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	06/08/2018

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 a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00264621. Complaint IN00264621 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558, F686 and F690. Survey dates: June 3, 4, 5, 6, 7 and 8, 2018 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 11 Medicaid: 56 Other: 21 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/13/18.	F 0000	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 of 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. The facility respectfully requests paper compliance for this survey.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons			

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

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	and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to ensure a resident's dignity was maintained related to toileting needs for 1 of 1	F 0550	The facility requests paper compliance for this citation.	07/08/2018

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	residents reviewed for dignity. (Resident 33) Finding includes: An interview with Resident 33 on 6/4/18 at 10:17 a.m., indicated when requesting to have a bowel movement (BM), the staff would place the resident in bed, turn her to one side and she would have BM on a pad underneath her. The resident stated, "I can't go that way, it isn't natural, it makes me feel like an animal." The resident indicated since she could not bear weight on her legs, the staff were unable to used a stand-up lift to place her on the toilet. The record for Resident 33 was reviewed on 6/7/18 at 1:22 p.m. Diagnoses included, but were not limited to, heart failure, depression, high blood pressure, diabetes, anxiety and chronic pain. A Quarterly Minimum Data Set (MDS) assessment, dated 3/14/18, indicated the resident was cognitively intact, required extensive assist of 2 staff for toileting, was dependant of 2 staff for transferring and had impairments to both upper and lower extremities. An interview with CNA 1, on 06/07/18 at 10:50 a.m., indicated the resident was assisted on the toilet but they did not have a sling that could be taken on and off the resident to allow them to transfer her to the toilet. The current procedure was for staff to lay the resident in the bed on her side to have a BM. An interview with the Director of Nursing on 6/8/18 at 8:30 a.m., indicated the facility should have made efforts to provide equipment to assist the resident with toileting and maintain the resident's dignity. She was in the process of		*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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Appropriate lift slings were order for resident and have been received by facility. II. 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; Interviewable residents were interviewed resident rights, dignity and respect, and no other residents were affected. III. What measures will be put into place and what systemic changes will be made to ensure that the	

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	getting a different sling to accommodate the resident. 3.1-3(t)		deficient practice does not recur; Nursing staff were re-educated on resident rights, including dignity/respect and toileting on 6/20-6/22/18. The facility Social Service Director/designee will conduct random interviews and/or observations of 5 residents per week to ensure Resident Rights being followed by staff. Any concerns will be documented on a Grievance/Concern form for appropriate follow-up. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and			

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	preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure positioning devices were provided, related to no trapeze for a resident's bed, and accessible related to a resident's call light not in reach for 2 of 2 residents reviewed for accommodation of needs. (Residents D and C) Findings include: 1. On 6/4/18 at 9:52 a.m., Resident D was observed in bed. The resident had both of his legs amputated below the knee. There was no trapeze noted on his bed. Interview with Resident D at that time, indicated he had been asking for trapeze for his bed for months and no one seemed to listen to him. On 6/5/18 at 9:56 a.m., the resident was observed in bed. There was no trapeze on his bed. The record for Resident D was reviewed on 6/5/18 at 9:58 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, heart failure, heart transplant status, bilateral amputation, muscle weakness, history of falling, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/1/18, indicated the resident was alert and oriented. A physician order, dated 2/2/18, indicated trapeze for continuous use. Interview with the MDS Coordinator on 6/6/18 at	F 0558	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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Trapeze was immediately placed in resident D's room. Call light was immediately placed in reach for resident C. II. 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; All residents have the potential to be affected by the finding. No other resident was found to be without their assistive device or	07/08/2018

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	9:15 a.m., indicated the resident had explained to her about the trapeze and she had asked therapy for help in obtaining one for him. She was unaware there was an order for a trapeze since 2/2018. 2. On 6/6/18 at 9:20 a.m., Resident C was observed sitting in a wheelchair near the foot of his bed. The resident was asked where his call light was located. The resident pointed towards the head of the bed and the call light was observed clipped to itself and out of reach. On 6/6/18 at 11:35 a.m., the resident was observed sitting in his room in a wheelchair at the end of his bed. The call light was clipped to itself at the head of the bed and out of the resident's reach. On 6/7/18 at 9:16 a.m., the resident was observed lying in bed. The call light was draped over the head of the bed with the button end near the floor. The resident was unable to reach the call light. An Admission Minimum Data Set (MDS) assessment, dated 4/25/18, indicated the resident was alert and oriented. Interview with the Director of Nursing on 6/7/18 at 11:31 a.m., indicated the resident was able to use the call light. The call light should have been within the resident's reach. This Federal tag relates to the Complaint IN00264621. 3.1-3(v)(1)		call light within reach. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were re-educated on assistive devices and call light positioning on 6/20 – 6/22/18. The DON/designee will complete an audit of all physician ordered positioning (change to positioning/ assistive) devices to ensure the devices are in place. Any device found not to be in place will be corrected as appropriate. After initial audit, the DON/designee will complete random audits of 5 residents per week to ensure positioning/assistive devices are in place. The DON/designee will complete random audits of 5 residents per week to ensure call lights are within resident reach. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to ensure each resident was free from abuse related to staff drawing inappropriate gestures on a resident's hand for 1 of 2 residents reviewed for abuse. (Resident 73) Finding includes: An interview with Resident 73 on 6/4/18 at 10:31 a.m., indicated CNA 2 took her hand and drew an inappropriate picture - a penis. The resident told the nurse and the CNA was fired. The record for Resident 73 was reviewed on 6/5/18 at 1:17 p.m. Diagnoses included, but were not limited to, cerebral palsy, paraplegia, abnormal posture, muscle weakness, post traumatic stress disorder, anxiety, major depressive disorder, heart disease, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/18, indicated the resident	F 0600	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.*	07/08/2018

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	was alert and oriented. Nursing notes, dated 2/5/18 by the Director of Nursing, indicated this writer was advised per nurse the resident indicated a CNA had drawn a picture with an ink pen on the resident's hand that was offensive to the resident. This writer spoke to the resident via telephone. The resident was alert and oriented. The resident indicated she was kind of mad about the awful picture the CNA put on her hand with an ink pen. The resident advised the CNA when she was drawing on her hand, not to draw on her hand. The resident felt offended by what the CNA had done and it was against her will. The resident indicated that she was the president of the resident council and if the CNA did it to her, what would she do to someone who could not speak for themselves. The incident report dated 2/5/18 at 9:30 p.m. indicated CNA 2 allegedly drew an inappropriate picture on the resident's hand with a colored pen. The CNA was immediately placed on suspension and sent home. A statement from RN 2 indicated she was notified by QMA 1 the resident had asked for an alcohol wipe to take off a drawing on her hand that someone drew. When writer approached resident there was a drawing on the back of the hand in black ink. Writer asked the resident if she knew what the drawing was and she stated, "it's a penis." Writer asked resident if she was offended by it and resident stated "Yes, I told her not to draw on my hand, and she did it anyway." A statement from QMA 1 indicated at around 9:15 p.m., she was passing her meds (medications) and the resident asked her for alcohol wipe to wipe off her hand. The resident showed her hand and		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 73- Drawing was removed from resident's skin and resident was assessed for mental anguish. Staff member was immediately suspended pending investigation and was terminated. II. 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; Interviewable residents were interviewed regarding abuse, dignity and respect, and no other residents were found to be affected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on Abuse on 6/20 – 6/23/18. The Social Service Director/designee will conduct random Abuse interviews and/or observations of 5 residents per week to ensure staff compliance with Abuse Policy. Any reported issues will be handled per the	

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	there was drawing of a penis. The resident indicated CNA 2 did it and she reported the problem to the nurse. Interview with Nurse Consultant 1 on 6/7/18 at 8:55 a.m., indicated she was aware of the incident at the time it happened and was aware of what the CNA did to the resident. She indicated the resident was not happy about the drawing, however, she liked the CNA and did not want to get her in trouble. The Nurse Consultant indicated the resident never feared for herself and the CNA was suspended immediately and terminated after the investigation. 3.1-27(a)		Abuse Policy. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 100% compliance is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §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			

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	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 alleged abuse was reported immediately related to an allegation of misappropriation of resident property for 1 of 2 residents reviewed for abuse. (Resident 55) Finding Includes: An interview with Resident 55 on 6/3/18 at 3:43 p.m., indicated she had been in the hospital recently and upon her return the the facility, a wrist blood pressure cuff and a small tool kit were missing from her room. She had reported the missing items to LPN 1 a few days prior and had not been asked about the missing items. The Resident's record was reviewed on 6/6/18 at 1:26 p.m. Diagnoses included, but were not limited to, pulmonary disease, anxiety, high blood pressure and arthritis. A 5-day Minimum Data Set (MDS) assessment, dated 4/26/18, indicated the resident was cognitively intact. On 06/05/18 at 11:30 a.m., a list of reportable occurrences provided by the Director of Nursing (DON), dated 12/2017 to present, indicated there	F 0609	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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Items were immediately replaced for residents.	07/08/2018

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	had not been an incident of misappropriation of resident property reported by this this resident. An interview with the Interim Administrator on 06/08/18 at 9:15 a.m., indicated the resident had reported the missing items to LPN 1 and the LPN should have immediately reported the occurrence to her. 3.1-28(c)		II. 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 were interviewed and no resident was found to have unreported missing items. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on Abuse Reporting on 6/20 – 6/22/18. The Social Service Director/designee will conduct random abuse audits and/or observations of 5 residents per week to ensure staff compliance with abuse reporting, including reporting of missing items. Any reported issues will be handled per the Abuse Policy. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 100% compliance is achieved x4 consecutive weeks. The QA Committee will identify any trends	

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			or patterns and make recommendations to revise the plan of correction as indicated.	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in			

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	paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a			

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	mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. Based on record review and interview, the facility failed to ensure a Level II PASARR (Preadmission Screening and Annual Resident Review) assessment was completed for 2 of 3 residents reviewed for PASARR. (Residents 19 and 73) Findings include: 1. The record for Resident 19 was reviewed on 6/5/18 at 3:27 p.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, major depressive disorder, delusional disorder, anxiety disorder, and unspecified psychosis not due to a substance or known physiological condition. The Annual Minimum Data Set (MDS) assessment, dated 8/10/17, indicated the resident was not currently considered by the State Level II PASARR process to have serious mental illness and/or intellectual disability. The PASARR Level I form, which was coded as "other" and had "annual" handwritten on the form was not dated. The second question on the form indicating if the resident had a diagnosis of major mental illness (limited to the following disorders: schizophrenic, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder, atypical psychosis or other psychotic disorder (not otherwise specified) or another mental disorder	F 0645	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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 19 had a new Level I completed. Resident 73 had new Level I completed. II. 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;	07/08/2018

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	that may lead to a chronic disability) was left blank. Question 3 was completed and identified the resident as having depression and receiving Lexapro for his depression. No other questions on the form were completed and the form was not signed and dated as completed. The section of the form related to "Certification of Level II Referral" was also not completed. Interview with the Social Service Director, on 6/8/18 at 9:30 a.m., indicated based on the documentation on the Level I screening, the resident was not referred for a Level II assessment. 2. The record for Resident 73 was reviewed on 6/5/18 at 1:17 p.m. Diagnoses included, but were not limited to, cerebral palsy, paraplegia, abnormal posture, muscle weakness, post traumatic stress disorder, anxiety, major depressive disorder, heart disease, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/18, indicated the resident was alert and oriented. There was no preadmission screening for level 2. An annual level 1 PASARR was completed on 6/1/14. The screen was never signed by Physician and/or the certification of Level II referral was not completed. Interview with the Interim Administrator on 6/4/18 at 10:00 a.m., indicated the only PASARR they were able to find was from 2014. She indicated the Physician had not signed it nor was there a determination if a level II review was needed.		Any resident requiring an annual Level II assessment has the potential to be affected by the finding. All Level I screening forms will be audited to ensure Level II assessments were completed for any resident triggering a Level II assessment. All Level II assessments will be reviewed to ensure annual reviews are completed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Social Service Director/designee will conduct 5 random audits of new admission resident Level I assessments to ensure completion of Level II assessments when applicable. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	3.1-29(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and			

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	desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review, and interview, the facility failed to ensure care plans were implemented related to providing interventions for a resident with a history of falls for 1 of 21 residents whose care plans were reviewed. (Resident 36) Finding includes: On 6/5/18 at 9:55 a.m., Resident 36 was observed seated in her wheelchair in the Linden activity room. She had plain white socks on her feet and the blue Dycem (a non-slip adhesive) underneath her bottom was not affixed to the seat cushion, it was pushed to the back of the chair and was not in place underneath her bottom. On 6/6/18 at 9:33 a.m., the Resident was observed in the Linden activity room. She had plain white socks on her feet, there was no Dycem noted to her seat cushion. On 6/7/18 at 9:20 a.m., the Resident was observed in the Linden dining room. She had plain white socks on her feet, there was no Dycem observed to her seat cushion. The record for Resident 36 was reviewed in 6/7/18 at 10:21 a.m. Diagnoses included, but were not	F 0656	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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Dycem was applied to resident's wheel chair and non-skid socks were applied per Care Plan. II. How other residents having the	07/08/2018

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	limited to, schizophrenia, hypertension, diabetes, and a history of falls. The Quarterly Minimum Data Set (MDS) assessment, dated 4/2/18, indicated the resident was severely cognitively impaired and required extensive two person physical assistance with transfers. A form titled "Initial Fall Occurrence," dated 3/24/18, indicated the resident fell head first from her wheelchair in the dining room. Upon assessment she was noted to have a hematoma to her mid forehead measuring 3 cm (centimeters) x (by) 2.8 cm x 0.3 cm and complaints of lower back pain. A care plan, revised on 2/12/18, indicated the resident was at risk for falls. The interventions included, but were not limited to, skid sole shoes or gripper socks and Dycem to the wheelchair. Interview with CNA 4 on 6/7/18 at 10:55 a.m., indicated the resident's safety precautions included, but were not limited to, non skids socks and Dycem to the wheelchair cushion. Observation at the time indicated the resident was wearing plain white socks and there was no Dycem to the resident's seat cushion. Interview with the Director of Nursing on 6/8/18 at 9:48 a.m., indicated the resident's safety interventions should have been in place. 3.1-35(a)		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the finding. Fall Risk Care Plans were reviewed to ensure fall interventions are in place as appropriate. No resident was found to be without their fall intervention. All care plans will be reviewed according to the care plan schedule over the next 90 days to ensure interventions are implemented and remain appropriate. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The staff were re-educated on fall interventions on 6/20 – 6/22/18. The DON/designee will conduct random audits of 5 residents per week to ensure Care Plan interventions are implemented . IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average	

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			of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility	F 0657		07/08/2018

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	failed to ensure the residents were involved in making decisions about their care related to medications and invitations to care plan meetings. The facility also failed to update the plan of care related to falls for 3 of 21 residents reviewed for care planning. (Residents B, 73, and 55) Findings include: 1. An interview with Resident B on 6/3/18 at 3:09 p.m., indicated she was not always informed of new medications or when something different was ordered. The record for Resident B was reviewed on 6/6/18 at 9:57 a.m. Diagnoses included, but were not limited to, stroke with hemiplegia, high blood pressure, type 2 diabetes, heart failure, osteoarthritis, and hypothyroidism. The Admission Minimum Data Set (MDS) assessment, dated 5/1/18, indicated the resident was alert and oriented. Physician orders, dated 5/4/18, indicated Myrbetriq ER (a medication for urinary incontinence) had been increased from 25 milligrams (mg) to 50 mg. There was no documentation in nursing notes indicating the resident was made aware. Physician orders, dated 5/22/18, indicated a new order for Zoloft (an antidepressant medication) 50 mg 1 daily. There was no documentation in nursing notes the resident was notified of the new medication. Interview with the Director of Nursing on 6/7/18 at		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.* . What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility reviewed Resident B's medications and physician orders with resident. Resident 73 had a Care Plan meeting with the IDT including Resident's family. Resident 55 had Care Plan Meeting with IDT. II. 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; An audit will be completed of care plan reviews completed in the last 30 days.	

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	9:15 a.m., indicated the nursing staff should have informed the resident of the new medications ordered by the Physician. 2. An interview on 6/4/18 at 9:36 a.m. with Resident 73, indicated she had not been invited to a care plan meeting in some time and was not always informed her of new Physician orders. The record for Resident 73 was reviewed on 6/5/18 at 1:17 p.m. Diagnoses included, but were not limited to, cerebral palsy, paraplegia, abnormal posture, muscle weakness, post traumatic stress disorder, anxiety, major depressive disorder, heart disease, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/18, indicated the resident was alert and oriented. A Social Service note, dated 12/12/17, indicated a care plan meeting invitation was sent to the resident and her sister. The resident was hospitalized on 1/18/18 and returned on 1/23/18, hospitalized on 3/10/18 and returned on 3/16/18 and hospitalized on 3/29/18 and returned on 5/4/18. The most recent updated plan of care was dated 5/7/18. Interview with the Director of Nursing on 6/7/18 at 9:15 a.m., indicated the resident has not been invited to a care plan meeting since 12/2017.3. The record for Resident 55 was reviewed on 6/5/18 at 10:39 a.m. Diagnoses included, but were not limited to, depression, anxiety, high blood pressure and arthritis.		An audit will be completed of physician orders received in the last 7 days to ensure residents were informed of the change in plan of care as appropriate. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/designee will audit 5 random resident orders per week to ensure resident/responsible party had been notified of changes. The Social Service Director/designee will audit 5 random Care Plans reviewed the prior week to ensure resident was invited and either attended the Care Plan or declined. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	A 5-day Minimum Data Set (MDS) assessment, dated 4/26/18, indicated the resident was cognitively intact and required set up help with bed mobility, transfers, toileting and eating. A Nurses' Progress note, dated 2/28/18, indicated the resident was observed on the floor in her room. An Interdisciplinary Team Meeting (IDT) Note, dated 3/1/18, indicated the resident had been given a different walker as an intervention to prevent falls and the care plan had been updated. A care plan, dated 7/27/17, indicated the resident was "...at moderate to high risk for falls related to generalized weakness and poor safety awareness...." The care plan lacked documentation an intervention was put into place after the resident's fall on 2/28/17. An interview with the Director of Nursing on 6/8/18 at 1:30 p.m., indicated the care plan should have been updated to reflect interventions put into place after the resident's most recent fall. 3.1-35(c)(1)			
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 provide Activities of Daily Living (ADL) assistance to a dependant resident related to fingernail care for 1 of 1 residents reviewed for Activities of Daily Living.	F 0677	The facility requests paper compliance for this citation.	07/08/2018

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	(Resident C) Finding includes: Interview with Resident C on 6/6/18 at 9:20 a.m., indicated he would like to have his fingernails cleaned. Observation at that time indicated the resident's fingernails were long and untrimmed with brown debris noted under his fingernails on both hands. Record review for Resident C was completed on 6/6/18 at 9:27 a.m. The resident's diagnoses included, but were not limited to, bilateral below knee amputations, hepatitis, diabetes, depression and high blood pressure. An Admission Minimum Data Set (MDS) assessment, completed on 4/25/18, indicated the resident was cognitively intact, extensive assist of 1 with bed mobility, dependent assist of 2 for transfers, extensive assist of 1 with toileting, and required extensive assistance with bathing. An interview with the Director of Nursing (DON), on 6/8/18 at 1:27 p.m., indicated nail care should have been performed during the resident's scheduled baths and showers. 3.1-38(a)(2)(A)		*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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C immediately received nail care. II. 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 were observed for ADL care and hygiene needs, and concerns were addressed as identified. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	

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			Staff were re-educated on ADL care and hygiene on 6/20 – 6/22/18. The DON/designee will conduct random audits of 5 residents per week to ensure proper ADL care has been provided. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure bruises and scratches were assessed for 2 of 3 residents reviewed for skin conditions (non-pressure	F 0684	The facility requests paper compliance for this citation.	07/08/2018

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	related), edema was assessed and monitored for 1 of 1 residents reviewed for edema, and signs and symptoms of constipation were monitored for 1 of 2 residents reviewed for constipation/ diarrhea. (Residents 18, 73, 13, and 294) Findings include: 1. On 6/4/18 at 11:24 a.m., Resident 18 was observed with bandaids to the top of both hands. The resident indicated she had been scratched by another resident and would not remove the bandaids. On 6/6/18 at 9:45 a.m., the resident was observed with a fading scratch to the top of her left hand. The resident continued to have bandaids on the top of her right hand and would not remove them. The record for Resident 18 was reviewed on 6/6/18 at 10:19 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, persistent mood disorder, unspecified psychosis, major depressive disorder and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/8/18, indicated the resident was cognitively intact for daily decision making. The 5/29/18 Weekly skin observation assessment, indicated the resident had skin areas to the left inner ankle and right lower leg. The record lacked documentation related to the resident's hands. The 6/5/18 Weekly skin observation assessment, indicated the resident's skin was intact and no concerns were noted. Interview with the Director of Nursing, on 6/8/18		*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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 18 later allowed bandaids to be removed and skin was intact under bandaid. Resident 73's nurse was educated on documenting edema when present. Care plan for edema was added. Resident 13 was assessed and documentation completed as appropriate. Resident 294 was assessed, physician notified and orders obtained. II. How other residents having the	

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	at 10:00 a.m., indicated the areas underneath the bandaids should have been addressed on the weekly skin assessment sheet. 2. On 6/3/18 at 2:47 p.m., Resident 73 was observed sitting in her wheelchair with swelling to both feet. On 6/4/18 at 9:45 a.m., the resident was observed sitting in her wheelchair and her feet were swollen. Interview with the resident at that time, indicated her feet were always swollen and sometimes she had to lay down, around 4 p.m., to decrease the swelling. On 6/5/18 at 9:55 a.m., 6/6/18 at 9:45 a.m. and 1:47 p.m., the resident was observed sitting in her wheelchair with edema (swelling) observed to both feet. The record for Resident 73 was reviewed on 6/5/18 at 1:17 p.m. Diagnoses included, but were not limited to, cerebral palsy, paraplegia, abnormal posture, muscle weakness, post traumatic stress disorder, anxiety, major depressive disorder, heart disease, heart failure, chronic respiratory failure, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/18, indicated the resident was alert and oriented. Physician orders dated 6/2018, indicated Furosemide (a diuretic) 40 milligrams (mg) 1 daily for heart failure. The weekly skin observations, dated 5/9, 5/16, and 5/23/18, indicated the resident had no edema and no foot concerns. A Physician progress note, dated 5/9/18, indicated		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents were assessed for non-pressure skin conditions and edema and any abnormal findings were addressed and documented. All current resident bowel movement records for the previous 7 days were reviewed and residents assessed as indicated. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nurses were re-educated on 6/20 – 6/22/18 regarding resident assessment and documentation of abnormal findings , including non-pressure skin conditions, edema and signs of constipation and review of BM alerts. The DON/designee will observe 5 random residents for skin conditions and edema to ensure any findings are documented appropriately. The DON/designee will review BM alerts at least 3x/week to ensure residents who have no BM documented in 3 days are assessed for signs of constipation. IV. 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;	

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	the resident had 1+ edema to bilateral lower extremities. Physician progress notes, dated 5/23/18 and 5/30/18, indicated the resident had 1+ pedal edema. There was no current plan of care for pedal edema. Interview with LPN 2 on 6/6/18 at 1:45 p.m., indicated there were times when the resident's feet were not as swollen as what they were currently. The resident's feet were always swollen, sometimes a little less than others, and it depended on the time of the day. Interview with the Director of Nursing on 6/07/18 9:04 a.m., indicated the resident does have chronic swelling in both of her feet. She had spoken to LPN 2 and instructed her that any type of edema or swelling was not normal and needed to be documented on the skin assessments.3. On 6/3/18 at 5:06 p.m., Resident 13 was observed in the Garden's main dining room. She had a quarter-sized purple discoloration to the top of her right hand. The record for Resident 13 was reviewed on 6/6/18 at 2:24 p.m. Diagnoses included, but were not limited to, Alzheimer's, diabetes, hypertension, and atrial fibrillation. The Quarterly Minimum Data Set (MDS) assessment, dated 3/7/18, indicated the resident was severely cognitively impaired. She required extensive assistance of one person with transfers. Medications received in the previous seven days included, but were not limited to, anticoagulants. A Physician's order, dated 4/24/18, indicated		The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Coumadin (an anticoagulant medication) 3 mg (milligrams) by mouth one time a day. A care plan, revised on 5/8/18, indicated the resident had a potential for bruising related to Coumadin therapy. The interventions included, but were not limited to, document any witnessed/ reported/ observed bruising or skin tears per policy. Note cause if known. The Weekly Skin Assessment, dated 5/21/18, indicated no bruising. There was no Weekly Skin Assessment dated 5/27/18 - 6/2/18. Interview with the Director of Nursing on 6/07/18 at 1:10 p.m., indicated the resident was assessed on 6/7/18, she had a purple bruise on the back of her right hand measuring 1 cm (centimeter) by 1 cm. The area should have been assessed and monitored. The "Monitoring of Bruises" policy, revised on 6/2015, provided by the Administrative Staff Associate, on 6/8/18 at 10:37 a.m., indicated, "When bruises are healing without complication as indicated on the above table, the nurse will monitor the site weekly."4. Interview with Resident 294 on 6/4/18 at 1:25 p.m., indicated he had not had a bowel movement in more than 3 days. Record review for Resident 294 was completed on 6/5/18 at 1:36 p.m., Diagnoses included, but were not limited to, anemia, atrial fibrillation and chronic kidney disease. A 5-day Minimum Data Set (MDS) assessment, dated 5/8/18, indicated the resident was cognitively intact and required extensive assistance with bed mobility, transfers and			

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	toileting. A report, titled "Bowel and Bladder Elimination" and provided by the Vice President of Clinical Operations on 6/5/18 at 2:40 p.m., indicated the resident's last bowel movement was 5/29/18. Interview with Vice President of Clinical Operations on 6/5/18 at 3:38 p.m. indicated after the resident went 3 days without a bowel movement, the nurse should have contacted the resident's physician for orders. 3.1-37(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 a resident who entered the facility with no pressure sores received the necessary treatment and services to prevent a pressure sore related to obtaining wound treatments timely and the application of medication to the wound bed for 2 of 2 residents	F 0686	The facility requests paper compliance for this citation. *This Plan of Correction is the*	07/08/2018

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	reviewed for pressure areas. (Residents B and E) Findings include: On 6/3/18 at 3:17 p.m., Resident B was observed in bed. At that time, she had turned on her call light and asked the CNAs to perform incontinence care. The CNAs removed her brief and rolled her on to her left side. There was a foam dressing noted with the date of 6/1/18 to her left inner buttock. On 6/7/18 at 10:29 a.m., RN 1 was observed during a pressure ulcer dressing change. CNA 3 was in the room to help reposition the resident on to her left side. RN 1 washed her hands with soap and water, and donned clean gloves to both hands. She removed the old dressing, removed her gloves and provided hand hygiene with alcohol gel. The RN donned a clean pair of gloves and wiped the pressure area clean with normal saline. She removed her gloves used alcohol gel and donned clean gloves. The RN applied a large amount of Medihoney (a debriding agent) onto her gloved fingers and spread the Medihoney over the wound and on the surrounding (good) skin including part of the left buttock. At that time, the RN was asked to stop what she was doing and was asked why she had spread the Medihoney over the entire buttocks and the wound bed. The RN indicated it was for protection, and was unable to explain what the Medihoney was used for. Nurse Consultant 2, who was in the room at that time, instructed the nurse to remove the Medihoney from the buttock and only apply it to the wound bed. Interview with Nurse Consultant 2 at that time, indicated the nurse should not have applied the Medihoney to the entire buttock area, and should have used a tongue depressor or Q-tip to apply		*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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B's dressing was immediately changed. RN 1 was immediately re-educated on treatment policy. The pressure ulcer identified on the survey has healed. Resident 54 has wound treatments in place. II. 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; All residents with pressure ulcers were reviewed to ensure treatment orders are in place and applied as ordered.	

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	the debriding agent to the wound bed instead of her gloved finger. The record for Resident B was reviewed on 6/6/18 at 9:57 a.m. Diagnoses included, but were not limited to, stroke with hemiplegia, high blood pressure, type 2 diabetes, heart failure, osteoarthritis, and hypothyroidism. The Admission Minimum Data Set (MDS) assessment, dated 5/1/18, indicated the resident was alert and oriented times 3 and was frequently incontinent of urine. The resident had no pressure areas on admission. Nursing notes, dated 6/1/18, indicated a new order for Medihoney and foam to left inner buttocks. The resident and husband were made aware of the new order. Nursing notes, dated 6/3/18 at 4:08 p.m., indicated the order was clarified by the wound doctor and a new order for a dressing change every 72 hours was noted. Physician order, dated 6/1/18, indicated cleanse left inner buttock with normal saline or wound cleanser. Pat dry, apply Medihoney and cover with foam dressing every day shift and as needed. Physician order, dated 6/3/18, indicated cleanse left inner buttock with normal saline or wound cleanser. Pat dry, apply Medihoney and cover with foam dressing every 3 days on day shift and as needed. Physician order, dated 4/25/18, indicated barrier cream to be applied as directed every 4 hours and as needed for dry skin and rash to and reddened buttocks.		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed staff were re-educated on wound treatment procedures and obtaining wound treatments timely on 6/20 – 6/22/18. The DON/designee will observe 5 random wound treatments per week to ensure treatment orders are present, proper treatment technique is followed and documentation is present. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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The Treatment Administration Records (TARS) for 4/2018, 5/2018 and 6/2018 indicated the barrier cream was not signed out as being applied.

A wound assessment details report, dated 5/23/18, indicated the resident had a facility acquired stage 2 pressure area to the left inner buttock which measured 1 centimeter (cm) by 1 cm by 0.1 cm and was 100% bright pink or red. The wound had a scant amount of drainage.

A wound assessment details report, dated 5/29/18, indicated the pressure sore measured 0.5 cm by 0.5 cm by 0.10 cm and was 100% red.

A wound assessment details report, dated 6/5/18, indicated the left inner buttock pressure sore measured 0.6 cm by 0.4 cm by 0.1 cm and 100% red.

Interview with the Director of Nursing on 6/7/18 at 9:15 a.m., indicated a treatment should have been obtained when the pressure area was initially observed on 5/23/18. 2. The record for Resident 54 was reviewed on 6/6/18 at 3:40 p.m. Diagnoses included, but were not limited to, dementia, hypertension, dysphagia, and contractures.

The Significant Change Minimum Data Set (MDS) Assessment, dated 4/26/18, indicated the resident was rarely/never understood and was totally dependent on staff.

The Wound Assessment Details Report, dated 5/29/18, indicated the resident had a facility-acquired unstageable pressure ulcer to the left heel measuring 3.4 by 2.5 cm by 0 cm.

The Wound Physician Assessment, dated

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	5/29/18, indicated new orders: Betadine (a skin antiseptic) every 1 day and heel protectors. The 5/2018 and 6/2018 Treatment Administration Record indicated no treatments in place dated 5/29/18 - 6/4/18. Interview with the Director of Nursing on 6/8/18 at 9:48 a.m., indicated the staff should have initiated the treatment as ordered. This Federal tag relates to the Complaint IN00264621. 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure	F 0688	The facility requests paper	07/08/2018

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	anti-contracture devices were applied for a resident with limited range of motion for 1 of 2 residents reviewed for limited range of motion. (Resident B) Finding includes: On 6/3/18 at 3:14 p.m., Resident B was observed lying in bed. Her left hand was curled into a fist. There was no anti-contracture device noted in her hand. At that time, the resident indicated her hand splint was in the dresser drawer and no one knew how to put it on. The record for Resident B was reviewed on 6/6/18 at 9:57 a.m. Diagnoses included, but were not limited to, stroke with hemiplegia, high blood pressure, type 2 diabetes, heart failure, osteoarthritis, and hypothyroidism. The Admission Minimum Data Set (MDS) assessment, dated 5/1/18, indicated the resident was alert and oriented and was frequently incontinent of urine. The resident had limited range of motion to one side of her upper extremities. A care plan, dated 6/4/18, indicated "I require the use of left/hand wrist splint related to history of stroke." The approaches were to apply in a.m. and remove in afternoon, as tolerated. Physician orders, dated 6/4/18, indicated a left/wrist hand splint to be applied in the morning and removed in the afternoon. Restorative nursing progress notes, dated 6/4/18, indicated apply left hand/wrist splint in a.m. and remove in afternoon as tolerated 4 to 6 times a week. The record lacked documentation a splint		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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B's hand splint was applied. II. 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; All residents utilizing anti-contracture devices were observed and no other residents were found to be without their devices.	

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	was applied prior to 6/4/18. Interview with Occupational Therapist (OT) 1 and the Therapy Director on 6/6/18 at 2:45 p.m., indicated the resident's splint was very new. They obtained the splint about 4 weeks ago on 5/11/18 and were working with the resident to make sure she could tolerate it. On 5/19/18 the resident was discharged from therapy, and restorative staff were to be donning on and off the splint every day. OT 1 indicated he thought the Restorative nurse was going to write the order for the splint, however, she did not, so he had just written the order for the splint on 6/4/18. The Therapy Director and OT 1 both indicated there was no documentation the splint was applied from 5/20-6/3/18. Interview with the Director of Nursing on 6/7/18 at 9:15 a.m., indicated the resident's splint should have been applied every day after she was discharged from therapy. 3.1-42(a)(1)		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were re-educated on anti-contracture devices on 6/20 – 6/22/18. The DON/designee will conduct random audits of residents with physician ordered anti-contracture devices at least 3x/week to ensure the devices are applied as ordered . IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on record review and interview, the facility failed to obtain a urinalysis for a resident who had signs and symptoms of a Urinary Tract Infection (UTI) for 1 of 2 residents reviewed for urinary tract infection. (Resident B) Finding includes:	F 0690	The facility requests paper compliance for this citation. *This Plan of Correction is the*	07/08/2018

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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
	An interview with Resident B on 6/03/18 at 3:17 p.m., indicated the doctor ordered blood work and a urinalysis last week, but it had not been collected. She did have some burning when she urinated. The record for Resident B was reviewed on 6/6/18 at 9:57 a.m. Diagnoses included, but were not limited to, stroke with hemiplegia, high blood pressure, type 2 diabetes, heart failure, osteoarthritis, and hypothyroidism. The Admission Minimum Data Set (MDS) assessment, dated 5/1/18, indicated the resident was alert, oriented and was frequently incontinent of urine. A Physician progress note by the Nurse Practitioner (NP), dated 5/4/18, indicated "The resident states over active bladder is worsening." The plan was to check urine with culture and sensitivity for UTI. Nursing notes, dated 5/4-5/8/18, indicated the record lacked documentation a urine sample was collected. Physician progress note by the NP, dated 5/25/18, indicated "The resident has some burning with urination." The plan was to obtain an urinalysis with culture and sensitivity. Nursing notes, dated 5/25-5/29/18, lacked documentation a urine sample was collected. Physician orders, dated 5/4/18 and 5/25/18, indicated urinalysis with culture and sensitivity. Review of lab results indicated there was no		*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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B's urine specimen was collected and sent to lab for analysis. II. 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; Review was completed for all residents with UA ordered in the last 30 days, and no other residents were found to be affected . III. What measures will be put into	

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	urinalysis for review. Interview with the Director of Nursing on 6/6/18 at 1:50 p.m., indicated the urinalysis should have been completed as ordered. This Federal tag relates to the Complaint IN00264621. 3.1-41(a)(2)		place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nursing staff were re-educated on obtaining physician ordered UAs on 6/20 – 6/22/18. The DON/designee will audit physician orders at least 3 times per week as follow up to ensure urine specimens are collected timely when ordered. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0697 SS=D	483.25(k) Pain Management			

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Bldg. 00	§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to assess and provide pain relief for increased neck pain for 1 of 1 residents reviewed for pain. (Resident 73) Finding includes: An interview with Resident 73 on 6/4/18 at 9:45 a.m., indicated she had increased neck pain. She had been taking Norco (a narcotic pain medication) three times a day and was not getting relief. She had an X-ray last week, but was unaware of the results. The record for Resident 73 was reviewed on 6/5/18 at 1:17 p.m. Diagnoses included, but were not limited to, cerebral palsy, paraplegia, abnormal posture, muscle weakness, post traumatic stress disorder, anxiety, major depressive disorder, heart disease, and high blood pressure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/18, indicated the resident was alert, oriented, and received scheduled and PRN (as needed) pain medication. The resident had occasional pain, with a pain rating of 6 out of 10. A Physician order, dated 4/17/18, indicated discontinue Aspercreme (a topical cream to treat inflammation such as arthritis) PRN. A Physician order, dated 5/10/18, indicated	F 0697	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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility obtained order for Aspercream for resident's pain. II. How other residents having the	07/08/2018

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	Hydrocodone (Norco) 5-325 milligrams (mg) three times a day at 6 a.m., 2 p.m., and 8 p.m. An order, dated 5/4/18, indicated Tylenol 650 mg every 4 hours for pain. A Physician order, dated 5/30/18, indicated obtain cervical spine X-ray. A pain screen assessment, dated 6/3/18, indicated the resident had no new pain and the medication ordered was effective. The resident had no observations of pain. The updated plan of care, dated 5/2018, indicated the resident had chronic pain. The approaches were to monitor and report signs of pain to the nurse. Interview with LPN 2 on 6/6/18 at 9:45 a.m., indicated she had thought Aspercreme was being applied to her neck as needed. She was unaware it had been discontinued on 4/17/18. The resident's neck pain had gotten progressively worse in the last week and that was why the cervical spine X-ray was ordered. The LPN was unaware of those X-ray results. The cervical spine X-ray report indicated the X-ray was obtained on 5/30/18 with the results back the same day. The impression was moderate arthritis with marked malalignment. The Nurse Practitioner was notified on 6/4/18. Interview with the Director of Nursing (DON) on 6/7/18 at 9:15 a.m., indicated she had spoken to the resident on 6/6/18 regarding her pain and the Aspercreme was reordered PRN for her neck pain. The resident liked the Aspercreme and was happy to have it reordered.		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident with pain has the potential to be affected. No other resident was found to have unaddressed pain. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed staff were re-educated on assessing and reporting increased pain on 6/20 – 6/22/18. The MDS Coordinator will conduct pain interviews with residents when completing MDS. Any resident stating they have increased or uncontrolled pain will be assessed and physician notified as appropriate to ensure appropriate pain management is in place. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify	

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	3.1-37(a)		any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed related to the removal of a dressing over a dialysis site for 1 of 1 residents reviewed for dialysis. (Resident C) Finding Includes: On 6/6/18 at 11:40 a.m. Resident C was observed sitting in a wheelchair in his room with a dressing over the fistula (an access site for dialysis) located on the resident's upper left arm. The resident indicated it had been in place since his dialysis treatment on 6/4/18. An interview with LPN 1 on 6/6/18 at 12:25 p.m. indicated the dressing over the resident's fistula site should have been removed on the evening shift on dialysis days. The resident went to the dialysis center on Mondays, Wednesdays and Fridays at approximately 11:30 a.m. and returned at approximately 3:30 p.m. On 6/7/18 at 9:15 a.m. the resident was observed	F 0698	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.* I. What corrective action(s) will be	07/08/2018

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	lying in bed with 2 dressings observed over the fistula site on the resident's left upper arm. He indicated the dressings had been in place since after his dialysis session on 6/6/18. Record review for Resident C was completed on 6/6/18 at 9:27 a.m. The resident's diagnoses included, but were not limited to, bilateral below knee amputations, hepatitis, diabetes, depression and high blood pressure. An Admission Minimum Data Set (MDS) assessment, completed on 4/25/18, indicated the resident was cognitively intact, required extensive assist of 1 with bed mobility, dependent assist of 2 for transfers, extensive of 1 with toileting, and extensive assistance with bathing. A Physician's Order, dated 4/20/18, indicated dialysis 3 times per week A Physician's Order, dated 4/18/18, indicated the dressing was to be removed form the dialysis fistula site 4 hours upon returning from dialysis and the site assessed every shift. An interview with the Director of Nursing (DON) on 6/8/18 at 10:07 a.m., indicated the Physician's orders should have been followed and the dialysis site assessed. 3.1-37(a)		accomplished for those residents found to have been affected by the deficient practice; Resident C had their dressing removed. II. 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; Dialysis residents were observed and no other residents were affected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed staff were re-educated on following physician orders and removal of dialysis pressure dressings following dialysis treatments on 6/20 – 6/22/18. The DON/designee will observe residents receiving dialysis at least 3x/week to ensure pressure dressings are removed as ordered following dialysis treatments. IV. 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;	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours			

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	worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to ensure the daily staffing pattern was posted for 1 of 6 days of the survey. This had the potential to affect all of the residents residing in the facility. Finding includes: On 6/3/18 at 1:30 p.m., the daily staffing sheet	F 0732	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	07/08/2018

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	posted at the Main Entrance area was dated 5/30/18. On 6/3/18 at 2:28 p.m., the daily staffing sheet posted on the Maple unit was dated 5/30/18. On 6/3/18 at 2:30 p.m., the daily staffing sheet posted at the Rehab unit Nurses' station was dated 6/1/18. Interview with the Director of Nursing, on 6/7/18 at 9:20 a.m., indicated the current staffing sheet was to be posted at the beginning of each day shift.		*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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Current nurse staffing sheets were placed on each unit. No residents were affected. II. 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; Daily nurse staffing sheets on all units were checked and were current. No residents were affected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	

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			The licensed staff were re-educated on posting staffing hours on a daily basis on 6/20 – 6/22/18. The DON/designee will audit the posting of staffing hours at least 5 times per week. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a			

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	resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, record review, and interview, the facility failed to ensure an ongoing behavior monitoring program was implemented and followed for 2 of 3 residents reviewed for mood/behavior. (Residents 22 and 37) Findings include: 1. On 6/3/18 at 2:30 p.m., Resident 22 was observed wandering up and down the halls of the Elm and Maple units. The resident would yell loudly, start to cry, and continue walking down the hall. At 3:46 p.m., staff were walking down the hall with the resident. On 6/5/18 at 1:14 p.m., the resident was yelling in the hall. On 6/6/18 at 9:40 a.m., the resident was seated in a recliner in the Activity room. The resident was approached by CNA 5 about going to the bathroom. The resident was resistive to stand and she indicated she didn't want to go. The resident was assisted out of the recliner by CNA 5, the resident again repeated she didn't want to go and her voice became louder each time she repeated the statement. The resident was escorted out of the Activity room by CNA 5 and RN 4. The resident became agitated and continued to scream she didn't want to go as the staff were escorting her down the hallway. As the CNA attempted to open the door to the shower room, the resident continued to yell. A Restorative CNA then approached the resident and walked her to her room. The resident started to yell again when was taken to the restroom in	F 0740	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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 22 and 37's behavior documentation is being completed as appropriate. II. 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 with behaviors has	07/08/2018

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	her room. The record for Resident 22 was reviewed on 6/6/18 at 1:05 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, dementia with behavioral disturbance, anxiety disorder, and panic disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 3/12/18, indicated the resident was cognitively impaired for decision making, had behaviors not directed towards others, and was resistive to care. The March 2018 plan of care, indicated the resident was diagnosed with dementia and had deficits in her short and long term memory. The resident needed cues and reminders to attend meals, activities and to complete her activities of daily living (ADL's). The interventions included, but were not limited to, assist resident with routine daily decision making, coaching through process, and as resident will allow. Explain all care before providing, giving at least 30 seconds of processing time. The plan of care, dated 3/19/18, indicated the resident experienced feelings of sadness, anxiety, uneasiness and depression characterized by ineffective coping, tearfulness, and motor agitation related to diagnoses of depression, Alzheimer's disease, panic disorder and pseudobulbar affect. Interventions included, but were not limited to, re-approach as needed. The June 2018 Behavior monitoring sheets lacked documentation of the resident's behaviors for the afternoon of 6/3/18 and there were no behaviors documented on 6/6/18.		the potential to be affected by the finding. Documentation of residents with known behaviors were reviewed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were re-educated on behavior documentation on 6/20 – 6/22/18. The Social Service Director/designee will observe for behaviors during rounds and perform a follow up audit for documentation, including interventions attempted, effectiveness and alternate interventions if appropriate, the following day at least 3 times per week to ensure behavior documentation is being completed. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make	

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	There was no behavior charting in the nursing progress notes for the above dates. Interview with the Vice President of Clinical Operations, on 6/6/18 at 2:30 p.m., indicated staff should have let the resident calm down and reapproached her at a later time. Interview with CNA 6, on 6/7/18 at 1:35 p.m., indicated behavior monitoring was completed in the computer. If a behavior was noticed, they were to notify nursing so they could complete a behavior note. 2. On 6/3/18 at 3:30 p.m., Resident 37 was observed seated in her wheelchair. At this time, the resident was observed yelling and cussing at residents and staff. On 6/4/18 at 9:30 a.m., the resident was yelling and cussing at staff. On 6/5/18 at 9:36 a.m., the resident was yelling and cussing at staff. At 1:05 p.m., she was yelling at a resident in the hallway. The record for Resident 37 was reviewed on 6/5/18 at 1:17 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance and mood disorder. The Admission Minimum Data Set (MDS) assessment, dated 3/16/18, indicated the resident was cognitively impaired for decision making, had verbal behavioral symptoms directed towards others and was resistive to care. The plan of care, dated 3/16/18, indicated the resident was resistant to care and verbally aggressive towards staff. Interventions included,		recommendations to revise the plan of correction as indicated.	

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	but were not limited to, allow resident to make independent choices, notify Physician/family if resident resisted care that posed harm to her well being. Review of the Behavior monitoring sheets for the previous 14 days, indicated the only behavior was wandering on 5/30/18. There was no behavior charting in the nursing progress notes for the previous 14 days. Interview with CNA 6 on 6/7/18 at 1:30 p.m., indicated the resident had a history of yelling and cursing at staff and residents. The CNA indicated if any behaviors were observed they were to be documented in the computer and the Nurse informed. Interview with the Director of Nursing, on 6/8/18 at 10:00 a.m., indicated the resident's behaviors should have been documented. 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and			

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	administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to obtain medications in a timely manner for 1 of 2 residents reviewed for infections (not UTI or respiratory) and for 1 of 3 residents reviewed for mood/behavior. (Residents 58 and 22) Findings include: 1. The record for Resident 58 was reviewed on 6/5/18 at 10:13 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, major depressive disorder and diabetes. A Physicians progress note, dated 6/1/18 at 2:29 p.m., indicated the resident's right eye was red and had a green colored discharge. A Physician's order, dated 6/1/18, indicated Tobramycin Solution (an antibiotic eye drop)	F 0755	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.*	07/08/2018

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	0.3%, instill 1 drop in both eyes four times a day for 7 days. A Nursing Progress Note, dated 6/3/18 at 12:18 p.m., indicated staff was waiting for the medication from the pharmacy. The June 2018 Medication Administration Record (MAR), indicated the eye drops had not been documented as being given on 6/1/18 and 6/2/18. The first dose of medication was documented as being given on 6/3/18 at 4:00 p.m. Interview with the Nurse Consultant, on 6/7/18 at 3:30 p.m., indicated the pharmacy makes three deliveries on weekdays and two daily on the weekends. The eye drops should have been delivered in a more timely manner. 2. The record for Resident 22 was reviewed on 6/6/18 at 1:05 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, dementia with behavioral disturbance, anxiety disorder, and panic disorder. A Physician's order, dated 4/27/18, indicated 1 milliliter (ml) of HABR (Haldol, Ativan, Benadryl and Reglan) paste topically to the forearm area every 6 hours. Rotate forearm sites and use double gloves to apply. An entry in the nursing progress notes, dated 4/30/18 at 9:24 p.m., indicated a message was received from the Physician regarding the HABR narcotic cream, the Physician responded, and would fax a new order to the pharmacy. The medication was received on 5/1/18. Interview with the Nurse Consultant, on 6/7/18 at 3:30 p.m., indicated the pharmacy makes three		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 58 has eye drops and is receiving the drops per physician order. Resident 22 has ordered medication and receiving per physician order. II. 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; New medication orders received in the last 7 days were reviewed and no other resident was found to be without medications. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The licensed nurses were re-educated on pharmacy policies on 6/20 – 6/22/18.	

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	deliveries on weekdays and two daily on the weekends. The HABR paste should have been delivered in a more timely manner. 3.1-25(a)		The DON/designee will audit 5 residents per week with new medication orders to ensure medications are available timely and administered per physician order. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. Based on observation, record review, and interview, the facility failed to ensure multidose insulin pens were dated after opening and the EDK (Emergency Drug Kit) was secured after opening for 1 of 2 medication rooms observed. (Pines North medication room)	F 0761	The facility requests paper compliance for this citation. *This Plan of Correction is the*	07/08/2018

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	Finding includes: On 6/7/18 at 1:49 p.m., in the Pines North med room the following was observed: a. There were 2 Victoza insulin pens open with no date. There was 1 Basaglar insulin quick pen open and no date. b. The narcotic EDK box was not secured with a zip tie. The box was observed on top of the counter inside the med room and was easily opened. There was a slip of paper inside the kit indicating a medication was removed on 6/4/18. Interview with RN 1 at that time, indicated there should have been a zip tie to secure the EDK box and the insulin pens should have been dated after opening. The revised 2/5/18 "Medication Storage" policy, provided by the Administrative Staff on 6/8/18 at 10:00 a.m., indicated once any medication was opened, facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Interview with Interim Administrator on 6/8/18 at 9:53 a.m., indicated the insulin pens should have been dated after opening and the EDK box should have been secured after opening. 3.1-25(j)		*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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The multidose insulin pen identified was disposed of according to facility policy, and a new pen was obtained and dated when opened. Appropriate zip ties were applied to EDK and EDK was replaced by pharmacy. II. 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 Medication storage and EDK audit was completed to ensure all EDK's were secured with zip ties and medication vials/bottles and	

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			multi-dose insulin pens were labeled as indicated when opened. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nursing staff were re-educated on dating opened medication vials /bottles and multi-dose pens and securing EDK after opening on 6/20 – 6/22/18. The DON/designee will conduct random medication cart audits 2 times per week to ensure proper dating of opened medication vials/bottles and multi-dose pens. Audits will continue until 4 consecutive weeks of compliance achieved. The DON/designee will complete an audit of EDK's at least 2x/week at varied times to ensure they are properly secured. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to a practitioner initiating antibiotic therapy without prior labs and/or culture results and prescribing antibiotics for infections that did not meet the McGreer Criteria for 1 of 2 residents reviewed for urinary tract infections. (Resident 78) Finding includes: The record for 78 was reviewed on 6/6/18 at 9:41 a.m. Diagnoses included Alzheimer's, falls, insomnia, urinary retention, foley catheter, and a history urinary tract infections (UTI). The 30-Day Minimum Data Set (MDS) assessment, dated 4/25/18, indicated the resident was severely cognitively impaired and required extensive one person physical assistance. A Physician's order, dated 5/7/18, indicated Macrobid (an antibiotic medication) 100 mg (milligrams), give one time a day as prophylactic. There were no Physician's orders related to	F 0881	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.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	07/08/2018

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	urinary lab cultures. A Physician progress note, dated 6/3/18, indicated patient has chronic UTI, presently on suppression therapy with Macrobid. Interview with the resident's spouse on 6/5/18 at 2:14 p.m., indicated she had a concern related to frequent UTI and requested the staff order antibiotics. Interview with the Director of Nursing (DON) on 6/6/18 at 4:32 p.m., indicated the resident was receiving Macrobid related to suppression therapy. The Nurse Practitioner ordered labs annually unless the resident was symptomatic. Interview with the DON on 6/8/18 at 9:48 a.m., indicated the facility had not ordered urinalysis/cultures since 2/7/18. The facility should have a system of monitoring to improve resident outcomes and reduce antibiotic resistance. 3.1-18(b)(1)		Resident 78 – Macrobid was discontinued and orders received to start UTI STAT (a supplement used to decrease chronic UTI's). Urine specimens will be obtained for culture if signs and symptoms of UTI are present and/or infection is suspected. II. 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; A review of residents receiving antibiotics was completed and no other resident was found to be affected by the finding. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility Nurse Practitioner and licensed nurses were re-educated on Antibiotic Stewardship, appropriate labs/testing and assessment of s/s of infection. The DON/designee will audit up to 5 residents on antibiotics weekly to ensure appropriate Antibiotic Stewardship is being followed i.e., appropriate labs, appropriate symptoms according to McGeer's criteria , etc.	

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			IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls and door frames, stained ceiling tile, peeling wallpaper, chipped paint, dirty carpets and rusted bolts on 4 of 6 units throughout the facility. (Pines North, Elm, Maple and Linden) Findings include: During the Environmental Tour, on 6/7/18 at 1:00 p.m. with the Maintenance and Housekeeping Supervisors, the following was observed: 1. Pines North	F 0921	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*	07/08/2018

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	a. The walls in Room 6 were marred. The bathroom walls and door were also gouged and marred. Two residents lived in the room and two residents shared the bathroom. 2. The Elm Unit a. The wall located next to the closet in Room 201 was gouged and marred. One resident lived in this room. b. There were stained ceiling tiles located next to the closet and above the resident's recliner in Room 204. One resident lived in this room. c. The edge of the wall located next to the closet was chipped and marred. The inside of the bathroom door was scratched and marred at the base. There was also an accumulation of wax build up along the baseboard in the bathroom. Two residents lived in this room and shared the bathroom. 3. The Maple Unit a. The inside of the bathroom door in Room 254 was scratched and marred at the base. There were rusted bolts exposed at the base of the toilet on each side. There was a pink plastic wash basin containing shoes inside of the shower. Two residents shared this bathroom. b. The inside of the bathroom door in Room 258 was scratched and marred at the base. There was also areas of peeling wood around the edge. Inside the shower was a foot stool and a toilet lift seat. Two residents shared this bathroom. c. The wall in room Room 259 had areas of chipped paint by the door. There was a section of		*required by the provisions of federal and state law.* I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No resident was found to have a negative outcome as a result of the finding. The walls in room 6, the bathroom walls and door will be repaired by 7/8/18. The wall next to the closet in room 201 will be repaired by 7/8/18. The ceiling tile, the edge wall next to closet, and the bathroom door in room 204 will be repaired by 7/8/18. The wax along the baseboard in the bathroom of room 204 will be cleaned by 7/8/18. The bathroom door in room 258 will be repaired by 7/8/18. The foot stool and toilet lift seat have been removed from the shower. The wall in room 259, and the torn wallpaper will be repaired by 7/8/18. The walls in room 261 will be repaired by 7/8/18. The corner of the wall next to the closet in room 271 will be repaired by 7/8/18. The torn wallpaper in room 277 will be repaired by 7/8/18. The walls and wallpaper in the Linden dining room will be repaired by 7/8/18.	

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	torn wallpaper near the recliner. One resident lived in this room. d. The walls in Room 261 were scratched and marred with areas of peeling paint next to the closet. Two residents lived in this room. 4. The Linden Unit a. The corner of the wall next to the closet in Room 271 was chipped and marred. One resident lived in this room. b. There was torn wallpaper and exposed drywall in Room 277. One resident lived in this room. c. There were sections of peeling wallpaper as well as marred and scuffed walls in the dining room. Interview with the Maintenance and Housekeeping Supervisors at the time, indicated all of the above were in need of cleaning and/or repair. 3.1-19(f)		II. 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; The Administrator/designee with the Housekeeping Supervisor and Maintenance Director will complete environmental rounds throughout the building to identify needed repairs and cleaning. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Housekeeping Supervisor and Maintenance Director will complete environmental rounds at least weekly to identify any areas needing repair and/or cleaning. The Administrator will review maintenance logs and complete follow up environmental rounds with the Housekeeping Supervisor and Maintenance Director monthly to ensure issues identified during weekly rounds were addressed. IV. 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; The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average	

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APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

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			of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	