

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 11/10/2015
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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 IN00184836.</p> <p>Complaint IN00184836- Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey date: November 10, 2015</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Census bed type: SNF/NF: 103 Total: 103</p> <p>Census payor type: Medicare: 19 Medicaid: 62 Other: 22 Total: 103</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on November 15, 2015.</p>	F 0000		

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 0323 SS=D Bldg. 00	<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. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided and interventions and procedures were in place to prevent residents from exiting the secured unit. The facility also failed to ensure elopement attempts were reported to staff members caring for the resident and the Administrator or Director of Nursing in a timely manner. This resulted in a delay in initiating an investigation of an elopement attempt, monitoring residents after elopement attempts, and implementation of interventions after an elopement attempt for 2 of 3 residents at risk for elopements in a sample of 3. (Residents #B & #C)</p> <p>Findings include:</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</i></p>	11/30/2015

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	<p>1. The record for Resident #B was reviewed on 11/10/15 at 9:16 a.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, vascular dementia, anxiety disorder, and high blood pressure.</p> <p>Review of the 9/25/15 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 impairment.</p> <p>The 10/2015 Progress Notes were reviewed. A Nursing entry was made on 10/16/15 at 7:14 p.m. This entry indicated the resident had attempted to leave the facility. No harm or injuries were observed from the attempt. The resident was redirected with good effect and no additional behaviors were noted. A wander guard (a device placed on a resident's arm or leg to prevent exit doors from opening when the resident was near an exit door) was put into place and 15 minutes checks were being completed to maintain the resident's safety.</p> <p>A Social Service Note was entered on 10/16/15 at 4:01 p.m. This entry was marked as a "late entry." This entry indicated the resident had gone down the</p>		<p><i>by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Safety of both Residents B and C has been maintained. Elopement Risk Assessments and care plans have been reviewed and updated.</p> <p>2) How the facility identified other residents:</p> <p>Elopement risk assessments for all current residents have been reviewed and updated as needed. Residents that triggered at high risk for elopement have been added to the elopement risk binder and their care plans have been reviewed and updated as needed.</p> <p>3) Measures put into place/ System changes:</p> <p>Staff have been in-serviced on what constitutes an elopement, steps to take if an elopement occurs or is attempted. In-service included suggestions for interventions to be utilized if a resident is actively exit seeking or is talking about leaving the building if they are unsafe to do so</p>		

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	<p>elevator with another resident's family member and exited the facility, Staff quickly intervened and escorted the resident back to the unit the resident had resided on. A wander guard had been issued.</p> <p>Review of the 10/16/15 Elopement/Unauthorized Leave Risk Review indicated the resident's score was (10). A score of (10) indicated the resident was at risk to elope.</p> <p>A 10/16/15 facility report was reviewed. The report indicated an incident occurred at 10:01 a.m. on 10/16/15. The report indicated Resident #B had been talking about needing to go to work in the morning on 10/16/15. The resident got into the elevator with some visitors who were leaving and the resident went outside by the reception desk and was observed by the receptionist. The resident was observed transferring herself into the lawn chair next to the door and was brought back into the facility by staff without any difficulties. An Elopement Risk assessment was completed and a wander guard was initiated at that time.</p> <p>When interviewed on 11/10/15 at 9:50 a.m., the Director of Nursing indicated staff had reported that early in the morning on 10/16/15 they were getting</p>		<p>independently.</p> <p>New protocol initiated in regard to all residents must be signed out if they are leaving their unit, this includes going to therapy, the beauty shop or just a walk around the community grounds. Signage has been posted on each Unit to remind visitors and staff to sign out residents before taking them off of their units.</p> <p>Access code for the elevator on the Dementia floor will be changed monthly and only employees of Aperion Care Valparaiso and emergency service personnel will have access to the code. Visitors will be assisted off of the unit by staff.</p> <p>4) How the corrective actions will be monitored:</p> <p>Audits of sign out sheets will be conducted on a weekly basis to monitor for compliance. Random audits will be done 3 x per week at varied times and shifts by observation to ensure that staff are assisting visitors off of the dementia units. Any identified non-compliance will be addressed with re-education/counseling as</p>		

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	<p>Resident #B up for breakfast and she talked about having to go to work. The resident was taken to breakfast and then into the TV room to watch TV. Staff reported on 10/16/15 they had last seen the resident around 10:00 a.m. sitting on a bench by the unit Nursing Station. When they came back out of the Nursing Station they did not see the resident so they looked for her. Staff then went downstairs to look for the resident. As the staff were getting out of elevator they observed the receptionist coming back into the building and then saw Resident #B outside on a chair.</p> <p>Continued interview with the Director of Nursing indicated the resident was ambulating by other visitors and the receptionist went to hold the door open and Resident #B went out of the doors. The Director of Nursing indicated they have a wanderguard system on the elevators to prevent residents with wanderguard devices in place from getting onto the elevator. The Director of Nursing also indicated in order for the elevator doors to open on the second floor a code had to be punched in. The Director of Nursing indicated staff members on the secured unit and the front desk receptionist were allowed to give family members the code to elevator door. The Director of Nursing indicated</p>		<p>indicated. Administrator or designee will be responsible for oversight of this process.</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: 11/30/2015</p>		

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	<p>after the above incident the facility placed a sign on the wall by the elevator to remind family members to not allow others on the elevator when they leave and have encouraged staff to put the code in for visitors. The Director of Nursing also stated there were still families that had the code and punched it in themselves.</p> <p>When interviewed on 11/10/15 at 12:50 p.m., the Director of Nursing indicated an elopement binder was to be in place at the front desk. The Director of Nursing indicated residents who had been assessed to be at elopement risk were given wanderguards and these residents were the ones required to be in the elopement books. The Director of Nursing indicated they noted the elopement book had not been at the front when they investigated the above incident. The Director of Nursing indicated Resident #B was not at risk for elopement prior to 10/16/15 and would not have been pictured in the elopement book.</p> <p>When interviewed on 11/10/15 at 12:00 p.m., the facility Administrator indicated he did not recall if there had been a sign by the upstairs elevator to remind visitors to not allow resident's on the elevator with them. The Administrator indicated</p>			

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	<p>if a family member asked for the code staff would give them the code.</p> <p>When interviewed on 11/10/15 at 2:20 p.m., the Director of Nursing indicated they were now not going to allow family members to put the code in without staff.</p> <p>2. On 11/10/15 at 8:45 a.m., Resident #C was observed sitting on a couch in the TV room on the secured unit. The resident had a wanderguard bracelet in place on his left ankle.</p> <p>The record for Resident #C was reviewed on 11/10/15 at 9:45 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes, and high blood pressure. The 8/17/15 Minimum Data Set (MDS) 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. The assessment also indicated the resident did not demonstrate any wandering behaviors.</p> <p>Review of the 9/19/15 Elopement/Unauthorized Leave Risk Review indicated the resident's score was (6). A score of (6) indicated the resident was at risk to elope.</p>			

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	<p>The 9/2015 Progress Notes were reviewed. An entry was made by Nursing on 9/19/15 at at 3:53 p.m. This entry indicated the resident talked about wanting to leave and to go in his car. Staff redirected the resident from the elevator and an wanderguard was put into place. An entry was made by Nursing on 9/19/15 at 10:47 p.m. This entry indicated between 6:00 p.m. to 8:00 p.m., Resident #B was asking about going home and asking where the exit was. At 6:45 p.m. the resident attempted to leave by the stairs by the Nursing station. No further attempts to leave the unit were noted on 9/19/15 through 9/21/15.</p> <p>A 9/21/15 facility report was reviewed. The report indicated an incident occurred on 9/19/15 at 7:30 p.m. The report indicated Administration received notification on 9/21/15 at 11:30 a.m. indicating staff heard the staircase door alarm and opened the door and saw Resident #C on the third step. No injuries or signs of emotional stress were noted. Staff interviews were initiated on 9/21/15 . CNA #1 was interviewed and indicated she heard the door alarm sounding on 9/19/15 at approximately 7:30 p.m. and she went to investigate. The CNA observed Resident #C standing on the third step and brought him back onto the unit and notified the Nurse on</p>			
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	<p>duty. Two other CNA's were interviewed on 9/21/15. Both CNA's indicated Resident #C had been talking about going home earlier in the shift and they had last seen him after dinner.</p> <p>When interviewed on 11/10/15 at 10:09 a.m., the Director of Nursing indicated she was first notified of the above occurrence on Monday 9/21/15. The Director of Nursing indicated staff did not inform her or the Administrator prior to 9/21/15. The Director of Nursing indicated they found out about the occurrence during their Clinical Meeting and review of Nursing Notes on 9/21/15 and began investigating the occurrence and talking with staff.</p> <p>The Director of Nursing indicated the Nurse did not inform the oncoming shift that the resident had exited the door and was found on the stairs on 9/19/15 at 7:30 p.m. The CNA's reported the resident had been talking about wanting to go home earlier in the shift but he was not exit seeking. The Director of Nursing indicated she and the Administrator should have been notified of the resident going out the stairway door at the time it occurred. The Director of Nursing indicated the Nurse did not include in the 24 hour shift to shift reporting that the resident had been observed on the steps</p>			

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	<p>as they only noted he had been trying to go through the door. The Director of Nursing indicated when any resident on the secured unit exits without permission or supervision they view the incident as an elopement and the incident is investigated.</p> <p>The Director of Nursing indicated she started inservicing staff on 9/22/15 to ensure they were aware if a resident was found to have left the secured unit without supervision it was a an elopement . The Director if Nursing indicated the staff were also instructed to notify herself and the Administrator at the time of the occurrence.</p> <p>The policy titled "Search Policy and Procedure" was reviewed on 11/10/15 at 2:11 p.m. The was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated all Nursing personnel were responsible for knowing the whereabouts of the residents they were assigned to care for.</p> <p>This Federal tag relates to Complaint IN00184836.</p> <p>3.1-45(a)(2)</p>			

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

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