

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 04/09/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F 000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 03/04/15. This visit included a PSR to the State Residential Licensure Survey.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00168674 completed on 03/04/15.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00169348, IN00169397, and IN00170455.</p> <p>Survey dates: April 8 & 9, 2015.</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Census bed type: SNF/NF: 55 Residential: 6 Total: 61</p> <p>Census Payor type: Medicare: 08 Medicaid: 34 Other: 13 Total: 55</p>	F 000		
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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 431 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in</p>			

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	<p>Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review and interview, the facility failed to ensure a controlled substance, FentaNyl patch (narcotic pain medication), was destroyed with two licensed witnesses when the used FentaNyl patch was removed from the resident and after the medication had been discontinued by the Physician, for 1 of 3 residents reviewed for controlled medications. (Resident #H)</p> <p>Finding includes:</p> <p>Resident #H's record was reviewed on 04/08/15 at 2:05 p.m. The resident's diagnoses included, but were not limited to Alzheimer's disease and diabetes mellitus.</p> <p>A Physician's Order, dated 05/20/14 indicated an order for FentaNyl patch (narcotic pain medication) 50 MCG (micrograms) per hour, apply one patch transdermally, one time a day every three days for pain and remove per schedule.</p> <p>The Medication Administration Record, dated 03/15, indicated the FentaNyl patch</p>	F 431	<p>F 431 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 # H was discharged from this facility on 4/4/2015. 2) How the facility identified other residents: An audit was performed of all current resident's medications. None were found to be prescribed a fentanyl patch. 3) Measures put into place/ System changes: A destruction sheet with places for two nurses to sign off was put into place. Nurses were in-serviced on the proper way to destroy a fentanyl patch including that two nurses must witness the</p>	04/24/2015	

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	<p>was removed from the resident on March 2, 7, and 11, 2015 prior to applying a new patch. There were no signatures to indicate the used patches were destroyed with two licensed witnesses.</p> <p>A Physician's Order, dated 03/17/15 at 4:08 p.m., indicated to discontinue the FentaNyl patch.</p> <p>The Controlled Drug Receipt/Record/Disposition Form, dated 03/15, indicated there were seven FentaNyl patches destroyed. The controlled Drug Receipt/Record/Disposition Form was signed by one Nurse, a second Nurse or Pharmacist had not witnessed the destruction of the FentaNyl patches.</p> <p>During an interview on 04/09/15 at 12:48 p.m., the Director of Nursing indicated the destruction of the FentaNyl patches had not been witnessed by two Nurses.</p> <p>A facility policy, dated 09/13, titled, "Destroying Medications", received from the Director of Nursing as current, indicated, "...3. Schedule II, III, and IV controlled drugs must be destroyed by two (2) licensed nurses or one (1) licensed nurse and pharmacist..."</p> <p>This deficiency was cited on 03/04/15.</p>		<p>destruction of the patch. There are currently no residents using a fentanyl patch in the facility. When a resident receives an order for a fentanyl patch the destruction sheet will be audited three times weekly by DON or designee for proper documentation and signatures of two nurses. If it is found that a nurse is not following the proper procedure they will be given one-on-one training by the DON or designee who discovered the improper documentation. 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: 04/24/2015</p>				

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F 465 SS=E Bldg. 00	<p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the environment was safe and sanitary, related to splatters on the wall, chipped and peeling paint, and gouges on the doors for 3 of 4 Hallways (North, West, South), which had the potential to effect 17 residents.</p> <p>Findings include:</p> <p>1. During observations on 04/08/15 at 9:01 a.m. to 9:40 a.m. and 11:04 a.m. to 11:09 a.m. the following was observed:</p> <p>A. There were over the toilet handrails</p>	F 465	<p>F 465 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: a) Bathroom adjoining rooms 12 & 14. Over the toilet handrails</p>	04/24/2015	

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	<p>which had peeling and chipped paint in the bathroom between rooms 12 and 14, which was used by three residents.</p> <p>B. There were splatters on the wall between the toilet and the sink in the bathroom of room 8, which was used by one resident.</p> <p>C. There were brown and white splatters on the wall next to and behind the toilet in the bathroom of 109, which was used by two residents.</p> <p>D. There were brown and white splatters on the wall by the toilet and behind the toilet in the bathroom of room 112, which was used by two residents.</p> <p>During an tour of the above rooms with the Administrator on 04/08/15 at 1:56 p.m., the Administrator acknowledged the peeling and chipped paint and the splatters on the wall in the bathrooms.</p> <p>2. During observations on 04/09/15 at 8:11 a.m. through 8:25 a.m., with the Administrator and the Director of Maintenance present, the following was observed:</p> <p>A. The bottom of the bathroom door was gouged in room 104. There were two residents who resided in the room.</p>		<p>paint was repaired on 4/08/2015. Audits in place to ensure toilet handrails are free of peeling and chipped paint.</p> <p>b) Room 8. Splatters on the wall between the toilet and the sink were removed on 4/08/2015. Wall between the toilet and the sink was painted on 4/10/2015. Audits in place to ensure wall is free of splatters. Housekeeping staff in serviced on 4/15/2015 regarding proper bathroom cleaning.</p> <p>c) Room 109. Brown and white splatters on the wall next to and behind the toilet were removed on 4/08/2015. Wall between the toilet and the sink was painted on 4/10/2015. Audits in place to ensure wall is free of splatters. Housekeeping staff in serviced on 4/15/2015 regarding proper bathroom cleaning.</p> <p>d) Room 112. Brown and white splatters on the wall by the toilet and behind the toilet were removed on 4/08/2015. Wall behind the toilet was painted on 4/10/2015. Audits in place to ensure wall if free of brown and white splatters. Housekeeping staff in-serviced on 4/15/2015 regarding proper bathroom cleaning.</p> <p>e) Room 104. Gouges to the bottom of the bathroom door to be repaired by 4/24/2015. Audits in place to ensure a safe environment for residents and staff.</p> <p>f) Room</p>		

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	<p>B. The door to the bathroom was gouged in room 112. There were 2 residents who resided in the room</p> <p>C. There were gouges on the room door to room 16. There were two residents who resided in the room.</p> <p>D. The inner bathroom door of room 18, located in the bathroom between rooms 17 and 18 was gouged. There were three residents who shared the bathroom.</p> <p>E. The outer door of room 20 was gouged. There were two residents who resided in the room.</p> <p>During an interview on 04/09/15 at 8:22 a.m., the Director of Maintenance indicated all the doors had been touched up with paint. The Director of Maintenance and the Administrator acknowledged the gouges were still present in the doors.</p> <p>This deficiency was cited on 03/04/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(f)</p>		<p>112. Gouges to the bathroom door to be repaired by 4/24/2015. Audits in place to ensure a safe environment for residents and staff. g) Room 16. Gouges on door of Room 16 to be repaired by 4/24/2015. Audits in place to ensure a safe environment for residents and staff. h) Room 18 inner bathroom door between 17 & 18. Gouges to the door to be repaired by 4/24/2015. Audits in place to ensure a safe environment for residents and staff. i) Room 20 outer door. Gouges to the outer door to be repaired by 4/24/2015. Audits in place to ensure a safe environment for residents and staff . 2) How the facility identified other residents: Audit will be completed of all resident rooms available for occupancy to identify any other environmental concerns. 3) Measures put into place/ System changes: Maintenance department will develop a schedule to complete inspection and repairs on at least 3 resident rooms per week until all rooms available for occupancy are completed. Schedule will then be implemented for inspection and repairs on all rooms available for occupancy at least semi-annually for routine maintenance and</p>		

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R 000 Bldg. 00	Aperion Care Demotte was found to be in compliance with 410 IAC 16.2-5 in regard to State Residential Survey.	R 000	<p>upkeep thereafter.</p> <p>Environmental Supervisor or Designee will perform rounds on assigned rooms at least 3x/week. Work orders will be written and submitted to maintenance for any issues requiring immediate attention.</p> <p>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: 4/24/2015</p>	