STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. BUILDING 00 B. WING	01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALPARAISO CARE & REHABILITATION	606 WALL STREET VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for the Investigation of Complaints IN00341438, IN00341857, IN00342670, and IN00344151. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00341438 - Unsubstantiated due to lack of evidence. Complaint IN00341857 - Unsubstantiated due to lack of evidence. Complaint IN00342670 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00344151 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey date: January 14, 2021 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 111 Total: 111 Census Payor Type: Medicare: 8 Medicaid: 91 Other: 12 Total: 111 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The creation and submission of this plan of correction does not constiture an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Facility is respectfully requesting a desk review for post-survey visit.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Quality review completed on 1/19/21.			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident received adequate assistance to prevent accidents, related to a resident dependent on two staff members for bed mobility receiving care from one staff member resulting in a fall, for 1 of 3 residents reviewed for accidents. (Resident E) Finding includes: Resident E's record was reviewed on 1/14/21 at 12:48 p.m. The diagnoses included, but were not limited to, respiratory failure. A Significant Change Minimum Data Set assessment, dated 11/19/20, indicated the resident was dependent on two staff members for bed mobility. The Care Plans, dated 10/7/20, indicated a risk for falls. The interventions included therapy was to screen and on 12/8/20, two person assistance with bed mobility was added. Also on 10/7/20, a Care Plan indicated assistance was needed for activities of daily living. The interventions	F 0689	F689 - Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident E had care plan updated to indicate two staff members are required for bed mobility. Staff have been in-serviced by Director of Nursing (DON). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Any resident requiring two staff members for bed mobility will have care plans and orders reviewed for accuracy. A facility audit will be conducted by the Director of	02/13/2021

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	included to assist with bed mobility as needed. A Fall Event form, dated 12/8/20, indicated a fall occurred on 12/8/20 at 1:45 a.m. The resident had rolled out of the bed while incontinence care was being completed. An Interdisciplinary Team Progress Note, dated 12/8/20 at 10:30 a.m., indicated a staff member was providing incontinence care and was changing the linen. The resident was rolled to the side and slid out of the bed. There was no injury. A low air loss bed was being utilized by the resident. The root cause of the fall was poor trunk control and the inability of the resident to keep self from completely rolling over. The immediate intervention was to have two assistance for bed mobility and to remove the low air loss mattress due to air movement caused the resident to roll from the bed. A Physical Therapy Discharge Summary, dated 10/19/20, indicated the resident required maximum assistance of two staff for bed mobility and the CNAs were educated for safe positioning and change of position. During an interview on 1/14/21 at 2:03 p.m., the Director of Nursing indicated one CNA had provided the incontinence care and acknowledged Physical Therapy indicated the resident was a maximum assist of two staff for bed mobility. This Federal Tag relates to Complaints IN00342670 and IN00344151. 3.1-45(a)(2)		Nursing (DON) and/or designee. Updates will made accordingly which will include physician and family notification. What measures will be put into place or what systemic changes will be made to ensure that the deificent practice does not recur: DON/designee will conduct in-service with clinical team to ensure information related to bed mobility is updated and communicated wtih staff. Updates and orders on resident bed mobility will be reviewed in clinical meeting by nurse management team daily. DON/designee will conduct in-service with nursing staff to review bed mobility requirements. 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: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DON/designee will be responsible for completion of the QAPI Audit tool related to bed mobility 5x's per week x 4 weeks and then monthly until 100% compliance is achieved. If threshold of 90% is	

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			not met, an action plan will be developed. Findings will be submitted to the QAPI committee for review and follow up. By what date the systemic changes will be completed: 2/13/2021	