained on 4/20/16. A facility policy, dated 2/2015, and received as current from the Director of Nursing, titled, "Blood Glucose Monitoring", indicated, "...Blood glucose results will be documented on the the Capillary Blood Glucose Monitoring Tool or on the medication administration record." This Federal Tag relates to complaint IN00199596. 3.1-35(g)(2)		scale insulin has been recorded and administered per resident specific physician's order. Any errors and/or discrepancies noted will immediately be corrected and promptly reported to physicians and responsible parties. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All physician orders for new admission and re-admission will be reviewed by two licensed nurses and signed by both nurses to verify accuracy in transcription of medications including insulin orders. The IDT/Nurse Management Team and/or Weekend Manager will review new physician orders daily to ensure all have been accurately transcribed to the E-MAR and updated as needed to the care plan. The DNS/Nurse Management Team and/or Weekend Manager will be responsible for daily review of the Medication Administration Record to ensure that all medications including insulin, blood sugar monitoring/accuchecks, insulin administration and sliding scale insulin have been recorded and administered per physician's order. A nursing in-service will be conducted on or before 6/3/16 by the DNS/designee. This in-service will include review of	

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			the policy related to medication administration, documentation, transcription of physician's orders and following physician's orders and resident specific care plans. **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:** Ongoing compliance with this corrective action will be monitored through the facility CQI Program. The DNS/designee will be responsible for completion of the CQI Tool titled, "MAR/TAR Review" daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 6/3/16.	
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview,	F 0323		06/03/2016

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	the facility failed to ensure a resident received adequate supervision and assistive devices to prevent accidents, which resulted in injuries from the falls that required sutures and hospitalization for the injuries for 1 of 3 residents reviewed for falls in a total sample of 6. (Residents #D) Finding includes: Resident #D's record was reviewed on 5/12/16 at 11 a.m. The resident's diagnoses included, but were not limited to, dementia with behaviors and Parkinson's disease. A Significant Change MDS (Minimum Data Set) assessment, dated 1/7/16, indicated the resident's cognition was moderately impaired, required extensive assistance of two staff for transfers, extensive assistance of one staff for ambulation, was a risk for falls, and had two falls without injury and one fall with injury since the last review. A care plan, dated 3/23/15 and reviewed on 1/14/16, indicated the resident was at risk for falls due to unsteady gait/standing balance, poor safety awareness, and had a history of falls. The approaches included, (3/11/16) self release belt with alarm while in		**F323 – Free of Accident Hazards/Supervision/Devices** It is the practice of this provider that each resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #D has been discharged from the facility. **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 who have been identified as being at risk for falls have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team to review all resident fall care plans. Each resident's fall care plan will be reviewed for accuracy and appropriateness to ensure safety interventions and fall prevention interventions are in place and being utilized per each resident's plan of care. Updates and	

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	wheelchair and (2/17/16) place in standard chair with alarm in dining room for meals. A Physician's Order, dated 2/18/16, indicated stationary chair alarm while in dining room, check function and placement and 3/11/16 - alarming self release seatbelt while up in wheelchair for reminder to seek assistance prior to independent transfer. A Nurses' Progress Note, dated 3/30/16 at 6:15 p.m., indicated, "res (resident) noted in west wing lounge at the table eating dinner, While (sic) writer was feeding another resident, writer suddenly heard a loud thump, writer turned back and observed res lying on the floor sideways, writer went to help res and noted bleeding from a laceration to L (left) side of head immediately applied pressure to site, neuro checks initiated, res eyes partially open but not responding to verbal stimuli. 911 called." The Hospital History and Physical, dated 3/31/16, indicated a CT of the head showed a left frontal cortical and intraparenchymal (left front of the skull) hemorrhage. A Hospital Neurosurgical Consult, dated 3/31/16, indicated the resident had a left		changes will be initiated as indicated. The Nurse Management Team will then conduct safety inspections of each resident's living environment to ensure safety and fall prevention interventions are in place and being properly utilized per the plan of care. All new admissions, re-admissions and residents with change in condition or change in safety needs will be identified for fall risk and individualized fall and safety precautions will be initiated by IDT based on identified need and communicated to all direct care staff. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee, Charge Nurses and/or Weekend Nurse Manager will be responsible for environmental inspections on all shifts of all resident rooms, living areas and safety equipment to ensure fall prevention interventions are in place and being properly utilized per the resident specific plan of care as well as adequate supervision when indicated. An all staff in-service will be conducted on or before 6/3/16. The DNS/designee is responsible for conducting this in-service and will review the facility Fall	

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	frontal lobe contusion. The note indicated the area was a very small contusion area of the brain. The impression indicated there was a small cerebral contusion and no surgery was needed. A Progress Note, dated 4/18/16, indicated the resident received three sutures in the Emergency Room to close the laceration of the head. The Fall Investigation, indicated a statement was received and signed by CNA #1 on 3/30/16, "I was in the dining area feeding a res with myself facing the res. I heard a loud noise and turned around to see what it is (sic) was. The res was on the floor. A nurse that was in the dining area also went to his aid." A statement received and signed by RN #2, dated 3/30/16, indicated, "res was @ west lounge @ table eating dinner while I was feeding another resident, I heard a loud thump. I turned back and observed res was on the floor...laceration to L side of head...was not responding to verbal stimuli." A statement signed by CNA #3 (assigned to resident #D), dated 3/30/16, indicated, "I was feeding (resident name)...(resident #D name) was roaming in his w/c (wheelchair). I saw no reason to put him		Management Program. This in-service will also include review of the importance of strict adherence to established care plans regarding resident specific fall and accident prevention interventions. Staff will be re-educated on the importance of providing adequate supervision to residents when indicated to prevent falls and accidents as well as appropriate use of individual assistive devices when identified on the plan of care. **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:** This corrective action will be monitored through the facility CQI Program. The DNS/designee will be responsible for completion of the CQI Tool titled, “Fall Management” daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date: 6/3/16.	

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	in a chair with the risk of falling when his tray wasn't here yet." The Fall Investigation, dated 3/30/16, indicated the resident had remained in the wheelchair in the West Lounge at dinner time and had not been seated in a stationary chair with the alarm on the chair. The Investigation indicated the self-release alarm belt was not on the resident at the time of the fall. During an interview on 5/12/16, the Director of Nursing (DON), indicated the self-release belt was not on the resident because he was up at the table. The DON indicated the resident's care plan approach and Physician's Order was to sit the resident in a stationary chair with an alarm when at the table for meals. During an interview on 5/12/16 at 1:30 p.m., the DON indicated CNA #3 had not placed the resident in the stationary chair because the resident was still roaming around in the wheelchair. The DON acknowledged the self-release belt alarm was not on the resident and if the resident was still in the wheelchair roaming around the self-release belt alarm was to be on the resident. A facility policy, dated 2/2015, titled, "Fall Management Program", received			

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	from the DON as current, indicated, "...A care plan will be developed at time of admission specific to each resident's fall risk factors. 4. The resident specific care requirements will be communicated to the assigned caregiver..." This Federal Tag relates to complaint IN00200104. 3.1-45(a)(2)			