

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00188012 completed on 12/7/2015.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00190090, IN00191079, IN00192068, and IN00192324.</p> <p>Complaint IN00188012-Not Corrected.</p> <p>Survey dates: January 27, 28, 29, and February 1, 2016.</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type: SNF: 5 SNF/NF: 104 Total: 109</p> <p>Census payor type: Medicare: 17 Medicaid: 87 Other: 5 Total: 109</p> <p>Sample: 11</p>	F 0000	<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>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 February 19, 2016.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/01/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0323 SS=G Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on February 9, 2016.</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. Based on record review and interview, the facility failed to ensure each resident was free from accidents related to ensuring a totally dependent resident received a physical two person assist during care which resulted in a fall with a laceration to the upper left eye lid area that required three (3) sutures for 1 of 3 residents reviewed for accidents. (Resident #E)</p> <p>Finding includes:  The record for Resident #E was reviewed</p>	F 0323	<p><b>Resident was not care planned for a two staff member assist at the time of the incident. This was past</b></p>	02/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>on 1/28/16 at 11:00 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis, aphasia, anxiety, and depression.</p> <p>The 6/29/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident was moderately impaired for decision making and had some cognitive impairment. The resident was an extensive physical two person assist with transfers and totally dependent with a physical two person assist with personal hygiene and bathing. The resident did not have a history of falls since the last assessment.</p> <p>The current and updated care plan dated 3/7/14 indicated the resident had a history of falls. The goal indicated, the resident will not experience any significant injury related to falls. The interventions included, but were not limited to, bed in low position, encourage resident to use handrails or assist devices properly, and if falls occur notify Physician, Director of Nursing (DON), and family.</p> <p>The Nursing Progress Notes dated 7/25/15 at 2:19 p.m., indicated the resident rolled out of bed while receiving an one person physical assist during care.</p>		<p><b>non-compliance at the time re-visit. F323 FREE OF ACCIDENTS/HAZARDS/SUPERVISION/DEVICES</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> · Resident E's Care Plan was updated to include bed mobility assistance and transfer status. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> · All resident ADL care plans and Kardex were reviewed to ensure bed mobility and transfer status were updated and accurate. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> · Nursing staff were re-educated regarding the use of the Care Plan and the Kardex to verify transfer and bed mobility</p>	
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/01/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The resident broke her eye glasses and was noted to have a 2.5 (cm) centimeter laceration to her upper left eye lid with a small amount of bleeding. At 2:32 p.m., the resident was sent out to the hospital per Physicians orders for evaluation and treatment.</p> <p>The Fall Investigation Worksheet dated 7/25/15 indicated the resident was on an air mattress while receiving care and rolled out of bed.</p> <p>Continued review of the Nursing Progress notes dated 7/25/15 at 5:35 p.m., indicated the resident returned from the hospital alert and verbally responsive with 3 sutures to her upper left eye lid area. The resident was also noted to have an as needed Tylenol order for pain or discomfort.</p> <p>Interview with the DON on 1/27/16 at 4:37 p.m., indicated the resident had a fall with an injury while receiving one person assisted care.</p> <p>This deficiency was cited on December 7,2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>		<p>status prior to providing care.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· Observation audits of ADL Care including bed mobility and transfers will be conducted on at least 10 residents per week on varied shifts x 14 days, then 5 residents per week on varied shifts thereafter.</li> <li>· Director of Nursing will be responsible for oversight of these audits.</li> <li>· The results of these audits will be reviewed in monthly QAPI meeting until 100% compliance is achieved x 3 consecutive months.</li> </ul>	

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

PRINTED: 02/22/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/01/2016
NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	