STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	08/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00205447. Complaint IN00205447 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: August 8 & 9, 2016 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Census bed type: SNF/NF: 51 Total: 51 Census payor type: Medicare: 08 Medicaid: 38 Other: 05 Total: 51 Sample: 4 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 8/10/16.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0323 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 fall prevention interventions were planned and implemented to prevent falls for 1 of 4 residents reviewed for falls. (Resident #D) Finding includes: The clinical record for Resident #D was reviewed on 08/08/16 at 1:50 P.M. Resident #D was admitted to the facility on 06/16/16 with diagnoses including but not limited to: anxiety disorder, sleep disorders, chronic congestive heart failure and chronic kidney disease stage 4. A Fall Risk Assessment, completed on 06/16/16 indicated the resident's score was a 16, which placed him in a "High Risk for Fall" category.	F 0323	**F 323 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 provision of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident D was no longer a resident at Aperion Care of Peru, as of June 30, 2016. **2) How the facility identified other residents:** All residents of Aperion Care who had fallen within the last 30 days of survey exit, as well as new admissions	09/08/2016

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	An interim care plan, completed for Resident #D with the Admission nursing assessment did not indicate any fall prevention plan. Nursing progress notes, completed on 06/17/16 at 1:00 P.M., indicated a bed alarm was sounding and the resident was observed to be sliding out of the side of the bed. His fall could not be prevented and he was assisted to the floor. He received a skin tear to his right upper arm. The fall incident report, provided by the DON on 08/09/16 at 1:30 P.M., indicated the resident's fall occurred on 06/19/16 at 4:05 . The report indicated the resident was in his bed attempting to sit up when he slid down the side of the bed, ending up on his hands and knees. The resident was documented as being disoriented, which was normal for this resident, there were no environmental factors marked, the room was marked as well lit and clutter free. There was no documentation of any mattress bolsters or a low bed on the incident report. A care plan initiated on 06/19/16 indicated the resident had experienced a fall. The interventions were as follows: "continue interventions on the at risk		since July 1, were audited for new fall interventions on careplan. **3) Measures put into place/systems changes:** All residents having a fall at Aperion Care will have their fall investigations reviewed by the clinical interdisciplinary team on the following business day to ensure intervention put into place and added to the fall careplan. All new admissions will be reviewed on the following business day by clinical IDT to ensure interim careplan initiated with fall prevention interventions initiated. A fall careplan inservice will be held for licensed nurses regarding fall careplans and interventions. **4) How the corrective actions will be monitored:** Upon completion of fall careplan updates, after fall, the careplan with update will be printed. IDT will then participate in a fall intervention audit weekly to ensure updated interventions on fall careplan and will follow up with further concerns, as indicated. Results of weekly audit will be reviewed monthly by the QA&A committee and will discontinue when compliance of 100% of achieved x3 months. Results of 5 times of a week audit of new admissions for fall interim careplan initiation will be reviewed monthly during QA&A and will discontinue when 100% compliance is achieved x 3 months. **Date of compliance: 09/08/2016**	

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	plan, monitor/document report x 72 hours to MD for s/sx (signs/ symptoms). Change in mental status new onset confusion, inability to maintain posture, agitation, nightlight on while in bed at hs (bedtime), provide activities that promote exercise and strength building where possible, provide 1:1 activities if bedbound, PT consult for strength and mobility, vital signs per facility protocol. Take BP lying/sitting/standing x first 24 hours." There was no specific plan implemented to prevent falls for Resident #D. It was also unclear what interventions were to be continued as there was no interim plan or interventions documented as being utilized. A nursing note, completed on 06/20/16 at 9:23 A.M., indicated a bolster on the resident's bed became loose. The note also indicated the care plan was to be updated to include a low bed with mat and a nightlight in his room. A nursing note, dated 06/26/16 at 12:45 P.M., indicated nursing heard a loud crash and Resident #D was found on the floor in his room. His head was by the bedside stand and he had a laceration to his right eyebrow area and a nosebleed. He was sent to an acute care facility. The acute care facility Emergency			

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	Department Chart indicated the resident was assessed with nasal, right elbow, right shoulder abrasions and a 4 centimeter laceration over the right eyebrow. The resident also had blood in his mouth. The resident was also diagnosed with an interaparenchymal hemorrhage of the brain. The resident was observed overnight in the acute care facility and received an injection of Vitamin K to reverse the blood thinning as he had been on blood thinning medication prior to his fall. He was readmitted to the health care facility on 06/27/16 on comfort measures. The resident expired on 06/30/16. A Fall Prevention Program, dated 01/01/2015, provided by the Director of Nursing on 08/09/16 at 1:50 P.M., indicated a fall risk assessment was to be completed by a licensed nurse at the time of admission. The assessment tool was to incorporate current clinical practice guidelines. The policy also indicated "safety interventions will be implemented for each resident identified at risk using a standard protocol...." The Standard Fall/Safety Precautions for all Residents included but was not limited to: orienting all residents to the use of the nurse call device, bed maintained in a position appropriate for			

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	resident transfers, bed locks to be checked and locked at all times, resident's personal possessions within reach when possible, environment kept clear of clutter, lighting will be appropriate for time of day and resident's desire, residents were to be observed every 2 hours for safety, call lights were to be answered promptly, side rails if assessed to be needed or desired, residents not left alone to toilet, dim lighting was to be left on in resident' s room at night and foot wear to be monitored. During an interview with the Director of Nursing on 08/09/16 at 11:00 A.M., she indicated the interim care plan should have been completed with the Nursing Admission Assessment on admission. She indicated there should have been interventions documented. She indicated after the resident returned from the acute care facility on 06/27/16, the facility had implemented other fall interventions including a bariatric bed but none of the interventions were documented and the resident expired before a care plan was revised. This Federal tag relates to Complaint #IN00205447. 3.1-45(a)(2)			

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