

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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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 Complaint IN00186595.</p> <p>Complaint IN00186595- Substantiated Federal/State deficiencies related to the allegations are cited at F166, F225, F226, F323, F371, F441, and F465.</p> <p>Survey dates: November 29, 2015 -December 1, 2015.</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type: Medicare: 18 Medicaid: 65 Other: 17 Total: 100</p> <p>Sample: 20</p> <p>Theses deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</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 0166 SS=D Bldg. 00	<p>Quality review completed by 26143, on December 8, 2015.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on record review and interview the facility failed to ensure resident grievances voiced at a Resident Council meeting were addressed and acted upon in a timely manner.</p> <p>Finding includes: The 11/4/15 Resident Council meeting minutes were reviewed on 12/1/15 at 12:00 p.m. A total of (12) residents attended the meeting. One resident expressed a concern that staff were checking her blood sugar one hour before dinner and then not again until later in the evening. Another concern indicated residents did not feel like they were getting their medications on time as scheduled. There were no Grievance Reports or any follow up or investigations into the above concerns presented by the residents.</p>	F 0166	<p>F 166 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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. 1) Immediate actions taken for those residents identified: Concerns voiced at the resident council meetings held in November 2015 have been addressed. 2) How the facility identified other residents: Review of orders for glucometer monitoring was done to identify other diabetic residents, no other residents</p>	12/29/2015

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	<p>The 11/24/15 Resident Council meeting minutes were also reviewed. A total of (13) residents attended the meeting. There was a concern voiced by same resident who voiced the above concern on 11/4/15. The resident concern indicated the she was having a hard time getting the Nurses to take her blood sugar at 4:00 p.m. Another concern indicated the Nurses were always late with their medications. Grievance Reports were completed for the above two concerns in addition to other concerns voiced.</p> <p>When interviewed on 12/1/15 at 12:30 p.m., the Director of Nursing indicated a Resident Council meeting was held on 11/4/15. The meeting was conducted by the HR (Human Resource) staff member as the Activity Director was not available to interview. The Director of Nursing indicated she had been aware the HR staff member had conducted the Resident Council Meeting. The Director of Nursing also indicated the concerns voiced at the meeting were to be written on grievance forms and she had not received any from the 11/4/15 meeting and did not ask for them.</p> <p>When interviewed on 12/1/15 at 12:50 p.m., the Human Resource staff member indicated this was the Activity Director's</p>		<p>with concerns about getting their blood sugars checked when they wanted it done. All residents that receive medications had the potential to be affected. 3) Measures put into place/ System changes: Licensed nurses have been re-educated on the importance of completing medication administration within the allocated time of one hour before and one hour after the scheduled time. Nurses also re-educated on the need to check a resident's blood sugar at the time that they request in conjunction with their routinely scheduled times for glucometers. Audits of medication administration times will be done a minimum of three times per week at random shifts and times to monitor for timeliness of medication administration. A minimum of 3 diabetic residents will be interviewed weekly to ensure that they are having their blood sugars checked at their scheduled times as well as any additional times that they have requested. Director of Nursing will be responsible for the oversight. Leadership has been educated on the process for addressing concerns voiced during Resident Council. The Activity Director or designee will document concerns</p>		

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	<p>last day at working and was not available. The Human Resource staff indicated she conducted the Resident Council meeting on 11/4/15. The HR staff member indicated she wrote the resident concerns on a piece of paper and did not know who to give them and was not aware the concerns were to written on a Grievance Report or typed up so this had not been done. The HR staff indicated she did not pass on the concerns to any other staff and they were not typed up from her notes until yesterday. The HR staff also indicated the facility Administrator was present towards the end of the meeting and up until yesterday no one asked for the minutes from the 11/4/15 meeting.</p> <p>When interviewed on 12/1/15 at 1:05 p.m., the facility Administrator indicated he was present for part of the 11/4/15 Resident Council meeting. The Administrator indicated he could not locate any Grievance Reports so the concerns were not addressed or written on Grievance Reports.</p> <p>The facility policy titled "Grievances and Concerns was reviewed on 12/1/15 at 3:05 p.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated the facility</p>		<p>voiced during the meeting in the minutes, they will also put concerns on Grievance Forms which will then be given to Social Services Director. Social Services will then give the grievances to the appropriate Department Leader for follow up. The responsible Department will address the concern, document what was done in regard to the concern and then return the Grievance documentation to Social Service. Grievances/Concerns should be addressed within 5 working days. Social Services will track dates received, date assigned and date completed. All concerns not addressed within the allocated time frame will be reported to the Administrator. to be addressed with responsible department. Social Services will bring information on grievances to the Quality Assurance Meetings for review.</p> <p>4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: December 29, 2015</p>	

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F 0225 SS=D Bldg. 00	<p>was responsible to thoroughly investigate all Resident and Family grievances and concerns. Grievance forms were to be given to Social Services to log and then to the appropriate department for follow-up within 48 hours. Grievance forms were then to be investigated.</p> <p>This Federal tag relates to Complaint IN00186595.</p> <p>3.1-7(a)(2)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>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 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 an allegation of possible verbal abuse was reported to the Administrator immediately for 1 of 2 allegations of abuse reviewed. (Resident #H) (CNA #5 and CNA #3)</p> <p>Finding includes:</p> <p>Review of a 10/2/15 Abuse allegation report indicated during an investigation into another Abuse Allegation CNA #5 was interviewed and reported she recalled that earlier in the night shift on 10/1/15 she observed CNA #3 arguing</p>	F 0225	<p>F 225 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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. 1) Immediate actions taken for those residents identified:</p>	12/29/2015

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	<p>with Resident #H and CNA #3 and Resident #H were going back and forth saying "shut up and go to bed." CNA #3 was suspended at this time.</p> <p>The record for Resident #H was reviewed on 11/29/15 at 11:13 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, psychotic disorder, and high blood pressure.</p> <p>Review of the 11/20/15 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (1). A score of (1) indicated the resident's cognitive patterns were severely impaired.</p> <p>When interviewed on 12/1/15 at 1:45 p.m., the Director of Nursing indicated on 10/2/15 at 7:45 a.m. the night shift Nurse called her and informed her that CNA #3 had been stating she was not going to do her work and was going to let the other CNA's do it. The Director of Nursing indicated she began an investigation and interviewing other staff members on 10/2/15. The Director of Nursing indicated she interviewed CNA #5 on 10/2/15 in the morning and the CNA informed her she noticed that Resident #H appeared tired and crabby. The Director of Nursing indicated CNA #5 called her back later on 10/2/15 and</p>		<p>Resident H was without any injury or emotional distress.</p> <p>2) How the facility identified other residents: All abuse allegations made in the past 30 days have been reviewed to ensure that the Administrator was notified immediately.</p> <p>3) Measures put into place/ System changes: Staff have been re-educated on abuse and the abuse protocol including that any potential abuse must be reported to the administrator immediately after insuring resident's safety. An audit will be conducted for each abuse allegation to verify that it was reported to the administrator immediately. Any episode of non-compliance in regard to notification will be addressed with education/disciplinary action as indicated. The Administrator will be responsible for the oversight. A minimum of 3 staff members will be interviewed weekly by Administrator/DON to determine if showing signs of burnout. If signs of burnout are noted intervention will be provided. During rounds staff members are talked to in regard to how they are doing and if they have any concerns. Staff are encouraged to come to supervisor if they have concerns or need to talk about anything. Summary of concerns identified will be brought to QA.</p>				

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F 0226 SS=D Bldg. 00	<p>indicated she recalled hearing CNA #3 and Resident #H both repeating "shut up and go to bed" on the night shift from 10/1/15 into 10/2/15. The Director of Nursing indicated CNA #5 should have reported the the above to her and the Administrator at the time it occurred on the night shift from 10/1/5 to 10/2/15.</p> <p>This Federal tag relates to Complaint IN00186595.</p> <p>3.1-28(d)</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 interview the facility failed to follow their policy related to reporting allegations of abuse to the facility Administrator immediately for 1 of 2 Abuse allegations reviewed. (Resident #H) (CNA #5 and CNA #3)</p>	F 0226	<p>4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/29/2015</p> <p>F 226 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or</p>	12/29/2015

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	<p>Finding includes:</p> <p>Review of a 10/2/15 Abuse allegation report indicated during an investigation into another Abuse Allegation CNA #5 was interviewed and reported she recalled that earlier in the night shift on 10/1/15 she observed CNA #3 arguing with Resident #H and CNA #3 and Resident #H were going back and forth saying "shut up and go to bed." CNA #3 was suspended at this time.</p> <p>When interviewed on 12/1/15 at 1:45 p.m., the Director of Nursing indicated on 10/2/15 at 7:45 a.m. the night shift Nurse called her and informed her that CNA #3 had been stating she was not going to do her work and was going to let the other CNA's do it. The Director of Nursing indicated she began an investigation and interviewing other staff members on 10/2/15. The Director of Nursing indicated she interviewed CNA #5 on 10/2/15 in the morning and the CNA informed her she noticed that Resident #H appeared tired and crabby. The Director of Nursing indicated CNA #5 called her back later on 10/2/15 and indicated she recalled hearing CNA #3 and Resident #H both repeating "shut up and go to bed" on the night shift from 10/1/15 into 10/2/15. The Director of</p>		<p><i>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: Resident H was without injury or emotional distress. 2) How the facility identified other residents: All abuse allegations made in the past 30 days have been reviewed to ensure that the Administrator was notified immediately. 3) Measures put into place/ System changes: Staff have been re-educated on abuse and the abuse protocol including that any potential abuse must be reported to the administrator immediately after insuring resident's safety. An audit will be conducted for each abuse allegation to verify that it was reported to the administrator immediately. Any episode of non-compliance in regard to notification will be addressed with education/disciplinary action as indicated. The Administrator will be responsible for the oversight. A minimum of 3 staff members will be interviewed weekly by Administrator/DON to determine if showing signs of</p>				

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F 0323 SS=D Bldg. 00	<p>Nursing indicated CNA #5 should have reported the the above to her and the Administrator at the time it occurred on the night shift from 10/1/5 to 10/2/15.</p> <p>The facility Incident Reporting and Investigating Policy was reviewed on 11/29/15 at 11:30 a.m. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated all alleged violations involving neglect or abuse were to be immediately reported to the Administrator.</p> <p>This Federal tag relates to Complaint IN00186595.</p> <p>3.1-28(d)</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</p>		<p>burnout. If signs of burnout are noted intervention will be provided. During rounds staff members are talked to in regard to how they are doing and if they have any concerns. Staff are encouraged to come to supervisor if they have concerns or need to talk about anything. Summary of concerns identified will be brought to QA. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/29/2015</p>	

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	<p>assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to wheel chair alarms not in place, unlocked shower rooms, and a lack of thorough investigations of falls for 3 of 4 residents reviewed for supervision in a sample of 20. (Residents #F, #N, and #P)</p> <p>Findings include:</p> <p>1. On 11/29/15 at 6:01 a.m. Resident #P was observed ambulating in front of the Nurses Station on the Linden Unit. This Unit was a secured unit for residents with diagnoses of dementia. The resident walked over to the Shower Room, opened the door, and walked into the Shower Room. The door was not locked. No staff members observed the resident enter the Shower Room. The resident exited the Shower Room at 6:04 a.m. No staff observed the resident exit the room. The CNA indicated he was not aware the resident had been in the Shower Room unattended. CNA #1 also indicated the Shower Room door should have been locked.</p> <p>The Shower Room was then observed. There was on open container of shaving cream on a grab bar in the shower stall. The label on the can read "Keep Out of</p>	F 0323	<p>F 323</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>Residents P was without injury. Resident F has his self- releasing belt in place on his wheelchair per his plan of care. Resident N was without injury and alarm replaced to her wheelchair.</p>	12/29/2015

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	<p>Reach of Children." An open plastic bag of disposable razors was also observed on a cart in the room. There were two razors in the bag. There was a plastic spray bottle on the edge near the wall register. The bottle was filled with "Hospital germicide disinfectant" for industrial or commercial use only. The warning label on the bottle read "Keep out of Reach of Children."</p> <p>When interviewed on 11/29/15 at 6:10 a.m. , RN #3 was informed Resident #P had been in the Shower Room unattended with the razors and disinfectant spray observed in the room. The RN also indicated the door should have been locked.</p> <p>The record for Resident #P was reviewed on 11/29/15 at 8:02 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, and high blood pressure. Review of the 11/6/15 Minimum Data Set significant change assessment indicated the residents BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired.</p> <p>2. On 11/29/15 at 5:20 a.m., CNA #1 was observed pushing Resident #F in a wheel chair into the Dining Room on the</p>		<p>2) How the facility identified other residents:</p> <p>All residents that reside on the dementia units are at risk to be affected if shower room doors are unlocked. Residents that have safety devices for fall prevention were checked and no other residents were affected. Fall investigations for the past 30 days have been reviewed to insure accuracy and completeness.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff educated on the importance of the shower rooms on the Dementia Units to be locked and for all sharps and chemicals be secured at all times. Also educated on the importance of all sharps and chemicals to be secured at all times in all shower rooms. Staff educated on the importance of making sure that all safety devices are in place per plan of care. Staff shown how to access each resident's kardex to find out what interventions are ordered.</p> <p>Licensed staff have been educated on how to properly complete post fall investigations.</p> <p>Audits will be done on a minimum of three times per week at random</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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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>Linden Unit. The resident had a self release seat belt in place.</p> <p>The record for Resident #F was reviewed on 11/30/15 at 1:20 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, convulsions, and psychosis. Review of the 10/7/15 Minimum Data Set quarterly assessment indicted the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired.</p> <p>The resident's current Care Plans were reviewed. A Care Plan last reviewed on 10/7/15 indicated the resident was at risk for falls related to poor safely awareness, impaired mobility, a history of falls, and the use of psychotropic medications. Care Plan interventions included, but were not limited to, to have a self releasing belt in place to his wheel chair.</p> <p>The 11/2015 Nursing Progress Notes were reviewed. An entry made on 11/9/15 at 11:03 p.m. indicated while being pushed in a wheel chair by staff, the resident fell forward and landed on his left side and left shoulder in the hallway.</p> <p>Review of the 11/9/15 Nursing Post- Fall</p>		<p>shifts and times to ensure that shower rooms are locked (on dementia units) and all sharps and chemicals are properly stored. A minimum of three residents per week will be monitored at varied times to ensure that their safety devices are in place per plan of care. A minimum of three fall investigations per week will be reviewed to ensure accuracy and completeness. Assistant Director of Nursing will be responsible for the oversight.</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 x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/29/2015</p>	

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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>Investigation report indicated the resident had a balance problem and received anti-anxiety and anti-seizure medications. The report indicated the fall occurred at 7:15 p.m. in the hallway. The report indicated the resident was sitting and bending over prior to the fall. The report did not indicated if the self release belt was in place and latched at the time of the fall.</p> <p>When interviewed on 11/30/15 at 3:30 p.m. the ADON (Assistant Director of Nursing) indicated she investigated the resident's 11/9/15 fall. The ADON indicated she had the CNA describe how the fall occurred and CNA indicated she had been pushing the resident out of the Dining Room and the resident was leaning forward. The ADON indicated she also reviewed the resident's Care Plans at the time of the investigation and indicated no interventions for alarms or seat belts were in place Upon viewing the resident's current Care Plans at this time, the AODN indicated she must have "missed that." The ADON also indicated the CNA did not report anything about the seat belt to her and she had not asked the CNA about any seat belt during the investigation to determine if the seat belt intervention had been in place at the time of the fall.</p>				

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	<p>3. On 11/29/15 at 6:00 a.m. Resident #N was observed in the Linden Dining Room. There was an alarm cord on the residents' wheel chair. No alarm box was attached to the alarm. Other residents were in the Dining room. No staff were in the Dining room at this time.</p> <p>The record for Resident #N was reviewed on 11/29/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, a history of falls, muscle weakness, and depressive disorder. Review of the 9/22/15 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) was a (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident had two or more falls since last admission, reentry or prior assessment. A 10/9/15 Fall Risk assessment indicated the resident's score was (16) which indicated the resident at risk for falls.</p> <p>The resident's current Care Plans were reviewed. A Care Plan last reviewed on 9/2/15 indicated the resident had the potential for falls related to a history of falls, poor safety awareness, impaired mobility, and the use psychotropic medications. Care Plan interventions</p>			

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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>included, but were not limited to an alarm in place to the wheel chair, wedge cushion in place, and a Dycem (a thin pad to prevent sliding) to her wheel chair. The intervention for the Dycem was initiated on 7/6/15.</p> <p>Review of the 10/2015 Nursing Progress notes indicated an entry was made on 10/20/15 at 11:26 a.m. This entry indicated the resident was found laying on the floor on her right side in the hallway near the Nursing Station. A laceration and slightly raised red area were noted to her forehead.</p> <p>An IDT (Inter-Disciplinary Team) Fall note was completed on 10/21/15 at 3:00 p.m. This note indicated the resident was found on the floor on her right side. The root cause of the fall was identified as the resident was leaning forward in the wheel chair and fell. The new intervention added was for a wedge cushion to be placed in the wheel chair.</p> <p>Review of the 10/21/15 Nursing Post-Fall Investigation report indicated the resident had a diagnosis of Alzheimer's diseased, history of falls, and received anti psychotic and antidepressant medications. The report also indicated the resident had a laceration as the result of the fall. Interventions in place at the</p>			

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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>time of the fall were, alarm to the bed and chair, low bed with mat, use of body pillow, scoop mattress, non skid footwear, and to follow the resident's preferences. The Dycem was not listed as an intervention.</p> <p>Review of the 11/2015 Nursing Progress notes indicated an entry was made on 3:36 p.m. This entry indicated the resident attending an activity in the unit Dining Room and slid herself forward out of the wheel chair. The entry also indicated a Dycem to the wheel chair was provided at this time.</p> <p>An IDT Fall noted was completed on 11/6/15 at 2:31 p.m. This note indicated the resident was at an activity and slid herself forward in the wheel chair landing on her buttock.</p> <p>A Nursing Post Fall Investigation report was completed on 11/5/15. This report indicated the resident had a diagnosis of Alzheimer's and received antianxiety and antidepressant medications and no injuries were noted. The report indicated the resident was at risk for falls and had a previous history of falls. The possible root cause of the fall was the resident slid too close to the edge of the chair. Fall interventions in place at the time of the fall were listed as alarms to the bed and</p>			

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F 0371 SS=D Bldg. 00	<p>wheel chair, a low bed with a mat in place, scoop mattress, and non skid foot wear. Dycem and wedge cushion were not listed. The report indicated the new recommended intervention was a Dycem to the wheel chair.</p> <p>When interviewed on 12/1/15 at 1:25 p.m., the ADON indicated the 11/4/15 fall was a witnessed fall as the resident fell at an activity with a group of people sitting at a table. The resident slid to the edge of her wheel chair and slid down on on her bottom. The ADON indicated no one determined if the Dycem had been in place at the time of the fall. The ADON indicated she was not aware the Dycem had been a previous intervention put into place in July and the investigation did not address the Dycem except to implement it as an intervention related to the 11/4/15 fall.</p> <p>This Federal tag relates to Complaint IN00186595.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>			

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure foods and beverages were stored under sanitary conditions related to a dusty ceiling fan and foods not dated or discarded for 1 of 1 Kitchen/Dining area on the Pines Unit. (The Main Dining and Kitchenette areas.)</p> <p>Finding includes:</p> <p>On 11/29/15 at 4:45 a.m. the following was observed in the Kitchen area on the Pines North unit:</p> <p>a. The ceiling fan was dirty and dusty with a large accumulation of dust on the blades.</p> <p>b. There following was observed in the refrigerator in the Kitchen area:</p> <p>A pitcher of orange juice dated 11/19/15 A container of Parmesan cheese dated 11/22/15 A cottage cheese fruit plated with no date. A tuna salad sandwich with no date.</p> <p>When interviewed on 11/30/15 the Director of Nursing indicated the above</p>	F 0371	<p>F 371 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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. 1) Immediate actions taken for those residents identified: Undated food and outdated liquids have been removed from the refrigerator. Ceiling fan has been cleaned. 2) How the facility identified other residents: The refrigerators in all kitchenettes have been checked for any undated or outdated food items, all undated or outdated food items have been removed. 3) Measures put into place/ System changes: Staff have been educated on dating all food items that are in the refrigerators and the importance of checking the dates of food/beverage items</p>	12/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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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 0441 SS=E Bldg. 00	<p>area should have been cleaned and the food items should have been dated or discarded.</p> <p>This Federal tag relates to Complaint IN00186595.</p> <p>3.1-21(i)(1)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>		<p>and disposing of them if outdated or undated. Audits will be done a minimum of three times per week at random times/shifts to ensure that all food items in the refrigerators is properly dated. Audits will also be done a minimum of three times per week at random times/shifts to identify any equipment that needs to be cleaned. Dietary Manager will be responsible for the oversight. Ceiling fans in the Dining Areas have been placed on a routine cleaning schedule and housekeeping assignments have been updated to include this task.</p> <p>4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/29/2015</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 12/01/2015
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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure hand washing was completed between resident to resident care and glucometers were sanitized as required between resident to resident care for (5) residents in a sample of 20. (Residents #T, #U, #V, #W and #Y) (RN #1 and RN #2)</p> <p>Findings include:</p> <p>1. The morning Medication</p>	F 0441	<p>F 441 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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</p>	12/29/2015

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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>Administration pass on the Pines North Unit was observed on 11/29/15 at 5:20 a.m. RN #1 was observed completing a glucometer check for Resident #T. The RN took the glucometer out of the Medication Cart. The RN wiped the glucometer with a disinfectant wipe for approximately 5 seconds. The RN did not leave the glucometer covered with the wipe for 5 minutes. The RN entered the resident's room and obtained a blood sample from the resident's finger. The RN left the room with gloves on and placed the glucometer lancet in the sharps container and removed her gloves. The RN then pulled another disinfectant wipe out and wiped down the glucometer for approximately 5 seconds with no gloves on. The RN did not leave the wipe on the glucometer after wiping it. The RN did not wash her hands or use any hand alcohol gel. RN #1 then preceded to enter the result of the glucometer on the computer.</p> <p>The RN then preceded to perform a blood glucose accuchecek for Resident #U. The RN put on a pair of disposable gloves. The RN did not wash her hands or use alcohol gel prior to putting on the gloves. RN #1 wiped the glucometer with a disinfectant wipe for approximately 5 seconds. The RN did not leave the wipe on the glucometer for 5</p>		<p><i>federal and state law.</i> 1) Immediate actions taken for those residents identified: Residents T, U, V, W, and Y are without any adverse effects. 2) How the facility identified other residents: Review of orders for glucometer checks done to identify other diabetic residents. 3) Measures put into place/ System changes: Licensed nurses have been educated on the glucometer cleaning guidelines. Observations will be done a minimum of three times per week at various shifts/times to ensure compliance with glucometer cleaning guidelines. Director of Nursing will be responsible for the oversight. Staff have been educated on handwashing protocol. Handwashing observations will be done for a minimum of 3 employees per week at random days/shifts. Any non-compliance will be addressed with the employee at that time. Results of observations will be presented at the Quality Assurance meetings. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of</p>	

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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>minutes. The RN then performed a glucometer check for Resident #U and placed the lancet in the Sharps container and pulled out a disinfectant wipe with her gloved hands and wiped the glucometer for for approximately 5 seconds. The RN then put on a new pair of gloves without washing or sanitizing her hands and drew up an insulin injection. The RN removed then removed her gloves and did not wash or sanitize her hands and then walked down the hall to the Nursing Station to another Medication Cart.</p> <p>RN #1 then removed a glucometer from the second Medication Cart . The RN did not wipe the glucometer with a disinfectant wipe. The RN entered Resident #V's room and put on a pair of disposable gloves and obtained a glucometer reading from the resident's finger. The RN then removed her gloves and went to the Sharps container to dispose the lancet. The RN then wiped the glucometer with a disinfectant wipe for approximately five seconds. RN #1 did not wash her hands or use alcohol gel prior to exiting the room after completing the glucometer test.</p> <p>2. On 11/29/15 at 6:40 a.m., RN #2 was observed completing a glucometer test</p>		compliance: 12/29/2015		

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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>for Resident #W. The RN wiped the glucometer with a germicidal wipe for no more then 10 seconds. The RN did not leave the wipe on the glucometer for five minutes. The RN then washed her hands and put a glove on her right hand and covered the fingers of her left hand with part of a glove. The RN performed the glucometer check and an "error" message was noted. The RN then left the room with the gloves on her hands and went out to the Medication Cart. The RN then entered the room and took off the gloves and put on a new pair of gloves without washing her hands..</p> <p>3. On 11/29/15 at 6:55 a..m., RN #2 entered Resident #Y's room with the glucometer and wiped down the glucometer with a germicidal wipe for no more then 10 seconds. The RN did not leave the wipe in place on the glucometer for 5 minutes. The RN then left the room with her gloves on as she had forgotten the lancet used to obtain the blood glucose test, obtained the lancet, and returned to the room with her gloves on and performed the glucose test. An "error" was read on the glucometer and the RN removed her gloves and left the room without washing her hands or completing any hand hygiene. The RN obtained another lancet from the cart and returned to the room. RN #2 then put on</p>			

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	<p>another pair of gloves without washing her hands.</p> <p>RN #2 then put on a pair of gloves and administered and insulin injection to the resident. The RN did not wash or sanitize her hands prior to putting the gloves on or after removing the gloves.</p> <p>When interviewed on 11/29/15 at 5:50 a.m., the Director of Nursing indicated the proper protocol for the cleaning the glucometer was to wipe the glucometer down with a germicidal and place the glucometer on a paper towel until it was completely dry. The Director of Nursing indicated staff were to wash their hands with soap and water after glove removal.</p> <p>When interviewed on 11/29/15 at 5:49 a.m., RN #1 indicated she was not aware how long the glucometer was supposed to be wiped down. The RN indicated she had not washed her hands after removing her gloves.</p> <p>The facility policy titled "Maintaining the Blood Glucose Meters" was reviewed on 11/29/15 at 11:30 a.m. There was no date on the policy. The Director of Nursing indicated the policy was current. The policy indicated the blood glucose meter was to be cleaned and disinfected between each resident test. The policy</p>			

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	<p>also indicated pre- moistened wipes with a 1:10 dilution of bleach and detergent were to be used. The policy also indicated the the meter was to be wiped, placed on clean surface, and allowed to air dry for a minimum of five minutes. The policy also indicted staff were to use put on non sterile gloves prior to the procedure and remove the gloves after. Handwashing was to be completed after the gloves were removed.</p> <p>The facility policy titled "Specific Medication Administration Procedures-Injectable Medication Administration" was reviewed on 11/30/15 at 2:07 p.m. The policy had a revised date of 6/8/15. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated hands were to washed with soap and water prior to preparing injectable medications and hands were to be sanitized with an approved sanitizer after the preparation. The policy also indicated gloves were to be worn when injection were given and the gloves were to be removed after the injection. Hands were then to be cleaned by sanitizing or washing after glove removal.</p> <p>This Federal tag relates to Complaint IN 00186595.</p>			

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F 0465 SS=D Bldg. 00	<p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to provide a clean and sanitary environment related to dirty floors and walls on 2 of 5 Units. (The Pines North and Linden units)</p> <p>Findings include:</p> <p>1. On 11/29/15 at 4:10 a.m. the following was observed on the Pines North unit.</p> <p>a. There was a strong urine odor noted in the hallway by rooms 15, 16, and 17.</p> <p>b. The floors by the Nursing Station and lounge areas across from the Nursing Station were dirty. Spillage was observed on the floors down the hallway. There was orange substance on the floor by the Nursing Station.</p> <p>On 11/29/15 at 9:41 a.m. the following was observed on the Pines North unit.</p>	F 0465	<p>F 465</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>	12/29/2015
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	<p>a. The strong urine odor was still noted in the hallway between rooms 15, 16, and 17.</p> <p>b. There was spillage on the shade of the large window in the lounge area across from the Nursing Station.</p> <p>c. The orange substance on the floor by the Nursing Station was still observed.</p> <p>2. On 11/29/15 at 4:30 a.m., the following was observed on the Linden unit.</p> <p>The floor across from the Nursing Station was dirty.</p> <p>This Federal tag relates to Complaint IN00186595.</p> <p>3.1-19(f)</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>Source of urine odor identified and corrected. Window shade in the Pines lounge area cleaned. Floor tiles that had orange stain on them have been replaced. Floor near the nurses station has been cleaned.</p> <p>2) How the facility identified other residents:</p> <p>House-wide observations have been made and items that need to be cleaned have been scheduled for completion.</p> <p>3) Measures put into place/ System changes:</p> <p>Environmental concern form initiated and made available on each unit.</p> <p>Staff educated on the use of Environmental Concern form and the process for resolution of identified concerns.</p>	

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			<p>Environmental audits will be done a minimum of three times per week on various days and shifts. All identified concerns will be scheduled for resolution.</p> <p>4) How the corrective actions will be monitored:</p> <p>Audits will be done a minimum of three times per week on various days and shifts. All identified concerns will be scheduled for resolution. The Administrator will be responsible for the oversight. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>12/29/2015</p>	