

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2016
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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00195996, IN00196896, IN00197683, and IN00197791.</p> <p>Complaint IN00195996 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F225, F226, F241, F282, F323, and F325.</p> <p>Complaint IN00196896 - Substantiated. Federal/State deficiencies related to the allegations are cited at F167, F241, F312, F323, and F356.</p> <p>Complaint IN00197683 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250, F282, F312, F323, and F505.</p> <p>Complaint IN00197791 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F241, F312, and F323.</p> <p>Survey dates: April 18, 19, 20, & 21, 2016</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p>	F 0000		
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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 0157 SS=D Bldg. 00	<p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 9 Medicaid: 59 Other: 23 Total:91</p> <p>Sample: 20</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completd by 32883 on 4/26/16.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician</p>			

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	<p>intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's family was notified of the resident's fall in a timely manner for 1 of 3 residents reviewed for fall in a sample of 20. (Resident #V)</p> <p>Finding includes:</p> <p>On 4/21/16 at 7:50 a.m., Resident #V was observed in wheelchair in the unit Dining Room. There were anti-tippers to the rear wheels of the wheelchair. A</p>	F 0157	<p>The facility requests paper compliance for this citation.</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</i></p>	05/11/2016

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	<p>personal alarm was also in place.</p> <p>The record for Resident #V was reviewed on 4/21/16 at 8:25 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, a history of falling, muscle weakness, and an irregular heart rhythm.</p> <p>The 2/12/2016 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive skills were severely impaired. The assessment also indicated the resident required extensive assistance of one staff member for bed mobility and transfers and had two or more fall since the last quarterly assessment.</p> <p>Review of the 4/2016 Progress Notes indicated an entry was made by Nursing on 4/19/16 at 1:45 a.m. The entry indicated the resident was found sitting on the floor and did not remember how she got there. The entry did not indicate the family was notified of the the fall.</p> <p>When interviewed on 4/21/16 at 10:45 a.m. the Director of Nursing indicated the family should have been notified of the fall on the midnight shift.</p>		<p><i>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>1) Immediate actions taken for those residents identified:</p> <p>Resident family was notified of this event timely on 4/19/2015 by nursing. Documentation of family acknowledgement of notification was presented to surveyor.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed of falls in the past 30 days to identify any other affected residents. Facility has notified any families of any events found in non-compliance with timely notification.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed staff were in-serviced on</p>				

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F 0167 SS=E Bldg. 00	<p>The facility policy titled "Physician/Family/Responsible Party Notification" was reviewed on 4/18/16 at 7:00 p.m. The policy had a revised date of 10/2015. The Director of Nursing provided the policy and verified it was current. The policy indicated medical care problems were to be communicated to the family/responsible party in a timely and efficient manner.</p> <p>This Federal tag relates to Complaints IN00195996.</p> <p>3.1-59(a)(1)</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available</p>		<p>notification guidelines. Each new fall occurrence will be reviewed during clinical meetings 5x/week to ensure timely notification of responsible party was completed. Any non-compliance will be addressed with additional education and/or disciplinary action as indicated. Assistant Director of Nursing/designee will be responsible for oversight of this process.</p> <p>4) How the corrective actions will be monitored:</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> <p>5) Date of compliance:</p> <p>5/11/2016</p>		

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	<p>for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure the most recent surveys were posted in the Survey Book .</p> <p>Finding includes:</p> <p>On 4/19/16 at 2:00 p.m. the Survey Results binder at the front desk was reviewed. The results of the following Surveys were not located in the Survey book.</p> <p>Complaint Investigation concluded on February 3, 2016.</p> <p>Complaint Investigation concluded on December 1, 2015.</p> <p>Complaint Investigation concluded on November 10, 2015.</p> <p>When interviewed on 4/19/16 at 2:00 p.m., the facility Administrator and the Director of Nursing indicated the Survey Reports should have been located in the Survey Binder.</p> <p>This Federal tag relates to Complaint IN00196896.</p> <p>3.1-3(b)(1)</p>	F 0167	<p>The facility requests paper compliance for this citation.</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>1) Immediate actions taken for those residents identified:</p> <p>No residents were identified in this allegation.</p> <p>2) How the facility identified other residents:</p> <p>All residents and visitors have the potential to be affected by this</p>	05/11/2016

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			<p>alleged deficient practice. This Facility's Survey Results Book is readily accessible to all residents and visitors at the main reception area. This Facility has had no noted concerns from residents or families related to this information not being in the Survey Book.</p> <p>3) Measures put into place/ System changes:</p> <p>The Survey Results Book was reviewed by the Executive Director. The Book was updated with complete survey information.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Executive Director/designee will audit the Survey Results book weekly x 4 weeks and monthly on-going to assure recent survey information is available, and that the Survey Book remains in the designated reception desk area.</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 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in</p>		<p>5) Date of compliance: 5/11/2016</p>		

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	<p>progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure misappropriation of property of medication did not occur related to missing narcotics noted for a resident for 1 of 2 allegations of misappropriation of property reviewed. (Resident #B)</p> <p>Finding includes:</p> <p>The record for Resident #B was reviewed on 4/20/16 at 11:45 a.m. The resident's diagnoses included, but were not limited to, palliative care, chronic ischemic heart disease, anxiety, Parkinson's disease, and depression.</p> <p>Review of the 3/9/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). A score of (6) indicated the resident's cognitive patterns were severely impaired. The assessment indicated the resident had received scheduled pain medications five</p>	F 0225	<p>The facility requests paper compliance for this citation.</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>1) Immediate actions taken for those residents identified:</p> <p>Facility self-identified this event and did an incident report to the ISDH</p>	05/11/2016			

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	<p>days during the reference period.</p> <p>The current Physician orders were reviewed. An order was written on 6/8/2015 for the resident to receive Norco 5-325 milligrams tablets twice a day at 8:00 a.m. and 8:00 p.m.</p> <p>A reported incident occurrence was reviewed on 4/20/16. The incident occurred on 3/17/16. The incident indicated the Nursing Supervisor was informed by an LPN that she thought some Morphine tablets might be missing for Resident #B. The LPN reported there were no Hydrocodone tablets or any narcotic count sheet in the book for the ordered Hydrocodone. The Hospice service was contacted and indicated they delivered 60 tablets on 3/11/16 and the Pharmacy was called and confirmed the delivery. The local Police were notified and all licensed Nurses and QMA's were called in to be drug tested with negative results. RN #3 did not return the facility calls and did not come back to work. RN #3 was the last one who signed out the Hydrocodone prior to it being reported missing.</p> <p>When interviewed on 4/20/16 at 11:40 a.m., the Director of Nursing indicated RN # 3 never came back to the facility. The Director of Nursing indicated a total</p>		<p>and ISNAP. Investigation noted no adverse effects from this event.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed of narcotic medications to assure that medication count and MAR documentation were in agreement. No other non-compliance was noted.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff was educated on misappropriation and guidelines for reporting. System of verifying actual narcotic counts as well as count of packaging units per narcotic was established. Licensed Nursing Staff and Q.M.A.'s were educated on the narcotic verification process.</p> <p>4) How the corrective actions will be monitored:</p> <p>Initial weekly reviews of all narcotic medications for 6 weeks were conducted with no further findings of non-compliance. The Director of Nursing/designee will continue to conduct audits of at least 3 residents</p>				

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F 0226 SS=D Bldg. 00	<p>of (51) Hydrocodone pills were unaccounted for. The Director of Nursing indicated the Police were notified again when the RN did not respond to facility calls.</p> <p>This Federal tag relates to Complaints IN00195996 and IN00197791.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews the facility failed to ensure misappropriation of property of medication did not occur related to missing narcotics noted for a resident for 1 of 2 allegations of misappropriation of property reviewed. (Resident #B)</p>	F 0226	<p>per week receiving narcotic medications. The facility Pharmacy consultant will also verify narcotics monthly and submit report to the Director of Nursing.</p> <p>The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 5/11/2016</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	05/11/2016

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	<p>Finding includes:</p> <p>A reported incident occurrence was reviewed on 4/20/16. The incident occurred on 3/17/16. The incident indicated the Nursing Supervisor was informed by an LPN that she thought some Morphine tablets might be missing for Resident #B. The LPN reported there were no Hydrocodone tablets or any narcotic count sheet in the book for the ordered Hydrocodone. The Hospice service was contacted and indicated they delivered 60 tablets on 3/11/16 and the Pharmacy was called and confirmed the delivery. The local Police were notified and all licensed Nurses and QMA's were called in to be drug tested with negative results. RN #3 did not return the facility calls and did not come back to work. RN #3 was the last one who signed out the Hydrocodone prior to it being reported missing.</p> <p>When interviewed on 4/20/16 at 11:40 a.m., the Director of Nursing indicated RN #3 never came back to the facility. The Director of Nursing indicated a total of (51) Hydrocodone pills were unaccounted for. The Director of Nursing indicated the Police were notified again when the RN did not respond to facility calls.</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>1) Immediate actions taken for those residents identified:</p> <p>Facility self-identified this event and did an incident report to the ISDH and ISNAP. Investigation noted no adverse effects from this event.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed of narcotic medications to assure that medication count and MAR documentation were in agreement. No other non-compliance was noted.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff was educated on misappropriation and guidelines for</p>	

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	<p>The facility Policy titled "Abuse, Neglect and Misappropriation of Resident Property" was reviewed on 4/20/16. There was no date on the policy. The Director of Nursing indicated the policy was current. The policy indicated the Misappropriation of Property meant the deliberate misplacement, exploitation or wrongful use of a resident's belongings and funds without the resident's consent.</p> <p>This Federal tag relates to Complaints IN00195996 and IN00197791</p> <p>3.1-28(c)</p>		<p>reporting. System of verifying actual narcotic counts as well as count of packaging units per narcotic was established. Licensed Nursing Staff and Q.M.A.'s were educated on the narcotic verification process.</p> <p>4) How the corrective actions will be monitored:</p> <p>Initial weekly reviews of all narcotic medications for 6 weeks were conducted with no further findings of non-compliance. The Director of Nursing/designee will continue to conduct audits of at least 3 residents per week receiving narcotic medications. The facility Pharmacy consultant will also verify narcotics monthly and submit report to the Director of Nursing.</p> <p>The results of these audits will be reviewed by the Quality Assurance Committee monthly for 6 months, or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance:</p> <p>5/11/2016</p>	

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F 0241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident was treated with respect and dignity related to stained clothing, clothing visibly labeled with the resident's name, staff verbally referring to resident's feeding status, and mimicking resident's statements for 5 residents in a sample of 20. (Residents #C, #P, #Y, #S, and #T)</p> <p>Findings include:</p> <p>1. On 4/19/16 at 9:00 a.m., Resident #S was observed sitting in a wheel chair in the Linden Unit Dining Room. The resident was dressed in purple pants and a white sweat shirt. There was a brown stain on the front of the resident's shirt. The stain was approximately 3 centimeters in diameter. The resident was non verbal at this time. Activity Aide #2 entered the Dining Room, approached the resident, and told the resident she was going to take her to listen to some music. The Activity Aide then wheeled the resident into a lounge area on the unit.</p>			F 0241	<p>The facility requests paper compliance for this citation.</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>1) Immediate actions taken for those residents identified:</p> <p>Resident S had her blouse changed when observed by nurse management.</p> <p>Resident P and T were without</p>		05/11/2016

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	<p>The Activity Aide did not notify any other staff of the stain on the resident's sweat shirt.</p> <p>On 4/19/16 at 9:15 p.m., the resident was observed still in the lounge. The Activity Aide was present. Four other residents were also in the lounge for the Music activity.</p> <p>On 4/19/16 at 9:36 a.m., CNA #3 took the resident to the Exercise Room. The resident's shirt had not been changed. The stain was still present on her white shirt. At 9:48 a.m., the resident was taken back to her room by the CNA. At 10:05 a.m. the resident was observed wearing a new shirt.</p> <p>The record for Resident #S was reviewed on 4/21/16 at 10:13 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety disorder, and major depressive disorder.</p> <p>Review of the 3/28/16 Minimum Data Set (MDS) quarterly assessment indicated the resident was rarely or never understood. The assessment indicated the resident required extensive assistance of one staff member for eating and dressing.</p> <p>The resident's current Care Plans were</p>		<p>emotional distress in reference to staff member allegedly referring to residents as "feeders".</p> <p>Resident C had clothing labeled by family prior to admission. Resident care plan was updated and family educated on better ways to identify resident clothing in the future.</p> <p>Resident Y event was reported to ISDH and an investigation was completed prior to this survey. This resident had no emotional distress related to this occurrence.</p> <p>2) How the facility identified other residents:</p> <p>No other residents were identified as being in common activities with stained clothing.</p> <p>No other occurrences of staff referring to assisted dining residents as "feeder" were observed, staff member identified is listed as PRN staff and has not returned to schedule.</p> <p>Facility was able to identify one other resident with personal clothing items labeled on the outside of clothing. Family was notified and educated on more appropriate means of labeling resident clothing. This resident's care plan was reviewed</p>				

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	<p>reviewed. A Care Plan dated 3/10/16 indicated the resident had a self care deficit due to weakness and impaired cognition and required assistance with daily care needs.</p> <p>2. The Lunch Meal service was observed on the second floor on 4/19/16 at 1:30 p.m. Seven residents were observed in the TV Lounge area for the meal service. Residents #P and #T were seated at a table with CNA #1. The other five residents were seated at adjacent tables. CNA #1 indicated the two residents at the table with her were "Feeders" and not all the other residents in the room were "Feeders."</p> <p>The record for Resident #P was reviewed on 4/20/16 at 11:30 a.m. The resident's diagnoses included, but were not limited to, dementia. The 2/26/16 Minimum Data Set (MDS) quarterly assessment indicated the residents cognitive patterns were severely impaired. The assessment also indicated the resident required one person assist with eating.</p> <p>The record for Resident #T was reviewed on 4/20/16 at 11:35 a.m. The resident's diagnoses included, but were not limited to, vascular dementia with behavioral disturbances. The 1/14/16 MDS quarterly assessment indicated cognitive</p>		<p>and updated.</p> <p>Reportable event of staff member "mimicking" a resident has a completed investigation resulting in disciplinary action. Staff were educated on resident dignity. Resident had no emotional distress from this event as resident was unaware of alleged events at the time.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff were educated on resident dignity and respect. Dignity observations will be conducted on varied shifts at least 5x/week x30 days, then at least 3x/week thereafter. Observations will include staff interactions with residents, and appropriate labeling and cleanliness of clothing. The Social Service Director/designee will be responsible for oversight of these audits. Any identified concerns will be addressed with education/disciplinary action as indicated.</p> <p>4) How the corrective actions will be monitored:</p>	

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	<p>skills were severely impaired.</p> <p>3. On 4/19/16 at 8:00 a.m., Resident #C was observed sitting in a wheelchair in the Linden Unit Dining Room. There was a label visible on the back of the resident's shirt with her name on it. On 4/19/16 at 9:00 a.m., the resident was observed in an activity on the unit. The resident was wearing the same shirt with her name visible on the label of the back of the shirt.</p> <p>The record of Resident #C was reviewed on 4/20/16 at 9:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and depressive disorder. The 3/18/16 Minimum Data Set (MDS) assessment indicated the resident's cognitive patterns were moderately impaired.</p> <p>4. A Reportable Occurrence report involving Resident #Y was reviewed. The report was dated 3/9/16. The report indicated RN #4 had reported that she observed RN #3 mimic Resident #Y's repetitive verbalization during shift change report. The resident was sitting in a chair near the Nurses' Station at the time. RN #4 indicated she was unaware if the resident had heard RN #3. The report indicated RN #3 was counseled on her behavior.</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> <p>5) Date of compliance: 5/11/2016</p>				

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F 0250 SS=D Bldg. 00	<p>The record for Resident #Y was reviewed on 4/21/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety disorder, depressive disorder, and heart failure.</p> <p>The 2/13/16 Minimum Data Set (MDS) significant change assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). A score of (6) indicated the resident's cognitive patterns were severely impaired.</p> <p>When interviewed on 4/20/16 at 2:05 p.m., the Director of Nursing indicated the above employee should not have mimicked the resident during report.</p> <p>This Federal tag relates to Complaints IN00195996, IN00196896, and IN00197791.</p> <p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 record review and interview,</p>	F 0250		05/11/2016

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	<p>the facility failed to ensure medically related Social Services were provided related to addressing a resident's request to transfer to another facility for 1 of 1 residents reviewed for requests to transfer out of the facility in a sample of 20. (Resident #R)</p> <p>Finding includes:</p> <p>The record for Resident #R was reviewed on 4/19/16 at 10:55 a.m. The resident's diagnoses included, but were not limited to, paraplegia, chronic pain, and iron deficiency.</p> <p>The 2/19/16 Minimum Data Set (MDS) annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact.</p> <p>When interviewed on 4/19/16 at 1:35 p.m., the resident indicated he had been trying to transfer to another facility and the facility kept telling him they don't have all the papers for him to transfer there. The resident indicated he has talked with Social Service about his concerns.</p> <p>The 2016 Social Service Progress Notes were reviewed. A note dated 1/18/16</p>		<p>The facility requests paper compliance for this citation.</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>1) Immediate actions taken for those residents identified:</p> <p>Social Services continues to make referrals to other skilled facilities for resident R. This concern is related to Social Services not maintaining documentation of referral requests made for this resident, not denial of services.</p> <p>2) How the facility identified other residents:</p>				

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	<p>indicated the Social Worker stopped in to see the resident upon his request. The Social Worker did explain that she faxed his information to the facility he requested but there was no bed available. The next Social Service Notes were dated 4/4/16, 4/6/16, and 4/7/16. There was no documentation addressing the resident's 1/18/16 request to be transferred to another facility.</p> <p>When interviewed on 4/19/16 at 1:58 p.m., the Social Worker indicated she had submitted information to other facilities but had shredded the papers after they were submitted. The Social Worker indicated she had sent referrals in the last month but had no documentation.</p> <p>This Federal tag relates to Complaint IN00197683.</p> <p>3.1-34(a)(6)</p>		<p>An audit of other residents identified as requesting transfer to another facility over the past 30 days were noted as having successful transfers completed.</p> <p>3) Measures put into place/ System changes:</p> <p>Social Services has implemented an organization binder to identify by resident any verification forms indicating initiated referrals with locations, dates and times of submission of referrals. Social Services will maintain an audit log that will be located in the binder with referrals/results noted, and the logs will be reviewed weekly. The Director of Social Services will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</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 0282 SS=E Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure services were provided per Physician orders related to topical medication patches not applied as ordered and oral medications not administered as ordered for 3 of 3 residents reviewed for medication administration in a sample of 20. The facility also failed to cancel their arrangements for transportation to an appointment for 1 of 3 residents reviewed for appointment transportation in a sample of 20. (Residents #E, #N, #W, and #G)</p> <p>Findings include:</p> <p>1. The closed record for Resident #E was reviewed on 4/20/16 at 8:00 a.m. The resident's diagnoses included, but were</p>	F 0282	<p>5) Date of compliance:</p> <p>5/11/2016</p> <p>The facility requests paper compliance for this citation.</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>	05/11/2016

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	<p>not limited to, mild cognitive impairment, insomnia, high blood pressure, and chronic obstructive pulmonary disease.</p> <p>The 3/4/16 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (10). A score of (10) indicated the resident's cognitive patterns were moderately impaired.</p> <p>The 2/2016 Physician orders were reviewed. An order was written on 2/27/16 for a Exelon Patch (a medicated patch administered for dementia) to be applied transdermally (topically) one time a day at 6:00 a.m. The order also indicated to remove the previous patch at the above time.</p> <p>Review of the 3/2016 MAR (Medication Administration Record) indicated the Exelon Patch was signed out as applied on 3/6/16 at 6:00 a.m. The MAR indicated the patch was not signed out as applied at 6:00 a.m. on 3/7/16.</p> <p>The 3/2016 Nursing Progress Notes were reviewed. An entry made on 3/7/16 at 3:43 p.m. indicated the resident's Exelon patch was replaced on the right chest due to a medication error on the midnight shift.</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>Resident E's Exelon patch was applied. Resident is discharged from facility</p> <p>Resident N's Exelon patch was applied.</p> <p>Resident W indicated no complaints/signs/symptoms of pain.</p> <p>Resident G received first aide for the skin tear. Resident is discharged from the facility.</p> <p>2) How the facility identified other residents:</p> <p>Facility reviewed April 2016 MAR's to identify any other residents that had been potentially affected.</p> <p>An audit was completed of all residents who had appointments scheduled in the last 30 days to identify any other residents affected.</p> <p>3) Measures put into place/ System changes:</p>		

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	<p>When interviewed on 4/20/16 at 2:05 p.m., the Director of Nursing indicated the residents family reported to staff the Exelon patch was not in place and staff verified no patch was in place.</p> <p>2. On 4/19/16 at 10:20 a.m. Resident #N was observed in her room. RN #2 checked for placement of the resident's Exelon patch. The resident had an Exelon patch to the left side of her upper chest. The patch was dated 4/18/16.</p> <p>The record for Resident #N was reviewed on 4/21/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to dementia, diabetes mellitus, and high blood pressure.</p> <p>The current Physician orders were reviewed. An order was written on 2/21/15 for the resident to have an Exelon 4.6 milligrams/hour applied once a day at 6:00 a.m.</p> <p>Review of the 4/2016 Medication Administration Record indicated the medication was not signed out at given by the night shift Nurse at 6:00 a.m.</p> <p>Review of the 2/10/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief</p>		<p>Licensed Nursing Staff and Q.M.A.s were educated on administering medications as ordered. An audit of medication administration records will be completed at least 3 times per week. A minimum of 3 residents per week will be observed for patch placement and corresponding documentation. The Director of Nursing/designee will be responsible for oversight of these audits.</p> <p>Resident appointment books will be reviewed weekly to verify if any appointments need to be cancelled or rescheduled. The Director of Social Services or designee will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</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> <p>5) Date of compliance:</p> <p>5/11/2016</p>	

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	<p>Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive patterns were moderately impaired.</p> <p>When interviewed on 4/19/16 at 10:30 a.m., RN #2 indicated the resident's patch was to be changed at 6:00 a.m. every morning. The RN indicated the Medication Record indicated the Exelon patch had not been signed out as applied at 6:00 a.m. this morning as ordered.</p> <p>3. The record for Resident #W was reviewed on 4/20/16 at 2:00 p.m. The resident's diagnoses included, but were not limited to Alzheimer disease, diabetes mellitus, and osteoporosis.</p> <p>Review of the current Physician orders indicated there was an order written on 2/19/15 for the resident to receive Tramadol (a pain medication) 50 milligrams two times a day.</p> <p>When interviewed on 4/20/16 at 8:00 a.m. RN #2 indicated when she received change of shift report from the night Nurse at the start of her Day shift on 4/19/16. The night shift reported that she had not been able to give some of the (4/19/16) 6:00 a.m. medications. RN #2 indicated Resident #W did not receive her 6:00 a.m. Tramadol until the next</p>			
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	<p>scheduled dose. RN #2 checked the narcotic sign out sheet at this time and confirmed the dose had not been given.</p> <p>When interviewed on 4/20/16 at 9:00 a.m., the Assistant Director of Nursing indicated the resident did not receive her 6:00 a.m. dose of Tramadol on 4/19/16 as ordered.</p> <p>4. The closed record for Resident #G was reviewed on 4/19/16 at 11:06 a.m. The resident's diagnoses included, but were not limited to, dementia, depressive disorder, high blood pressure, and muscle weakness.</p> <p>The 9/2015 Nursing Progress Notes were reviewed. An entry on 9/4/15 at 12:39 p.m. indicated the resident did have an appointment with the Oral Surgery facility on 9/8/15 at 11:00 a.m. The family did have the writer cancel the appointment and the appointment was not to be rescheduled.</p> <p>An entry on 9/8/15 at 1:16 p.m. indicated the resident was returned on the facility van from an appointment. The entry noted the resident became scared when being loaded onto the lift and reached out to grab something to hold on to. A skin tear was noted to the resident's right forearm.</p>			

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F 0312 SS=D Bldg. 00	<p>When interviewed on 4/19/16 the Director of Nursing indicated the appointment had been canceled and the facility forgot to cancel the transportation service so the resident was sent out and returned to the facility.</p> <p>This Federal tag relates to Complaints IN00195996 and IN00197683.</p> <p>3.1-35(g)(1)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure the necessary treatment and services to maintain personal hygiene were provided by staff related to showers not being completed for 1 of 3 residents reviewed for bathing/showers in a sample of 20. (Resident #H)</p>	F 0312	<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	05/11/2016

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	<p>Finding includes:</p> <p>On 4/19/16 at 9:10 a.m., Resident #H was observed sitting her recliner chair in her room. The resident's eyes were closed. The resident was dressed and was wearing white tennis shoes.</p> <p>The record for Resident #H was reviewed on 4/19/16 at 10:00 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, major depressive disorder, insomnia, and a history of falling.</p> <p>Review of the 2/14/16 Minimal Data Set (MDS) annual assessment indicated no BIMS (Brief Interview for Mental Status) was completed as the resident rarely or never understood. The assessment indicated the resident required extensive assistance of a staff member for personal hygiene and was totally dependent on one staff member for bathing.</p> <p>The resident's current Care Plans were reviewed. The Care Plans were dated 2/26/16. A Care Plan indicated the resident had a self care deficit related to dementia, requires supervision with ambulation, limited to extensive assistance with transfers, and extensive to complete dependence on one staff</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>1) Immediate actions taken for those residents identified:</p> <p>Resident H has received all scheduled showers since noted event.</p> <p>2) How the facility identified other residents:</p> <p>An audit of showers for past 30 days was completed to identify any other residents that may have been affected. Residents identified were assessed with no distress or concerns/body odors from missing a scheduled shower.</p> <p>3) Measures put into place/ System changes:</p>	

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F 0323 SS=E Bldg. 00	<p>member for bathing.</p> <p>Review of the 4/2016 ADL (Activities of Daily Living) Bathing Activity record indicated the resident's bathing preference was for showers to be given. The record indicated the resident received showers on 4/5/16, 4/8/16, and 4/15/16. These showers were all given on the Day shift. There was no documentation of resident refusal of showers on the record.</p> <p>When interviewed on 4/20/16 at 1:35 p.m., the Director of Nursing indicated the resident's preference was for showers to be given on Tuesdays and Fridays and the resident did not receive on shower on 4/12/16 (Tuesday) as scheduled.</p> <p>This Federal tag relates to Complaints IN00196896, IN00197683, and IN00197791.</p> <p>3.1- 38(a)(3)(A)</p> <p>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.</p>		<p>Nursing staff was educated on importance of providing showers as requested/scheduled. An audit of shower documentation on at least 10 residents will be completed 2x/week x30 days, then weekly thereafter to ensure showers are offered as per each resident preference. The Director of Nursing/designee will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</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> <p>5) Date of compliance:</p> <p>5/11/2016</p>	
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	<p>Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided to prevent hazards related to an unlocked Shower Room on 1 of 5 Units (Linden Unit). The facility also failed to ensure fall interventions were in place at the time falls occurred and follow up recommendations were completed after review of falls for 3 of 3 residents reviewed for falls in a sample of 20. (Residents #G, #Q, and #V)</p> <p>Findings include:</p> <p>1. On 4/21/16 at 7:50 a.m., Resident #V was observed in wheelchair in the unit Dining Room. There were anti-tippers to the rear wheels of the wheelchair. A personal alarm was also in place.</p> <p>The record for Resident #V was reviewed on 4/21/16 at 8:25 a.m. The resident's diagnoses included, but were not limited to, also Alzheimer's disease, a history of falling, muscle weakness, and an irregular heart rhythm.</p> <p>The 2/12/2016 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive skills were severely impaired. The</p>	F 0323	<p>The facility requests paper compliance for this citation.</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>1) Immediate actions taken for those residents identified:</p> <p>Shower room door was closed. Hazards were removed from the shower room.</p> <p>Resident V has appropriate footwear in place.</p> <p>Resident Q's Physician was notified, no new orders for labs were received.</p> <p>Resident G has been discharged from the facility.</p>	05/11/2016	

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	<p>assessment also indicated the resident required extensive assistance of one one staff member for bed mobility and transfers and had two or more falls since the last quarterly assessment.</p> <p>The resident's current Care Plans were reviewed. The Care Plans were last revised on 2/18/16. A Care Plan indicated the resident was at risk for falling related to poor safety awareness, weakness, and a history of falls. Interventions included, but were not limited to, provide proper, well-maintained footwear and non-skid socks to be used. The intervention for non-skid socks to be used was initiated on 4/8/2015.</p> <p>Review of the 4/2016 Progress Notes indicated an entry was made by Nursing on 4/19/16 at 1:45 a.m. The entry indicated the resident was found sitting on the floor and did not remember how she got there. The entry indicated the resident was wearing regular socks without non-slip grip. They were changed to gripper socks.</p> <p>When interviewed on 4/21/16 at 10:45 a.m. the Director of Nursing indicated the resident should have non-skid socks on as per the plan of care.</p>		<p>2) How the facility identified other residents:</p> <p>Fall incident reports for April 2016 and care plans of residents identified were reviewed to ensure interventions were implemented.</p> <p>Shower room doors on all units were checked to ensure that they were locked and all hazards were secured. No other areas or residents were affected.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff were educated on facility protocol for shower room doors being closed, proper storage of hazards, fall prevention interventions and assuring interventions are in place per plan of care.</p> <p>Shower rooms in various areas of facility will be audited a minimum of 3 x per week on varied shifts by the Director of Nursing or designee to ensure shower room doors and hazards are secured.</p>	

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	<p>2. The record for Resident #Q was reviewed on 4/20/16 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, high blood pressure, and osteoarthritis.</p> <p>The 1/29/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) was unable to be completed. The assessment indicated the resident required extensive assistance of one staff member for transfers, dressing, toileting, and personal hygiene. The assessment indicated the resident had impairment in range of motion of both her upper extremities. The assessment indicated the resident had two or more falls since admission.</p> <p>The resident's current Care Plans were reviewed. A current Care Plan indicated the resident was at risk for falls related to impaired mobility and use of psychotropic medications. Care Plan interventions included, encourage the resident to request assistance, proper footwear in place, assistive devices available, non-skid socks, and staff to offer toileting during early morning rounds.</p> <p>Review of the 4/6/16 Nursing Progress Notes indicated an entry was made on</p>		<p>A minimum of 3 residents identified as high risk for falls will be reviewed weekly to ensure fall interventions are in place according to care plan.</p> <p>An audit will be completed weekly of all falls that occurred the previous week to ensure that fall interventions and recommendations were completed.</p> <p>Any non-compliance noted will be addressed with education/discipline action as indicated.</p> <p>The Director of Nursing will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</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> <p>5) Date of compliance:</p> <p>5/11/2015</p>	

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	<p>4/6/16 at 12:09 p.m. and indicated the CNA reported the resident was found sitting on the floor in her room. The Physician was made aware.</p> <p>A Nursing Post-Fall Investigation form was completed on 4/7/16. The form indicated the resident fell in her room on 4/6/16 at 11:30 a.m. The form indicated new interventions to be implemented included for staff to request lab tests from the Physician.</p> <p>Review of the Nursing Progress Notes, Physician orders, and laboratory tests results indicated there was no record of the facility request for laboratory tests.</p> <p>When interviewed on 4/20/16 at 2:00 p.m., the Director of Nursing indicated the recommendation should have been addressed.</p> <p>3. The closed record for Resident #G was reviewed on 4/19/16 at 11:06 a.m. The resident's diagnoses included, but were not limited to, dementia, depressive disorder, high blood pressure, peripheral vascular disease, and muscle weakness.</p> <p>The 3/4/16 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of</p>			

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	<p>(3) indicated the resident's cognitive patterns for decision making were severely impaired. The assessment indicated the resident required extensive assistance of two staff members for bed mobility and toilet use.</p> <p>A Fall Risk Assessment completed on 3/12/16 indicated the resident's score was (10). A score of (10) indicated the resident was at risk for falls.</p> <p>The resident's current Care Plans were reviewed. A Care Plan dated 3/3/16 indicated the resident was at risk for falls related to poor safety awareness, impaired mobility, and psychotropic medication use. Care Plan interventions included for staff to ensure the resident was wearing appropriate footwear when mobilizing in the wheelchair.</p> <p>A Falls Investigation Worksheet report was completed on 4/13/16. The report indicated the resident had just completed breakfast and the CNA started to push the resident in the wheel chair about a foot and the resident fell forward from the wheelchair. The leg rests were not on the wheelchair. The report indicated the Fall Committee noted the root cause analysis for the fall was noted that the leg rests to the wheelchair were not attached. Recommendations/interventions put into</p>			

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	<p>place at the time of the fall included to send the resident to the hospital Emergency Room, CNA that got the resident up in the morning was counseled and the Care Plans were updated.</p> <p>When interviewed on 4/19/16 at 2:00 p.m., the Director of Nursing indicated the the report indicated the foot rests were to be in place when the resident was up in the wheel chair.</p> <p>4. On 4/20/2016 at 5:40 a.m. the Shower Room door on the Linden unit (a secured dementia unit) was fully open. No staff were present in view of the Shower Room. Resident #M was observed in the hall and seated in a chair across from the entrance to the Shower Room. A total of (14) residents resided on the Linden unit.</p> <p>There were (5) disposable razors on a three tiered cart in the room. There was a small can of shaving cream on a bar in the shower stall. Precautions on the can indicated "Keep out of reach of children." There was also an open bottle of mouthwash also labeled "Keep out of reach of children." A can of "Disinfectant Spray for Health Care" was on a shelf in the closet. The can was labeled "Keep out of reach of children."</p> <p>The window to the outside was opened</p>			
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F 0325 SS=D Bldg. 00	<p>opened approximately one inch and the screen bracket was pulled away from the frame leaving an open gap with no screen approximately 1 cm.</p> <p>When interviewed on 4/20/16 at 5:50 a.m., RN #1 indicated the Shower Room door was to be locked when not in use.</p> <p>This Federal tag relates to Complaints IN00195996, IN00196896, IN00197683, and IN00197791.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p>			

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	<p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure weights were monitored upon admission and per the facility policy for 1 of 3 residents reviewed for weight loss in a sample of 20. (Resident #E)</p> <p>Finding includes:</p> <p>The closed record for Resident #E was reviewed on 4/20/16 at 8:00 a.m. The resident's diagnoses included, but were not limited to, mild cognitive impairment, insomnia, high blood pressure, and chronic obstructive pulmonary disease.</p> <p>Review of the 2/26/16 Admission assessment indicated the resident's weight was not recorded on the weight section of the assessment form. The only weight recorded in the resident's record was completed on 3/2/16.</p> <p>A Dietary Progress Note was completed on 2/29/16 at 1:26 p.m. There was no documentation of the resident's weight. The Progress Note indicated the resident was newly admitted and were awaiting further information.</p> <p>When interviewed on 4/20/16 at 2:07</p>	F 0325	<p>The facility requests paper compliance for this citation.</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>1) Immediate actions taken for those residents identified:</p> <p>Resident E has been discharged from the facility.</p> <p>2) How the facility identified other residents:</p> <p>An audit of resident weights for admissions in April 2016 was completed. No other concerns of</p>	05/11/2016

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	<p>p.m., the Director of Nursing indicated there were no other weights recorded for the resident. The Director of Nursing indicated weights were to be completed upon admission, then weekly for four weeks, and then monthly thereafter.</p> <p>The facility policy title "Weight Measurement" was reviewed on 4/21/16 at 1:30 p.m. The policy was dated 11/2012. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated residents' weights were to be recorded upon admission and a baseline weight was to be established upon admission. Residents were to be weighed weekly for four weeks after admission and monthly thereafter.</p> <p>This Federal tag relates to Complaint IN00195996.</p> <p>3.1-46(a)(1)</p>		<p>non-compliance were noted.</p> <p>3) Measures put into place/ System changes:</p> <p>Nursing staff were educated on the importance of obtaining weights at the time of admission/readmission and guidelines for weight documentation.</p> <p>A designated staff member has been assigned to coordinate the obtaining of weekly weights. Admission weights will be reviewed by the Director of Nursing/designee within 24-72 hours after admission to ensure weights were obtained and documented timely.</p> <p>Admission/readmission and weekly weights will be reviewed weekly by the Nutrition at Risk team to ensure weights are obtained as required.</p> <p>Any noted non-compliance will be addressed with education/disciplinary action as indicated.</p> <p>The Director of Nursing and Dietary Manager will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p>		

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F 0356 SS=E 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"> o Facility name. o The current date. 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"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <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"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written</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> <p>5) Date of compliance: 5/11/2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2016
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NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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	<p>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 and interview the facility failed to ensure Staffing data signs were posted on a daily basis as required.</p> <p>Finding includes:</p> <p>During the Orientaton Tour on 4/18/16 at 6:00 p.m. No signs were posted at the Main Entrance on any of the Units (The Manor rehab unit, Pines North unit, Pines South unit, Elm unit, Maple unit, and the Linden unit)</p> <p>No information was posted indicating the current date, the total number and actual hours worked by licensed and unlicensed Nursing staff directly repsonible for resident care per shift, includings RN's LPN's, CNA's, and the total facility resident census.</p> <p>When interviewed on 4/20/16 at 2:30 p.m., the Director of Nursing indicated the required staff postings should have been posted daily.</p>	F 0356	<p>The facility requests paper compliance for this citation.</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>1) Immediate actions taken for those residents identified:</p> <p>Scheduled nursing staffing sheets were updated and placed near the entrance of Pines Building main entrance and Manor Building main entrance. No residents were affected</p>	05/11/2016

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	<p>This Federal tag relates to Complaint IN00196896.</p> <p>3.1-17(a)</p>		<p>by this alleged deficient practice.</p> <p>2) How the facility identified other residents:</p> <p>No concerns have been noted from residents/families/visitors for this alleged deficient practice.</p> <p>3) Measures put into place/ System changes:</p> <p>Facility scheduler will complete staffing sheets daily and provide them to be posted as well as updating corrections if staffing changes. The Charge Nurse for Pines unit and Manor Rehab unit will ensure the nursing staff postings are posted at the beginning of the shift daily. The Director of Nursing/designee will audit these postings a minimum of 3 days per week on random days and times to assure they are current and readily visible to residents/guests. Any findings of non-compliance will be reported to the Director of Nursing/Administrator and will be addressed with education/disciplinary action of indicated.</p> <p>4) How the corrective actions will</p>	

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F 0505 SS=D Bldg. 00	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings. Based on record review and interview the facility failed to ensure the laboratory results of a Urinalysis test were sent to the resident's Urologist as ordered for 1 of 3 residents reviewed for urinary tract infections in a sample of 20. (Resident #E)</p> <p>Finding includes:</p> <p>The closed record for Resident #E was reviewed on 4/19/16 at 11:06 a.m. The resident's diagnoses included, but were not limited to, dementia, depressive disorder, high blood pressure, and muscle weakness.</p> <p>Review of the 2/2016 Physician orders</p>	F 0505	<p>be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months, or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance:</p> <p>5/11/2015</p> <p>The facility requests paper compliance for this citation.</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</i></p>	05/11/2016	

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	<p>indicated an order was written on 2/28/16 to obtain a Urinalysis and Culture and Sensitivity (C & S) test. An order was written on 2/29/16 to report the Urinalysis and Culture and Sensitivity results to the resident's Urologist when the C& S results were in.</p> <p>Review of the Nursing Progress Notes from 2/28/16 through 3/6/16 indicated there was no record of the results being called or faxed to the Urologist as ordered.</p> <p>When interviewed on 4/21/16 at 8:30 a.m., the Director of Nursing indicated the laboratory test results were not sent to the Urologist as ordered.</p> <p>This Federal tag relates to Complaint IN00197683.</p> <p>3.1-49(f)(2)</p>		<p><i>law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident G has discharged from the facility.</p> <p>2) How the facility identified other residents:</p> <p>An audit of April labs was completed to ensure Physician notification.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses have been educated on the Physician notification guidelines.</p> <p>The Director of Nursing or designee will audit lab results a minimum of 2 x per week to ensure physicians are notified of results as indicated. Non-compliance will be addressed with education/disciplinary action as indicated.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be</p>	

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			<p>reviewed in Quality Assurance Meeting monthly x6 months, or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance:</p> <p>5/11/2016</p>		