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	11/12/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00363279, IN00363654, IN00365322, and IN00365941. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00363279 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00363654- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00365322 - Substantiated. Federal/State deficiencies related to the allegations are cited at F607 and F609. Complaint IN00365941 - Substantiated. Federal/State deficiencies related to the allegations are cited at F607 and F609. Unrelated deficiency is cited. Survey dates: November 8, 9, 10, and 12, 2021 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Type: Medicare: 4 Medicaid: 96 Other: 10 Total: 110	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The facility respectfully requests a desk review for compliance.	

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/19/21.			
F 0607 SS=E Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on record review and interview, the facility failed to ensure the facility abuse policy was implemented in a a timely manner, related to staff members not reporting allegations of abuse to the Administrator/Designee immediately and not ensuring the residents' safety after the allegations were reported related to the staff member continuing to work at the facility after an allegation was reported, for 1 of 7 abuse allegations reviewed. This had the potential to affect 28 residents who reside on the Memory Care Unit. (Residents E, C, J, and G, Employees 3, 4, 5, and 6) Findings include: An Indiana Department of Health (IDOH) reported incident, indicated on 10/19/21 at 7:01 p.m. there	F 0607	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents E, C, F and G had investigation completed which included head to toe assessments with no findings; medication administration records/count completed with no concerns noted and psychosocial monitoring completed with no changes in normal routines. Abuse was not substantiated. **How other residents having the potential to be affected by the same deficient practice will be**	12/27/2021

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	was an anonymous concern voiced related to staff interactions with residents on the Memory Care Unit, related to Employee 5 and Employee 6, Residents C, E, and F. Resident G was added to the reported incident on 10/22/21. A typed and signed statement provided to the Administrator on 10/20/21 from Employee 3, and dated 10/18/21, indicated: Employee 5 had informed Employee 3 that Resident E has struck her, and as she (Employee 5) walked away she indicated they would be lucky to find that b****'s body and Employee 4 had heard her and said she could not talk like that to the residents. Employee 5 informed informed Employee 4 Resident E could not hear her. Employee 3 notified Employee 4 by telephone, later in the shift, and asked her what happened. Employee 4 then informed Employee 3, that Resident E was awake during the night and Employee 5 had been speaking unkind to the resident and she overheard Employee 5 call the resident a B****. Employee 3 indicated she had not reported the allegation to the Administrator until approximately 4 p.m. on 10/18/21 and the Administrator suggested that she should encourage Employee 4 to write a statement about what had happened and that Employee 5 would be working the Memory Care Unit that evening. Employee 3 indicated, then at approximately 10 p.m. on 10/18/2, Employee 5 administered medications to Residents C, E, and an unknown name of the third resident. (Identified as Resident G in an email from the Corporate Compliance Officer on 10/20/21) and indicated Employee 5 stated, "that should do it and then (sic) should be		**identified and what corrective action(s) will be taken:** Residents residing on the Cottage have the potential to be affected by the alleged deficient practice. Cottage residents were interviewed by SSD/Designee to ensure no additional abuse concerns occurred which were not investigated or reported. Skin sweeps were completed by DNS/Designee for those residents unable to be interviewed. There were no additional concerns noted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Executive Director/Designee will in-service all staff on abuse policy and procedures to include prohibition and prevention of abuse, neglect and exploitation of residents and misappropriation of resident property. Training on abuse policy is done with all new hires during orientation, annually, and as needed. Home office representative will in-service Executive Director on abuse policies and procedures on investigation process on any such allegations. Residents will be interviewed by Social Services/designees to ensure no concerns have occurred without an investigation and appropriate	

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	asleep soon." Employee 3 also indicated approximately 9 p.m. on 10/18/21, Resident C was awake and had been confused and thought the employees were her children who had skipped school. Employee 5 then informed Resident C she was dropping out of school and continued to taunt the resident. The resident became upset, her agitation had increased, and she began to yell. Employee 3 indicated she had not immediately reported the allegations to the Administrator nor had she stopped the taunting of the resident. She indicated prior to this allegation, she had witnessed Employee 6 jerk items away from the residents, tell them she was going to call the police if they didn't cooperate, and told Resident J she would, "perform pillow therapy on her", and had gestured towards covering her face with a pillow. Employee 3 indicated she had not reported these incidents to Administrator. A signed statement from Employee 4, dated 10/20/21, indicated on October 18, 2021 at 12:51 p.m., she was notified by Employee 3 and was asked what happened in the Memory Care Unit the night before. She indicated she had been standing by the Nurses' Station and the Shower Door and heard a commotion. When she turned around Employee 6 had informed her Resident E had hit Employee 5. She then heard Employee 5 state, "you b****." During an interview on 11/8/21 at 8:57 a.m., Employee 4 indicated she had heard Employee 5 call the resident a b****. She had not reported the incident until Employee 3 had notified her and asked her to write a statement. She indicated she knew that all allegations of abuse were to be		reporting. ED will attend Resident Council meeting with permission to encourage residents to voice concerns immediately. **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:** To ensure ongoing compliance with this corrective action, Executive Director/Designee will be responsible for QAPI (Quality Assurance Performance Improvement) Audit Tool weekly x4 weeks and monthly for at least 6 months. If 100% compliance is not achieved, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	reported to the Administrator immediately and should have reported it when she heard it. During an interview on 11/8/21 at 1:30 p.m., the Administrator indicated she had not reported the allegations from Employee 3 to the IDOH on 10/18/21 because this was a third party allegation and Employee 3 had not witnessed nor heard Employee 5 call Resident a b****. She was unaware of the other allegations until 10/19/21 at 10:01 p.m., when she received information from the Corporate Compliance Officer that an anonymous call had been received with several allegations of abuse. She then started the investigation of the abuse allegations. During an interview on 11/12/21 at 1:06 p.m., the Administrator indicated the allegation was reported on 10/18/21 at approximately 4 p.m. Employee 5 worked the evening/night shift on 10/18/21 after the allegation was reported. A facility abuse policy, dated 2/2020, and received from the Administrator as current, indicated the Administrator and/or Director of Nursing were to be notified immediately of any witnessed abuse or any suspicion of abuse and an investigation of the allegation would be initiated. Any staff member implicated in the alleged abused would be removed from the facility immediately. This Federal tag relates to Complaints IN00365322 and IN00365941. 3.1-28(a) 3.1-28(c) 3.1-28(d)			
F 0609 SS=D	483.12(c)(1)(4) Reporting of Alleged Violations			

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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an allegation of abuse was reported in a timely manner to the Indiana Department of Health (IDOH) for 1 of 7 abuse allegations reviewed. (Resident E, Employees 3, 5, and 6) Findings include:	F 0609	**F609** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Investigation was conducted on Resident E with no findings. Abuse was not substantiated.	12/27/2021

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	During an interview on 11/8/21 at 1:30 a.m., the Administrator indicated on 10/18/21, Employee 3 had reported that Employee 4 had overheard Employee 5 call Resident E a b**** after the resident had hit Employee 5. She had not reported the incident since it had been a third party allegation. During an interview on 11/12/21 at 1:06 p.m., the Administrator indicated Employee 3 had met with her to report the incident on 10/18/21 at approximately 4 p.m. She had not considered this an allegation of abuse and the incident had not been reported to the IDOH until 10/19/21 after an anonymous call with additional concerns was received by the Corporate Compliance Officer. The facility's abuse policy, dated 2/2020, and received from the Administrator as current, indicated the Administrator was to ensure all alleged violations were to be reported immediately, or no later than two hours after the allegation is made. This Federal tag relates to Complaints IN00365322 and IN00365941. 3.1-28(c)		**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:** Residents residing on the Cottage have the potential to be affected by the alleged deficient practice. All other reportables for the last 3 months were reviewed by Home Office Staff to ensure reportables were reported timely per policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Executive Director will be in-serviced by Home Office Designee on timely reporting on alleged violations. Home Office staff will review reportables to ensure reportable is submitted timely. The Administrator will be immediately notified of any allegations of abuse and will ensure that the notification will be made to the state agency within 2 hours of being notified of that alleged abuse. An investigation will be initiated immediately. ED/Designee will review the daily activity report to ensure any allegation of abuse was reported immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance with this corrective action ED/Designee will complete Abuse Reporting QAPI tool weekly x4 weeks and monthly for at least 6 months. If 100% compliance is not achieved an action plan will be developed. Findings will be submitted to QAPI committee for review and follow up.	
F 0689 SS=J 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 provide supervision to prevent an elopement of a cognitively and mentally impaired resident, who exited the facility unsupervised. The resident was last seen by an employee of the facility at 8:45 a.m. and exited out of the Main Dining Room door at 8:56 a.m. The facility was unaware the resident was not in the building for 4 1/4 hours. The Responsible Party/Power of Attorney was not notified for over 6 hours the resident had eloped and had not notified the local Police Department of the missing resident. The Responsible Party/Power of Attorney notified the local Police Department and the resident was	F 0689	Past noncompliance: No POC required.	11/29/2021

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	located in a parking lot, 0.9 miles from the facility, for 1 of 5 residents reviewed for supervision. (Resident M) The immediate jeopardy began on 9/18/21 when the facility was unaware the resident had exited the facility without supervision. The alarm to the door he exited was activated upon exiting and an employee silenced the alarm with a code, without looking outside to see if anyone had left through the door. The Resident Representative/Power of Attorney was not notified in a timely manner, and the local Police Department was not notified of the missing resident for approximately 2 hours after the facility had realized the resident was missing. The resident had walked to a local restaurant, 0.9 miles from the facility, was located in a parking lot, and was brought back to the facility by the local Police Department. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy at 3:10 p.m. on 11/9/21. The immediate jeopardy was removed, and the deficient practice corrected on 9/30/21 prior to the start of the survey and was therefore Past Noncompliance. Finding includes: An Indiana Department of Health (IDOH) reportable incident, indicated on 9/18/21 at 1:01 p.m., the Administrator and the DON were informed Resident M was missing from the facility, a Code Silver (missing resident) was called. The video camera at the facility was reviewed to confirm the resident exited the building without supervision. The family and police were notified and the resident was brought back to the facility. The resident had left the facility to buy cigarettes. The resident's cognitive status was intact, though the Physician assessed			

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	the resident as incompetent. Resident M's record was reviewed on 11/9/21 at 9:25 a.m. The diagnoses included, but were not limited to, vascular dementia, Parkinson's disease, and schizophrenia. A Quarterly Minimum Data Set assessment, dated 7/12/21, indicated an intact cognitive status, and required supervision of one staff member for ambulation, no behaviors, and received an antipsychotic and an antidepressant medication for seven of the past seven days. An Elopement Risk assessment, dated 7/12/21, indicated a history of eloping from home or facility, had been assigned a security bracelet, and had a recent elopement in the past month. The Care Plans included: On 5/7/18, and discontinued on 9/29/21, indicated a risk for for elopement, he displayed an impaired cognitive function, ambulated independently, often requested to go home, and was pushing/pulling on an exit door. The interventions included, on 6/18/21, offer a drink or snack and redirect him to a different area, 2/23/21, encourage participation in activities, 7/8/21 - daily walks or sit outside daily with activities, 5/18/20 - 15 minute checks, offer and assist with going to the patio, offer to assist with a phone call or video chat with his family, 5/7/21 - all facility exits were secured and security bracelet was placed. On 9/6/18, has delusional or paranoid thinking, fearful of others harming him or conspiring against him. The interventions included, maintain consistent daily routine and Psychiatric services as needed.			

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	On 5/7/18, short and long term memory deficit with impaired decision making skills present. Wanders around the facility. The interventions included to encourage independence and cueing. On 5/7/18, he is unable to return to the community due to a need for 24 hour care secondary to multiple diagnoses that affect cognition and judgement. On 4/17/18, he was a risk for falls. The interventions included, non-skid footwear. A History and Physical from a prior facility, dated 1/25/17, indicated the resident a poor historian and had been deemed incompetent. A Preadmission Screening and Resident Review (PASRR) assessment, dated 9/17/21, indicated significant difficulty communicating, had difficulty recognizing familiar people or familiar objects, and had short and long term memory impairments. A Physician's Order, dated 4/27/18, indicated a Wanderguard security bracelet was initiated. A Speech Therapy Discharge Summary, dated 8/9/21, indicated a mild cognitive deficit was present. He had compromised recall, problem-solving, and safety awareness and judgement, and required continued 24-hour care for safety, and he was a safety and elopement risk. A Psychiatric Physician Assistant's Progress Notes, dated 9/7/21, indicated a sleep and energy deficit was noted and he was oriented only to person and place. A Licensed Clinical Social Worker's (LCSW)			

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	progress note, dated 9/11/21 at 8:42 p.m., indicated he was oriented to self and had displayed exit seeking behaviors. A Nurse's Progress note on 6/12/21 at 8:11 a.m., indicated at 7:50 a.m. the resident had exited the front door and was jogging down the street. The staff witnessed the exit and were able to divert him back into the facility. The Nurses' Progress Notes on 9/18/21 indicated: At 3:13 p.m., the Power of Attorney(POA) notified of the resident's elopement. She requested the local Police Department be notified and was informed by the Nurse she was unable to report the resident as missing due to his cognitive score indicated he had no cognition problems and he was considered as leaving against medical advice (AMA). The POA indicated she would notify the Police herself. The Administrator, DON, the Nursing Manager, and the Physician on call were notified. (this was the first documentation of the resident being missing) At 3:44 p.m., the resident was brought back to the facility by the local police. The resident had been found at a local restaurant and had been sitting at the restaurant since his elopement from the facility. The POA was notified the resident had returned to the facility. A Physician's Progress Note, Dated 9/20/21 at 9:57 a.m. and late entry on 9/29/21 at 10:04 a.m., indicated, cognition status was assessed and he was unable to make his own decisions. He was not able to completely grasp his situation or the danger when he exited the building on 9/18/21. During an interview with the Administrator on			

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	11/9/21 at 8:15 a.m., she indicated she had watched a video of the facility on 9/18/21. He had exited the facility by a door in the Main Dining Room. The alarm on the door had been activated, and Employee 1 had come from the hallway, placed the code in the alarm box, and silenced the alarm. The video indicated the resident had kicked the door open. The last time he had been seen by staff was at 8:45 a.m. when the Nurse had given him his medication. He had been in the dining room eating breakfast, then exited the door at 8:56 a.m.. Employee 2 was scheduled to supervise the Dining Room, and had exited the same door, for an unknown reason, at 8:45 a.m. There were still a couple residents in the Dining Room when Employee 1 exited out the door. When the staff could not find the resident a Code Silver was announced. The facility was unable to reach the Administrator, so they notified the DON, who notified the Regional Manager, who indicated the resident had no cognitive deficits so the facility could not call it an elopement and to treat it as exiting against medical advice. The POA had not been notified due to the Regional Manager had indicated it was not an elopement. When the POA was notified, she was upset. The facility had notified the Police after notification of the POA. She indicated no staff members were interviewed about the elopement since she was able to see on the video what occurred. The Administrator presented an Email, dated 11/9/21 at 11:39 a.m., addressed to the Regional Manager on 9/19/21, which indicated, the resident ambulated throughout the facility independently, so it was not unusual for the staff not to know where the resident was at until the next meal. The video indicated the resident stood from the breakfast table in the Main Dining Room and pushed the Dining Room exit door open at 8:56			

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	155166	A. BUILDING 00 B. WING	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	a.m. This door was used by staff to take trash out to the dumpster. Soon after the resident exited, Employee 1 entered the Dining Room from the hallway and used the key pad to silence the alarm. She assumed the alarm was going off, since he had entered the code. The family had not been notified until the facility could confirm the resident actually exited on his own. The Police were notified and informed them they had received a call earlier in the day, which a restaurant had concerns about a gentleman who had been there since 10 a.m. The Police had went to the restaurant and the gentleman had informed them he was homeless and had slept at the park the night before. The Police had informed the gentleman he had to leave the restaurant. Once the facility had notified the Police, they realized this was the missing resident and found the man walking in the parking lot and escorted him back to the facility. "...He is definitely not safe to go out...." During an interview on 11/9/21 at 11:58 a.m., Employee 1 indicated the alarm to the door in the Dining Room had been activated and the code was entered and the alarm was silenced. He had not looked outside to see who went out the door. During an interview on 11/9/21 at 1:21 p.m., Employee 2 indicated she had exited the Dining Room Door to go out to her car. She entered the code prior to the exit, so the alarm was not activated. She had not witnessed the resident outside of the facility. During an interview on 11/9/21 at 1:32 p.m., the POA indicated she was upset the facility had not called her until 3 p.m. since the resident had been missing since 9 a.m. She requested the Police be notified and was told she would have to call the			

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	Police because of his cognitive status. She indicated she had notified the Police and was told by the Police, the facility needed to call and report the missing resident. She notified the facility and told them they needed to call and report the resident as missing. The Police had seen the resident earlier when they entered the the restaurant. During an interview on 11/9/21 at 2:13 p.m., the Administrator indicated between 1 p.m. and the resident's return to the facility, she had watched the video. She indicated staff had searched the building and drove around the neighborhood. The facility had not wanted to call the POA until they knew the resident was no longer in the building and he goes out with family frequently so they were not sure if he was with family. A Police Report, dated 9/18/21, indicated the facility notified the Police of the missing resident at 3:23; p.m. The resident had left the facility approximately on 9/18/21 at 9 a.m. The resident was found in a parking lot at 3:26 p.m. and escorted back to the facility at 3:32 p.m. A facility policy, dated 10/2017, titled, "Elopement Prevention and Response Program", received from the Administrator as current, indicated the facility staff were responsible for knowing the location of the residents under their care. If location of the resident was unknown, a Code Silver is activated, a head count is completed, the Leave of Absence sign out book is to be reviewed, a search of the facility and outside grounds are to be completed. If the resident was not found, the Police and the resident's Responsible Party would be notified, and the search would be expanded to the surrounding neighborhoods.			

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	The past noncompliance immediate jeopardy began on 9/18/21. The immediate jeopardy was removed and the deficient practice corrected by 9/30/21 after the facility implemented a systemic plan that included the following actions: the resident was placed on 15 minute checks, a stronger magnetic lock was placed on the exit door, the alarm was upgraded into the a centralized foyer to ensure it was also audible in the hallways. All but 14 staff had been re-educated on the elopement procedure and response to the door alarms. All staff not educated were either on leave or work as needed and would be educated prior to working at the facility. All residents were assessed for being an elopement risk. Staff were interviewed and were knowledgeable of the policy and procedure to follow with a missing resident, door alarm activation, and notification of family and police as needed per policy. 3.1-25(a)(2)			