

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F000000	<p>This visit was for the Investigation of Complaint IN00155708 and IN00155929.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00155215 completed on August 25, 2014.</p> <p>Complaint IN00155708-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00155929-Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: September 9 and 10, 2014</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Yolanda Love, RN-TC Cynthia (Cyndy) Stramel, RN (September 10, 2014)</p> <p>Census bed type: SNF: 6 SNF/NF: 105 Total: 111</p>	F000000	<p>F309 The facility requestspaper compliance for this citation. <i>This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged 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. 1) Immediate actiontaken for those residents identified: Resident #H assessed from head to toe by nurse and then by unitmanager. Physician was notified of skinconcern and observation of pain during care, and new orders were received. 2) How the facilityidentified other residents: Allresidents had their skin assessed and pain evaluations completed by unit managers/woundnurse. Physicians will be notified of any new skin concerns or concerns of painas indicated. 3) Measures put intoplace/ System changes: Licensed nurses will be in-servicedregarding wound care program and pain management program. CNA's will be in-servicedregarding the reporting of any new skin concerns and any</i></p>	
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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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F000157 SS=D	<p>Census payor type: Medicare: 12 Medicaid: 96 Other: 3 Total: 111</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.1-3.1.</p> <p>Quality review completed on September 15, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental,</p>		<p>complaints of pain during care. Progress notes and physician orders will be reviewed up to 5 times a week to identify any new skin concerns. All new skin concerns identified will be re-assessed by the unit manager/wound nurse to ensure accurate observation and documentation of the skin concern, as well as to ensure appropriate treatment orders are obtained. Care observations will be performed on at least 5 residents per week on varied shifts to ensure ongoing compliance and to identify any pain or new skin concerns. The Director of Nursing or designee is responsible for oversight of these audits and observations. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 10/10/14</p>		

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	<p>or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the Physician was notified of a wound condition. The facility also failed to obtain continued treatment orders for the wound for 1 of 3 residents reviewed for non-pressure skin related issues. (Resident #B)</p> <p>Findings include:</p> <p>On 9/10/14 at 12:05 p.m. Resident #B's care was observed. CNA #1 assisted LPN #1 with pericare and wound care. They indicated the resident had some redness and excoriation to the groin areas that</p>	F000157	<p>F157</p> <p>The facility requestspaper compliance for this citation.</p> <p><i>This Plan of Correction isthe center's credible allegation of compliance. Preparation and/or execution of this plan of correctiondoes not constitute admission or agreement by the provider of the truth of thefacts alleged 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</i></p>	10/10/2014

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	<p>was almost resolved. The resident had a small 0.5 centimeter (cm) round open area on her left buttock that was bleeding and a slit-type open area approximately 1 x 0.3 cm under her left abdominal fold that was red and had mild drainage surrounding the wound. There was no dressing on the wound. Interview with the LPN at that time indicated the wound had been there for a couple weeks. They were treating her skin issues with Aloe Vesta lotion (a skin protectant). She further indicated when a new wound was observed, an initial skin sheet was to be completed, and the Wound Nurse would complete weekly assessments on the wound.</p> <p>Review of Nursing Notes indicated the wound was first noted on 8/23/14 at 7:21 a.m., the area was referred to as "mons pubis" in the Nursing Notes. Nursing Note dated 8/24/14 at 4:08 a.m. indicated "New order for periguard skin protectant to pubis q (every) shift until open area healed..."</p> <p>A Nursing Note dated 8/25/14 at 2:55 p.m. indicated the order was changed to Aloe Vesta for the mons pubis wound. There was no further documentation in the Nursing Notes related to the mons pubis wound after that.</p>		<p><i>federal and statelaw.</i></p> <p>1) Immediate actionstaken for those residents identified:</p> <p>Resident #B assessed from head to toe by nurse and then by unitmanager. Physician was notified of skinconcern and observation of pain during care, and new orders were received.</p> <p>2) How the facilityidentified other residents:</p> <p>Allresidents had their skin assessed and pain evaluations completed by unit managers/woundnurse. Physicians will be notified of any new skin concerns or concerns of painas indicated.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses will be in-servicedregarding physician notification of new wound/skin concerns and obtainingongoing treatment orders as indicated.</p> <p>Progress notes and physicianorders will be reviewed up to 5 times a week to identify any new skin concernsand to ensure physician is notified of new skin concerns and/or need forongoing treatment or changes.</p> <p>The Director of Nursing ordesignee is responsible for</p>				

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	<p>The Weekly Skin Assessment sheets for August and September 2014 were reviewed. None of the assessments involved the wound to the mons pubis area.</p> <p>There was no evidence of documentation indicating an initial skin sheet related to the mons pubis wound.</p> <p>Interview with the Wound Nurse on 9/10/14 at approximately 1:30 p.m., indicated she was not aware of the mons pubis wound. She indicated she would assess the resident at that time. After she assessed the resident, the Wound Nurse indicated the wound had some drainage and the Physician needed to be notified. She asked LPN #1 if she had spoken to the Physician about that wound and she indicated she had not.</p> <p>The September 2014 Treatment Administration Record (TAR) was reviewed. The record indicated Aloe Vesta ointment to the right armpit was completed on 9/3/14 and Aloe Vesta to the groin was completed on 9/3/14. There was no treatment in place for the mons pubis wound.</p> <p>The Physician's orders were reviewed with the DON on 9/10/14 at 4:15 p.m. There was an order dated 8/28/14 for Aloe Vista to be applied to the right</p>		<p>oversight of these audits.</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: 10/10/14</p>		

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F000309 SS=G	<p>armpit area for seven days and on 8/23/14 for Aloe Vista to be applied to groin area. There was no order for treatment to the mons pubis. The DON indicated the treatment orders were completed on 9/4/13. There were no additional orders for skin related issues.</p> <p>3.1-5(a)(3)</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 observation, record review and</p>	F000309	F309 The facility requestspaper compliance for	10/10/2014

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	<p>interview, the facility failed to ensure necessary services and treatments were provided related to the lack of assessment and intervention in a timely manner for a resident with pain. The facility also failed to ensure necessary services and treatments were provided related to the lack of assessment and treatment to an open wound on a resident's abdomen for 1 of 3 residents reviewed for non-pressure skin related issues. (Resident #B)</p> <p>Findings include:</p> <p>1. Resident #B was initially observed on 9/10/14 at 9:30 a.m. She was in her bed moaning, her face was contorted and there were tears on her face. She would open her eyes, but was unable to communicate. Her hands were contracted and she had palm protectors in both hands. LPN #1 indicated she was having pain due to excoriation to her buttocks and it was time to reposition her. She repositioned the resident. She indicated the resident had a prescription for Norco (a narcotic pain medication) as needed. She did not receive a scheduled pain medication.</p> <p>At 12:05 p.m., at 9/10/14 another observation was made with LPN #1. The LPN gave the resident her noon</p>		<p>this citation. <i>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 action taken for those residents identified:</i> Resident #B was assessed from head to toe by nurse and unit manager and was medicated for pain. Physician was notified of skin concern and observation of pain during care, and new orders were received. 2) How the facility identified other residents: All residents had their skin assessed and pain evaluations completed by unit managers/wound nurse. Physicians will be notified of any new skin concerns or concerns of pain as indicated. 3) Measures put into place/ System changes: Licensed nurses will be in-service regarding wound care program and pain management program. CNA's will be in-service regarding the reporting of any new skin concerns and any complaints of pain during care. Progress notes and physician orders will be reviewed up to 5 times a week to identify</p>				

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	<p>medications through the feeding tube. The resident was grimacing and would moan at times. CNA #1 assisted the LPN with pericare and wound care. They indicated the resident had some redness and excoriation to her groin areas. The resident had a small 0.5 centimeter (cm) round open area on her left buttock that was bleeding and a slit-type open area approximately 1 x 0.3 cm under her left abdominal fold that was red and had mild drainage surrounding the wound. There was no dressing on the wound. The resident continued to grimace and moan during care. Interview with the LPN at this time indicated the wound had been there a couple of weeks. They were treating her skin issues with Aloe Vesta lotion (a skin protectant). She further indicated when a new wound was observed, an initial skin sheet was to be completed, and the Wound Nurse would complete weekly assessments of the wound. At 12:25 p.m., the LPN indicated the resident was having pain. She indicated one of the noon medications was Baclofen (a muscle relaxant), and that some of the resident's pain was from her legs and she would wait half an hour to see if the Baclofen relieved the pain. She then removed the dressing to the residents G-tube site, cleansed the area and applied a new dressing.</p>		<p>any new skin concerns. All new skin concerns identified will be re-assessed by the unit manager/wound nurse to ensure accurate observation and documentation of the skin concern, as well as to ensure appropriate treatment orders are obtained. Care observations will be performed on at least 5 residents per week on varied shifts to ensure ongoing compliance and to identify any pain or new skin concerns. The Director of Nursing or designee is responsible for oversight of these audits and observations. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 10/10/14</p>				

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	<p>At 12:55 p.m. on 9/10/14 Restorative Aide (RA) #1 removed the palm protectors. When the resident's hands were opened, she yelled out and grimaced. The RA indicated she might be having pain, and he would notify the nurse. He then continued to remove the other palm protector.</p> <p>The resident's record was reviewed on 9/10/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, history of cerebral vascular accident (CVA), kidney stones, and osteoarthritis. She had a gastrostomy (G-tube) tube for feeding.</p> <p>The Significant Change Minimum Data Set assessment dated 7/30/14, indicated the resident was rarely or never understood, and required full care for bed mobility, transfers, and activities of daily living.</p> <p>Review of Nursing Notes indicated the wound was first noted on 8/23/14 at 7:21 a.m., the area was referred to as "mons pubis" in the Nursing Note. Nursing Note dated 8/24/14 at 4:08 a.m. indicated "New order for periguard skin protectant to pubis q (every) shift until open area healed..."</p>			

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	<p>A Nursing Note dated 8/25/14 at 2:55 p.m. indicated the order was changed to Aloe Vesta for the mons pubis wound. There was no further documentation in the Nursing Notes related to the mons pubis wound after that.</p> <p>The Weekly Skin Assessment sheets for August and September 2014 were reviewed. None of the assessments involved the wound to the mons pubis area. There was no evidence of documentation indicating an initial skin sheet related to the mons pubis wound.</p> <p>The September 2014 Medication Administration Record (MAR) was reviewed. Norco 5/325 milligrams (mg) start date 7/28/14, give 1 tablet every 6 hours as needed. Norco had been given one time in September on 9/9/14.</p> <p>The September 2014 Treatment Administration Record (TAR) was reviewed. The record indicated Aloe Vesta ointment to the right armpit was completed on 9/3/14 and Aloe Vesta to the groin was completed on 9/3/14. There was no treatment in place for the mons pubis wound.</p> <p>The Physician's orders were reviewed with the DON on 9/10/14 at 4:15 p.m. There was an order dated 8/28/14 for</p>			

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	<p>Aloe Vista to be applied to the right armpit area for seven days and on 8/23/14 for Aloe Vista to be applied to groin area. There was no order for treatment to the mons pubis. The DON indicated the treatment orders were completed on 9/4/13. There were no additional orders for skin related issues.</p> <p>A care plan dated 10/11/13 indicated the resident had potential for pain related to immobility. The goal was, "Will have no signs of pain (restlessness, facial grimacing, guarding of affected area, yelling out, tearfulness) through next review. The interventions included to assess for signs of pain, administer medications as ordered and notify MD if ineffective.</p> <p>A care plan dated 10/3/11 was for pain related to contractures. The goal was to have relief from pain within 1 hour of intervention. Interventions included to medicate as ordered and note effectiveness, document and report non-verbal sign of pain.</p> <p>A care plan for contracture management of hands dated 12/28/13 indicated the resident was to wear palm protectors 3-7 times a week. An updated intervention on 6/23/14 was to apply palm protectors before breakfast and remove after lunch;</p>			

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	<p>and inform nurse of signs of pain.</p> <p>Nursing Notes for 9/2014 were reviewed. There was one entry for the month dated 9/9/14 related to the resident crying with pain in her facial expression. There were no other entries.</p> <p>At 1:03 p.m., the resident was observed with the Director of Nursing (DON). Care had been completed and the resident was alone in her room. Her face was contorted and tearful. The DON approached the resident and massaged her arm, "oh honey, don't worry, the nurse is getting your pain medication". The LPN entered and gave her pain medication.</p> <p>Interview with the DON at that time indicated the resident had previously been on scheduled Norco, but it had made her lethargic. She also indicated the staff was aware they should be assessing for pain.</p> <p>Interview with the Wound Nurse on 9/10/14 at approximately 1:30 p.m., indicated she was not aware of the mons pubis wound. She indicated she would assess the resident at that time. After she assessed the resident, the Wound Nurse indicated the wound had some drainage and the Physician needed to be notified.</p>						

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	<p>The policy, Pain Evaluation, dated 3/21/02, was received from the DON on 9/10/14 at 3:45 p.m. The policy indicated the purpose was to provide "...optimal comfort through a pain control plan..." The policy further indicated, "Nursing will document any complaints or signs/symptoms of pain in the progress notes".</p> <p>3.1-37(a)</p>				