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	07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE VALPARAISO	3301 N CALUMET AVE VALPARAISO, IN 46383

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F 0000 Bldg. 00	This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure survey completed on 6/8/18. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. This visit was in conjunction with the PSR to Complaint IN00264621 completed on 6/8/18. This visit was in conjunction with the Investigation of Complaint IN00267422. Complaint IN00264621 - Corrected. Complaint IN00267422 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited at F689. Survey dates: July 17, 18, & 19, 2018 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 10 Medicaid: 47 Other: 27 Total: 84 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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	Quality review completed on 7/24/18.			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide supervision to prevent a resident with known behaviors of hitting, kicking, punching and physical aggression prior to admission from engaging in three resident to resident altercations involving physical and sexual aggressiveness for 3 of 3 incidents reviewed. (Residents 2) The Immediate Jeopardy began on 7/17/18 at 6:49 p.m., after the resident had his second resident to resident physical altercation of allegedly striking another resident in the face with a coffee cup, after which facility staff did not provide adequate supervision which led to the third altercation of sexual aggressiveness. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 7/18/18 at 4:40 p.m. The Immediate Jeopardy was removed on 7/19/18, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding includes: On 7/17/18 at 1:10 p.m., Resident 2 was observed	F 0689	***ABATEMENT PLAN*** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for residents identified:** 1. The accused resident was removed from the room social service met with the resident who had no recollection with no change in mood, behavior and no signs of fear 2. Residents were separated and the alleged aggressor was removed from the situation and	07/30/2018

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	ambulating in the Elm activity room. At that time, the resident walked by a female resident and placed his hand on her cheek and rubbed her neck. There was an Activity Aide in the room, however, she did not see the interaction between both residents. The female resident did not respond to the resident's actions. The record for Resident 2 was reviewed on 7/18/18 at 2:45 p.m. The resident was admitted to the facility on 7/17/18 at 12:15 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia with behaviors, diabetes, high blood pressure, and kidney failure. The history and physical from the hospital, dated 7/2/18, indicated the patient presents with aggressive behaviors and hallucinations for the last 2 weeks. Per the family, the patient has been living at home, kicking, hitting and punching other family members including his wife. The patient had been urinating all over the place. The behaviors and agitation increased at night. Nursing notes, dated 7/17/18 at 2:52 p.m., indicated the resident entered the facility per ambulance. The resident was alert to name only. Unable to obtain vital signs due to resident continued to refuse. Nursing notes, dated 7/17/18 at 8:15 p.m., indicated the resident was uncooperative and resisted care. The resident was a new transfer and was having difficulty adjusting to the facility. Resident has been aggressive towards peers, not easily redirected. A care plan, dated 7/17/18, indicated the resident found comfort in touching soft body parts. Family reported that he had touched their breasts, not in a sexual manner but because it was soft.		two caregivers were assigned to monitor while arrangements were made for a psychiatric hospital stay. **2) How the facility identified other residents who could potentially be affected:** · All residents have the potential to be affected by the alleged deficient practice · Behavior logs and risk management will be reviewed for last 30 days to identify other residents with potential aggressive behaviors. **3) Measures put into place/ System changes:** · **All staff will be educated PRIOR to next scheduled shift on** o **Behavior management** o **Reporting unusual occurrence** o **Specific progressive interventions after each behavior and/or incident** o **One to one intervention should be implemented when residents demonstrate risk to themselves or others until other appropriate interventions can be implemented.** § **IDT meeting will be held to determine continuation or discontinuation of 1:1** o **One:one supervision** § **One to one is defined as a**	

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	The approaches were the resident would not become sexually inappropriate and would accept redirection. A care plan, dated 7/17/18, indicated the resident did not like to be touched. If resident needs to be assessed, he needs to be asked prior to touching him. A care plan, dated 7/17/18, indicated the resident was a wanderer and was disoriented to place. The resident wandered aimlessly. The approaches were to distract the resident from wandering by offering pleasant diversions and structured activities. A care plan, dated 7/17/18, indicated the resident was resistive to care. A behavior monitoring assessment, dated 7/17/18 at 3:45 p.m. (describing the 2:45 p.m. incident), indicated the resident wandered into another resident's room and was physically aggressive. The interventions were to provide 1:1, conversation, and to leave the resident alone and reapproach. A behavior monitoring assessment, dated 7/18/18 at 12:54 p.m., indicated the resident was verbally aggressive with another resident. The interventions were to provide 1:1, conversation, and to leave the resident alone and reapproach. An incident provided by the Director of Nursing (DON), dated 7/17/18 at 2:45 p.m., indicated Resident 2 hit Resident 3 on the side of his face knocking his oxygen cannula out of his nose. Both residents were separated and there was no injury. Resident 3 was not alert and oriented. The preventative measure put in place at that time, was to shadow Resident 2 until he was able to be		**caregiver dedicated to the resident** **§ When assigned caregiver is on scheduled break an alternate staff member will be placed with the resident** **4) How the corrective actions will be monitored:** · DON/Designee will review risk management five times per week for aggressive behaviors and the IDT will develop appropriate plan of care · DON/Designee will perform random observations of the 1:1 intervention up to 5 times per week at varied times when implemented to ensure direct supervision is being provided with associate dedicated to that resident. · The Director of Nursing will be responsible for oversight of these audits and observations. · The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. *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*	

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	redirected. An incident provided by the DON, dated 7/17/18 at 6:49 p.m., indicated Resident 2 entered Resident 4's room and would not leave. Resident 4 reported that she had asked the resident to leave her room and did so by placing her hand on his upper body to assist him out of the room, then Resident 2 hit her on the left side of the face between the upper cheek and ear with a coffee cup that he picked up in her room. Both residents were separated and there was no injury noted. Staff assisted Resident 2 ambulating in the hallway and provided 1 on 1 conversations with him until family arrived. The preventative measure put in place at that time, was the resident's family was notified and asked to come and help orient the resident. The family stayed with the resident until he was resting and then they left. An Activity progress note, dated 7/18/18 at 12:53 p.m., indicated "Writer was assisting in serving lunch on the Maple unit and observed resident going from table to table picking up silverware and other resident belongings. Writer redirected resident several times. Resident began following writer. Writer assist 1:1 with resident to other unit. Resident was cooperative with staff and sitting with other residents in the activity room. Activity staff and nursing were informed of the resident on the other unit throughout the day. Writer informed activity staff to be 1:1 with resident while writer stepped off the unit. Nursing staff was informed." (Sic) Nursing notes, dated 7/18/18 at 1:03 p.m., indicated the resident refused all morning medications. The Physician was notified. Interview with the DON on 7/18/18 at 3:00 p.m.,		*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.*	

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	indicated the Activity Director (AD) took it upon herself to watch the resident and provide 1 to 1 supervision during the day since he had refused his medications earlier in the morning. An incident provided by the DON, dated 7/18/18 at 1:45 p.m., indicated Resident 5 was heard "hollering out" from her room. The Activity Aide went into the room and witnessed Resident 2 pulling Resident 5's hair forcefully forward. He had his left leg bent and on her leg. His erect penis was out of the top of his pajamas. Both residents were fully clothed. Resident 5 was not alert and oriented. There was no injury. Resident 2 was immediately removed away from the resident. On 7/18/18 at 2:40 p.m., Resident 2 was transferred to the hospital. Interview with the DON on 7/18/18 at 3:00 p.m., indicated the Activity Director took the resident into the Linden unit (a locked unit within the memory care unit that housed low functioning and the most dependent residents) for activities. The AD and another Activity Aide were conducting an activity with the resident and Resident 2 was also participating. The AD told the aide the resident was on 1 to 1 and she was going to take a break. At that time, the AD left the Linden unit. The resident was participating, however, he decided to leave the dining room where the activity was occurring and started wandering down the hallway. The aide got up and looked out of the door and saw the resident was walking down the hallway. She went back into the room and told the residents she would be right back, she had to go and get Resident 2. As the aide walked down the hall, she heard a female resident hollering from her room walked in the room and saw Resident 2 pulling her hair and head forcefully forward. The resident was on top of her with his erect penis sticking out of his pajamas. The DON			

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	indicated they had just sent the resident out to the hospital. Interview with the DON on 7/18/18 at 3:15 p.m., indicated she was fully aware of the resident's prior behaviors before he was admitted. They had met with the resident's family 3 times before the resident was admitted to the facility. The DON indicated the family made them fully aware that the resident's behaviors were worse at night. The DON had a plan which was to have an extra CNA work from 3:00 p.m. to 8:00 p.m. to provide constant supervision (1 to 1) with the resident, for the first week to get the resident acclimated to the memory care unit. The DON did not implement the extra CNA on 7/17/18. The DON indicated she did not officially put the resident on 1 to 1 supervision and that was the AD's choice to provide that extra care. The DON had no plan to provide constant supervision for the resident, even after the second incident of alleged physical aggression. She indicated the nursing staff decided to stop shadowing the resident after the first incident because he was participating in activities and the family had told them they were coming in later, however, the family did not come to the facility until they were called in after the second incident. Interview with the DON on 7/19/18 at 8:25 a.m., indicated after further investigation regarding the second incident with the coffee cup, the event was unwitnessed between both residents and a visitor in the next room heard Resident 4 calling for help to get the resident out of her room and did not see Resident 2 striking her with a coffee cup. She indicated Resident 4 was holding the coffee cup in her hand. The DON indicated there was documentation in the "Risk Management" section of the clinical record which indicated the resident was provided with 1 on 1 conversations after the			

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	incident. Interview with the AD on 7/19/18 at 8:35 a.m., indicated she had witnessed the resident spit out his morning medications. The AD noticed Resident 2 touching other resident's silverware, cups, and plates and getting in their personal space. She tried to redirect him, and he begun to follow her around, so she took it upon herself to watch the resident and keep him busy. She indicated she had taken him to the Linden unit earlier in the day to participate in activities and he did very well. After lunch was served, she saw the resident becoming more and more agitated and decided to take him back to the Linden unit to join the activity. There was an activity aide in the dining room and she informed her that Resident 2 was calming down a bit and was seated on the couch next to a female resident. The AD informed the aide the resident needed to be watched closely and she was leaving the unit and taking a break. Interview with the Activity Aide on 7/19/18 at 9:18 a.m., indicated she had entered the Linden unit around 1:30 p.m., and the AD was there with Resident 2. The AD had informed her she was going to take a break and to "keep an eye" on Resident 2 especially around other residents. The aide indicated she gathered puzzles together for the activity. At that time, the resident got up and walked out of the dining room and she followed him to a room where he urinated all over. She redirected him back to the small activity room where he sat on the couch next to a female resident. She left that room and went around the corner to the dining room where the other residents were located to check on them. She then heard a loud scream, a different scream from another resident. She immediately got up to check out the situation and walked into the room			

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	where Resident 2 was pulling Resident 5's hair and had one leg on top of her with his pajama pants on, however, his erect penis was out of his brief. She indicated the blanket that had been covering the resident was on the floor. Both residents were fully dressed. The Immediate Jeopardy that began on 7/17/18 was removed on 7/19/18 when the facility began inservicing staff on the behavior management program, when one to one interventions should be implemented after specific behaviors or incidents, the one to one definition and the supervision of staff after one to ones have been initiated, but the noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff were available to be inserviced and there were no residents to observe who required constant supervision during this time. 3.1-45(a)(2)			