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		05/13/2015

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

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F 000 Bldg. 00	This visit was for the Investigation of Complaint IN00173263. Complaints IN00173263-Substantiated. Federal/State deficiency related to the allegations are cited at F323. Survey Dates: May 12 & 13, 2015 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census bed type: SNF/NF: 132 Total: 132 Census payor type: Medicare: 10 Medicaid: 112 Other: 10 Total: 132 Sample: 3 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.	F 000	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. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey desk review on or after May 31, 2015.	

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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F 323 SS=D 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, the facility failed to ensure a resident received supervision and assistance to prevent falls and risk of injury, related to a resident not supervised outside at night, leaving the facility without the Guardian's knowledge, and moving a resident after a fall, before the nurse could assess the resident for injury, for 1 of 3 residents reviewed for accident hazards in a total sample of 3. (Resident #B) Findings include: Resident #B's record was reviewed on 05/12/15 at 9:34 a.m. The resident's diagnoses included, but were not limited to Parkinson's disease and dementia. There was an order appointing permanent Guardian over the resident and estate of the incapacitated resident signed as	F 323	**F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/ DEVICES** Thefacility must ensure that the resident environment remains as free of accidenthazards as is possible; and each resident receives adequate supervision andassistance devices to prevent accidents **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□□Resident #B's received supervision andassistance to	05/31/2015

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	effective on 03/12/15. The 5-Day/Admission Minimum Data Set (MDS) assessment, dated 01/12/15 indicated the resident's cognition was intact, had no behaviors, required extensive assistance of two or more staff for transfers and bed mobility, and had falls prior to the admission into the facility. The 30-Day MDS assessment, dated 03/28/15, indicated the resident's cognition was intact, had no behaviors, required extensive assistance of one for transfers and bed mobility, was unsteady with standing and could stabilize self, and had no falls since the resident had been re-admitted. A care plan, dated 01/07/15, indicated the resident was a fall risk related to Parkinson's disease, unsteady gait, medications, and non-compliant with safety measures. The approaches included, gentle reminders and encouragement to have assistance when going outside (added 04/15/15) and gentle reminders to ask for assistance (added 02/27/15). A Fall Event, dated 04/15/15 at 6:49 p.m., indicated a Speech Therapist had observed the resident falling to his knees		prevent falls and no longer resides at the facility. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •□□□□□□□Residents residing in the facility have thepotential to be affected by the alleged deficient practice. •□□□□□□□Social Services completed a chart audit forany resident that has a guardian and informed IDT of those residents with aguardianship. •□□□□□□□DNS reviewed all residents that have a careplan for fall interventions to ensure interventions are in place per the careplan. •□□□□□□□Inservice all staff on Fall PreventionInterventions and Supervision as well as Guardianship/POA/Responsible Party bythe CEC/designee will be completed by 5/31/15. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□□□Rounds arecompleted each shift by the charge nurse, Unit Managers and Customer	

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	in the parking lot, as he was crossing the parking lot to go to the bus stop to smoke a cigarette. The resident was assessed to have an abrasion to the left knee. The note indicated the Speech Therapist encouraged the resident not to move until staff were present and could assist him. During an interview on 05/12/15 at 9:51 a.m., the Social Service Director indicated the residents' in the facility can go outside and walk. She indicated the facility had a little park they could go out to. During an interview on 05/12/15, the East Unit Manager indicated the residents' can go outside and walk, but cannot go off the facility property. The Director of Nursing (DoN) indicated the resident had gone outside by himself. She indicated the resident was unaware the Guardian did not want him outside on his own. A Nurses' Note, dated 05/07/15 at 10 a.m., indicated the DoN had met with the resident to discuss that his Guardian's wishes that he does not go outside or leave facility grounds. The note indicated the resident had voiced he had left the property, "for an hour or so yesterday."		Care Reps,to monitor resident care, safety to ensure fall interventions are in place perresident profile and care plan. Concernsare addressed with the Unit Managers. •□□□□□□□The Director of Nursing Services is responsibleto monitor for facility compliance. •□□□□□□□Safety/SupervisionObservations will be documented on the Nursing Rounds Checklist and CustomerCare Rounds Sheets daily. **Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place** •□□□□□□□The “FallManagement” CQI tool will be completed weekly x 4, then monthlythereafter. •□□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□□Data will be submitted to the CQI Committeefor review and follow up. •□□□□□□□Noncompliance with facility procedures mayresult in disciplinary action.	

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	The Resident's sign out form, indicated the resident was signed out on 05/06/15 at 7:05 p.m. and returned at 9 p.m. on 05/06/15. During an interview on 05/12/15 at 12:44 p.m., the DoN indicated a friend of another resident in the building signed Resident #B out for the leave of absence and the resident had left the facility by truck, with this friend. She indicated the Nurse on duty (LPN #1) had notified the Guardian and the Guardian was upset he had left on the leave of absence. The DoN indicated the Nurse should not have let the resident leave the facility without prior approval of the Guardian. During an interview on 05/12/15 at 3:46 p.m., LPN #1 indicated the resident's Guardian had not been notified prior to the resident leaving with the friend. LPN #1 indicated she was unaware she needed to call the Guardian. She indicated the, "friend" had informed her where they were going and about a half hour after the resident left, she notified the Guardian about the leave of absence and was told by the Guardian the resident should not have left the facility. A Fall Event, dated 05/10/15 at 3 p.m., indicated the resident had an unwitnessed fall in the bathroom and had reopened the			

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	abrasion on his left knee. A Nurses' Note, dated 05/11/15 at 1 p.m., indicated the resident had reported he had fallen in the bathroom when he was ambulating without his walker. The note indicated the resident had stated his left knee was scabbed and had reopened. The assessment indicated the resident had an abrasion noted to the left knee. A Post Fall Investigation, dated 05/12/15, indicated CNA #2 had assisted the resident off the floor prior to calling the Nurse on duty to assess the resident's condition. During an interview on 05/12/15 at 2:17 p.m., the East Unit Manager indicated CNA #2 had assisted the resident off the floor and then went to the Nurse. She indicated the Nurse went to the resident within 10 minutes of the fall. A signed statement from CNA #2, dated 05/13/15, indicated CNA #2 had entered the resident's bathroom when summoned by the resident's family and found the resident siting on the floor with his back resting against the wall and legs out in front of him. The statement indicated the resident had been attempting to get up from the floor without assistance and the CNA had assisted him onto the toilet.			

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	The statement indicated the resident's left knee was bleeding and she then went to inform the Nurse of the resident's fall. A facility policy, dated 02/15, titled, "Fall Management Program", received from the DoN as current, indicated, "...Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and provide necessary treatment..." A Professional Resource, titled, "Division of Long Term Care Nurse Aide Training Program July 1998", "Topic 8: Emergencies", indicated, "...Falls...Call for help immediately. Keep the resident in the same position until the nurse examines the resident..." This Federal Tag relates to complaint IN00173263. 3.1-45(a)(2)			