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	10/04/2016

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 IN00209604. Complaint IN00209604 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: October 3 & 4, 2016 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Census bed type: SNF/NF: 88 Total: 88 Census payor type: Medicare: 11 Medicaid: 59 Other: 18 Total: 88 Sample: 6 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on October 5, 2016.	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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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 implement fall interventions to prevent accidents related to falls as per the resident care plan for 1 of 3 residents reviewed for falls in a sample of 6. (Resident #B) Finding includes: During Orientation Tour on 10/3/16 at 8:40 a.m., Resident #B was observed sitting in a wheel chair in the Linden Unit Dining Room. There was a coiled alarm cord around the arm handle of the wheel chair. No alarm box was attached to the cord. There were no anti roll backs on the resident's wheel chair. There were no bags on the wheel chair arms. On 10/3/16 at 8:50 a.m., the resident remained in the Dining Room. No alarm box was attached to the alarm cord on the wheel chair. There were no anti roll	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.* **1) Immediate actions taken for those residents identified:**	10/21/2016

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	backs on the resident's wheel chair. There were no bags on the wheel chair arms. At 8:55 a.m., the resident was observed propelling herself out of the Dining Room into the hallway. On 10/3/16 at 11:34 a.m., the resident was observed in the unit Dining Room. The alarm cord was now attached to an alarm box. No anti roll backs were in place on the wheel chair. There were no bags on the arms of the wheel chair. On 10/3/16 at 12:25 p.m., the resident was observed in the unit Dining Room. No anti roll backs were in place on the wheel chair. There were no bags on the arms of the wheel chair. On 10/31/6 at 2:35 p.m., the resident was observed propelling herself in the hallway in her wheel chair. No anti roll backs were in place on the wheel chair. There were no bags on the arms of the wheel chair. The record for Resident #B was reviewed on 10/3/16 at 10:57 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, history of falls, atrial fibrillation (irregular heart rate), and depressive disorder.		Resident B remains on the Linden dementia unit. Chair alarm was replaced on the chair. Anti-rollback device was installed on Resident B's wheel chair. Wheelchair bags were attached to the wheelchair bilaterally. Care plan was reviewed and revised to note that resident does remove bags from wheelchair at times. **2) How the facility identified other residents:** An audit of residents at risk for falls was completed to assure care planned interventions were in place. Any findings of non-compliance were corrected. **3) Measures put into place/ System changes:** Falling leaf program initiated throughout the facility. Nursing staff and management were in-serviced on the program. Falling leaf identifiers were placed near resident beds and on the resident room door frames. Guardian Angels were in-serviced on different wheel chair devices and how to identify them, how to access the Kardex form for their assigned residents and how to use the Guardian Angel Rounding tool to report any concerns of non-compliance. Guardian Angels	

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	The 9/19/16 Minimum Data Set (MDS) quarterly assessment was reviewed. The resident's cognitive skills were moderately impaired. The resident required extensive assistance of one staff member for transfers and bed mobility. The resident had one fall since her admission or readmission. A Fall Risk assessment was completed on 9/20/2016. The resident's score was (16). A score of (16) indicated the resident at risk for falls. The current Care Plans were reviewed. A Care Plan initiated on 3/15/15 indicated the resident was at risk for falls related to poor safety awareness, diagnoses of Parkinson's Disease, a history of falling, and the use of psychotropic medications. The Care Plan was last revised on 9/2/16. Care plan interventions included, but were not limited to, bed/chair alarm, anti roll backs to the wheel chair, and wheel chair bags to bilateral sides of the wheel chair. When interviewed on 10/3/16 at 3:15 p.m., Activity Staff #1 indicated there were no wheel chair bags in the resident's room during the day for her to place on the wheel chair. The staff member indicated she thought they were in the laundry.		will audit a minimum of 10 residents per week x 6 weeks, 5 residents per week x 6 weeks, and continue as determined by the QAPI committee. Guardian Angel rounding tools will be reviewed in daily stand up meetings for compliance. **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:** **10/21/2016**	

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	When interviewed on 10/3/16 at 3:18 p.m., the Unit Manager indicated Resident #B should have had bags on her wheel chair. The Unit Manager indicated the bags were available in the Therapy Department. When interviewed on 10/3/16 at 4:05 p.m., the Director of Nursing indicated the anti roll backs and the bags to the resident's wheel chair should have been in place. This Federal tag relates to Complaint IN00209604. 3.1-45(a)(2)			