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

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

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00190090, IN00191079, IN00192068, and IN00192324.<br><br>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00188012 completed on 12/7/2015.<br><br>Complaint IN00190090-Substantiated. Federal/State deficiencies related to the allegations are cited at F323.<br><br>Complaint IN00191079-Substantiated. Federal/State deficiencies related to the allegations are cited at F329.<br><br>Complaint IN00192068-Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00192324-Substantiated. No deficiencies related to the allegations are cited.<br><br>Unrelated deficiency is cited.<br><br>Survey dates: January 27, 28, 29, and February 1, 2016.<br><br>Facility number: 008505 | F 0000 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>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 | |

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

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| | Provider number: 155580<br>AIM number: 200064830<br><br>Census bed type:<br>SNF: 5<br>SNF/NF: 104<br>Total: 109<br><br>Census payor type:<br>Medicare: 17<br>Medicaid: 87<br>Other: 5<br>Total: 109<br><br>Sample: 11<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed by 26143, on February 9, 2016. | | | |
| F 0323<br>SS=G<br>Bldg. 00 | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>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. | | | |

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| | 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)<br><br>Finding includes:<br><br>The record for Resident #E was reviewed 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.<br><br>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.<br><br>The current and updated care plan dated | F 0323 | Resident was not care planned for a two staff member assist at the time of the incident. This was past non-compliance at the time re-visit.<br>**F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/DEVICES**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br><br>· Resident E's Care Plan was updated to include bed mobility assistance and transfer status.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**<br><br>· All resident ADL care plans and Kardex were reviewed to ensure bed mobility and transfer status were updated and accurate.<br><br>**What measures will be put into place or what systemic changes you will make to** | 02/19/2016 |

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| | 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.<br><br>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. 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.<br><br>The Fall Investigation Worksheet dated 7/25/15 indicated the resident was on an air mattress while receiving care and rolled out of bed.<br><br>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 | | **ensure that the deficient practice does not recur**<br><br>· Nursing staff were re-educated regarding the use of the Care Plan and the Kardex to verify transfer and bed mobility status prior to providing care.<br><br>**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**<br><br>· 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.<br><br>· Director of Nursing will be responsible for oversite of these audits.<br><br>· The results of these audits will be reviewed in monthly QAPI meeting until 100% compliance is achieved x 3 consecutive months. | |

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| | discomfort.<br><br>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.<br><br>This Federal tag relates to Complaint IN00190090.<br><br>3.1-45(a)(2) | | | |
| F 0329<br>SS=D<br>Bldg. 00 | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically | | | |

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| | contraindicated, in an effort to discontinue these drugs.<br>Based on record review and interview, the facility failed to ensure each residents medication regime was free from unnecessary medications related to notifying the Physician of a resident's blood pressure readings 160/90 or greater for 1 of 3 residents reviewed for unnecessary medications. (Resident #D)<br><br>Finding includes:<br><br>The closed record for Resident #D was reviewed on 1/28/16 at 11:15 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, diabetes, and hypertension.<br><br>The 11/13/15 Admission Minimum Data Set Assessment (MDS) indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was alert and oriented with no cognitive impairment.<br><br>The care plan indicated the resident had hypertension, the interventions included, but were not limited to, report to Physician any signs or symptoms of malignant hypertension.<br><br>The 11/13/15 Physician's Progress Notes indicated the resident developed Septic Shock two months ago and was taken off | F 0329 | **F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br><br>· Resident D has been discharged from the facility.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**<br><br>· All recorded resident blood pressures were reviewed from 2/1/16 to present to identify any other residents that were affected. Physicians will be notified as indicated.<br><br>· All residents receiving antihypertensive medications were identified and reviewed. | 02/19/2016 |

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| | all blood pressure medications. Monitor blood pressure every shift, currently asymptomatic.<br><br>The Medication Administration Record (MAR) dated November 2015 indicated the following:<br><br>-11/13/15 at 10:00 p.m., 168/84<br>-11/14/15 at 06:00 a.m., 155/100<br>-11/15/15 at 12:00 p.m., 158/100<br>-11/15/15 at 10:00 p.m., 158/100<br>-11/16/15 at 06:00 a.m., 158/100<br>-11/16/15 at 12:00 p.m., 162/102<br>-11/16/15 at 10:00 p.m., 162/102<br>-11/18/15 at 10:00 p.m., 191/99<br>-11/19/15 at 06:00 a.m., 168/88<br>-11/21/15 at 06:00 a.m., 166/90<br>-11/22/15 at 10:00 p.m., 166/90<br>-11/27/15 at 12:00 p.m., 170/100<br>-11/27/15 at 10:00 p.m., 168/100<br>-11/29/15 at 12:00 p.m., 151/102<br><br>Review of the Nursing Progress notes indicated no documentation the Physician had been notified of the elevated blood pressure readings.<br><br>Interview with the Director of Nursing (DON) on 1/29/16 at 9:05 a.m., indicated the Nursing staff should have notified the Physician of the resident's elevated blood pressure readings. | | **What measures will be put into place or what systemic changes you will make to**<br><br>**ensure that the deficient practice does not recur**<br><br>· Licensed Nurses and QMA's will be re-educated regarding reporting and physician notification of abnormal vital signs.<br><br>**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**<br><br>· An audit of Blood Pressures will be conducted on at least 10 residents per week receiving any hypertensive medication x 14 days, then 5 residents per week on thereafter.<br><br>· Director of Nursing will be responsible for oversite of these audits.<br><br>· The results of these audits will be reviewed in monthly QAPI meeting until 100% compliance is achieved x 3 consecutive months. | |

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| | The current Physician/Family/Responsible Party Notification policy provided by the DON on 1/29/15 at 9:00 a.m., indicated the following:<br><br>"The facility will inform the resident; consult with the resident's Physician; and if known, notify the resident's legal representative or an interested family member when there is:<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status....."<br><br>This Federal tag relates to Complaint IN00191079.<br><br>3.1-48 (b)(2) | | | |
| F 0431 SS=D Bldg. 00 | 483.60(b), (d), (e)<br>DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility | | | |

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| | must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation, record review and interview, the facility failed to ensure the EDK (Emergency Drug Kit) boxes were stored properly and safely on 1 of 3 units. (The 100 Unit)<br><br>Finding includes:<br><br>On 1/29/16 at 8:00 a.m., during a medication administration with LPN #1 the 100 Unit medication room was observed. Three EDK boxes were observed on the counter top, each of the boxes were unlocked.<br><br>Interview at the time with LPN #1 | F 0431 | **F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br><br>· Locks were placed on the Emergency Drug Kit boxes. | 02/19/2016 |

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| | indicated all three of the EDK boxes should have been locked.<br><br>Interview with the Director of Nursing on 1/29/16 at 8:10 a.m., indicated the EDK boxes should have been locked.<br><br>3.1-25(k)(2) | | **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**<br><br>· Emergency Drug Kits on all units were checked to ensure that they were properly secured.<br><br>**What measures will be put into place or what systemic changes you will make to**<br><br>**ensure that the deficient practice does not recur**<br><br>· Nursing staff were re-educated regarding Locking and Securing of Emergency Drug Kits after each use.<br><br>**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**<br><br>· Observation rounds will be | |

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| | | | conducted on varied shifts at least 5 times per week to ensure that the Emergency Drug Kits are properly stored and secured.<br><br>· Director of Nursing/designee will be responsible for oversite of these audits.<br><br>· The results of these audits will be reviewed in monthly QAPI meeting until 100% compliance is achieved x 3 consecutive months. | |
| F 9999<br><br>Bldg. 00 | Based on record review and interview, the facility failed to ensure an incidence of unusual occurrence was reported to the State Agency for 1 of 3 accidents reviewed. (Resident #E)<br><br>Finding includes:<br><br>The record for Resident #E was reviewed 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.<br><br>The Nursing Progress Notes dated 7/25/15 indicated the resident rolled out of bed while receiving care. The resident broke her eye glasses and was noted to have a 2.5 (cm) centimeter laceration to | F 9999 | **F9999 FINAL OBSERVATIONS**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**<br><br>· Resident E was assessed and the care plan was updated as appropriate.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** | 02/19/2016 |

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| | her upper left eye lid with a small amount of bleeding.<br><br>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.<br><br>The Fall Investigation Worksheet dated 7/25/15 indicated the resident was on an air mattress while receiving care and rolled out of bed. There was no documentation indicating the resident sustained an injury.<br><br>Interview with the Director of Nursing (DON) on 1/27/16 at 4:37 p.m., indicated she did not report to the State Agency Resident #B fell out of bed, broke her eyeglasses, and sustained a 2.5 cm laceration to her upper left eye lid while receiving care.<br><br>Interview with the Administrator on 2/1/16 at 1:00 p.m., indicated the facility should have reported the incident to the State Agency.<br><br>The Incident Reporting and Investigation Policy dated 7/15/15 provided by the | | · Risk Management Incident Reports were reviewed for the past 90 days to identify if any other residents were affected.<br><br>**What measures will be put into place or what systemic changes you will make to**<br><br>**ensure that the deficient practice does not recur**<br><br>· Nursing staff will be re-educated on reporting of unusual occurrences and or injuries. The Director of Nursing and Administrator were re-educated on Incident Reporting Guidelines by the Nurse Consultant.<br><br>**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**<br><br>· The Administrator/designee will review all incident reports | |

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| (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 |
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| | DON on 1/28/15 at 9:59 a.m., indicated the following:<br><br>"Immediately informing the division by telephone, followed by written notice with-in twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any:<br>(D) Major accidents<br><br>5. Major Accidents-unexpected or unintentional events resulting in any fracture or other outcomes that require medical treatment beyond the basic first aid or ER/physician evaluation.<br><br>Note: Includes injuries resulting from improper care techniques." | | weekly to ensure ISDH is notified of unusual occurrences per policy.<br><br>· The results of these audits will be reviewed in monthly QAPI meeting until 100% compliance is achieved x 3 consecutive months. | |