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	09/06/2016

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

(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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00208809. Complaint IN00208809 - Substantiated. Federal/State deficiencies related to the allegations are cited at F371. Unrelated deficiency cited. Survey dates: September 6 & 7, 2016 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census bed type: SNF/NF: 87 Total: 87 Census payor type: Medicare: 10 Medicaid: 65 Other: 12 Total: 87 Sample: 12 These deficiencies reflect 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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	Quality review completed by 32883 on 9/7/16.			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision related to hall doors not alarming and outdoor patio gait not locked as required for 1 of 1 residents reviewed for elopements in a sample of 12. (Resident #H) Finding includes: On 9/6/16 at 10:40 a.m. Resident #H was observed in bed. The resident's bed was in the low position. The record for Resident #H was reviewed on 9/6/16 at 10:18 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, failure to thrive, chronic obstructive pulmonary disease, and	F 0323	**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.*	09/30/2016

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	depression. An Elopement Risk Assessment was completed on 8/1/16. The assessment indicated the resident was not at risk for elopement. A Social Service Note was completed on 8/2/16 at 4:15 p.m. This entry indicated the resident had left the building. A Nursing Assessment was completed on 8/2/16 at 1:30 p.m. The entry indicated the resident had short term memory impairment and impaired decision making ability. The assessment indicated the resident walked in her room independently and required only supervision for walking in the corridor. When interviewed on 9/6/16 at 11:15 a.m., Social Worker #1 indicated on 8/1/16 she and the ADON (Assistant Director of Nursing) heard the exit door to the secured courtyard alarms sound. These exit doors were at the end of the hallway. There was a door to enter the area where the second exit doors were located. The Social Worker indicated the first door they exited from the unit had a door alarm on it and a Velcro stop sign on it. The Social Worker indicated the stop sign was in place and when they opened the door, the door alarm did not sound. They then opened the exit doors		**1) Immediate actions taken for those residents identified:** Resident H was returned to unit, assessed with no injury. Door alarms and gate were checked immediately. Interior door alarm was not activated, but when activated worked properly. Exterior door alarm worked and was working during event. Patio gate latch was not closed completely during event, but follow up checks noted the gate latching properly and arming when latched. Resident H had no further elopement events, Resident H has since discharged from the facility. **2) How the facility identified other residents:** All residents that reside on the Elm/Maple dementia unit have the potential to be affected by this alleged deficient practice. All door alarms were checked for proper functioning. **3) Measures put into place/ System changes:** Staff were in-serviced on the importance of activating the inner patio exit door alarm whenever staff/residents/families are not using the patio area. An audit log	

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	and entered the secured outdoor patio area. Resident #H was observed standing in the parking lot below the patio area. The Social Worker indicated the area was gated with a code alarm on the gate. This door had been left ajar and appeared to be how Resident #H exited to the parking lot. When interviewed on 9/6/16 at 11:30 a.m., the Maintenance Director indicated Resident #H had exited the building from the locked patio area. The Maintenance Director indicated there was a door at the end of the Elm hall that used be a sitting or library area. This door had a door alarm in place that sounded when the door was opened. The door led to the second set of doors which then led to the outdoor patio area. The second set of doors were locked by a code and an alarm sounded at the Nursing station when they were opened. He further indicated, for fire safety reasons, the doors could be opened by pushing on them for (15) seconds and they exited to the secured patio area. The patio had two gates. One side was locked with a key and the other side had a code alarm on it. The Maintenance Director indicated the resident exited through the coded gait and they believe it had not been latched shut at the time Resident #H exited.		sheet was initiated for the charge nurses to check and log the inner door alarm 1x per shift to assure alarm is activated and in working order. Nursing staff were in-serviced on this procedure. Maintenance department has added the exterior gate latch to the regular door alarm checks. Dementia unit door alarms will be checked for proper functioning and the patio gate will be checked for proper latching and functioning 5x/ week for 2 weeks, 3x/ week for 2 weeks then weekly thereafter. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **9/30/2016**	

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	Continued interview with the Maintenance Director indicated he checked the glass doors which lead to the patio once a week. He indicated he turned off the first door alarm to get to these glass exit doors. He indicated he did not routinely check the first door on the Nursing unit when he completed his weekly checks of the outer doors. When interviewed on 9/6/16 at 11:41 p.m., the facility Administrator indicated the alarm on the panel at the Nursing Station sounded showing the outer door had been opened and staff responded. The Administrator indicated the latch on the gate leading from the secured patio to the parking lot area should have been locked. The Administrator indicated when they checked the latch on the door after the resident exited it was working correctly. 3.1-45(a)(1) .			

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F 0371 SS=D Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was stored under sanitary conditions related to open foods a beverages not labeled at the time they were opened, prepared foods left in the refrigerator longer then allowed and at improper temperatures, and spillage in the microwave and refrigerator in 1 of 2 Unit Dining Rooms observed on the Timber floor. (The Linden Dining Room). Findings include: 1. The Kitchen area in the Linden Dining Room on the Timbre Unit was observed on 9/6/16 at 8:40 a.m. A total of (12) residents resided on the Linden section of the Timbre unit. The following observations were noted: a. There were four bowls of jello with plastic lids in the unit refrigerator. The bowls were dated 9/1/16.	F 0371	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were identified in this citation. The	09/30/2016

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	b. There were thirteen individual cartons of 2% milk in the unit refrigerator. Five of the carton were dated 8/27/16, three of the cartons were dated 9/2/16, and five of the containers were dated 9/3/16. c. There were three opened bottles of beverages which had no "date opened" marked on them. d. There were five open containers of various flavors of thickened liquids. The containers were not marked with the date they were first opened. e. There was a clear plastic container with food in it. The container was not marked with any resident name, date, or identifying label. f. There were approximately (3) small individual butter spread packets in the condiment rack on the counter in the Dining Room. The label indicated the butter packets were best if kept refrigerated. g. The thermometer in the refrigerator registered 48 - 50 degrees Fahrenheit. h. There was food spillage inside the microwave oven on the counter next to the refrigerator. There was dried beverage spillage on the shelves in the refrigerator.		outdated/undated food items were removed from the Linden refrigerator. The refrigerator and microwave were cleaned. All individual butter spread packets not in the refrigerator were disposed of. **2) How the facility identified other residents:** All residents on the Linden unit have the potential to be affected by this alleged deficient practice. All remaining dining room pantry refrigerators and microwaves were checked for outdated/undated food items. Refrigerators and microwaves were cleaned, and condiment containers were inspected for butter spread packets that were not refrigerated. No residents have been noted to be directly affected. **3) Measures put into place/ System changes:** Staff have been in-serviced on importance of assuring unit pantry refrigerators and microwaves are kept clean, only resident food items are stored in the refrigerator and are labeled/ dated properly, un-opened cartons of food must be disposed of by factory expiration date and	

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	2. Food temperatures of the jello and puddings in the Linden Dining Room refrigerator were taken at 8:50 a.m. with the Dietary Manager present. The temperature of one of the bowls of pudding was 48.0 degrees Fahrenheit. The Dietary Manager indicated the temperature should have been cooler. When interviewed on 9/6/16 at 12:15 p.m., the Dietary Manager indicated the above areas were in need of cleaning. The Dietary Manager indicated the food items were to marked with the dated they were first opened. This Federal tag relates to Complaint IN00208809. 3.1-21(i)(3)		any condiments requiring refrigeration are stored in the refrigerator. Dining room managers were in-serviced on implemented audit tool to check the pantry refrigerators/ microwaves for compliance of temperature, cleanliness and proper storage of food items. Audits are required for a minimum of 5x per week on various units and meals. Labels for marking/dating items and permanent markers were located on each unit for convenience of staff to assure compliance. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months, or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **9/30/2016**	