

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/20/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE TOLLESTON PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00177682.</p> <p>Complaint IN00177682- Substantiated. Federal/State deficiency related to the allegation is cited at F314.</p> <p>Survey date: July 20, 2015</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Census payor type: Medicare: 9 Medicaid: 87 Other: 8 Total: 104</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance 410 IAC 16.2-3.1.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0314 SS=D Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 observation, record review, and interview, the facility failed to ensure the necessary treatment and services were provided for pressure ulcers related to pressure ulcer dressings not in place and weekly skin observations not completed for 2 of 3 residents reviewed for pressure ulcers in a sample of 3. (Residents #C and #D)</p> <p>Findings include:</p> <p>1. During Orientation Tour accompanied by the Unit Manager on 7/20/15 at 8:25 a.m., Resident #D was observed in bed. LPN #1 was also present. The resident was turned to his right side and his brief was removed. The resident had an open area to his coccyx area. There was no dressing or bandage covering the wound. The open area measured approximately 4 cm (centimeters) x 3 cm. The wound</p>	F 0314	<p>F 314 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident # D - treatment was rendered immediately Resident # C – Has been discharged from the facility 2) How the facility identified other residents: An observation audit was completed of all residents with orders for dressing changes on 7/22/15 to ensure dressings were present</p>	07/30/2015			

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	<p>edges appeared dry and pale yellow in color. LPN #1 confirmed no dressings were present.</p> <p>The record for Resident #D was reviewed on 7/20/15 at 11:42 a.m. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure, gastrostomy, head injury, and persistent vegetative state.</p> <p>The current Physician orders were reviewed. An order was written on 6/30/15 to cleanse the sacrum wound with wound cleanser, pat dry, apply a Prisma dressing, and cover the area with a dry dressing every Monday, Wednesday, and Friday.</p> <p>Review of the 6/15/15 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two staff members for bed mobility and transfers. The assessment also indicated the resident was dependent on one staff member for personal hygiene and bathing. The assessment indicated the resident was at risk for pressure ulcer and had one Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer.</p>		<p>and treatments completed as ordered. An audit was completed on all residents for weekly skin assessments. 3) Measures put into place/ System changes: Licensed Nurses and CNA's will be re-educated regarding checking dressings for placement and notifying nurse when the dressing comes off during care. Licensed Nurses will be educated to check placement of dressing every shift. Observation audits will be completed on at least 5 residents per week to ensure that dressing is in place on varied shifts. Licensed Nurses will be re-educated regarding completing weekly skin assessments per facility protocol. Audits will be completed on at least 5 residents per week to ensure that weekly skin assessment were completed per protocol. The Director of Nursing or designee will be responsible for the oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 Months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 7/30/15</p>	

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	<p>The 7/17/15 Skin-Pressure/ Diabetic/Stasis/Arterial Wound report was reviewed. The report indicated the resident had a Stage IV pressure ulcer to the sacrum. The pressure ulcer measured 4.5 cm x 5.3 cm x 0.5 cm</p> <p>When interviewed on 7/20/15 at 8:25 a.m., LPN #1 indicated she had not removed any dressings from the resident's coccyx area. The LPN indicated the resident was to have a dressing in place to cover the sacral pressure ulcer.</p> <p>When interviewed on 7/20/15 at 9:05 a.m., CNA #2 indicated he was assigned to care for Resident #D on the day shift today. The CNA indicated he had not provided incontinence care to the resident so far on the day shift. CNA #2 indicated he had not remove any dressings to the resident's coccyx area.</p> <p>When interviewed on 7/20/15 at 8:40 a.m., the Unit Manager indicated the dressing to the resident's coccyx should have been in place.</p> <p>2. The closed record for Resident #C was reviewed on 7/20/15 at 9:43 a.m. The resident's diagnoses included, but were not limited to, dementia, peripheral vascular disease, anemia, high blood pressure, and depressive disorder.</p>			

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	<p>The 6/22/15 Minimum Data (MDS) annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The assessment indicated the resident was at risk for the development of pressure ulcers.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 4/27/11 indicated the resident was at risk for pressure ulcers related to immobility. The Care Plan was last updated with a target goal date of 9/2/15. Care plan interventions included, but not limited to, weekly skin assessments to be completed.</p> <p>A Weekly Skin Observation note was completed on 5/20/15. The note indicated the resident's skin was intact and no foot concerns were identified</p> <p>The next Weekly Skin Observation note was completed on 5/30/15. The note indicated the resident had a new 7 cm open area to the right heel. The Physician and the Responsible Party were notified.</p> <p>The 5/2015 Nursing Progress Notes were</p>			

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	<p>reviewed. An entry made on 5/30/15 at 11:50 p.m. indicated the resident's right heel was noted to be bleeding and an open area was observed to the heel.</p> <p>A Skin-Pressure/Diabetic/Stasis/Arterial Wound Report indicated the resident had an open area to the right heel The report had an "effective date" of 6/5/15 noted . The report indicated the resident had a Suspected Deep tissue pressure ulcer measuring 5.2 cm x 5.0 cm. The report also indicated a scant amount of drainage was noted.</p> <p>When interviewed on 7/20/15 at 11:43 a.m., the ADON (Assist Director of Musing) indicted the above Skin-Pressure/Diabetes/Stasis/ Arterial Wound report was completed on 6/3/15 and had not been entered into the electronic record until 6/5/15. The ADON indicated weekly skin assessments were to be completed weekly for all residents on a Shower day. The ADON indicated no weekly skin reports were completed between 5/20/15 and 5/30/15.</p> <p>The facility policy titled "Skin Condition and Pressure Ulcer Assessment" was reviewed on 7/20/15 at 1:30 p.m. the policy had "current version" date of 6/2012. The ADON provided the policy</p>			

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	<p>and indicated the policy was current. The policy indicated all residents known or not known to have skin problems were to have a body check/assessment completed at least weekly by a licensed nurse.</p> <p>This Federal tag relates to Complaint IN00177682.</p> <p>3.1-40(a)(2)</p>				