

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER APERION CARE PERU	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 WEST MATADOR ST PERU, IN 46970
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F000000	<p>This visit was for the Investigation of Complaint IN00158749.</p> <p>Complaint #IN00158749 - Substantiated. Federal/State deficiencies related to this allegation are cited at F309.</p> <p>Survey date: October 31, 2014</p> <p>Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750</p> <p>Survey team: Julie Wagoner, RN, TC Deb Kammeyer, RN</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 13 Medicaid: 41 Other: 12 Total: 66</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		
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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.

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F000309 SS=D	<p>Quality Review completed on November 7, 2014, by Brenda Meredith, R.N.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary 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.</p> <p>Based on record review and interviews, the facility failed to ensure a resident with observed symptoms of a condition change was thoroughly assessed for 1 of 4 residents reviewed. (Resident C)</p> <p>Finding includes:</p> <p>The clinical record for Resident C was reviewed on 10/31/14 at 11:00 A.M. Resident C was admitted to the facility, on 09/07/13, with diagnosis, including but not limited to hypertension, history of transischemic attacks, peripheral vascular disease, chronic obstructive pulmonary disease, dysphagia, diabetes, congestive heart failure, and chronic kidney disease.</p>	F000309	<p>F309</p> <p>The facility requestspaper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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></p>	11/24/2014

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	<p>Review of the nursing progress notes, from 10/21/14 - 10/27/14, indicated the following issues were documented:</p> <p>On 10/21/14, the resident's conjunctivitis was being treated, there were no adverse reactions noted to an increase in antidepressant and dementia medications, and a respiratory treatment had been administered due to audible wheezing.</p> <p>On 10/22/14, the resident was documented to have no adverse reactions to an increase in antidepressant and dementia medications, her diuretic medication was discontinued, and the resident was noted to have two bowel movements.</p> <p>On 10/23/14, the resident was given PRN (as needed) medication three times for foot pain, had no adverse reactions to an increase in antidepressant and dementia medications, had a urine sample obtained and her care plan was reviewed.</p> <p>On 10/24/14, the resident had no adverse reactions to an increase in antidepressant and dementia medication, and the physician was notified of urinalysis results.</p> <p>On 10/25/14, the resident was medicated with PRN medication, had no adverse reactions to an increase in antidepressant and dementia medication and had a temperature documented.</p> <p>On 10/26/14, the resident had no adverse</p>		<p>1) Immediate actionstaken for those residents identified:</p> <p>Resident C is no longer at the facility.</p> <p>2) How the facilityidentified other residents:</p> <p>All residents have the potentialto be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>CNA's will be re-educatedregarding use of "New Alert" option in computerized ADL charting to documentany change in resident condition, as well as verbal notification. This will trigger an alert to notify thenurse of the change in condition.</p> <p>Licensed nurses will bere-educated on change in condition alerts triggered by CNA documentation, andappropriate assessment and documentation of change in condition.</p> <p>The Director of Nursing or designee will audit triggered alerts for change in condition and follow updocumentation at least 3-5x/week to ensure appropriate follow up assessment anddocumentation were completed as identified.</p>				

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	<p>reactions to an increase in antidepressant and dementia medications.</p> <p>On 10/27/14 at 2:04 A.M., "Resident found in room by aid pale cool and not breathing. Was last seen around 0130 [1:340 A.M.]. Resident around 0200 [2:00 A.M.] was checked on by aid and found in declined condition. Resident immediately started CPR [Cardiopulmonary Resuscitation] due to full code. Called MD [doctor], family, and 911 to inform EMS [Emergency Medical Service] came and evaluated, pronounced dead. Family said resident wanted to be sent to [name and location of funeral home]...."</p> <p>Interview with an anonymous staff member, #10, on 10/31/14 at 11:00 A.M., indicated on 10/24/14, the resident was noted to be slurring her speech, had uncontrolled jerking movements and was not able standing up very well when assisted. The staff member indicated she had informed Licensed Nurse #1 of her concern. She indicated the nurse told her the resident was "Fine" and was "Just bored." Staff member #10 indicated she had heard from an anonymous night shift staff member the resident had "begged" to go to the hospital.</p> <p>Interview with another anonymous staff member #11, on 10/31/14 at 11:15 A.M.,</p>		<p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 11/24/14</p>				

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	<p>indicated on 10/24/14, Resident C was noted to have a condition change, her speech noted to be slurred and she was noticeably "shaky." She indicated she had informed Licensed Nurse #1 and she had told the staff member Resident C was "fine." She indicated Resident C was noted, on 10/25/14 and 10/26/14, to sleep in longer than normal in the mornings.</p> <p>Interview with anonymous staff member #12, on 10/31/14 at 1:05 P.M., indicated one day in the past week Resident C was noted to be less responsive and "blah" when she was being pushed in her wheelchair from the dining room. The staff member indicated she checked the resident's oxygen saturation level with an oximeter and noted it was only 83%. She indicated she informed Licensed Nurse #2. She indicated the nurse put oxygen on the resident and assisted staff member #12 in placing the resident in her bed and the nurse took her vital signs.</p> <p>Interview with anonymous staff member #13, on 10/31/14 at 1:10 P.M., indicated during the afternoon, on 10/26/14 Resident C had complained of stomach discomfort and her belly looked "red." She indicated she had notified Licensed nurse #3. Staff member #13 also indicated a few days before 10/26/14 she had noted the resident was real "shaky."</p>						

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	<p>She indicated she had told the charge nurse but could not remember which nurse she had told.</p> <p>Interview with a Physical Therapy Assistant, staff member #14, on 10/31/14 at 11:49 A.M., indicated Resident C had been "sick" for about a week and was acting "like she had a cold or the flu, tired and not energetic." He indicated he did not inform any nursing staff because he knew she was being treated for an infection.</p> <p>Interview with LPN nurse #1, on 10/31/14 at 2:00 P.M., indicated she did not remember any staff member expressing concerns with Resident C in the past week or so. She indicated the resident was being treated for a urinary tract infection. She indicated if she had received any complaints she would have assessed the resident but would not necessarily document the assessment if she did not "find anything." She indicated she might have documented the concerns on a 24 hour nurse report form.</p> <p>Interview with LPN #2, on 10/31/14 at 2:10 P.M., indicated Resident C had been "tired" recently but she was being treated for a urinary tract infection. She indicated she did not remember being alerted to the resident low oxygen level</p>			

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	<p>by any staff member. She indicated she administered a breathing treatment to the resident because she was "wheezy." She indicated she did not place oxygen onto the resident because the resident was already wearing oxygen. She indicated she assisted to lay the resident in her bed per the resident's request.</p> <p>Interview with LPN #3, on 10/31/14 at 3:00 P.M., indicated she did not remember any significant issues on 10/26/14 with Resident C. She did remember a staff member mentioning something about the resident's stomach, had talked to the resident, assessed her stomach, noted normal bowel sounds and a reddened area "like a crease from a blanket." She indicated the reddened area dissipated and the resident did not complain of discomfort. She indicated she did not document the issue because the resident did not complain of pain and the reddened area dissipated.</p> <p>Interview with the Unit Manager for the facility, LPN #4, on 10/31/14 at 2:25 P.M., indicated she had not done any direct care for Resident C in the past week but did not remember any staff member expressing concern with Resident C's condition. She indicated she knew the resident had made complaints of not feeling well, but the resident had</p>				

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	<p>recently been started on an antibiotic for a urinary tract infection. When asked if the antibiotic was the medication initiated on 10/15/14, she confirmed it was. LPN #4 indicated if a licensed nurse was notified of any abnormal issue or concern she should evaluate the resident and document the reported symptom in their assessment even if they did not verify the symptoms.</p> <p>Interview with the Director of Nursing, on 10/31/14 at 3:15 P.M., during the exit conference, indicated the nursing staff "documented by exception" and would not have documented an assessment unless they noted something abnormal. She indicated there was no way to verify the concerns were brought to the attention of the licensed nursing staff.</p> <p>Review of the 24 hour report forms, from 10/21/14 - 10/27/14, indicated the resident's temperature was documented on 2 occasions, a respiratory treatment was documented, the need for a urinalysis test was documented several times, a new order to discontinue a diuretic medication and obtain a lab test was documented, a full set of vital signs including blood oxygen saturation level was documented once, the resident's blood sugar was documented 7 times,, and "tired today" was documented on the evening shift of</p>						

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	10/26/14. There was no other assessment documented on the 24 hour report forms. This Federal tag relates to Complaint IN00158749. 3.1-37(a)				