STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 00 B. WING	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE VALPARAISO	3301 N CALUMET AVE 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 IN00255150, IN00257403, and IN00258886. Complaint IN00255150- Substantiated. Federal/State deficiencies related to the allegations are cited at F623 and F625. Complaint IN00257403- Substantiated. Federal/State deficiencies related to the allegations are cited at F623 and F625. Complaint IN00258886- Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, F679, and F686. Survey dates: April 24 & 25, 2018 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census bed type: SNF/NF: 89 Total: 89 Census payor type: Medicare: 14 Medicaid: 69 Other: 6 Total: 89 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**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 provisions of federal and state law.*	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes.			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)			

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	Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, record review, and interview, the facility failed to ensure the Physician and Family were notified of the development of a pressure ulcer for 1 of 3 residents reviewed for notification of change. (Resident D) Finding includes: On 4/24/18 a 2:41 p.m., the ADON (Assistant Director of Nursing) and CNA 4 repositioned Resident D on her side in the bed. The resident was incontinent of stool. There was stool around and on an open area on the coccyx/buttock fold area. No dressing was in place on the open area. The ADON indicated she would obtain a treatment order from the Physician at this time. The record for Resident D was reviewed on 4/24/18 at 2:03 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, high blood pressure, and arthropathy. A Quarterly Minimum Data Set (MDS) assessment was completed on 4/6/18. The resident's cognitive skills for decision making were severely impaired. Extensive assistance of staff was required for bed mobility, toileting, personal hygiene, and locomotion on the unit. The resident was at risk for the development of pressure ulcers. No	F 0580	**F580 Family/Physician Notification** **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 provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Family of Resident “D” was notified of wound and new treatment. Physician was notified and new orders received and carried out. **2) How the facility identified other residents:** Audit for prior 30 days completed	05/21/2018

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	pressure ulcers were present. The current Physician orders were reviewed. No Physician orders were noted for any pressure ulcer treatments prior to 4/24/18. A Weekly Skin Observation note, completed on 4/19/18 at 2:50 p.m., indicated a small open area between the buttock cheeks was noted. The area was cleansed and dressed. There was no further assessment of the open area. No Physician or family notification was documented. The 4/2018 Nursing Progress notes were reviewed. An entry, completed on 4/19/18 at 2:16 p.m., indicated an "open spot" was observed on the resident's "bottom." Venelex (a topical ointment) was applied and the area was dressed with a comfort foam border dressing. There was no documentation of Physician or family notification of the open area. A Nursing Progress note, completed on 4/24/18 at 3:38 p.m., indicated the Stage II open area found on the coccyx measured 1.0 cm(centimeter) x 0.5 cm. The Physician was notified and a treatment order was obtained. When interviewed on 4/24/18 at 3:00 p.m., the Assistant Director of Nursing indicated she found out about the open area yesterday and a text was sent to the Wound Nurse. The Physician and family should have been notified when the open area was first documented on 4/19/18. This Federal tag relates to Complaint IN00258886. 3.1-5(a)(3)		and those residents identified as having pressure area or where the physician/family should have been notified and made notification if needed. **3) Measures put into place/ System changes:** Licensed Nursing Personnel/SSD education regarding Physician and family notification will be completed by May 21, 2018. **4) How the corrective actions will be monitored:** Audits will be conducted by DON/ADON/Designee 5 days per week to ensure notifications to Physician/family including but not limited to change in condition using tracking log for 6 months or >80 % compliance. Review of tracking log will occur during QAPI for 6 months or >80% compliance. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 5/21/2018**	

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F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is			

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	required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill			

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	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record record review and interview, the facility failed to provide written information to the Responsible Parties regarding the transfer, bed hold policy, and permitting the resident to return to the facility for 2 of 2 residents transferred to the hospital. (Residents B and J) Findings include: 1. The closed record for Resident B was reviewed on 4/24/18 at 1:14 p.m. The resident was admitted on 2/7/18 and discharged to the hospital on 2/9/18. Diagnoses included, but were not limited to Alzheimer's disease, metabolic encepholpathy, and unspecified psychosis upon admission. The resident did not return the facility. A Physician's order was obtained on 2/9/18 to send the resident to (hospital name) Emergency	F 0623	F-623 Transfer/Discharge **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 provisions of federal and state law.*	05/21/2018

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	Room for Psychiatric evaluation. The facility could not provide verification of the following being given to the responsible party: A. "Notice of Transfer or Discharge" form for the resident's transfer to the hospital on 2/9/18. Information to be completed on the form included, but was not limited to, the date of discharge, location discharged to, reason for transfer or discharge, and verification of the facility's bed hold policy and a copy of the above such "Notice of Transfer or Discharge" with contact information of a facility employee to contact about the bed hold policy." B. "Notice of Transfer or Discharge Request for Hearing" policy to appeal a transfer/discharge with the Indiana State Department of Health. C. "Bed Reserve Policy Notification" policy to be given upon admission and at the time one leaves for a hospitalization. 2. The closed record for Resident J was reviewed on 4/25/18 at 1:56 p.m. The resident was admitted to the facility on 1/5/18 and discharged on 3/21/18. Diagnoses included, but were not limited to, schizophrenia, convulsions, and metabolic encephalopathy. A Physician's order was obtained on 3/21/18 to send the resident to the hospital for post follow up surgery. The facility could not provide verification of the following: A. "Notice of Transfer or Discharge" form for the resident's transfer to the hospital on 2/9/18. Information to be completed on the form included, but was not limited to, the date of discharge, location discharged to, reason for transfer or discharge, and verification of the facility's bed		**1) Immediate actions taken for those residents identified:** All responsible or responsible parties will be given the current Aperion Care transfer notice. In addition residents or responsible will be notified of the current state requirement of providing a notice of transfer by May 21, 2018. **2) How the facility identified other residents:** All residents who transfer or discharge have the risk to be affected by the alleged deficient practice. Audit of transfer/discharged residents from prior 30 days those who did not meet standard of care will be provided with transfer/discharge policy. **3) Measures put into place/ System changes:** Licensed Nursing Staff &SSD will be reeducated on Transfer/Discharge Process by May 21, 2018. SSD or designee will complete an audit every Monday through Friday on all transfers and bed hold for the duration of 6 months or when 80% compliance is achieved. **4) How the corrective actions will be monitored:** Discrepancies upon audit findings will result in further education for individual that performs below acceptable standards. The education will be by teach back method by the SSD or designee.	

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	hold policy and a copy of the above such "Notice of Transfer or Discharge" with contact information of a facility employee to contact about the bed hold policy." B. "Notice of Transfer or Discharge Request for Hearing" policy to appeal a transfer/discharge with the Indiana State Department of Health. C. "Bed Reserve Policy Notification" policy to be given upon admission and at the time one leaves for a hospitalization. When interviewed on 4/24/18 at 3:15 p.m., the facility Administrator indicated the above forms had not been completed and/or given to Residents B and J or their Responsible parties upon transfer to the hospital. This Federal tag relates to Complaints IN00257403 and IN00255150 3.1-12(6)(A)		Any further discrepancies will be monitored by ADON/DON/ or designee The corrective action will be reviewed monthly in QAPI for 6 months or >80% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 5/21/2018**	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;			

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	(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record record review and interview, the facility failed to provide written information to the Responsible Party regarding the transfer, bed hold policy, and permitting the resident to return to the facility for 2 of 2 residents transferred to the hospitals. (Residents B and J) Findings include: 1. The closed record for Resident B was reviewed on 4/24/18 at 1:14 p.m. The resident was admitted on 2/7/18 and discharged to the hospital on 2/9/18. Diagnoses included, but were not limited to Alzheimer's disease, metabolic encepholpathy, and unspecified psychosis upon admission. The resident did not return the facility. A Physician's order was obtained on 2/9/18 to send the resident to (hospital name) Emergency Room for Psychiatric evaluation. The facility could not provide verification of the "Bed Reserve Policy Notification" policy that was to be given upon admission and at the time one leaves for a hospitalization.	F 0625	F-625 Notice of Bed Hold **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 provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** All responsible or responsible parties will be given the current Aperion Care bed hold policy. In addition residents or responsible	05/21/2018

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	2. The closed record for Resident J was reviewed on 4/25/18 at 1:56 p.m. The resident was admitted to the facility on 1/5/18 and discharged on 3/21/18. Diagnoses included, but were not limited to, schizophrenia, convulsions, and metabolic encephalopathy. A Physician's order was obtained on 3/21/18 to send the resident to Methodist hospital for post follow up surgery. The facility could not provide verification of "Bed Reserve Policy Notification" policy to be given upon admission and at the time one leaves for a hospitalization. When interviewed on 4/24/18 at 3:15 p.m., the facility Administrator indicated the above forms had not been completed and/or given to Residents B and J or the Responsible Parties upon transfer to the hospital. This Federal tag relates to Complaints IN00255510 and IN00257403. 3.1-12(a)(25)		will be notified of the current state requirement of providing a notice of transfer by May 21, 2018. **2) How the facility identified other residents:** All residents who transfer or discharge have the risk to be affected by the alleged deficient practice. Audit of transfer/discharged residents from prior 30 days those who did not meet standard of care will be provided with transfer/discharge policy. **3) Measures put into place/ System changes:** Licensed Nursing Staff &SSD will be reeducated on Bed Hold and Transfer/Discharge Process by May 21, 2018. **4) How the corrective actions will be monitored:** SSD or designee will complete an audit every Monday through Friday on all transfers and bed hold for the duration of 6 months or when 80% compliance is achieved. Discrepancies upon audit findings will result in further education for individual that performs below acceptable standards. The education will be by teach back method by the SSD or designee. Any further discrepancies will be monitored by ADON/DON/ or designee. The corrective action will be reviewed monthly in QAPI for 6 months or when 80% compliance	

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			is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance: 5/21/2018**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure care was provided related to activities of daily living (ADL's) for 2 of 4 residents observed for incontinence care. (Residents C and E) Findings include: 1. On 4/24/18 at 8:42 a.m., Resident C was observed in a Broda chair in the Activity Room on the Linden Unit. The resident's eyes were closed and she was nonverbal. A Hoyer lift pad was under the resident. The Broda chair was reclined and the resident was on her back. The resident remained in the Broda chair in the Activity Room. The Activity Director transported the resident to the Dining Room at 11:17 a.m. Continuous observation from 8:42 a.m. through 11:17 a.m. indicated no staff had repositioned the resident or transported the resident back to her room for incontinence care. The Linden food cart arrived to the unit at 11:37 a.m. On 4/24/18 at 2:42 p.m., the resident was observed in the Broda chair in the Activity Room. The	F 0677	**F-677 ADL care provided for dependent residents** **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 provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	05/21/2018

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APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

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	resident was on her back. Activity Aide 3 was present in the room. The Activity Aide indicated the resident had been in the room since she came to relieve the other Aide at 2:00 p.m. On 4/24/18 at 3:27 p.m., the resident remained in the Broda chair in the Activity Room. Per surveyor request, CNA 2 (evening shift) and LPN 3 transported the the resident to her room. The resident was put into bed via the Hoyer lift by both above staff members. CNA 2 removed the resident's pants and disposable brief. A strong urine odor was present. The brief was saturated to each side and up to one to two inches from the top. The CNA indicated she was not informed of the last time the resident had been changed when she started her shift. The record for Resident C was reviewed on 4/25/18 at 11:16 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, epilepsy, and depressive disorder. A Quarterly Minimum Data Set (MDS) assessment was completed on 1/3/18. The resident was rarely or never understood and had no behaviors or rejection of care. Extensive assistance was needed for transfers, locomotion on the unit, personal hygiene, and toileting. The resident was always incontinent of bowel and bladder. Range of motion impairment was present on both lower and both upper extremities. A Care Plan, last revised on 11/30/17, indicated the resident had an ADL self care deficit related to the dementia disease process. Intervention included, hoyer lift for transfers, and two staff to provide incontinence care. When interviewed on 4/24/18 at 3:50 p.m., the facility Administrator indicated the resident		Resident's C, and E were provided care per their plan of care. **2) How the facility identified other residents:** All residents who require assistance with ADL's have the risk to be affected by the alleged deficient practice. Audit of care plans on all residents that required dependent care from prior 30 days prior to insure care plan of ADL needs are noted. **3) Measures put into place/ System changes:** Nursing staff education to be conducted on ADL care by May 21, 2018. **4) How the corrective actions will be monitored:** DON or designee will complete the dependent ADL audit 3 times per week on varied shifts for 4 weeks completing and then weekly for 6 months or when 80% compliance is achieved. The corrective actions will be reviewed monthly for 6 months or when 80% compliance is achieved. Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 5/21/2018** **F-677 ADL care provided for dependent residents – incontinence** **The facility requests paper**	

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	should have been provided incontinence in a timely manner. 2. On 4/24/18 at 8:30 a.m., Resident E was taken from the Dining Room to the Activity Room on the unit. The resident remained in the Activity room until the Activity Director transferred the resident to the Dining Room at 11:12 a.m. The resident was not taken out of Activity room during the above time or provided any repositioning in the wheel chair. The record for Resident E was reviewed on 4/25/18 at 10:01 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, glaucoma, and depressive disorder. A Quarterly Minimum Data set (MDS) assessment was completed on 3/22/18. The resident cognitive skills for decision making were severely impaired. The resident did not reject care. Extensive assistance of staff was required for bed mobility and locomotion on the unit. Total dependence of two staff member was required for transfers. A Care Plan, last revised on 3/15/18, indicated the resident was at risk for pressure ulcers related to incontinence and immobility. Interventions included, but were not limited to, assist with repositioning as tolerated and notify the Nurse of any skin breakdown. When interviewed on 4/24/18 at 3:50 a.m., the facility Administrator indicated the residents should have been repositioned and checked for incontinence care. This Federal tag relates to Complaint IN00258886. 3.1-38(a)(2)(C)		**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 provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident's C, &E were provided care per their plan of care. **2) How the facility identified other residents:** All residents who require assistance with incontinence care have the risk to be affected by the alleged deficient practice. Audit of care plans on all residents that required incontinent care from prior 30 days prior to insure care plan for incontinent needs are noted. **3) Measures put into place/ System changes:** Nursing staff education to be conducted on incontinence care by May 21, 2018.	

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			4) How the corrective actions will be monitored: DON or designee will complete the ADL audit 3 times per week on varied shifts for 4 weeks completing and then weekly for 6 months or when 80% compliance is achieved. The corrective actions will be reviewed monthly for 6 months or when 80% compliance is achieved in QAPI. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 5/21/2018**	
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure activities were provided for residents as per their preferences and individual functional levels for 4 of 5 residents observed for activities. (Residents	F 0679	**F679 ACTIVITIES MEET INTEREST/NEEDS EACH RESIDENT** **The facility requests paper**	05/21/2018

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	C, D, E & F) Findings include: 1. On 4/24/18 at 8:18 a.m., Activity Staff transported Resident D from the Linden Unit Dining Room to the Activity Room next to the Dining Room. The resident was in a wheel chair. On 4/24/18 at 8:19 a.m., other staff transported Residents E and G from the Linden Unit Dining Room to the Activity Room next the the Dining Room. The residents were transported in wheel chairs. On 4/24/18 at 8:35 a.m., CNA 2 transported Resident F from her room to the Activity Room in a geri chair. Residents F, E, G, and C were seated next to each other against a wall in the Activity Room. Activity Aide 1 was present in the Activity Room. Activity Aide 1 began reading a book aloud to the residents at 8:42 a.m. Resident F was in geri chair with her eyes open. Resident G was in a wheel chair with her eyes open. Resident E was asleep in her wheel chair. Resident C was asleep in the Broda recliner chair. On 4/24/18 at 8:55 a.m., Resident F was leaning forward in her geri chair. The Activity Aide called out Resident F's name twice and asked her to sit back. The resident eyes were open. At 9:05 a.m. the Activity Aide was still reading from the book and called out Resident E's name asking her if she liked pizza. Resident E opened her eyes for a second or two and closed them again without answering. On 4/24/18 at 9:11 a.m., Activity Aide 1 was now starting a balloon toss with the residents in the		**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 provisions of federal and state law.* **1.) Immediate actions taken for those residents identified:** Residents C, D, E, F, G preferences for interests and activities was update and Care plans updated **2) How the facility identified other residents:** All residents have the potential to be affected by this alleged deficient practice. All residents' preferences/interests for activities were update and care plans updated **3) Measures put into place/ System changes:** Activity staff/ activity	

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	room. Resident C was not given a Styrofoam noodle to hit the balloon, but others residents were. Resident D remained asleep. Activity Aide 2 entered the Activity Room and Aide 1 left the room at this time. On 4/24/18 at 9:41 a.m. Activity Aide 2 now setting up a bean bag bucket toss in the Activity Room. Residents G was the only resident participating. Resident F remained in her geri chair against the wall. Resident E was asleep in her wheel chair and Resident C was reclined in a Broda chair with her eyes closed. On 4/24/18 at 9:52 a.m. Activity Aide 2 was now sitting on the couch in the Activity Room. Resident G was in a wheel chair in front of the Aide. The Aide was reading a book to the resident. The other three residents remained in their chairs against the wall. Another resident entered the Activity Room and stated, "everyone's sitting there with their mouths open. I don't want to be here." At 10:22 a.m. the Activity Aide was now painting Resident G's finger nails. At 10:34 a.m., the Activity Aide was setting up the bean bag bucket toss again. Resident E was asleep in the wheel chair and still holding the noodle from the previous balloon toss event. At 10:43 two different residents were in the Activity Room. One of the residents was participating in the bean bag bucket. The Aide was asked for the name of the resident. The Aide indicated she did not know the residents name as she is "not down here that often." The Activity Aide also indicated she did not know Resident C's name. On 4/24/18 at 11:16 a.m., the Activity staff began transporting the residents into the Dining Room for lunch. Residents C, D, E, and F were all taken		Director/designee will be re-educated on the facility activity programs by the Executive Director/designee by 5/17/18. **4) How the corrective actions will be monitored:** The Activities Review tool will be completed at least 3 times a week for 4 weeks and weekly thereafter for 6 months or when 80% compliance is achieved. The Executive Director/Designee is responsible for compliance. The corrective actions will be reviewed monthly for 6 months or when 80% compliance is achieved in QAPI. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **5/21/2018**	

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	from the Activity Room to the Dining Room. 2. The record for Resident C was reviewed on 4/25/18 at 11:16 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, epilepsy, and depressive disorder. A Quarterly Minimum Data Set (MDS) assessment was completed on 1/3/18. The resident was rarely or never understood and had no behaviors or rejection of care. Extensive assistance was needed for transfers, locomotion on the unit, personal hygiene, and toileting. An Activities-Preference Interview was completed with the family on 1/29/18. It was very important for the resident to do things with groups of people, listen to music, and participate in religious services. A Care Plan, last revised on 2/15/18, indicated the resident was at risk for decrease in mood and increase in behaviors due to nursing home placement, diagnoses of depression, and use of anti-depressants. Interventions included, but were not limited to, encourage the resident to participated in activities. A Care Plan, last revised on 3/15/18, indicated the resident will yell out during care. Interventions included, but were not limited to, provide a program of activities that accommodate the resident's abilities. The residents room was observed on 4/25/18 at 1:00 p.m. There was no radio or music player observed in the resident's room. 3. The record for Resident D was reviewed on 4/24/18 at 2:03 p.m. Diagnoses included, but were not limited to, dementia without behavioral			

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	disturbances and high blood pressure. A Quarterly Minimum Data Set (MDS) assessment was completed on 4/6/18. The resident was rarely or never understood. Cognitive skills for decision making were severely impaired. The resident did not reject care. Extensive staff assisted was needed for bed mobility, dressing, personal hygiene, and locomotion on the unit. An Activities -Preference Interview was completed with the family on 10/3/17. The resident was rarely or never understood. It was very important for the resident to listen to music she liked and to participate in religious services or activities. A Care Plan, last revised on 4/13/18, indicated the resident was at risk for decrease in mood and increase in behaviors due to nursing home placement and a diagnosis of major depressive disorder. 4. The record for Resident E was reviewed on 4/25/18 at 10:01 a.m. Diagnoses included, but were not limited to, cognitive communication deficit, glaucoma, and depressive disorder. A Quarterly Minimum Data set (MDS) assessment was completed on 3/22/18. The resident cognitive skills for decision making were severely impaired. The resident did not reject care. Extensive assistance of staff was required for bed mobility and locomotion on the unit. Total dependence of two staff member was required for transfers. An Activity -Preference Interview was completed. The resident was usually understood. It was very important for the resident to listen to music she liked and to do things she liked with groups of people.			

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	A Care Plan, last revised on 1/17/18, indicated the resident had dementia and needs cues and reminders. Interventions include, but are not limited to, assist with daily decision making and invite, remind, and escort resident to activity programs, and use residents names in approaching in a calm manner. A Care Plan, last revised on 3/19/18, indicated the resident was dependent on staff for emotional, intellectual, physical, and social needs. She enjoys games, crafts, music, religious services, sing along's, and manicures. Interventions included, but were not limited to, ensure that activities the resident is attending are compatible with her mental and physical capacities, and reminders of and transport to activities are provided when needed. The residents room was observed on 4/25/18 at 1:00 p.m. There was no radio or music player observed in the residents room. When interviewed on 4/24/18 at 2:40 p.m., the facility Administrator indicated the staff should provide ongoing activities for the residents according to their needs. Activity staff should know the names of the residents and their preferences. When interviewed on 4/25/18 at 8:15 a.m., the Activity Director indicated she began communication with family members of the residents on the unit. Activity staff should be familiar with the resident names and preferences. Activities should be provided to meet interests and needs of each resident. This Federal tag relates to Complaints IN00258886.			

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	3.1-33(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure an area of skin breakdown was assessed and treated when initially observed resulting in the development of a Stage II pressure area for 1 of 3 residents reviewed for risk of pressure ulcer development. (Resident D) Finding includes: On 4/24/18 at 8:18 a.m., Resident D was seated in a wheel chair in the Linden Dining Room. Activity staff transported the resident into the Activity Room. A Hoyer (mechanical lift) pad was under the resident. The resident remained in the Activity Room until 11:12 a.m., when staff transported the resident directly from the Activity Room back to the Dining Room for lunch. On 4/24/18 a 2:41 p.m., the ADON (Assistant	F 0686	F686 Pressure Ulcers **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 provisions of federal and state law.*	05/21/2018

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	Director of Nursing) and CNA 4 repositioned the resident on her side in the bed. The resident was incontinent of stool. There was stool around and on the open area on the coccyx/buttock fold area. No dressing was in place on the open area. The ADON indicated she would obtain a treatment order from the Physician. On 4/25/18 at 12:25 p.m., the Wound Care Physician assessed the open area to the coccyx area. The Physician identified the area as a Stage II pressure ulcer. The record for Resident D was reviewed on 4/24/18 at 2:03 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, high blood pressure, and arthopathy. A Quarterly Minimum Data Set (MDS) assessment was completed on 4/6/18. The resident's cognitive skills for decision making were severely impaired. Extensive assistance of staff was required for bed mobility, toileting, personal hygiene, and locomotion on the unit. The resident was at risk for the development of pressure ulcers. No pressure ulcers were present. A Care Plan, last revised on 4/13/18, indicated at risk for pressure ulcer development. Interventions included, but were not limited to, provide routine repositioning an notify Nursing promptly of any signs of skin breakdown. A Care Plan, last revised on 4/13/18, indicated a self care deficit. Assistance was required with daily care needs. Interventions included, but were not limited to, extensive assistance of one or two staff for routine toileting. Complete dependence of one staff for bathing.		**1) Immediate actions taken for those residents identified:** Resident D was assessed by wound nurse and Ameriwound Physician, measurement, description and staging completed. Treatment was ordered. Weekly and PRN measurements and monitoring until healed. Review of current pressure prevention plan of care. **2) How the facility identified other residents:** All residents can be affected. A facility wide skin sweep performed by DON/ADON and designee any new skin issues addressed **3) Measures put into place/ System changes:** Nursing personnel will be education on pressure prevention, identification, assessment and treatment of pressure areas. Completed by May 21, 2018. **4) How the corrective actions will be monitored:** Audits will be completed per DON/ADON/Designee, 3 times per week of 3 residents' with wounds to ensure correct treatment; as ordered, treatment in place and on-going assessment until healed for a duration of 6 months. Completed November 30, 2018. Corrective action will be reported during Monthly QAPI for 6 months. Completed November 30, 2018. The results of these audits will be reviewed in Quality compliance 6	

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	The current Physician orders indicated no Physician orders were noted for any pressure ulcer treatments prior to 4/24/18 at 3:38 p.m. A Nursing Progress note, completed on 4/19/18 at 2:16 p.m., indicated an "open spot" was observed on the resident's "bottom." Venelex (a topical ointment) was applied and the area was dressed with a comfort foam border dressing. There was no documentation of Physician notification of the open area. A Nursing Progress note, completed on 4/24/18 at 3:38 p.m., indicated the Stage II open area found on the coccyx measured 1.0 cm (centimeter) x 0.5 cm. The Physician was notified and a treatment order was obtained. A Weekly Skin Observation note, completed on 4/19/18 at 2:50 p.m., indicated a small open area between the buttock cheeks was noted. The area was cleansed and dressed. There was no further assessment of the open area. No Physician notification was noted. A Weekly Skin Observation note, completed on 4/10/18 at 9:57 p.m., indicated the resident's skin was intact. No concerns were noted. When interviewed on 4/24/18 at 3:00 p.m., the Assistant Director of Nursing indicated she found out about the open area yesterday/Monday and a text was sent to the Wound Nurse. The Wound Nurse does rounds on Sundays, Tuesdays, and Thursdays. No treatment orders were in place. Staff should have completed an assessment of the open area when first observed. The facility "Pressure Ulcer Prevention" policy		months or when 80% compliance is achieved. The corrective actions will be reviewed monthly for 6 months or when 80% compliance is achieved in QAPI. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 5/21/2018**	

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	155277	A. BUILDING 00 B. WING	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE VALPARAISO	3301 N CALUMET AVE 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
	was provided by the facility Administrator on 4/24/18 and identified as the current policy to be used by staff. The policy was last revised on 1/15/18. Staff were to inspect the resident's skin during daily bathing, hygiene, and repositioning. Dependent residents were to be turned approximately every two hours or as needed. This Federal tag relates to Complaint IN00258886. 3.1-40(a)(2)			