

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155277</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/19/2018</b>	
NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE VALPARAISO</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>3301 N CALUMET AVE</b> <b>VALPARAISO, IN 46383</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00267422.</p> <p>This visit was in conjunction with 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.</p> <p>This visit was in conjunction with the PSR to Complaint IN00264621 completed on 6/8/18.</p> <p>Complaint IN00267422 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00264621 - Corrected.</p> <p>Unrelated deficiencies are cited at F689.</p> <p>Survey dates: July 17, 18, &amp; 19, 2018</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Census Bed Type: SNF/NF: 84 Total: 84</p> <p>Census Payor Type: Medicare: 10 Medicaid: 47 Other: 27 Total: 84</p> <p>Aperion Care Valparaiso was found to be in</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155277</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/19/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>APERION CARE VALPARAISO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3301 N CALUMET AVE</b> <b>VALPARAISO, IN 46383</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	Continued From page 1 compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00267422.  Quality review completed on 7/24/18.	F 000			