

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00198544.</p> <p>Complaint IN00198544 - Substantiated. Federal/State deficiencies related to the allegations were cited at F282 and F309.</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Census bed type: SNF: 03 SNF/NF: 69 Residential: 06 Total: 78</p> <p>Census payor type: Medicare: 8 Medicaid: 44 Other: 20 Total: 72</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 4/29/16.</p>	F 0000		
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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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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow Physician's Orders, related to notifying the Surgeon for wound care orders and timely administration of an intravenous (IV) antibiotic, for 1 of 3 residents reviewed for Physician's Orders in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 4/27/16 at 11:56 a.m. The resident's diagnoses included, but were not limited to diabetes mellitus, heart failure, neuropathy, end stage renal disease,</p>	F 0282	<p>F282</p> <p>The facility requestspaper compliance for this citation.</p> <p>This plan of correction is the center's credible allegationof compliance. Preparation and/or execution of this plan of correction doesnot constitute admission or agreement by the provider of the truth of the factsalleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw.</p> <p>1.Immediate actions taken for those residentsidentified:</p> <p>Resident #B expired 4/12/16 prior tothe survey.</p>	05/13/2016	

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	<p>osteomyelitis, and post amputation of the right great toe due to gangrene related to diabetes mellitus.</p> <p>Hospital Discharge Transfer Orders, dated 3/18/16, included an order for ertapenem (antibiotic) 500 mg IV daily and Please call (Surgeon's Name) when arriving to nursing home for orders, office number was provided.</p> <p>A Nurses' Progress Note, dated 3/19/16 at 1:24 a.m., indicated the Nurse Practitioner gave an order to follow the hospital discharge orders.</p> <p>The MAR, dated 3/2016, indicated the first dose of ertapenem was administered on 3/21/16 at 1 p.m.</p> <p>There was no information in the 3/18/16 and 3/19/16 Nurses' Progress Notes to indicate the Surgeon had been notified for orders.</p> <p>During an interview on 4/28/16 at 9:41 a.m., the DON indicated the ertapenem had been delivered from the pharmacy on 3/19/16 and was not sure why it had not been administered on 3/19/16.</p> <p>During an interview on 4/28/16 at 2:31 p.m., LPN #1 indicated the Surgeon had not been notified for orders as ordered on</p>				<p>1.How the facility identified other residents: An audit will be completed of all physician orders received in the last 30 days, including but not limited to hospital discharge orders, medication orders and wound treatment orders to ensure physician orders were followed and medications and treatments were administered per physician orders and plan of care.</p> <p>1.Measures put into place /System changes : Licensed nurses will be re-educated regarding following physician orders, including but not limited to implementing hospital discharge orders and administering wound treatments and medications according to physician orders and plan of care.</p> <p>1.How the corrective actions will be monitored : The Director of Nursing/designee will review all new physician orders at least 3x/week, including hospital discharge orders, medication and treatment orders to ensure orders are transcribed accurately and implemented. The Director of Nursing/designee will audit MAR/TAR and medication supply of at least 5 residents per week, including residents with new orders to</p>		

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F 0309 SS=D Bldg. 00	<p>the Hospital Discharge Orders.</p> <p>This Federal Tag relates to Complaint IN00198544.</p> <p>3.1-35(g)(2)</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 interview, the facility failed to ensure a resident was provided the necessary care and services for treatment of an arterial stasis wound (wound caused by decrease blood flow)/surgical site, related to the wound vac (negative pressure wound therapy) not set at the correct setting, no assessment of when the wound vac was applied and the functioning of the wound vac. The facility also failed to ensure the wound vac was charged and functioning while the resident was received dialysis outside of the facility, for 1 of 3 residents reviewed for wounds in a total sample of 3. (Resident #B)</p>	F 0309	<p>verify medications/treatments are available and administered timely according to physician orders. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved for three consecutive months.</p> <p>1. Date of Compliance : 5/13/2016</p> <p>F309 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.</p> <p>1. Immediate actions taken for those residents identified: Resident #B expired 4/12/16 prior to the survey.</p>	05/13/2016

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	<p>Finding includes:</p> <p>Resident #B's record was reviewed on 4/27/16 at 11:56 a.m. The resident's diagnoses included, but were not limited to diabetes mellitus, heart failure, neuropathy, end stage renal disease, osteomyelitis, and post amputation of the right great toe due to gangrene related to diabetes mellitus.</p> <p>The Admission/Re-Admit Observation assessment, dated 3/18/16 at 7:50 p.m., indicated the resident had a right toe amputation surgical wound 5.8 cm (centimeter) by 3.6 cm with a depth of 4.0 cm with blackened tissue outer edges of the wound. The assessment had not indicated the resident had a wound vac applied.</p> <p>A Physician's Order, dated 3/19/16, indicated the wound vac on the right great toe area was to be set at 100 mmHg (millimeters of mercury/unit of pressure).</p> <p>A Nurses' Progress Note, dated 4/1/16 at 9:33 p.m., late entry for 3/19/16 at 12:32 a.m., indicated the Nurse had attempted to call and get an Authorization Code for the wound vac to change the setting and the company was not open.</p>		<p>1.How the facility identified otherresidents: Residents receiving woundtreatments were reviewed to ensure appropriate treatments were in place. Noother residents in the facility are receiving negative pressure wound therapy(wound V.A.C.).</p> <p>1.Measures put into place/system changes. Licensed nurses were educated on4/8/16 by Cork Medical representative regarding negative pressure woundtherapy, including troubleshooting of device, how to change settings, andprocedure for applying the wound dressing. Licensed nurses will bere-educated regarding documentation of wound V.A.C. application,functioning/settings, and assessment of wound drainage, as well as ensuringthat device is charged and charger sent with residents when out of facility forappointments.</p> <p>1.How the corrective actions will bemonitored: The Director of Nursing/Designee will monitor all referrals and new admissions for special equipment needs.Director of Nursing/Designee will ensure staff is educated according to policyfor special equipment prior to new admission arriving to facility. The Director of Nursing/Designee will audit all new admissions and readmissions to ensure skin</p>		

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	<p>A 72 Hour Admission Charting assessment, dated 3/19/16 at 6:10 p.m., indicated the resident had a wound vac to the right foot. There was no assessment of the drainage of the wound or the functioning of the wound vac.</p> <p>A 72 Hour Admission Charting assessment, dated 3/21/16 at 10:26 a.m., indicated the resident had a wound vac to the right right foot. There was no assessment of the drainage of the wound or the functioning of the wound vac.</p> <p>A Skin Pressure/Stasis Ulcer assessment, dated 3/23/16 at 10:38 a.m., indicated the wound vac was draining a small amount of bloody drainage.</p> <p>A Skin Pressure/Stasis Ulcer assessment, dated 3/25/16 at 8:59 a.m., indicated there was a small amount of bloody drainage in the collection container.</p> <p>The Treatment Administration Record (TAR), dated 3/2016, indicated the the wound vac dressing had been changed on 3/21/16 and 3/23/16.</p> <p>The Nurses' Progress Notes, dated 3/18/16 through 3/25/16, had not indicated the wound vac had been applied, was functioning at 100 mmHg, or had an assessment of the drainage.</p>		<p>concerns are identified, orders are in place for monitoring and/or treatment, and that all areas identified have appropriate ongoing assessment documentation.</p> <p>The Director of Nursing/ designee will observe at least 3 wound dressings/treatments per week on varied shifts to ensure treatments are administered per physician orders and plan of care. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved for three consecutive months.</p> <p>1. Date of compliance: 5/13/16</p>	

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	<p>A Nurses' Progress Note, dated 3/25/16 at 3:46 p.m., indicated the resident had been transferred to the hospital from the dialysis center.</p> <p>The Emergency Room (ER) History and Physical, dated 3/25/16, indicated the resident was transferred to the ER due to low blood pressure and altered mental status. The note indicated there had been a wound vac on the resident's right first toe amputation site. The admission diagnoses included altered mental status, end stage renal dialysis, elevated troponim (proteins released with heart muscle damage), and lactic acidosis (increase of lactic acid).</p> <p>A Hospital Wound Nurse Progress Note, dated 3/26/16 at 10:33 a.m., indicated the resident's family had stated the wound vac was not functioning properly at the facility and the wound vac had been set to 80 mmHG for a while and often had a leak in the dressing, had not held a charge and the charging cable was not sent with the resident to dialysis, and the battery had died.</p> <p>During an interview on 4/27/16 at 12 p.m., the Director of Nursing (DON) indicated the resident's family had voiced concerns about the wound vac being sent</p>			

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	<p>to dialysis without the charger and the wound vac battery had died while the resident was at dialysis and also about the wound vac not functioning at the correct setting. The DON indicated the concerns were investigated.</p> <p>The investigation to the concern, received from the DON on 4/27/16 at 12 p.m., indicated the Admitting Nurse (LPN #1) indicated she had observed the settings were incorrect on the wound vac and had passed the information on to another nurse who attempted to call the company to obtain an administration code so the setting could be changed. The investigation indicated the setting had remained at 80mmHG throughout the weekend and Monday (March 18, 19, 20, and 21, 2016) and on Tuesday March 22, 2016, a nurse found the instruction pamphlet and was able to move the setting to the correct amount at 100mmHG.</p> <p>During an interview on 4/27/16 at 1:50 p.m., the ADON indicated the wound vac was set at 80 mmHg when applied to the resident's wound and an authorization code was needed to change the setting for the wound vac. She indicated she and LPN #1 had applied the dressing and the wound vac the evening the resident had arrived at the facility.</p>			

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	<p>During an interview on 4/27/16 at 2:02 p.m., the DON indicated the wound vac was at the wrong setting until the staff found the book for the pump with the instructions on how to change the setting. The DON indicated the resident went to dialysis on 3/25/16 and the power cord was not sent with the wound vac. The DON indicated she had called the nurse at dialysis and was told the wound vac was working but by the time the resident arrived at the hospital the battery died.</p> <p>During an interview on 4/28/16 at 8:59 a.m., the DON indicated the booklet for the wound vac was attached to the vac and was unsure why the staff had not looked at the booklet for instructions to change the setting. LPN #2 indicated she had looked in the booklet and found the instructions for setting the wound vac.</p> <p>The wound vac booklet, faxed from the Company Representative on 4/28/16 at 2:58 p.m., indicated to change the pressure, enter administrative mode, change pressure, and confirm with ok.</p> <p>During an interview on 4/28/16 at 11 a.m., the Dialysis Nurse indicated the wound vac had started beeping while the resident was at dialysis. She estimated the vac beeped for a "couple hours" and</p>			

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	<p>when the Medics came to transfer the resident to the ER, the wound vac was no longer beeping. She indicated at dialysis they are not trained to work with wound vacs. She indicated a power cord for the wound vac had not been sent with the resident.</p> <p>During interviews on 4/28/16 at 2:31 p.m., LPN #1 and the ADON indicated the wound vac had been applied on the evening of the resident's admission. The ADON indicated she had not looked at the booklet on the wound vac. LPN #1 indicated she had not seen the the instructions to change the wound vac settings. The ADON indicated the booklet said a key code was needed to change the settings. The ADON indicated the wound vac application was in a difficult spot on the resident's right foot and she had to tape it a couple times because it would not keep a good seal.</p> <p>This Federal Tag relates to Complaint IN00198544.</p> <p>3.1-37(a)</p>				

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

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