

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  04/08/2015
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NAME OF PROVIDER OR SUPPLIER  APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00170807.</p> <p>Complaint IN00170807- Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey date: April 8, 2015</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type: SNF: 2 SNF/NF: 107 Total: 109</p> <p>Census payor type: Medicare: 14 Medicaid: 89 Other: 6 Total: 109</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
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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 323 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 to prevent resident elopements from the facility related to the lack of continuous supervision while escorting residents off the secured unit for 1 of 3 residents reviewed as elopement risks in the sample of 4. (Resident #C) (Activity Aide #1)</p> <p>Finding includes:</p> <p>During Orientation Tour on 4/8/15 at 8:45 a.m., Resident #C was observed in bed in her room. The resident resided on a secured unit. The resident was awake and responded to staff when they entered the room.</p>	F 323	<p><b>F323</b></p> <p><b>The facility requests paper compliance for this citation.</b></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>	04/20/2015

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	<p>The record for Resident #C was reviewed on 4/8/15 at 9:12 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, dementia with behavioral disturbances, generalized anxiety disorders, and muscle weakness.</p> <p>The current Physician orders were reviewed. There was an order written on 11/1/2011 for the resident to be admitted to the Special Care Unit (the secured unit).</p> <p>Review of the 2/2/15 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 patterns were severely impaired. The assessment also indicated the resident required limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non weight bearing assistance) of one person for walking in the room and corridor. The assessment also indicated the resident had impairment in range of motion on both upper and both lower extremities. The assessment also indicated the resident's balance while walking was not steady, but the resident was able to stabilize without staff assist. The assessment also indicated the resident required supervision of one staff</p>		<p><i>by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #C was returned to facility, head to toe assessment completed with no injuries noted and placed on 15 minute checks x5 days. Family and Physician were notified. Elopement Risk assessment was completed, plan of care was reviewed and updated.</p> <p><b>2) How the facility identified other residents:</b></p> <p>Elopement Risk Assessments and elopement risk care plans for all residents will be reviewed and revised as indicated.</p> <p><b>3) Measures put into place/ System changes:</b></p>		

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	<p>member for locomotion on and off the unit.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 5/10/2011 indicated the resident was at risk for elopement as evidenced by recent elopement from a facility and verbalizing intent to leave the facility. The Care Plan was last revised on 3/30/15. Care Plan interventions included for staff to distract the resident from wandering by offering pleasant diversions, activities, food, conversations, television, and books.</p> <p>Review of the 2/26/15 and 3/26/15 Behavioral Management Team review notes indicated the resident had a history of exit seeking and aggressive behaviors with no behaviors during the above periods.</p> <p>Review of a 3/27/15 Incident Report Form indicated staff noted Resident #C was absent from a group activity and was later located outside of the facility and was returned to the facility. Fifteen minute observation checks of the resident were initiated upon return into the facility. No injuries were noted to the resident.</p> <p>The facility investigation of the above occurrence was reviewed. Interviews</p>		<p>Elopement Risk book was reviewed and updated.</p> <p>Security system vendor adjusted locking mechanism on front entrance door to lock immediately with no delay on 3-30-15.</p> <p>Activity and nursing staff were re-educated regarding identification of residents at risk for elopement, elopement risk book location, and supervision of residents on secured unit when attending activities outside of the secured unit.</p> <p>Activity and nursing staff were educated to transport no more than 2 residents per staff member at a time when transporting out of the secured unit to ensure proper supervision is provided at all times, including during activities.</p> <p>The above stated in-services were initiated on 3-27-15.</p> <p><b>4) How the corrective actions will be monitored:</b></p>		

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	<p>were obtained from staff members. Staff inservices were initiated on the day of the incident.</p> <p>When interviewed on 4/7/15 at 9:52 a.m., the Director of Nursing indicated staff had been taking Resident #C out of the secured unit to attend an activity event in the Main Dining Room on 3/27/15 at approximately 1:45 p.m. The event had been scheduled to begin at 2:00 p.m. Activity Aide #1 took Resident #C and two other male residents out of the secured unit to attend the 2:00 p.m. activity. Another Activity Aide (Activity Aide #2) observed Activity Aide walking with the three resident and assisted the two male residents into the Dining Room. Activity Aide #1 failed to escort Resident #C into the Dining Room.</p> <p>Continued interview with the Director of Nursing at the above time indicated CNA #3 had been coming out of the Dining Room and approached her in the hallway. The CNA informed her Activity Aide had brought the Resident #C out of the secured unit and they could not locate the resident. The Director of Nursing indicated she then alerted the front desk receptionist and an emergency announcement was made to alert all staff of the above. Activity Aide #1 was interviewed immediately and indicated</p>		<p>The Activity Director/designee will randomly observe compliance with supervision of residents during transport from secured unit to activities off the unit according to varied activity schedule and times.</p> <p>The Social Service Director or designee will randomly audit at least 3 residents per week to ensure Elopement Risk assessment, elopement risk care plans and elopement risk book are updated as indicated for those residents identified at risk.</p> <p>Maintenance staff will check exit doors weekly to ensure proper functioning and locking action.</p> <p>All elopement and attempted elopement occurrences will be reviewed by Interdisciplinary Team to ensure appropriate interventions were in place prior to and following occurrence. Any concerns will be addressed to identify root cause and preventative/ corrective actions will be put in place.</p>	

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	<p>she had assisted Resident #C off the secured unit to attend the activity and thought the other Activity Aide had taken the resident into the Dining Room. The Director of Nursing indicated the Unit Manager located the resident walking approximately 3 blocks from the facility and the resident was returned into the facility at 2:04 p.m.</p> <p>Continued interview with the Director of Nursing at the above time indicated the front desk receptionist had to push a button to allow entrance or exit from the inside door of the front entrance. The Director of Nursing indicated the receptionist was present at the front desk and had just let a visitor in and that visitor was standing in front of the desk to sign the log in book. The door had a ten second delay system in place and they believed Resident #C could have exited at that time as the resident was ambulatory and the visitor at the desk could have blocked the view of the receptionist while standing at the desk and signing in.</p> <p>When interviewed on 4/7/15 at 11:29 a.m., the Director of Nursing indicated she interviewed Activity Aide #1 and Activity Aide #2 again after the resident returned into the building. Activity Aide #1 indicated she had brought Resident #C</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><b>5) Date of compliance: 4/20/15</b></p>	

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	<p>out of the secured unit and thought Activity Aide #2 had taken her into the Dining Room. When Activity Aide #2 was interviewed she indicated she had been going down the hall and saw Activity Aide #1 walking with two male residents and Resident #C from the secured unit and she then took only the two male residents into the Dining Room.</p> <p>When interviewed on 4/7/15 at 10:25 a.m., the Unit Manager indicated she located the resident standing on the side walk a short distance from the facility. There were no other people in the area. The resident responded when her name was called and got into the car without any problems. The Unit Manager indicated the resident was alert, talking, and showed no signs of distress or resistance.</p> <p>The Activity Director was interviewed on 4/7/15 at 12:13 p.m. The Activity Director indicated the Activity Aides were directed when they bring residents off of the secured unit for activities they were to bring two residents at a time and to supervise the residents at all times. They were also to communicate to the staff in the room when the residents were brought into the room if they were not going to stay with the residents they brought into the activity. The Activity</p>			

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	<p>Director indicated the Activity Aide #1 should have stayed with Resident #C or reported to another staff member.</p> <p>When interviewed on 4/7/15 at 12:15 p.m., the Executive Director indicated the Activity Aides go into the secured unit and ask the residents if they would like to go to the activity. The Executive Director indicated the residents were to be supervised when taken off the secured unit for activities.</p> <p>When interviewed on 4/7/15 at 1:10 p.m., Activity Aide #4 indicated the procedure for bringing residents from the secured unit to activity events was to take two residents at a time and report to the Activity Aide in the room to make sure there was always some one to watch the residents.</p> <p>When interviewed on 4/7/15 at 12:52 p.m., Activity Aide #5 indicated when they bring residents from the secured unit to an activity off the unit they were to bring only two residents at at times and escort them into the room where the activity was going on. The Activity Aide indicated if no staff were in the room at the time they were to either stay with the residents or take them back to the unit.</p> <p>The facility policy titled "Elopement Risk</p>			

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	<p>Assessment Protocol" was reviewed on 4/7/15 at 12:11 p.m., The Executive Director provide the policy. The Policy indicated the facility was to inform the employees of residents at risk for elopement. The employees were to be informed of effective interventions and assign key staff on all the shifts to be primarily responsible for monitoring the locations of the residents.</p> <p>This Federal tag relates to Complaint IN00170807.</p> <p>3.1-45(a)(2)</p>				