

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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	<p>This visit was for the Investigation of Complaints IN00182824 and IN00183011.</p> <p>Complaint IN00182824-Substantiated. Substantiated Federal/State deficiency related to the allegations was cited at F328.</p> <p>Complaint IN00183011-Substantiated. Federal/State deficiencies related to the allegations are cited at F166, F204, F225, F226, F314, and F520.</p> <p>Unrelated deficiencies cited.</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Census bed type: SNF: 01 SNF/NF: 68 Residential: 10 Total: 79</p> <p>Census payor type: Medicare: 11 Medicaid: 43 Other: 15</p>	F 0000		
------------------------	---	--------	--	--

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.

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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 0157 SS=D Bldg. 00	<p>Total: 69</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on November 6, 2015.</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, 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>			

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<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 resident's Physician was notified of a fall with injuries and a significant medication error in a timely manner for 1 of 3 residents reviewed for falls and 1 of 1 resident reviewed for medication errors in a sample of 11. (Resident #L)</p> <p>Finding includes:</p> <p>The record for Resident #L was reviewed on 10/29/15 at 10:39 a.m. The resident's diagnoses included, but were not limited to, cognitive communication deficit, bipolar disorder, dementia, depressive disorder, and high blood pressure.</p> <p>Review of the 8/21/15 Minimum Data Set (MDS) Significant Change assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (0). A score of (0) indicated the</p>	F 0157	<p>F157</p> <p>The facility requests paper 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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #L: Physician was notified of the fall that occurred on 8/31/15 at 14:13 with injury on 9/1/15 at 7:00am when the facility became aware of the fall.</p>	11/16/2015

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>resident's cognitive patterns were severely impaired. The assessment also indicated the resident had no behaviors. The assessment also indicated the resident required limited assistance of two staff members for bed mobility, dressing, eating, and personal hygiene.</p> <p>The 8/2015 Nurses' Notes were reviewed. A late entry was entered on 8/31/15 at 2:25 p.m. The entry indicated at 2:13 p.m. the resident fell out of her wheel chair onto the floor. Injuries were noted and neurological checks were initiated. There was no documentation of the resident's Physician being notified of the fall or the injuries at this time. Further entries on 8/31/15 indicated there was no documentation of the Physician being notified on 8/31/15 of the resident's fall and injuries.</p> <p>The 8/31/15 Witnessed Fall report was reviewed. The report indicated the resident was noted to have fallen forward from her wheel chair. The resident had a bloody nose and bruising starting to appear around her left eye. Neurological checks were initiated and the resident refused to leave cold compresses in place to her face. A small linear laceration was also noted to the bridge of the resident's nose. The laceration measured 2.5 cm in length. There was no documentation of</p>		<p>Physician was notified of medication error immediately on 10/24/15 at 6:30am when the nurse became aware that the medication error had occurred.</p> <p>2) How the facility identified other residents:</p> <p>Documentation of all residents that sustained a fall with injury in the last 30 days will be reviewed to ensure physician was notified in a timely manner.</p> <p>Documentation of all residents that had a medication error occurrence in the last 30 days will be reviewed to ensure physician was notified in a timely manner.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses will be re-educated regarding physician notification policy and process for medication error reporting..</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or designee will audit documentation after each fall and/or medication error as they occur to ensure physician was notified as required in a timely manner. Any deficiencies</p>				

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>the Physician being notified of the resident's fall or injuries.</p> <p>The 10/2015 current Physician orders were reviewed. An order was written on 9/3/15 for the resident to receive Morphine gel (a narcotic medication). The order indicated 40 mg (milligrams)/ml (milliliters): to apply 0.4 ml transdermally (topically to the skin) every 8 hours at 12:00 a.m., 8:00 a.m., and 4:00 p.m. Review of the October 2015 Medication Administration Record indicated the Morphine dose was signed out as administered on 10/24/15 at 12:00 a.m.</p> <p>Review of the 10/24/15 Incident Report Form indicated on 10/24/15 at 6:30 a.m. a discrepancy was noted in the narcotic count involving Morphine cream for Resident #L. A Medication Error report was completed. A 10/24/15 Medication Error Report indicated the LPN had given the midnight dose of Morphine. A fax message was then received and the LPN realized she had given too much of the Morphine to Resident #L at 12:00 a.m. The facility investigation report indicated the LPN was suspended on 10/24/15 related to a significant medication error and false documentation. A second report was completed on 10/28/15. This report indicated LPN #1 administered the</p>		<p>noted will be addressed and appropriate follow up measures taken as indicated.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months.</p> <p>5) Date of compliance: 11-16-15</p>	

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>wrong dose of medication and falsified documentation of the medication error.</p> <p>Review of the 10/24/15 Nurses' Notes and assessments indicated the resident's Physician had not been notified on 10/24/15 at 2:00 a.m. when the LPN first realized she had given the incorrect dose of the Morphine to the resident.</p> <p>When interviewed on 10/29/15 at 1:15 p.m., the Director of Nursing indicated the resident was given the incorrect dose of Morphine on 10/24/15 at 12:00 a.m. The Director of Nursing indicated she was first informed of the medication error on 10/24/15 at approximately 8:00 a.m. when she received a telephone call from LPN #1. At this time LPN #1 reported she had administered Morphine to Resident #L at 12:00 a.m. and later at 2:00 a.m. realized a medication error had occurred. The Director of Nursing indicated the Physician's Nurse Practitioner was first notified of the medication error on 10/24/15 at 6:30 a.m.</p> <p>The facility policy titled "Physician/Family/Responsible Party Notification" was received on 10/27/15 at 2:09 p.m. The policy had a revised date of 10/2015. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated</p>			

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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 0166 SS=D Bldg. 00	<p>medical problems were to be communicated the attending Physician in a timely, effective, and efficient manner. The policy indicated the Physician was to be informed of accidents resulting in injury. The policy also indicated the Physician was to be notified of any need to alter a resident's treatment.</p> <p>3.1-5(a)(1) 3.1-5(a)(3)</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure staff members followed the grievance protocol related to not reporting, not following up on grievances timely, and not following the facility's grievance policy, when residents and family members voiced concerns about missing rings and clothing for 2 of 3 residents reviewed for missing items, in a total sample of 11. (Residents #C and #J)</p>	F 0166	<p>F166</p> <p>The facility requests paper 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</i></p>	11/16/2015	

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>Findings include:</p> <p>1. During a family interview on 10/27/15 at 5:20 p.m., Resident #C's Power of Attorney (POA) indicated she had been at the facility visiting the resident and had noticed the resident's rings were not on her fingers. She indicated she had asked the nurse about the missing rings and was informed the rings were removed from the resident's fingers due to edema, and had been placed in a plastic cup in the Medication Cart. The POA indicated the Nurse went to the Medication Cart and took the plastic cup out and indicated the gold band was no longer in the plastic cup with the other rings. The POA indicated the Nurse said the ring had been stolen. The POA indicated the Nurse wrote up a report and indicated she was going to tell the Administrator about the missing gold band. The POA indicated this had occurred either in March or April and was unsure of the Nurse's name. The POA indicated she had been notified by the Administrator to find out the cost of the missing ring, after the resident had been discharged from the facility, May 16, 2015. She indicated the Administrator informed her to locate a ring comparable to the missing ring and to find out the cost of the ring, and when she (POA) had done this, the Administrator informed her the facility</p>		<p><i>plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #C- Resident was discharged from facility. The facility did make an effort to resolve the grievance regarding the ring, but the family declined the offer made.</p> <p>Resident #J- The facility has spoken to the resident and family regarding the missing sweaters and ring, and an acceptable resolution has been agreed upon.</p> <p>2) How the facility identified other residents:</p> <p>An audit will be completed of all grievances received in the last 30 days to ensure follow up and investigation was completed timely.</p> <p>3) Measures put in place/ System changes:</p> <p>Staff will be re-educated regarding grievance policy for concerns and missing items.</p> <p>The Social Service Director will review and audit all new grievances received and those that require follow up in the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>would not pay the amount of money the ring was estimated to cost and she was offered a smaller amount of money from the Administrator and had not accepted the offer.</p> <p>Resident #C's record was reviewed on 10/28/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to advanced Alzheimer's disease, bladder cancer, and chronic obstructive pulmonary disease.</p> <p>A Grievance/Concern Form, dated 03/13/15, completed by the Social Service Director, indicated the concern was voiced by the past Director of Nursing (DoN). The Grievance/Concern Form indicated the DoN reported to the Social Service Director the resident was missing a gold wedding band. The Investigation/Follow-up indicated the Social Service Director spoke to the POA and received a description of the ring and the Social Service Director informed the Housekeeping Department and the Administrator to start the investigation. The form indicated the Administrator signed and dated the form on 03/13/15 and the resolution indicated the POA was not able to give a description of the ring and the resolution was pending.</p> <p>A Nurses' Progress Note, dated 05/16/15</p>		<p>dailyinterdisciplinary department head meeting at least 3x/week to ensureinvestigations are in progress and resolution received timely. The Administrator will be responsible foroversight of these audits and investigations.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of theseaudits will be reviewed in Quality Assurance Meeting monthly until 100%compliance is achieved x3 consecutive months.</p> <p>5) Date ofcompliance: 11-16-15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>at 12:13 p.m., indicated the resident was discharged to another facility.</p> <p>A Social Service Progress Note, dated 05/18/15 at 10:44 a.m., indicated the Social Service Director notified the POA and left a message in regards to the resident's ring and was waiting for a return call.</p> <p>There was no further Progress Notes in the resident's record after 05/18/15.</p> <p>A typed letter, written by the Administrator, dated 08/14/15, and sent to the POA's Husband, indicated a "good faith" monetary amount was offered to the POA. There was no further follow-up on the missing ring.</p> <p>During an interview on 10/28/15 at 1:09 p.m., the Administrator indicated the Social Service Director was not in the facility. The Administrator indicated an investigation had not been completed on the missing ring. The Administrator indicated no one had followed-up with the POA until May.</p> <p>During an interview on 10/29/15 at 8:56 a.m., the Administrator indicated the Social Service Director would not be in the building today.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>2. During an interview on 10/28/15 at 8:40 a.m., Resident #J indicated she has had missing items. She indicated she had a ring missing and it was never found. She indicated she was unsure when the ring went missing. She indicated the facility had offered to replace it but she could not find one like the missing ring.</p> <p>Resident #J's record was reviewed on 10/28/15 at 1:55 p.m. The resident's diagnoses included, but were not limited to, stroke and traumatic brain injury.</p> <p>A Quarterly Minimum Data Set assessment, dated 09/05/15, indicated the resident's cognition was intact.</p> <p>A Resident Council Concern/Recommendation form (form used for the Resident Council Minutes), dated 06/24/15, indicated Resident #J reported she had two sweaters missing. The response, dated 06/25/15, indicated the facility had been searched for the sweaters and the resident's daughter had looked for the sweaters at home and the sweaters were not at the daughter's house. The form was signed by the Housekeeping Supervisor and the Administrator.</p> <p>A Resident Council Concern/Recommendation form, dated</p>						

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>07/28/15, indicated the resident continued to have two sweaters missing. The response, dated 08/24/15, indicated the sweaters had been searched for in every closet in the building.</p> <p>A Resident Council Concern/Recommendation form, dated 08/26/15, indicated Resident #J was missing two sweaters. The response, dated 08/31/15, indicated the sweaters had been reported missing since 06/24/15 and the building had been searched. The form was signed by the Housekeeping Supervisor and the Administrator.</p> <p>A Resident Council Concern/Recommendation form, dated 09/30/15, indicated Resident #J had two sweaters missing and a diamond ring. The note indicated the ring was missing, "long ago". The response, signed and dated 10/01/15 by the Housekeeping Supervisor, indicated this was the third month in a row the sweaters had been looked for and the response indicated, "...I have no idea about the diamond ring that is missing never heard about it. I have asked my staff if they have ever heard anything about a missing ring or have had to look for a diamond ring for (Resident Name), no one has."</p> <p>A Grievance/Concern Form, dated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>10/29/15, signed by the Housekeeping Supervisor, indicated since 06/24/15 Resident Council meetings, the resident had reported two sweaters missing, and the resident's daughter had taken several items of clothing home, and the sweaters were not taken home. The form indicated the daughter had purchased the sweaters from a second hand store and had no value but they were brand name and the facility had been searched and the sweaters were not located.</p> <p>During an interview on 10/29/15 at 8:56 a.m., the Administrator indicated she had spoke with the Housekeeping Supervisor and she had the grievance form. The Administrator indicated the Activity Director conducted a Resident Council Meetings and gave the concerns to Laundry. The Administrator indicated the Resident Council Concern/Recommendation form had not been given to her. The Administrator indicated she could not remember if the missing diamond ring had been reported to her. She indicated there had been no follow-up on the missing items.</p> <p>An un-dated policy, titled, "Grievances and Concerns", received as current from the Administrator on 10/28/15 at 2:31 p.m., indicated, "It is the Policy of this Facility to thoroughly investigate all</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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 0204 SS=D	<p>Resident and family grievances/concerns...Completed Grievance/Concern Forms will be given to the Social Service Department. The Social Service Department will route the Grievance/Concern Form to the appropriate department within 24-48 hours. 4. A prompt investigation will be completed and documented by the appropriate staff member on the facility's Grievance/Concern Form. 5. After the investigation and resolution, the completed Grievance/Concern Form will be given to the Administrator for final review...7. Within 5 working days of the date the Grievance/Concern Form was filed, the Resident and/or family member shall be informed orally of the results of the investigation...A grievance/concern involving alleged Resident abuse will immediately directed to the Administrator, Direction of Nursing and Social Service Director and investigated immediately..."</p> <p>This Federal Tag relates to Complaint IN00183011.</p> <p>3.1-7(b)</p> <p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
Bldg. 00	<p>TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>Based on record review and interview, the facility failed to provide thorough information about a resident's care and status, to a facility the resident was being discharged to, for 1 of 1 resident reviewed for transfer/discharge, in a total sample of 11. (Resident #C)</p> <p>Finding includes:</p> <p>Resident #C's record was reviewed on 10/28/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to advanced Alzheimer's disease, bladder cancer, and chronic obstructive pulmonary disease.</p> <p>A Physician's order, dated 05/05/15, indicated the resident had a urinary catheter, and to change the catheter as</p>	F 0204	<p>F204</p> <p>The facility requests paper 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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident C was discharged from the facility on 5/16/15.</p>	11/16/2015

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>needed of leakage or blockage.</p> <p>A Physician's order, dated 05/12/15, indicated Medihoney Wound/Burn Dressing Gel (pressure area treatment) to left ischium , every three days and cover with a Dermalvin (foam dressing used for opened pressure areas).</p> <p>A Physician's order, dated 05/13/15, indicated skin prep wipes (protective film for intact skin) to bilateral heels every shift for skin breakdown.</p> <p>A Skin-Other Skin Condition Report, dated 05/12/15, indicated a deep tissue injury (injury to underlying tissue below the skin's surface, from prolonged pressure in an area) with shearing to left ischium (buttock). Physician and family notified on 05/12/15.</p> <p>A Skin-Pressure/Diabetic/Stasis/Arterial Wound Report, dated 05/13/15, indicated, left buttock, 6 centimeters (cm) by 2.6 by unable to determine depth, suspected deep tissue injury and left heel, pressure, 4.2 cm by 3.8 cm unable to determine depth, unstagable (full thickness tissue loss is covered by slough and/or eschar in the wound bed).</p> <p>A Discharge/Transfer/LOA (leave of absence) form, dated 05/14/15, indicated</p>		<p>2) How the facility identified other residents:</p> <p>An audit will be completed on all residents discharged home or to another facility in the last 30 days to ensure discharge instructions were complete and accurate.</p> <p>3) Measures put into place/ System changes:</p> <p>Discharge Instructions Assessment has been revised to include additional information on skin condition, treatments, indwelling catheter orders, etc. (see attachment)</p> <p>Licensed nurses and department managers will be educated on completion of new discharge instructions assessment.</p> <p>4) How the corrective actions will be monitored:</p> <p>All discharge instruction assessments will be audited prior to and/or following discharges as they occur to ensure discharge instructions and skin assessment are complete and accurate.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p>The results of these audits will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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 0225 SS=D Bldg. 00	<p>the resident's discharge date was 05/16/15 at 12 p.m. to another Nursing Home for an admission. The area for Nutritional Needs was left blank and Special Instructions was left empty. The discharge instructions did not indicate the resident had a catheter and pressure sores.</p> <p>A Nurse's Progress Note, dated 05/16/15 at 12:05 p.m., indicated, the resident had just left with the transferring company, with oxygen. The note did not indicate a report was called to the facility the resident was being transferred to.</p> <p>During an interview on 10/28/15 at 10:12 a.m., the Assistant Director of Nursing (ADoN) indicated the transfer/discharge form had not included the urinary catheter or pressure ulcers.</p> <p>This Federal Tag relates to Complaint IN00183011.</p> <p>3.1-(a)(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered</p>		<p>reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months.</p> <p>5) Date of compliance: 11-16-15</p>				

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based record review and interview, the facility failed to ensure allegations of misappropriation of resident property and injuries of unknown origins were reported to the Administrator and Indiana State Department of Health (ISDH), and</p>	F 0225	<p>F225</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of</i></p>	11/16/2015

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>investigated in a timely manner, for 2 of 3 residents reviewed for missing items and 1 of 2 residents reviewed for bruising, in a total sample of 11. (Residents #C, #J, and #M)</p> <p>Findings include:</p> <p>1. Resident #M's record was reviewed on 10/29/15 at 12:41 p.m. The resident's diagnoses included, but was not limited to, dementia and hypertension.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 08/01/15, indicated the resident's cognition was severely impaired, required supervision for transfers and ambulation, and had one fall with injury.</p> <p>A Fall Interdisciplinary Team note, dated 10/13/15 at 4:21 p.m., late entry of 09/21/15 at 1 a.m., indicated, "...observed sitting up in her chair in her room with a bump on her head. she (sic) was unable to say what happened...unknown if fall occurred..."</p> <p>A Nurses' Progress Note, dated 09/21/15 at 02:35 a.m., indicated, "Writer was called to residents (sic) room by CNA to find resident sitting (sic) in her chair CNA noticed a walnut size red raised area above left eye brow. Resident could not</p>		<p><i>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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #C- Resident was discharged from the facility.</p> <p>Resident #J- Report was filed with ISDH regarding missing ring on 11/3/15. Resolution was discussed with resident and family and agreed upon.</p> <p>Resident #M- Resident was assessed and report was filed with ISDH on 10/29/15 regarding bruising to left eye observed.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed of skin observations and grievances for missing items in the last 30 days to identify any other residents that maybe affected.</p> <p>3) Measures put into place/ System</p>				

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>tell writer what happened. There was nothing on the floor that would cause her to trip/slip...ice applied to forehead notified on call nurse and MD."</p> <p>A Weekly Skin Observations form, dated 09/21/15 at 10:05 a.m., indicated skin concerns were observed, with bruising of the lower back, and left buttock, and a hematoma of the forehead above the left eye and the resident refused to allow the nurse to measure areas of bruising for three attempts.</p> <p>A Nurses' Progress Note, dated 09/22/15 at 12:49 a.m., indicated, "...Hematoma to left forehead, bruise to mid back and buttocks."</p> <p>A Nurses' Progress Note, dated 09/22/15 at 8:45 a.m., indicated, "...Swelling observed at site. Reddish-purple bruising noted."</p> <p>A Nurses' Progress Note, dated 09/22/15 at 4:45 p.m., "....Green bruising noted."</p> <p>During an interview on 10/29/15 at 1:17 p.m., the Administrator indicated the cause of the hematoma was not investigated. The Administrator indicated she was unaware of the bruising on the resident's back and buttock.</p>		<p>changes:</p> <p>Policies for Abuse Reporting and Investigations werereviewed.</p> <p>Staff will be re-educated regarding reporting of abusereporting, grievances, missing items and injuries.</p> <p>4) How the corrective actions will be monitored:</p> <p>Theinterdisciplinary team will review progress notes and grievances during morningmeeting at least 3x/week to ensure all concerns are investigated and reportedto ISDH according to facility policy.</p> <p>The Administratorwill be responsible for oversight of these audits.</p> <p>The results of theseaudits will be reviewed in Quality Assurance Meeting monthly until 100%compliance is achieved x3 consecutive months.</p> <p>5) Date ofcompliance: 11-16-15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>During an interview on 10/29/15 at 1:37 p.m., the Director of Nursing (DoN) indicated the notes were out of sequence on 09/21/15 at 1 a.m. and 2:35 a.m. because of late entries. The DoN indicated she was unaware of the bruising of the back and buttock. The Administrator indicated the hematoma to the eye had not been reported and she was unaware of the bruising of the buttock and back. She indicated she would not of reported the hematoma to the eye because it had not met the criteria for reporting.</p> <p>2. During a family interview on 10/27/15 at 5:20 p.m., Resident #C's Power of Attorney (POA) indicated she had been at the facility visiting the resident and had noticed the resident's rings were not on her finger. She indicated she asked the nurse about the missing rings and was informed the rings were removed from the resident's fingers due to edema, and had been placed in a plastic cup in the Medication Cart. The POA indicated the Nurse went to the Medication Cart and took the plastic cup out and indicated the gold band was no longer in the plastic cup with the other rings. The POA indicated the Nurse said the ring had been stolen. The POA indicated the Nurse wrote up a report and indicated she was going to tell the Administrator about</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>the missing gold band. The POA indicated this had occurred either in March or April and was unsure of the Nurse's name.</p> <p>Resident #C's record was reviewed on 10/28/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to advanced Alzheimer's disease, bladder cancer, and chronic obstructive pulmonary disease.</p> <p>A Grievance/Concern Form, dated 03/13/15, completed by the Social Service Director, indicated the concern was voiced by the past Director of Nursing (DoN). The Grievance/Concern Form indicated the DoN reported to the Social Service Director the resident was missing a gold wedding band. The Investigation/Follow-up indicated the Social Service Director spoke to the POA and received a description of the ring and the Social Service Director informed the Housekeeping Department and the Administrator to start the investigation. The form indicated the Administrator signed and dated the form on 03/13/15 and the resolution indicated the POA was not able to give a description of the ring and the resolution was pending.</p> <p>During an interview on 10/28/15 at 1:09 p.m., the Administrator indicated the</p>			

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>Social Service Director was not in the facility. The Administrator indicated an investigation had not been completed on the missing ring. The Administrator indicated the missing ring had not been reported to the ISDH.</p> <p>3. During an interview on 10/28/15 at 8:40 a.m., Resident #J indicated she has had missing items. She indicated she had a ring missing and it was never found. She indicated she was unsure when the ring went missing.</p> <p>Resident #J's record was reviewed on 10/28/15 at 1:55 p.m. The resident's diagnoses included, but were not limited to, stroke and traumatic brain injury.</p> <p>A Quarterly Minimum Data Set assessment, dated 09/05/15, indicated the resident's cognition was intact.</p> <p>A Resident Council Concern/Recommendation form, dated 09/30/15, indicated Resident #J voiced she had a diamond ring missing, "long ago". The response, signed and dated 10/01/15 by the Housekeeping Supervisor, indicated "...I have no idea about the diamond ring that is missing never heard about it. I have asked my staff if they have ever heard anything about a missing ring or have had to look</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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 0226 SS=D Bldg. 00	<p>for a diamond ring for (Resident Name), no one has."</p> <p>During an interview on 10/29/15 at 8:56 a.m., the Administrator indicated she could not remember if the missing diamond ring had been reported to her. She indicated there had been no investigation of the missing ring and she had not notified the ISDH of the missing diamond ring.</p> <p>This Federal Tag relates to Complaint IN00183011.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their abuse policy, related to investigating and reporting injuries of unknown origins and allegations of misappropriation of residents' property, related to bruising</p>	F 0226	<p>F226</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of</i></p>	11/16/2015			

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>and missing rings, for 2 of 3 residents reviewed for missing items and 1 of 2 residents reviewed for bruising, in a total sample of 11. (Residents #C, #J, and #M)</p> <p>Findings include:</p> <p>1. Resident #M's record was reviewed on 10/29/15 at 12:41 p.m. The resident's diagnoses included, but was not limited to, dementia and hypertension.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 08/01/15, indicated the resident's cognition was severely impaired, required supervision for transfers and ambulation, and had one fall with injury.</p> <p>A Fall Interdisciplinary Team note, dated 10/13/15 at 4:21 p.m., late entry of 09/21/15 at 1 a.m., indicated, "...observed sitting up in her chair in her room with a bump on her head. she (sic) was unable to say what happened...unknown if fall occurred..."</p> <p>A Nurses' Progress Note, dated 09/21/15 at 02:35 a.m., indicated, "Writer was called to residents (sic) room by CNA to find resident siting (sic) in her chair CNA noticed a walnut size red raised area above left eye brow. Resident could not tell writer what happened. There was</p>		<p><i>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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #C- Resident was discharged from the facility.</p> <p>Resident #J- Report was filed with ISDH regarding missing ring on 11/3/15. Resolution was discussed with resident and family and agreed upon.</p> <p>Resident #M- Resident was assessed and report was filed with ISDH on 10/29/15 regarding bruising to left eye observed.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed of skin observations and grievances for missing items in the last 30 days to identify any other residents that maybe affected.</p> <p>3) Measures put into place/ System</p>	

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>nothing on the floor that would cause her to trip/slip...ice applied to forehead notified on call nurse and MD."</p> <p>A Weekly Skin Observations form, dated 09/21/15 at 10:05 a.m., indicated skin concerns were observed, with bruising of the lower back, and left buttock, and a hematoma of the forehead above the left eye and the resident refused to allow the nurse to measure areas of bruising for three attempts.</p> <p>A Nurses' Progress Note, dated 09/22/15 at 12:49 a.m., indicated, "...Hematoma to left forehead, bruise to mid back and buttocks."</p> <p>A Nurses' Progress Note, dated 09/22/15 at 8:45 a.m., indicated, "...Swelling observed at site. Reddish-purple bruising noted."</p> <p>During an interview on 10/29/15 at 1:17 p.m., the Administrator indicated the cause of the hematoma was not investigated. The Administrator indicated she was unaware of the bruising on the resident's back and buttock.</p> <p>During an interview on 10/29/15 at 1:37 p.m., the Director of Nursing (DoN) indicated the notes were out of sequence on 09/21/15 at 1 a.m. and 2:35 a.m.</p>		<p>changes:</p> <p>Policies for Abuse Reporting and Investigations werereviewed.</p> <p>Staff will be re-educated regarding reporting of abusereporting, grievances, missing items and injuries.</p> <p>4) How the corrective actions will be monitored:</p> <p>Theinterdisciplinary team will review progress notes and grievances during morningmeeting at least 3x/week to ensure all concerns are investigated and reportedto ISDH according to facility policy.</p> <p>The Administratorwill be responsible for oversight of these audits.</p> <p>The results of theseaudits will be reviewed in Quality Assurance Meeting monthly until 100%compliance is achieved x3 consecutive months.</p> <p>5) Date ofcompliance: 11-16-15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>because of late entries. The DoN indicated she was unaware of the bruising of the back and buttock. The Administrator indicated the hematoma to the eye had not been reported and she was unaware of the bruising of the buttock and back. She indicated she would not have reported the hematoma to the eye because it had not met the criteria for reporting.</p> <p>2. During a family interview on 10/27/15 at 5:20 p.m., Resident #C's Power of Attorney (POA) indicated she had been at the facility visiting the resident and had noticed the resident's rings were not on her finger. She indicated she asked the nurse about the missing rings and was informed the rings were removed from the resident's fingers due to edema, and had been placed in a plastic cup in the Medication Cart. The POA indicated the Nurse went to the Medication Cart and took the plastic cup out and indicated the gold band was no longer in the plastic cup with the other rings. The POA indicated the Nurse said the ring had been stolen. The POA indicated the Nurse wrote up a report and indicated she was going to tell the Administrator about the missing gold band. The POA indicated this had occurred either in March or April and was unsure of the Nurse's name.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>Resident #C's record was reviewed on 10/28/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to advanced Alzheimer's disease, bladder cancer, and chronic obstructive pulmonary disease.</p> <p>A Grievance/Concern Form, dated 03/13/15, completed by the Social Service Director, indicated the concern was voiced by the past Director of Nursing (DoN). The Grievance/Concern Form indicated the DoN reported to the Social Service Director the resident was missing a gold wedding band. The Investigation/Follow-up indicated the Social Service Director spoke to the POA and received a description of the ring and the Social Service Director informed the Housekeeping Department and the Administrator to start the investigation. The form indicated the Administrator signed and dated the form on 03/13/15 and the resolution indicated the POA was not able to give a description of the ring and the resolution was pending.</p> <p>During an interview on 10/28/15 at 1:09 p.m., the Administrator indicated the Social Service Director was not in the facility. The Administrator indicated an investigation had not been completed on the missing ring. The Administrator</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>indicated the missing ring had not been reported to the ISDH.</p> <p>3. During an interview on 10/28/15 at 8:40 a.m., Resident #J indicated she has had missing items. She indicated she had a ring missing and it was never found. She indicated she was unsure when the ring went missing.</p> <p>Resident #J's record was reviewed on 10/28/15 at 1:55 p.m. The resident's diagnoses included, but were not limited to, stroke and traumatic brain injury.</p> <p>A Quarterly Minimum Data Set assessment, dated 09/05/15, indicated the resident's cognition was intact.</p> <p>A Resident Council Concern/Recommendation form, dated 09/30/15, indicated Resident #J voiced she had a diamond ring missing, "long ago". The response, signed and dated 10/01/15 by the Housekeeping Supervisor, indicated "...I have no idea about the diamond ring that is missing never heard about it. I have asked my staff if they have ever heard anything about a missing ring or have had to look for a diamond ring for (Resident Name), no one has."</p> <p>During an interview on 10/29/15 at 8:56</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>a.m., the Administrator indicated she could not remember if the missing diamond ring had been reported to her. She indicated there had been no investigation of the missing ring and she had not notified the ISDH of the missing diamond ring.</p> <p>A facility policy, dated 01/12, titled, "Abuse, Neglect, and Misappropriation of Resident Property", received from the Assistant Director of Nursing as current, indicated, "...The facility will ensure that all allegations...including injuries of unknown source are reported immediately to the Administrator of the facility and to other officials in accordance with state law...The facility will keep evidence that all alleged violations are thoroughly investigated..."</p> <p>A facility policy, dated 07/15/2015, titled, "Incident Reporting and Investigating", received from the Administrator as current, indicated, "...The facility must ensure that all alleged violations...including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator (sic) of the facility and to other officials in accordance with State law...The results of all investigations must be reported to the administrator (sic)...within 5 working</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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 0281 SS=D Bldg. 00	<p>days of the incident...Types of incidents reportable under Federal and State rules...examples of suspicious injuries: black eye, marks or bruising...on back, buttocks, or neck...Residents' property includes all residents' possessions, regardless of their apparent value..."</p> <p>This Federal Tag relates to Complaint IN00183011.</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview the facility failed to ensure professional standards of quality were followed related to the administration of an incorrect dose of a narcotic medication, failure to monitor the resident for adverse consequences after the administration of the medication, and falsification of the records related the medication error for 1 of 1 residents reviewed for medication errors in a sample of 11. (Resident #L) (LPN #1)</p> <p>Finding includes.</p>	F 0281	<p>F281</p> <p>The facility requests paper 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</i></p>	11/16/2015	

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>The record for Resident #L was reviewed on 10/29/15 at 10:39 a.m. The resident's diagnoses included, but were not limited to, bipolar disorder, dementia, depressive disorder, and high blood pressure.</p> <p>The current Physician orders were reviewed. An order was written on 9/3/15 for the resident to receive Morphine gel (a narcotic medication). The order indicated 40 mg (milligrams)/ml (milliliters): to apply 0.4 ml transdermally (topically to the skin) every 8 hours at 12:00 a.m., 8:00 a.m., and 4:00 p.m. Review of the October 2015 Medication Administration Record indicated the Morphine dose was signed out as administered on 10/24/15 at 12:00 a.m.</p> <p>Review of the 10/24/15 Incident Report Form indicated on 10/24/15 at 6:30 a.m. a discrepancy was noted in the narcotic count involving Morphine cream for Resident #L. A Medication Error report was completed. A 10/24/15 Medication Error Report indicated the LPN had given the midnight dose of Morphine. A fax message was then received and the LPN realized too much of the Morphine had been given to Resident #L. The facility investigation report indicated the LPN was suspended on 10/24/15 related to a</p>		<p><i>and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #L was immediately assessed and physician was notified of medication error and assessment findings upon discovery of medication error on 10/24/15 at 6:30am. Resident had no noted adverse effects or change in condition observed at the time of assessment.</p> <p>LPN #1 struck out the incorrect documentation, entered accurate documentation and was subsequently terminated upon completion of the investigation.</p> <p>2) How the facility identified other residents:</p> <p>An audit will be completed of all reported medication errors in the last 30 days to ensure that appropriate and accurate documentation and monitoring was completed following the discovery of the medication error.</p> <p>3) Measures put in place/ System changes:</p> <p>Pharmacy and Director of Nursing will re-educate licensed nurses and QMA's regarding medication administration/dosage</p>		

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>significant medication error and false documentation. A second report was completed on 10/28/15. This report indicated the LPN #1 administered the wrong dose of medication and falsified documentation of the medication error. The LPN was discharged from employment at the facility.</p> <p>When interviewed on 10/29/15 at 1:15 p.m., the Director of Nursing indicated the resident was given the incorrect dose of Morphine on 10/24/15. The Director of Nursing indicated she was first informed of the error 10/24/15 at approximately 8:00 a.m. when she received a telephone call from LPN #1. At this time LPN #1 reported she had administered Morphine 150 mg to Resident #L at 12:00 a.m. and later at 2:00 a.m. realized a medication error had occurred. The Director of Nursing indicated she came into the facility to investigate the medication error. The Director of Nursing indicated she found discrepancies in LPN#1's statement and documentation. The Director of Nursing indicated LPN #1 called her at approximately 8:00 a.m. on 10/24/15 and the LPN told her a medication error occurred at 12:00 a.m. The LPN indicated she had administered 150 milligrams of Morphine to Resident #L at 12:00 a.m. and realized the error at 2:00</p>		<p>calculations, procedure for reporting medication errors, timely physician notification of error, monitoring of residents following medication error and documentation.</p> <p>Medication administration competency will be completed on all licensed nurses and QMA's.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or designee will complete a medication administration observation at least 3x/week on varied shifts x30 days, then 2x/week x30 days, weekly x30 days, and monthly thereafter as needed until 100% compliance is achieved x3 consecutive months.</p> <p>The Director of Nursing or designee will audit documentation following medication errors as they occur to ensure physician was notified timely, and that appropriate monitoring and documentation were completed. These audits will be ongoing.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months.</p> <p>5) Date of compliance: 11-16-15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>a.m. The Director of Nursing indicated the LPN informed her she had checked the resident's vital signs every hour after the medication error was noted. The Director of Nursing indicated her investigation revealed LPN#1 did not know she administered the incorrect dose of Morphine until then end of the shift at 6:30 a.m. when LPN #1 was completing the shift to shift change narcotic counts with the oncoming day shift Nurse. The Director of Nursing indicated she observed the packaging the Morphine syringe had been in and noted the resident had been administered the whole syringe of the topically Morphine at 12:00 a.m. The Director of Nursing indicated the the resident received 150 milligrams of Morphine at 12:00 a.m. on 10/24/15. The Director of Nursing also indicated she spoke with the day shift Nurse that morning and the Nurse indicated the medication error was first noted by her and LPN#1 at that time (change of shift at narcotic count between 6:00 a.m.- 6:30 a.m.) The Director of Nursing also indicated LPN #1 falsified the resident's record. The LPN documented the Nurse Practitioner was notified prior at the time of the error and the resident assessments were completed . The Director of Nursing indicated she herself called the Nurse Practitioner when she came to the facility on 10/24/15</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>and the Nurse Practitioner indicated she had not been called until 6:30 a.m. and at that time the LPN had no vital signs to report to the Nurse Practitioner. The Director of Nursing indicated LPN could not have assessed the resident after 2:00 a.m. as she later acknowledged she was not aware of the error until the end of the shift at 6:30 a.m.</p> <p>The Indiana State Board of Nursing Statue for RN's indicated the following: Rule 2. Registered Nursing: 848 IAC 2-2-3, Section 3 indicates "nursing behaviors failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public shall constitute unprofessional conduct. These behaviors include, but are not limited to the following: (1) Using unsafe judgement, technical skills, or inappropriate interpersonal behaviors in providing nursing care."</p> <p>The 2014 Nursing 2014 Drug Handbook indicated Morphine was a narcotic opioid analgesic. Adverse reactions included, but were not limited to, bradycardia(low heart rate), hypotension (low blood pressure), respiratory arrest (absence of respirations), and seizures. The Drug Handbook also indicated practice of administering medications safely</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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 0314 SS=D Bldg. 00	<p>included eight rights of medication administration. The eight rights included, but were not limited to, The right dose, the right response, and the right documentation. To ensure the right dose of the medication was administered included checking the label with the prescriber's order. To ensure the right response included to monitor the resident's response to the medication. To ensure the right documentation included to accurately document the drug administered. The monitoring of documentation included to monitor the resident's response to the medication.</p> <p>3.1-35(g)(1)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview the</p>	F 0314	<p>F314</p> <p>The facility requestpaper</p>	11/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>facility failed to ensure a resident with pressure ulcers received necessary care and services, related to a pressure area not thoroughly assessed for size and stage for 1 of 3 residents reviewed for pressure areas in a total sample of 11. (Resident #C)</p> <p>Finding Includes:</p> <p>Resident #C's record was reviewed on 10/28/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to advanced Alzheimer's disease, bladder cancer, and chronic obstructive pulmonary disease. Resident #C had been discharged from the facility on 05/16/15.</p> <p>A Physician's order, dated 05/12/15, indicated Medihoney Wound/Burn Dressing Gel (pressure area treatment) to left ischium , every three days and cover with a Dermalevin (foam dressing used for opened pressure areas).</p> <p>A Nurses' Note, dated 05/12/15 at 12:09 p.m., indicated " 4.2 cm (centimeter) by 3.8 cm fluid filled blister to left heel noted. 6 cm by 2.6 cm deep tissue bruise with open area to left ischium."</p> <p>A Skin-Other Skin Condition Report, dated 05/12/15, indicated a deep tissue injury (injury to underlying tissue below</p>		<p>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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #C was discharged from the facility on 5/16/15.</p> <p>2) How the facility identified other residents:</p> <p>An audit will be completed to identify all residents with pressure ulcers in the last 30 days to ensure documentation of size and stage of wounds are complete.</p> <p>An audit will be completed on all residents discharged home or to another facility in the last 30 days to ensure discharge instructions were complete and accurate.</p> <p>3) Measures put in place/ System changes:</p>				

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>the skin's surface, from prolonged pressure in an area) with shearing to left ischium (buttock). Physician and family notified on 05/12/15.</p> <p>A Skin-Pressure/Diabetic/Stasis/Arterial Wound Report, dated 05/13/15, indicated, left buttock, 6 centimeters (cm) by 2.6 by unable to determine depth, suspected deep tissue injury.</p> <p>A Discharge/Transfer/LOA (leave of absence) form, dated 05/14/15, indicated the resident's discharge date was 05/16/15 at 12 p.m. to another Nursing Home for an admission. The area for Special Instructions was left empty. The discharge instructions did not indicate the resident had pressure sores.</p> <p>The Admission Assessment from the Nursing Home the resident was transferred to, dated 05/16/15 at 10:59 p.m., indicated the resident was admitted with a stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts) pressure ulcer of the buttock.</p> <p>During an interview on 10/28/15 at 10:12 a.m., the Assistant Director of Nursing (ADoN) indicated the Medihoney and foam dressing was ordered for the shearing area which was open. The</p>		<p>Discharge Instructions Assessment has been revised to include additional information on skin condition upon discharge and treatment orders (see attachment).</p> <p>Licensed nurses will be educated on wound documentation and completion of new discharge instructions assessment, including documentation of skin condition on discharge and treatment orders.</p> <p>4) How the corrective actions will be monitored:</p> <p>All discharge instruction assessments will be reviewed prior to and/or following discharges as they occur to ensure discharge instructions and skin assessment are complete and accurate.</p> <p>Wound documentation will be reviewed weekly for all residents with pressure ulcers to ensure that documentation is complete, including size and stage of wounds.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months.</p>		

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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 0315 SS=D Bldg. 00	<p>ADoN indicated there had been no assessment of the open area from the shearing. She indicated there had been no assessments of the pressure areas before the resident was transferred to the other Nursing Facility.</p> <p>This Federal Tag relates to Complaint IN00183011.</p> <p>3.1-40(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to assess a resident for the need of a urinary catheter and failed to thoroughly assess if the resident had a urinary catheter for 1 of 1 residents reviewed with a urinary catheter in a total sample of 11.</p>	F 0315	<p>5) Date of compliance: 11-16-15</p> <p>F315</p> <p>The facility request paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	11/16/2015	

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>Finding includes:</p> <p>Resident #C's record was reviewed on 10/28/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to advanced Alzheimer's disease, bladder cancer, and chronic obstructive pulmonary disease.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 05/14/15, indicated the resident had a urinary catheter.</p> <p>A Physician's re-admission order, dated 05/05/15, indicated the resident had a urinary catheter, and to change the catheter as needed of leakage or blockage.</p> <p>A Re-Admission Nurses' Assessment, dated 05/05/15 at 7 p.m., indicated the resident was admitted with a urinary catheter.</p> <p>The Treatment Administration Record, dated 05/15, indicated urinary catheter care had been completed every shift except 05/11/15 on day shift, 05/14/15 on night shift, and 05/15/15 on the evening shift.</p> <p>A Physician's Progress Note, dated 05/06/15 at 12:59 p.m., indicated the resident's urinary catheter was draining</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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident C was discharged from the facility on 5/16/15.</p> <p>2) How the facility identified other residents:</p> <p>An audit was completed to identify all other residents who have an indwelling catheter, and documentation was reviewed, including Bowel & Bladder assessment to ensure documentation was accurate.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed staff will be re-educated regarding completion of Foley Catheter Assessment, appropriate diagnoses/ indications for use, and documentation of catheter use in progress/ skilled charting notes.</p>		

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>dark yellow urine.</p> <p>The Nurses' Progress Notes indicated: 05/06/15 at 1:14 p.m.- "Urine color...No odor or hematuria (blood in urine) observed or reported at this time. Resident is incontinent. Unable to determine clarity..."</p> <p>05/07/15 at 3:35 a.m.- "...Pain on urination: catheter..."</p> <p>05/07/15 at 12:18 p.m.-"...Change in continence: Has a foley (urinary catheter) in place..."</p> <p>05/07/15 at 8:33 p.m.- "...resident has a foley..."</p> <p>05/09/15 15 1:54 p.m.-"...resident is on catheter..."</p> <p>05/09/15 at 6:58 p.m.-"...resident has a foley in place..."</p> <p>5/10/15 at 4:09 a.m.-"...foley catheter in place..."</p> <p>05/11/15 at 1:41 a.m.-"...foley catheter present..."</p> <p>05/12/13 at 1:27 a.m.-"...resident has catheter..."</p>		<p>4) How the corrective actions will be monitored:</p> <p>New Admission and Re-admission assessment audits will be reviewed as they occur to verify if indwelling catheter is present, as well as visual verification. If indwelling catheter is present, an audit will be completed to ensure that order is present with appropriate diagnosis/indication for use, Foley Catheter Evaluation is completed, and that Bowel & Bladder Assessment has been completed and is accurate. These audits will be completed until 100% compliance is achieved x3 consecutive months.</p> <p>An audit of progress note documentation will be completed on residents with an indwelling catheter weekly x30 days, then monthly thereafter until 100% compliance is achieved for 3 consecutive months.</p> <p>The Director of Nursing will be responsible for oversight of these audits.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months.</p> <p>5) Date of compliance: 11-16-15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>05/12/15 at 9:50 a.m.- Skilled Charting "...catheter in place..."</p> <p>05/12/15 at 1 p.m.-"...foley no pain noted..."</p> <p>05/13/15 at 7:46 a.m.- Late Entry Skilled Charting-"...Urine characteristics: yellow. Resident uses pads/briefs, check and change..."</p> <p>05/13/15 at 1:58 p.m.-"...Resident has catheter..."</p> <p>A Bowel/Bladder Assessment, dated 05/13/15 at 7:46 a.m., indicated the resident used incontinent pads/briefs and had multiple daily episodes of urinary incontinency.</p> <p>A Restorative Incontinence Observation, dated 05/13/15 at 7:47 a.m., indicated the reason for the assessment was quarterly, the resident was always incontinent, was a poor candidate for toileting program and would be placed on a check and change program.</p> <p>A Quarterly Clinical Summary, dated 05/15/15 at 3:28 a.m., indicated the resident had a urinary catheter.</p> <p>There was no documentation to indicate the resident's catheter had been removed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>by the Nurses' on 05/06/15 and 05/13/15 when the Nurses' Notes indicated the catheter did not have a catheter. There was no order to discontinue the catheter on 05/06/15 and 05/13/15. There was no documentation to indicate the catheter had been changed in the Nurses' Notes or the Treatment Administration Record on 05/06/15 and 05/13/15.</p> <p>There was no assessment and diagnosis to support the use of a urinary catheter from 05/05/15 through 05/16/15, when the resident was discharged from the facility.</p> <p>During an interview with the Director of Nursing (DoN), the Assistant Director of Nursing (ADoN), and the MDS Nurse on 10/28/15 at 10:12 a.m., the DoN indicated the resident had an order for an urinary catheter. The ADoN indicated the resident had returned from the hospital with the catheter in place. The DoN indicated the assessment on 05/13/15 indicated the resident was incontinent, then indicated she was not sure if the resident had a catheter or not. The MDS Nurse indicated the catheter could have came out or was discontinued when she completed the assessment on 05/13/15. The MDS Nurse indicated there was no order to discontinue the catheter. The MDS Nurse indicated on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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 0323 SS=G Bldg. 00	<p>the TAR, the catheter care had been completed on 05/13/15. The DoN indicated if the catheter had been out due to changing the catheter, it would have been documented in the Nurses' Notes and there was no documentation to indicate the catheter was changed. The DoN indicated the assessment for the reason for the catheter should have been completed when the resident was re-admitted.</p> <p>During an interview on 10/28/15 at 1:52 p.m., the DoN indicated the facility did not have a policy for assessment for the use of an urinary catheter.</p> <p>3.1-41(a)(1)</p> <p>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 record review and interview, the facility failed to ensure residents' were free from accident hazards and received adequate assistance devices to prevent accidents related to transferring residents with a mechanical lift with 1</p>	F 0323	<p>F323 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</p>	11/16/2015	

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>person assistance, and the residents fell or were lowered to the floor, which caused 1 resident to receive a fracture of the upper humerus bone (arm), and failed to thoroughly investigate the reason for the fall, for 3 of 3 residents reviewed for falls, in a total sample of 11. (Residents #J, #K, and #L)</p> <p>Findings include:</p> <p>1. Resident #J's record was reviewed on 10/28/15 at 1:55 p.m. The resident's diagnoses included, but were not limited to, stroke with right sided hemiparesis and traumatic brain injury.</p> <p>An Annual Minimum Data Set (MDS) assessment, dated 06/05/15, indicated the resident's cognition was intact, required extensive assistance of two staff for bed mobility and transfers, and had impairment in movement of one of the upper and lower extremities.</p> <p>A care plan, initiated on 03/09/11, indicated the resident was a risk for falls. The interventions included utilize a sit to stand mechanical lift for transfers, initiated on 11/03/11.</p> <p>A Fall Assessment, dated 08/13/15, indicated the resident was a high risk for falls.</p>		<p><i>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. IDR Request: The facility disputes the allegation that "the facility failed to ensure residents' were free from accident hazards and received adequate assistance devices to prevent accidents related to transferring residents with a mechanical lift with 1 person assistance" The facility did provide the appropriate assistance device for Resident #J according to manufacturer guidelines, which indicate that transfers may be performed with the sit to stand lift with one person assistance;</i></p> <p>1) Immediate action taken for those residents identified: Resident #J- resident was changed to a Hoyer lift for transfers immediately following the fall on 10/17/15. Resident #K- Staff were re-educated regarding use of 2 staff for mechanical lift transfers on 8/17/15. Resident #L- Despite not using the facility "Fall Investigation Worksheet" at the time of the fall on 8/31/15 as indicated in the 2567, this incident was investigated and reported to ISDH as required. Physician was</p>				

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>A Nurses' Progress Note, dated 08/13/15 at 10:09 a.m., indicated the Nurse was called to the shower room to assist a CNA with the resident and upon entering the room the resident was holding onto the lift with her knees on the floor. The note indicated the resident complained of discomfort, rated a seven out of ten, to her right knee and the resident's Physician was notified.</p> <p>A Nurses' Progress Note, dated 08/14/15 at 2:32 a.m., indicated the resident complained of pain of the right leg and knee, rated a 10 out of 10, the right knee had an abrasion and redness of the right lower leg.</p> <p>A Nurses' Progress Note, dated 08/14/15 at 2:57 a.m., indicated the resident continued to complain of right knee, foot, and buttock pain.</p> <p>A Fall IDT (Interdisciplinary Team) Note, dated 08/17/15 at 10:46 a.m., indicated the resident was using the sit to stand lift. Her foot was not in the correct position and the staff member attempted to fix her foot and the resident would not let her. The note indicated when the staff member began to raise the lift, the resident's foot began to slip off the lift and the staff was unable to get the</p>		<p>notified of fall on 9/1/15. 2) How the facility identified other residents: An audit will be completed to identify all residents at risk for falls and who use mechanical lifts for transfers. 3) Measures put in place/ System changes: The Director of Nursing re-educated licensed staff on completing the Fall Investigation Worksheet after each fall. Nursing staff were re-educated regarding the use of 2 staff members for all mechanical lift transfers (hoyer and sit-to-stand lifts). 4) How the corrective actions will be monitored: The Director of Nursing or designee will observe staff perform mechanical lift transfers on varied shifts as follows: 5 transfers per week on varied shifts x30 days, 3 transfers per week on varied shifts x30 days, then 1 transfer per week thereafter on varied shifts until 100% compliance is achieved x3 consecutive months. The Director of Nursing or designee will review all falls to ensure Fall Investigation Worksheet is completed and interview statements are obtained as indicated. The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 11-16-15</p>		

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>resident's feet back onto the lift so three staff members lowered the resident to the ground. The Root Cause of the fall was listed as improper foot placement and transfer technique and the staff was in-serviced about proper lift usage and foot placement.</p> <p>A Fall IDT Note, dated 08/17/15 at 10:58 a.m., indicated, "Root cause of fall: Resident has previously been deemed by therapy as unsafe to use the sit to stand lift because of weakness and foot placement. Family and resident were previously educated about this and her risk for injury, but they still will not use anything but the sit to stand lift. It was recommended that she use the hoyer lift but refused to use it..."</p> <p>A Physician's Progress Note, dated 08/21/15 at 1:01 p.m., indicated the resident had pain to the right leg from the hip to the ankle since the fall. The right side was flaccid post CVA (stroke), and the resident had not wanted an x-ray.</p> <p>A Nurses' Progress Note, dated 08/23/15 at 3:04 p.m., indicated the resident approved an x-ray and an order was received to x-ray the right knee, lower leg, ankle and foot.</p> <p>A Nurses' Progress Note, dated 08/23/15</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>at 7:22 p.m., indicated there were no fractures.</p> <p>During a telephone interview, on 10/28/15 at 3:02 p.m., with the Administrator present, CNA #7 indicated she had used the sit to stand lift without assistance from another staff member. She indicated she had tried to reposition the resident's feet and the resident said she was "ok" so she lifted the resident and pulled the lift out and the resident's foot started to slip, and the resident was lowered to the floor. CNA #7 indicated she did not know she was not suppose to use the mechanical lift by herself.</p> <p>An in-service form, dated 08/17/15, indicated, "All lift transfers hoyer and sit to stand are to be done with two people. This is what the (Company Name) policy is..."</p> <p>During an interview on 10/28/15 at 8:40 a.m., Resident #J indicated she had fallen from the sit to stand lift. She indicated there had been one CNA assisting with her transfer with the lift, and the CNA had her standing and attempted to sit her in the chair and she was not back far enough, so the CNA raised her up and attempted to place her in the chair again, and she still was not placed far enough back. Resident #J indicated the CNA had</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>lifted her up again and then she had lost her grip on the hand hold of the lift and fell backwards to the floor. The resident indicated there was no sling being used. The resident indicated there were usually two staff who assist with the lift transfer but this time only one CNA had assisted her.</p> <p>A CNA Care Card, dated 10/01/15, indicated Resident #J was a two person assist with the sit to stand lift.</p> <p>A Nurses' Progress Note, dated 10/17/15 at 3:02 p.m., indicated, "resident in sit to stand. affected arm slipped and resident was lowered to floor by nurses aid (sic)...resident complaining that right shoulder hurts and right knee hurts...ambulance called."</p> <p>A Nurses' Note, dated 10/17/15 at 7 p.m., indicated the resident had returned from the hospital and complained of pain of 10 on a scale of 1-10 to the right shoulder.</p> <p>A Fall Investigation Worksheet, dated 10/19/15, indicated the time of the fall on 10/17/15 was 1:40 p.m., the resident was up in the sit to stand lift and the affected arm (right) slipped and resident was lowered to the floor. The investigation indicated CNA #8 had been transferring the resident with one assistance and the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>resident was unable to use her right upper and lower extremity due to hemiparesis.</p> <p>The Indiana State Department of Health reportable incident report, dated 10/19/15, indicated the resident was diagnosed with a proximal fracture to the right humerus (right upper arm) on 10/17/15.</p> <p>A Physician's Progress Note, dated 10/21/15 at 1:29 p.m., indicated, "...Pt (patient) reports that she fell...diagnosed with right humeral surgical neck fracture. Pt returned to facility with sling to right arm. Pt. reports severe pain if someone touches her right hand..."</p> <p>During an interview on 10/28/15 at 2:37 p.m., the Director of Nursing (DoN) the resident had never said there had been no sling used with the sit to stand transfer. The DoN indicated the resident had told her during the investigation she had fallen to the floor not lowered to the floor, after the CNA had moved the lift up and down 2-3 times during the transfer. The DoN indicated she had not documented the resident's interview. The DoN indicated she had not interviewed the CNA.</p> <p>During an interview on 10/28/15 at 3:30 p.m., CNA #9 indicated she had assisted</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>the resident off the floor and the sit to stand lift was in the corner of the bathroom and the sling was attached to the lift.</p> <p>2. Resident #K's record was reviewed on 10/29/15 at 9:30 a.m. The resident's diagnoses included, stroke with left sided hemiparesis and diabetes mellitus.</p> <p>A Quarterly MDS assessment, dated 06/06/15, indicated the resident's cognition was intact, had one sided upper and lower extremity impairments, and required extensive assistance of two for bed mobility and transfers.</p> <p>A care plan, initiated on 03/02/11, indicated the resident was a fall risk and the staff were to use a sit to stand life for all transfers (intervention added on 12/29/13).</p> <p>A care plan, dated 01/16/15, indicated the resident had impaired range of motion of the left upper and lower extremity due to hemiparesis and required passive range of motion to the left extremities.</p> <p>A Quarterly Clinical Summary, dated 06/11/15, at 1:25 a.m., indicated the resident was unable to bear weight, had impaired balance and weakness.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>A Nurses' Note, dated 08/16/15 at 11:02 p.m., indicated at 6:50 p.m., the resident was found on the floor on his back with the sit to stand lift upright next to the resident. The note indicated the sling was around the resident and the CNA said the lift had fallen over with the resident when the resident was being transferred to bed. The resident was assessed with no injuries.</p> <p>The IDT Note, dated 08/17/15 at 11:17 a.m., indicated the resident was being transferred with the sit to stand lift and when the lift was close to the bed the staff closed the legs of the lift to get the lift under the bed frame and the lift started to tip to the side and the staff lowered the lift and resident down to the floor slowly.</p> <p>During an interview on 10/29/15 at 9:02 a.m., the DoN indicated the resident's fall had not been investigated and had not been reported due to there had been no injury. She indicated one CNA had attempted the transfer with the sit to stand lift.</p> <p>During an interview on 10/29/15 at 10:06 a.m., Resident #K Indicated there had been only one CNA using the lift the night of his fall. He indicated he had fallen over in the lift to the floor. He</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>indicated his back hurt, but once he was in bed he didn't have any further pain.</p> <p>The CNA Performance Checklist, received from the Administrator on 10/29/15 at 2 p.m., titled, "Using Mechanical Lift", indicated, "...Assemble equipment and request help from co-workers..."</p> <p>The Manufacturer's Instructions for the stand up lift, received from the DoN on 11/29/15 at 11:02 a.m., indicated, "...The stand up lift may be operated by one healthcare professional for all lifting preparation, transferring from and transferring to procedures with a cooperative, partial weight -bearing patient. However, since medical conditions vary,..healthcare professional evaluate the need for assistance and determine whether more than one assistant is appropriate in each case to safely perform the transfer...Individuals that use the standing patient sling must be able to support the majority of their own weight, otherwise injury may occur..."</p> <p>3. The record for Resident #L was reviewed on 10/29/15 at 10:39 a.m. The resident's diagnoses included, but were not limited to, cognitive communication deficit, bipolar disorder, dementia, depressive disorder, and high blood</p>			

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>pressure.</p> <p>Review of the 8/21/15 Minimum Data Set (MDS) Significant Change assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (0). A score of (0) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident had no behaviors. The assessment also indicated the resident required limited assistance of two staff members for bed mobility, dressing, eating, and personal hygiene.</p> <p>A Fall Risk assessment completed on 8/31/15 indicated the resident's score was (18). A score of (18) indicated the resident was at risk for falls. The resident's current Care Plans were reviewed. A Care Plan initiated on 10/9/14 indicated the resident had the potential for falls related to a history of falls and decreased mobility. The Care Plan was last reviewed on 8/27/15. Care Plan interventions included, but were not limited to, bed pad alarm, alarming seat belt to the wheel chair, anti tippers to the the front of the wheel chair, and keep her frequently used items in reach.</p> <p>The 8/2015 Nurses' Notes were reviewed. A late entry was entered on 8/31/15 at 2:25 p.m. The entry indicated at 2:13</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>p.m. the resident fell out of her wheel chair onto the floor. Injuries were noted and neurological checks were initiated. There was no documentation of the resident's Physician being notified of the fall at this time. Further entries on 8/31/15 indicated there was no documentation of the Physician being notified on 8/31/15 of the resident's fall and injuries.</p> <p>The 8/31/15 Witnessed Fall report was reviewed. The report indicated the resident was noted to have fallen forward from there wheel chair. The resident had a bloody nose and bruising starting to appear around her left eye. Neurological checks were initiated and the resident refused to leave cold compresses in place to her face. A small linear laceration was also noted to the bridge of the resident's nose. The laceration measured 2.5 cm in length.</p> <p>A Skin Condition report was initiated on 9/1/15 at 1:20 a.m. The report indicated the resident fell on 8/31/15 and bruising was noted to the resident's face. Bruising to the left eye lid measured 3.5 cm(centimeters) wide x 2 cm high and the left inner canthis to the cheek measured 3 cm x 0.5 cm. Bruising the right inner nose/eye area measured 2.5 cm x 0.5 cm.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>A CT scan of the facial bones was completed on 9/1/15 at 6:50 p.m. The CT scan results indicated there a medial angulations of the bridge of the left nasal bone suggestive of a fracture. The final impression indicated the finding could be acute but the exact onset was difficult to determine.</p> <p>When interviewed on 10/29/15 at 11:50 a.m. the Director of Nursing indicated the resident fell on 8/31/15 at 2:13 p.m. The Director of Nursing indicated she worked as a floor Nurse on the day shift on 9/1/15 and was assigned to care for Resident #L . The Director of Nursing indicated the night shift Nurse reported to her the resident had bruising which progressed through the night and the Physician had been faxed. The Director of Nursing indicated when she then assessed the black bruising was noted to the both her eye areas.</p> <p>Continued interview with the Director of Nursing indicated an investigation was initiated on 9/1/15. The Director of Nursing indicated a Falls Investigation Worksheet was to be completed by Nursing staff at the time of a fall and this was not done related to the above fall with injuries.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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 0328 SS=G Bldg. 00	<p>Review of a Fall Investigation Worksheet form indicated staff were to complete information on the resident's current medications, behaviors past falls, assistive devices in place, medical changes in condition, a physical assessment of the resident, and the environmental factors. The form also Staff were to note interventions put into place at the time of the fall.</p> <p>The facility policy titled "Fall Evaluation and Investigation" was reviewed on 10/29/15 at 2:50 p.m. The policy had a revised date of 8/2013. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated when a resident fall occurred Licensed Nurses were to initiate an investigation at the time.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care;</p>						

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure a resident had the needed supplies in the facility to care for a drainage catheter (PleurX) placed in the pleural space (lung) to drain fluid accumulation in the pleural space, which caused a resident to exhibit signs of increased shortness of breath and increased anxiety, and the resident had to be transferred to the Emergency Room for drainage of the catheter, in which the hospital drained 700 milliliters of fluid and the resident's symptoms of increased shortness of breath and increased anxiety had resolved after the fluid had been drained. The facility also failed to assess the resident before the resident was transferred to the Emergency room and failed to assess the resident's respiratory status before and after nebulizer treatments had been administered, for 1 of 3 residents reviewed for nebulizer treatments. (Resident # B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 10/27/15 at 9:32 a.m. The resident's diagnoses included, but were not limited to, pneumonia, lung cancer, chronic</p>	F 0328	<p>F328 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>IDR Request: The facility disputes that actual harm occurred to this resident as stated in the 2567. The facility alleges that appropriate care and services were provided and that no actual harm occurred to this resident.</p> <p>1) Immediate action taken for those residents identified: Resident #B- Pleurexcatheter was obtained on 9/14/15 from another facility, and shipment arrived 9/15/15. Resident was discharged from the facility on 9/30/15. 2) How the facility identified other residents: An audit was completed to identify all residents receiving nebulizer treatments. No other residents in the facility have</p>	11/16/2015			

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>obstructive pulmonary disease. The resident was admitted into the facility from an acute care hospital on 09/11/15.</p> <p>The Admission/5-Day Minimum Data Set assessment, dated 09/18/15, indicated the resident's cognition was intact.</p> <p>A care plan, dated 09/23/15, indicated, the resident received steroids (anti-inflammatory) for pneumonia. The interventions included, administer nebulizer medications as ordered, assess for shortness of breath, assess vitals and lung sounds.</p> <p>The Physician's Orders, dated 09/11/15, indicated, Breath sounds every 4 hours as needed (respiratory treatment), drain right side PleurX catheter as needed for pleural effusion (fluid accumulation), drain right sided PleurX catheter every day shift every Monday, Wednesday, and Friday, Ipratropium-Albuterol Solution (medications for lungs) 0.5-2.5 milligrams per 3 milliliters, nebulizer every 4 hours as needed for shortness of breath.</p> <p>The Nurses' Progress Notes indicated: 09/14/15 at 9:30 a.m.-Nebulizer was administered due to the resident complaining of shortness of breath and the oxygen saturation (O2 SAT) was 98%</p>		<p>a Pleurex catheter. 3) Measures put into place/ System changes: Licensed nurses will be re-educated regarding respiratory assessment and documentation related to nebulizer treatments (pre and postadministration) and change in condition/ respiratory distress. The Director of Nursing or designee will review all potential admissions and re-admissions to determine any special equipment needs and ensure that equipment is available prior to admission.</p> <p>4) How the corrective actions will be monitored: The Director of Nursing or designee will audit new admissions and re-admissions as they occur to ensure special equipment is available as indicated. The Director of Nursing or designee will review nebulizer documentation to ensure assessment is documented prior to and following nebulizer treatment on at least 3 residents per week x30 days, then 1 resident per week thereafter until 100% compliance is achieved x3 consecutive months. The Director of Nursing or designee will observe at least 1 nebulizer treatment weekly during medication administration observations on varied shifts until 100% compliance is achieved x3 consecutive months. The Director of Nursing or designee will review documentation on all residents transferred out to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>(normal 90-100%).</p> <p>09/14/15 at 10:22 a.m.-"writer made aware by floor nurse that pt (patient) PleurX tube scheduled to be changed today. drainage (sic) kit ordered on 09/10/15 but has not arrived. medical records (sic) called supplier who stated it was enroute from Los Angeles , and would most likely arrive Wednesday 09/16/15. pt was complaining of sob per nurse who administered ned (sic) (nebulizer) tx (treatment)..."</p> <p>09/14/15 at 11:34 a.m. late entry for 9:45 a.m.-"Res (resident) transferred from bed to gurney without incident..."</p> <p>The Transfer Form, dated 09/14/15 at 10 a.m., indicated the resident was transferred to an acute care hospital for evaluation. No assessment was completed on the resident at the time of the transfer.</p> <p>The Ambulance report, dated 09/14/15 at 10:08 a.m., indicated the resident's complaint was respiratory distress, respirations were 26, and the O2 SAT was 98% on oxygen at three liters. The report indicated, "...having difficulty breathing with 'fluid on the lungs that needs drained'...Last draining was this past Friday...Pt. presents in moderate</p>		<p>hospital with an acute change in condition to ensure that the appropriate assessment was completed and documented. The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 11-16-15</p>	

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>distress...Breathing obviously labored. Noted minor wheezing at both upper lobes and decreased sounds at the bases...Pt. is oddment (sic) that he will be fine once the fluid is drained and is very upset at the nursing home delay..."</p> <p>The Emergency Department Notes, dated 09/14/15, indicated a diagnosis of dyspnea (shortness of breath) and the PleurX catheter was drained by an Intensive Care Nurse and 700 milliliters was drained from the catheter. The notes indicated the resident was resting comfortably and in no acute distress after having the catheter drained. The resident indicated complete resolution of all of his symptoms after the drainage.</p> <p>The Emergency Department Physician's Note, dated 09/14/15, indicated, the resident's PleurX had been drained three days ago, was scheduled to be drained today, and the facility was unable to drain the catheter because they had not received the equipment. The note indicated the resident had a breathing treatment hoping for some relief but the treatment had not helped.</p> <p>The Treatment Administration Record, dated 09/15, indicated the catheter was drained on Mondays, Wednesdays, and Fridays at the facility as ordered, after the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>Hospital drained the catheter on 09/14/15, and was also drained on 09/17/15 (Thursday), 09/19/15 (Saturday), and 09/20/15 (Sunday), with drainage being from 150 to 650 milliliters.</p> <p>During an interview on 10/27/15 at 11:52 a.m., the Medical Records Nurse (orders supplies), indicated the Admission Coordinator informed her about the resident's pleural catheter. She indicated she called and ordered the catheter and it should have come in on Friday.</p> <p>An order invoice, dated 09/10/15 (Thursday) at 11:39 a.m. Pacific Time, the one case (10 in a case) of PleurX drainage kits had been ordered with overnight priority. An order tracking number had also been included on the invoice.</p> <p>During an interview on 10/27/15 at 12 p.m., with the Admission Coordinator and the Director of Nursing (DoN), the Admission Coordinator indicated she had been informed a "day or two" before the resident was to be admitted into the facility about the pleural drainage tube and had informed the DoN, the Assistant Director of Nursing (ADoN), and the Medical Records Nurse. The DoN indicated the catheter was ordered to be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>changed/drained on Thursday (09/10/15). The DoN indicated the orders for the drainage tube was on Monday, Wednesday, and Friday, and the facility thought they would get the drainage tube on time. She indicated they had received a drainage tube from another facility, after the resident had been sent to the Emergency Room.</p> <p>During an interview on 10/27/15 at 12:11 p.m., the Medical Records Nurse indicated she was unsure if she was in the facility on 09/11/15 when the supplies came in. She was unsure if she had checked the supplies to see if the catheter had arrived. She indicated she did not know the catheter had not arrived.</p> <p>During an interview on 10/27/15 at 12:20 p.m., the DoN indicated on 09/14/15 everything happened quickly. She indicated the resident started yelling and was insistent about wanting to go to the hospital.</p> <p>During an interview on 10/27/15 at 1:21 p.m., LPN #10 indicated on 09/14/15, the resident all of a sudden had shortness of breath and then she realized there were no supplies to drain his pleural catheter.</p> <p>During an interview on 10/28/15 at 10:12 a.m., the Medical Records Nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>indicated she was not working on Friday 09/11/15 and the staff put the supplies away.</p> <p>The Medication Administration Record, dated 09/15, indicated the resident received the as needed nebulizer treatment on:</p> <p>09/13/15 at 3:39 p.m. and no breath sounds were assessed before/during/ or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/14/15 at 9:30 a.m. and no breath sounds were assessed before/during/ or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/18/15 at 3:43 p.m. and no breath sounds were assessed before/during/ or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/19/15 at 3:32 p.m. and no breath sounds were assessed before/during/ or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/20/15 at 4:36 A.M. and no breath sounds were assessed before/during/ or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/22/15 at 9:56 a.m. and no breath sounds were assessed during or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/23/15 at 7:31 a.m. and 11:53 a.m. and no breath sounds were assessed before/during/ or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/24/15 at 4:31 p.m. and 9 p.m. and no breath sounds were assessed during or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/25/15 at 4:55 a.m., 2:44 p.m., and 8 p.m. and no breath sounds were assessed before/during/ or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/26/15 at 12 a.m. and 4:29 a.m. and no breath sounds were assessed before/during/ or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>09/26/15 at 10:26 a.m. and no breath</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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 0333 SS=D Bldg. 00	<p>sounds were assessed during or after the treatment. No pulse and respirations were obtained after the treatment.</p> <p>During an interview on 10/27/15 at 11:52 a.m., the DoN acknowledged the breathing assessments were not completed when the nebulizer treatment was administered.</p> <p>A facility policy, dated 08/14, received by the DoN as current, titled, "Nebulizer Therapy", indicated, "...Obtain pulse and respirations prior to beginning treatment and after treatment has been completed. Monitor breath sounds and cough after the treatment..."</p> <p>This Federal Tag relates to Complaint IN00182824.</p> <p>3.1-47(a)(6)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to remain free of significant medication errors related to the incorrect dose of a narcotic</p>	F 0333	<p>F333</p> <p>The facility requestspaper compliance for this citation.</p>	11/16/2015

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 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>medication administered for 1 of 1 resident reviewed for medication errors in a sample of 11. (Resident #L) (LPN #1)</p> <p>Finding includes:</p> <p>The record for Resident #L was reviewed on 10/29/15 at 10:39 a.m. The resident's diagnoses included, but were not limited to, bipolar disorder, dementia, depressive disorder, and high blood pressure.</p> <p>Review of the 8/21/15 Minimum Data Set (MDS) Significant Change assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (0). A score of (0) indicated the resident's cognitive patterns were severely impaired.</p> <p>The current Physician orders were reviewed. An order was written on 9/3/15 for the resident to receive Morphine gel (a narcotic medication). The order indicated 40 mg (milligrams)/ml (milliliters): to apply 0.4 ml transdermally (topically to the skin) every 8 hours at 12:00 a.m., 8:00 a.m., and 4:00 p.m. Review of the October 2015 Medication Administration Record indicated the Morphine dose was signed out as administered on 10/24/15 at 12:00 a.m.</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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #L was immediately assessed and physician was notified of medication error and assessment findings upon discovery of medication error on 10/24/15 at 6:30am. Resident had no noted adverse effects or change in condition observed at the time of assessment.</p> <p>LPN #1 struck out the incorrect documentation, entered accurate documentation and was subsequently terminated upon completion of the investigation.</p> <p>2) How the facility identified other residents:</p> <p>An audit will be completed of all reported medication errors in the last 30 days to ensure that appropriate</p>				

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>A Nurses' Progress Note, dated 10/24/15 at 6:40 a.m., indicated during the shift change a medication error had occurred and the resident was assessed at this time. The note indicated the resident was able to be aroused without difficulty, had no respiratory difficulties, and the blood pressure was 158/94, pulse 61, and the oxygen saturation level was 97% on room air.</p> <p>Review of the 10/24/15 Incident Report Form indicated on 10/24/15 at 6:30 a.m. a discrepancy was noted in the narcotic count involving Morphine cream for Resident #L. A Medication Error report was completed. A 10/24/15 Medication Error Report indicated the LPN had given the midnight dose of Morphine. A fax message was then received from Pharmacy and the LPN realized too much of the Morphine had been given to Resident #L. The facility investigation report indicated the LPN was suspended on 10/24/15 related to a significant medication error and false documentation. A second report was completed on 10/28/15. This report indicated the LPN #1 administered the wrong dose of medication and falsified documentation of the medication error. The LPN was discharged from employment at the facility.</p>		<p>and accurate documentation and monitoring was completed following the discovery of the medication error.</p> <p>3) Measures put into place/ System changes:</p> <p>Pharmacy and Director of Nursing will re-educate licensed nurses and QMA's regarding medication administration/dosage calculations, procedure for reporting medication errors, timely physician notification of error, monitoring of residents following medication error and documentation.</p> <p>Medication administration competency will be completed on all licensed nurses and QMA's.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or designee will complete a medication administration observation at least 3x/week on varied shifts x30 days, then 2x/week x30 days, weekly x30 days, and monthly thereafter as needed until 100% compliance is achieved x3 consecutive months.</p> <p>The Director of Nursing or designee will audit documentation following medication errors as they occur to ensure physician was notified timely, and that appropriate monitoring and documentation were completed. These audits will be ongoing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>When interviewed on 10/29/15 at 1:15 p.m., the Director of Nursing indicated the resident was given the incorrect dose of Morphine on 10/24/15. The Director of Nursing indicated she was first informed of the error 10/24/15 at approximately 8:00 a.m. when she received a telephone call from LPN #1. At this time LPN #1 reported she had administered Morphine to Resident #L at 12:00 a.m. and later at 2:00 a.m. realized a medication error had occurred. The Director of Nursing indicated she came into the facility to investigate the medication error. The Director of Nursing indicated she found discrepancies in LPN#1's statement and documentation. The Director of Nursing indicated LPN #1 called her at approximately 8:00 a.m. on 10/24/15 and the LPN told her a medication error occurred at 12:00 a.m. and she had administered 150 milligrams of Morphine to Resident #L at 12:00 a.m. and realized the error at 2:00 a.m. The Director of Nursing indicated the LPN informed her she had checked the resident's vital signs every hours after the medication error was noted. The Director of Nursing indicated her investigation revealed LPN#1 did not know she administered the incorrect dose of Morphine until then end of the shift at</p>		<p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months.</p> <p>5) Date of compliance: 11-16-15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>6:30 a.m. when LPN #1 was completing the shift to shift change narcotic counts with the oncoming day shift Nurse. The Director of Nursing indicated she observed the packaging the Morphine syringe had been in and noted the resident had been administered the whole syringe of the topically Morphine at 12:00 a.m. The Director of Nursing indicated the resident received 150 milligrams of Morphine at 12:00 a.m. on 10/24/15. The Director of Nursing also indicated she spoke with the day shift Nurse that morning and the Nurse indicated the medication error was found by her and LPN#1 at that time (change of shift at narcotic count between 6:00 a.m.-6:30 a.m.) The Director of Nursing also indicated LPN #1 falsified the resident's record. The LPN documented the Nurse Practitioner was notified prior to the time of the error and the resident assessments. The Director of Nursing indicated she herself called the Nurse Practitioner when she came to the facility on 10/24/15 and the Nurse Practitioner indicated she had not been called until 6:30 a.m. and at that time the LPN had no vital signs to report to the Nurse Practitioner.</p> <p>The 2014 Nursing 2014 Drug Handbook indicated Morphine was a narcotic opioid analgesic. Adverse reactions included, but were not limited to, bradycardia(low</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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 0520 SS=G Bldg. 00	<p>heart rate), hypotension (low blood pressure), respiratory arrest (absence of respirations), and seizures. The Drug Handbook also indicated practice of administering medications safely included eight rights of medication administration. The eight rights included, but were not limited to, to ensure the right dose of the medication if administered. Ensuring the right dose is administered was to include checking the label with the prescriber's order.</p> <p>3.1-48(c)(2)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related</p>			

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify and implement plans of action to correct quality deficiencies related to falls and grievances for 3 of 3 residents with falls (Residents #J, #L, and #K) and 2 of 3 residents with grievances (Residents #C and #J) in a total sample of 11.</p> <p>Findings include:</p> <p>1. Resident #J's record was reviewed on 10/28/15 at 1:55 p.m. The resident's diagnoses included, but were not limited to, stroke with right sided hemiparesis and traumatic brain injury.</p> <p>The Resident's Record indicated the resident had fallen on 08/13/15 at 10:09 a.m. and 10/17/15 at 3:02 p.m.</p> <p>During an interview on 10/28/15 at 2:37 p.m., the Director of Nursing (DoN) indicated she had not documented the resident's interview. The DoN indicated she had not interviewed the CNA.</p> <p>During an interview on 10/28/15 at 8:40</p>	F 0520	<p>F520 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>IDR Request:</p> <p>The facility disputes the allegation that the facility failed to identify and implement plans of action to correct quality deficiencies related to falls and grievances and that actual harm occurred to any resident as a result.</p> <p>1) Immediate action taken for those residents identified: Resident #J- resident was changed to a Hoyer lift for transfers immediately following the fall on 10/17/15. Resident #K- Staff were re-educated regarding use of 2 staff for mechanical lift transfers on 8/17/15. Resident #L- Despite not using the facility</p>	11/16/2015

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>a.m., Resident #J indicated she has had missing items. She indicated she had a ring missing and the ring was never found. She indicated she was unsure when the ring went missing. She indicated the facility had offered to replace it but she could not find one like the missing ring.</p> <p>Review of the Resident Council Minutes, indicated the Resident had voiced a grievance of two sweaters being missing during the 06/24/15, 07/28/15, 08/26/15, and 09/30/15 meetings. The resident also voiced the grievance of a diamond ring being missing during the 09/30/15 meeting.</p> <p>During an interview on 10/29/15 at 8:56 a.m., the Administrator indicated the Activity Director conducted the Resident Council Meetings and gave the concerns to Laundry. The Administrator indicated the A Resident Council Concern/Recommendation form had not been given to her. The Administrator indicated she could not remember if the missing diamond ring had been reported to her. She indicated there had been no follow-up on the missing items.</p> <p>2. Resident #K's record was reviewed on 10/29/15 at 9:30 a.m. The resident's diagnoses included, stroke with left sided</p>		<p>"FallInvestigation Worksheet" at the time of the fall on 8/31/15 as indicated in the2567, this incident was investigated and reported to ISDH as required.Physician was notified of fall on 9/1/15.</p> <p>Resident #C- Resident was discharged from facility. The facility did make an effort to resolvethe grievance regarding the ring, but the family declined the offer made. Resident #J- The facility has spoken to the resident andfamily regarding the missing sweaters and ring, and an acceptable resolutionhas been agreed upon. 2) How the facilityidentified other residents: An audit will be completed of all grievances received in thelast 30 days to ensure follow up and investigation was completed timely. An audit will be completed to identify all residents at riskfor falls and who use mechanical lifts for transfers.</p> <p>3) Measures put intoplace/ System changes: Department Managers were re-educated regarding developmentand implementation of plans of actions for trends or quality deficiencies, aswell as items to be reviewed in Quality Assurance meeting monthly. 4) How the corrective actions will be monitored: Concerns and trendsidentified through investigations and audits will be reviewed weekly to ensureaction plans are developed and implemented. The Administrator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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	
	<p>hemiparesis and diabetes mellitus.</p> <p>The Resident's Record indicated the resident had a fall on 08/16/15 at 6:50 p.m.</p> <p>During an interview on 10/29/15 at 9:02 a.m., the DoN indicated the resident's fall had not been investigated.</p> <p>3. The record for Resident #L was reviewed on 10/29/15 at 10:39 a.m. The resident's diagnoses included, but were not limited to, cognitive communication deficit, bipolar disorder, dementia, depressive disorder, and high blood pressure.</p> <p>The Resident's Record indicated the resident had fallen on 08/31/15 at 2:13 p.m.</p> <p>During an interview on 10/29/15 at 11:50 a.m., the Director of Nursing indicated an investigation was initiated on 9/1/15. The Director of Nursing indicated a Falls Investigation Worksheet was to be completed by Nursing staff at the time of a fall and this was not done related to the above fall with injuries.</p> <p>4. Resident #C's record was reviewed on 10/28/15 at 2:51 p.m. The resident's diagnoses included, but were not limited</p>		<p>will be responsible for oversight of these reviews and will ensure that items are added to the Quality Assurance agenda monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 11-16-15</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>to advanced Alzheimer's disease, bladder cancer, and chronic obstructive pulmonary disease.</p> <p>A Grievance/Concern Form, dated 03/13/15, completed by the Social Service Director, indicated the concern was voiced by the past Director of Nursing (DoN). The Grievance/Concern Form indicated the DoN reported to the Social Service Director the resident was missing a gold wedding band. The Investigation/Follow-up indicated the Social Service Director spoke to the POA to get a description of the ring and the Social Service Director informed the Housekeeping Department and the Administrator to start the investigation. The form indicated the Administrator signed the and dated the form on 03/13/15 and the resolution indicated the POA was not able to give a description of the ring and the resolution was pending.</p> <p>A Social Service Progress Note, dated 05/18/15 at 10:44 a.m., indicated the Social Service Director notified the POA and left a message in regards to the resident's ring and was waiting for a return call.</p> <p>There were no further Progress Notes in the resident's record after 05/18/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>A typed letter, written by the Administrator, dated 08/14/15, and sent to the POA's Husband, indicated a "good faith" monetary amount was offered to the POA. There was no further follow-up on the missing ring.</p> <p>During an interview on 10/28/15 at 1:09 p.m., the Administrator indicated the Social Service Director was not in the facility. The Administrator indicated an investigation had not been completed on the missing ring. The Administrator indicated no one had followed-up with the POA until May.</p> <p>During an interview on 10/29/15 at 3:18 p.m., the Administrator indicated she was the Quality Assurance (QA) Coordinator. She indicated the committee meets monthly and the Supervisors meet daily. She indicated falls and grievances were discussed in the QA meetings. The Administrator indicated the committee discuss fall investigations. She indicated she was unaware the fall investigations were not completed and this should have been found during the QA process. She indicated the grievances should have been discussed in the morning meetings but had not been and she had not realized there had been a break in the system.</p> <p>This Federal Tag relates to Complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
(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 9999 Bldg. 00	<p>IN00183011.</p> <p>3.1-52(b)(2)</p> <p>3.1-25 Pharmacy Services</p> <p>The administration of drugs and treatments, including alcoholic beverages, nutrition concentrates, and therapeutic supplements, shall be as ordered by the attending physician and shall be supervised by a licensed nurse as follows:</p> <p>(8) Per required need (PRN) medications may be administered only upon authorization of a licensed nurse or physician. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview,</p>	F 9999	<p>F9999</p> <p>The facility requests paper 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> <p>1) Immediate action taken for those residents identified:</p> <p>Resident #B has been discharged from the facility.</p> <p>2) How the facility identified other residents:</p>	11/16/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
(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			
	<p>the facility failed to ensure as needed medication (PRN) was only administered upon authorization by a licensed nurse or physician, for 1 of 3 residents reviewed for nebulizer treatments in a total sample of 11. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 10/27/15 at 9:32 a.m. The resident's diagnoses included, but were not limited to, pneumonia, lung cancer, chronic obstructive pulmonary disease. The resident was admitted to the facility from an acute care hospital on 09/11/15.</p> <p>The Physician's Orders, dated 09/11/15, indicated, Ipratropium-Albuterol Solution (medications for lungs) 0.5-2.5 milligrams per 3 milliliters, nebulizer every 4 hours as needed for shortness of breath.</p> <p>The Medication Administration Record, dated 09/15, indicated the resident received the Ipratropium-Albuterol nebulizer treatment on 09/13/15 at 3:39 p.m. The initials in the administration record were those of QMA #11.</p> <p>A Nurses' Progress Note, entered by QMA #11, dated 09/13/15 3:39 p.m., indicated QMA #11 administered the</p>		<p>All residents receiving PRN medications and nebulizertreatments have the potential to be affected.</p> <p>3) Measures put intoplace/ System changes:</p> <p>Licensed staff and QMA's will be re-educated regarding QMA'scope of practice and documentation requirements for administration of PRNmedications.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director ofNursing or designee will review PRN medication report to ensure appropriatenotification and documentation are completed on at least 5 residents per weekx60 days, then 5 residents monthly thereafter until 100% compliance is achievedx3 consecutive months.</p> <p>The results of theseaudits will be reviewed in Quality Assurance Meeting monthly until 100%compliance is achieved x3 consecutive months.</p> <p>5) Date ofcompliance: 11-16-15</p>				

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 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
--	--

(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
	<p>Ipratropium-Albuteral nebulizer at 3:39 p.m. for shortness of breath. There was no prior approval given from a licensed nurse or physician.</p> <p>During an interview on 10/27/15 at 12 p.m., the Director of Nursing indicated she was unaware the QMA administered the PRN nebulizer treatment.</p> <p>A QMA job description, received as current from the Administrator on 10/27/15 at 12:46 p.m., indicated, "...administering and documenting PRN medications only under the direction of staff nurse..."</p> <p>3.1-25(b)(8)</p>			