

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
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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 IN00178940.</p> <p>Complaint IN00178940-Substantiated. Federal/State deficiencies related to the allegations are cited at F328, F441, and F9999.</p> <p>Survey dates: August 3 & 4, 2015</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census payor type: Medicare: 8 Medicaid: 87 Other: 6 Total: 101</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</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.

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F 0328 SS=D Bldg. 00	<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; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to ensure appropriate tracheostomy care was provided related to cleaning the tracheostomy site during the observation of trach care for 1 of 3 residents reviewed for tracheostomy care in a sample of 7. (Resident #D) (LPN #3)</p> <p>Finding includes:</p> <p>On 8/3/15 at 10:50 a.m., Resident #D was observed in bed. The resident had a tracheostomy tube in place. LPN #3 was present in the resident's room preparing to render tracheostomy care for the resident. The LPN opened a disposable tracheostomy care kit and put on the sterile gloves inside the kit. LPN #3 then proceeded to use the pipe cleaner to clean around the tracheostomy site.</p>	F 0328	<p>F328</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</i></p>	08/21/2015

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	<p>The record for Resident #D was reviewed on 8/3/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, tracheostomy, high blood pressure, intracranial hemorrhage, and chronic renal failure.</p> <p>A 7/22/15 Admission/Readmission Observation Note was reviewed. The note was entered at 7:04 p.m. The note indicated the resident received respiratory treatment which included, but were not limited to, oxygen, suctioning, nebulizer treatments, and tracheostomy care as ordered. The note also indicated the resident's respiratory rate was regular and the resident had no cough.</p> <p>The current Physician orders were reviewed. The following orders were written on 7/23/15: Trach (tracheostomy) care every shift. Change the trach collar daily and as needed. May suction trach every shift as needed. Cleanse the non disposable inner cannula daily and as needed.</p> <p>When interviewed on 8/4/15 at 8:05 a.m., the Director of Nursing indicated cotton tip applicators were to be used to clean the area around the outer cannula. The Director of Nursing also indicated the</p>		<p><i>law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #D: Assessment was performed of skin surrounding tracheostomy site, with no abnormal findings.</p> <p>LPN #3 was immediately re-educated regarding procedure for tracheostomy care.</p> <p>2) How the facility identified other residents:</p> <p>Facility currently has one other resident with a tracheostomy. Assessment was completed on the other resident with tracheostomy, with no abnormal findings.</p> <p>3) Measures put into place/ System changes:</p>		

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	<p>pipe cleaners were to be used to clean the inner cannula as per the facility policy.</p> <p>The facility policy titled "Tracheostomy Care- Suctioning, Cleaning, and Changing Type" was reviewed on 8/3/15 at 11:55 a.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated the outside of the outer cannula was to be cleaned as needed using cotton tip applicators. The policy also indicated the inner cannula was to be thoroughly cleaned using a pipe cleaner or cotton tipped applicators.</p> <p>This Federal tag relates to Complaint IN00178940.</p> <p>3.1-47(a)(4)</p>		<p>Licensed Nurses will be re-educated regarding procedure for tracheostomy care. Additional training and return demonstration will be completed by Respiratory Therapist.</p> <p>Director of Nursing or designee will observe tracheostomy care at least 2x/week on varied shifts to ensure proper procedure is followed.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 8/21/15</p>	

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F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure</p>	F 0441	F441	08/21/2015

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	<p>hand hygiene was completed and suction catheters remained sterile during tracheostomy care and suctioning for 1 of 3 residents reviewed for tracheostomy care in a sample of 7. (Resident #D) (LPN #3)</p> <p>Finding includes:</p> <p>On 8/3/15 at 10:50 a.m., Resident #D was observed in bed. The resident had a tracheostomy tube in place. LPN #3 was present in the resident's room preparing to render tracheostomy care for the resident. The LPN put on a pair of disposable gloves and moved a chair in the residents room, picked up a garbage can from one side of the residents' bed and moved it the other side of the bed. The LPN removed the disposable gloves and left the room and returned to the room. LPN #3 did not wash her hands or apply alcohol gel to her hands upon entering the resident's room. The LPN then put on a new pair of disposable gloves. The LPN preceded to change the suction canister at the resident's bedside and placed the used canister into a plastic bag. The LPN then removed her gloves and did not wash her hands or apply alcohol gel to her hands.</p> <p>Continued observation indicated the LPN then opened a trach kit and connected</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 actions taken for those residents identified:</p> <p>Resident #D was assessed with no abnormal findings.</p> <p>LPN #3 was immediately re-educated regarding infection control measure, handwashing and tracheostomy care/suctioning procedure.</p>	

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	<p>the catheter to the suction tubing. The LPN then put on the sterile gloves which were in the kit and picked up the suction tubing. The suction catheter tip touched the resident's bed pillow and the resident's gown prior to the LPN suctioning around the tracheostomy site.</p> <p>The record for Resident #D was reviewed on 8/3/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, tracheotomy, high blood pressure, intracranial hemorrhage, and chronic renal failure.</p> <p>A 7/22/15 Admission/Readmission Observation Note was reviewed. The note was entered at 7:04 p.m. The note indicated the resident received respiratory treatment which included, but were not limited to, oxygen, suctioning, nebulizer treatments, and tracheostomy care as ordered. The note also indicated the resident's respiratory rate was regular and the resident had no cough.</p> <p>The current Physician orders were reviewed. The following orders were written on 7/23/15: Trach (tracheostomy) care every shift. Change the trach collar daily and as needed. May suction trach every shift as needed. Cleanse the non disposable inner cannula</p>		<p>2) How the facility identified other residents:</p> <p>Facility currently has one other resident with a tracheostomy. Assessment was completed on the other resident with tracheostomy, with no abnormal findings.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses will be re-educated regarding tracheostomy care and suctioning, infection control measures, including handwashing, and glove use during clean or sterile procedures.</p> <p>Director of Nursing or designee will observe tracheostomy care at least 2x/week on varied shifts to ensure proper procedure is followed.</p>				

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	<p>daily and as needed.</p> <p>The facility policy titled "Tracheotomy Care- Suctioning, Cleaning, and Changing Type" was reviewed on 8/3/15 at 11:55 a.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated sterile gloves were to be applied after turning the suction machine on keeping one gloved hand and the suction catheter sterile.</p> <p>The facility policy titled "Hand Washing " was reviewed on 8/4/15 at 9:01 a.m. The policy had a revised dated of 4/2012. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated hands were to be washed before putting on gloves and after taking gloves off. The policy also indicated alcohol based hand rubs could be used between gloving if hands were not visually soiled.</p> <p>When interviewed on 8/3/15 , the Director of Nursing indicated the suction catheter tip should have remained sterile when removed from the kit. The Director of Nursing also indicated hand washing or hygiene should have been completed after touching items.</p>		<p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 8/21/15</p>		

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F 9999 Bldg. 00	<p>This Federal tag relates to Complaint IN00178940.</p> <p>3.1-18(a) 3.1-18(l)</p> <p>3-3-13(b)(1) ADMINISTRATION AND MANAGEMENT.</p> <p>The Licensee shall provide the number of staff as required to carry out all the functions of the facility, including: -initial orientation of all employees</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure Job Specific orientation was completed for 3 of 6 Nursing Employee files reviewed.</p> <p>Finding includes:</p> <p>The Employee Records were reviewed on 8/4/15 at 12:15 p.m.. Job Specific Orientation records were not available for (3) of (6) Nursing Employee files reviewed. No Job Specific Orientation</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>	08/21/2015	

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	<p>checklist were completed for the following: RN #1- hired on 3/19/15 LPN #1- hired on 6/25/15 LPN #2- hired on 4/2/15</p> <p>When interviewed on 8/4/15 at 2:00 p.m., the Director of Nursing indicated the Job Specific orientation lists should have been completed for the above staff members.</p> <p>This State tag relates to Complaint IN00178940.</p>		<p>1) Immediate actions taken for those residents identified:</p> <p>RN #1 is no longer employed at the facility.</p> <p>LPN #1 and LPN #2- Job specific orientation checklists were completed.</p> <p>2) How the facility identified other residents:</p> <p>An audit will be completed on nursing employee files to ensure job specific orientation has been completed.</p> <p>3) Measures put into place/ System changes:</p> <p>The Human Resources Director or</p>	

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			<p>designee will audit all new employee files within 14 days of hire to ensure job specific orientation checklist has been completed.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 8/21/15</p>	