

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/03/2015
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NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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F 0000  Bldg. 00	<p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00177352 completed on July 17, 2015.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00180682.</p> <p>Survey dates: August 31, 2015 and September 2 &amp; 3, 2015.</p> <p>Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850</p> <p>Census Bed Type: SNF: 3 SNF/NF: 50 Total: 53</p> <p>Census Payor Type: Medicare: 6 Medicaid: 37 Other: 10 Total: 53</p> <p>Sample: 3 Supplemental Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 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 0157 SS=G Bldg. 00	<p>Quality Review completed on 21662 on September 9, 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> <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</p>			

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	<p>interested family member.</p> <p>Based on record review and interview the facility failed to ensure immediate notification of the resident's legal representative and physician for intervention, when a resident had a pressure ulcer which deteriorated for 1 of 4 resident's reviewed for notification of change in condition. (Resident "B").</p> <p>This deficient practice resulted resulted in a delay of treatment, a decline in a resident's condition (Resident "B") where the resident was subsequently transported and admitted to Intensive Care of the local area hospital for sepsis, and treatment of a Stage Four Pressure ulcer.</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 08-31-15 at 1:00 p.m. Diagnoses included, but were not limited to, dementia with behaviors, dysphagia, depressive disorder, and hypothyroidism. These diagnoses remained current at the time of the record review.</p> <p>The record indicated that at the time the resident was admitted to the facility the resident's skin was intact. The Initial Braden scale (a system used to identify resident's at risk for pressure ulcers), dated 05-19-15 indicated the resident was</p>	F 0157	<p><b>F157</b></p> <p><b>The facility requests paper compliance for this citation.</b></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><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #B was discharged from the facility.</p>	09/21/2015			

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	<p>at risk for the development of pressure ulcers.</p> <p>The resident's plan of care, dated 07-21-15, instructed the nursing staff to "Observe/document/report to MD [Medical Doctor] PRN [as needed] changes in skin status. Appearance, Color, wound healing, s/sx [signs/symptoms] of infection, wound size (Length times Width times Depth), Stage."</p> <p>A review of the Interdisciplinary Progress Notes indicated the following:</p> <p>"07-20-15 20:40 [8:40 p.m.] - Coccyx reported as a pink intact area."</p> <p>"07-22-15 14:02 [2:02 p.m.] - Coccyx reported as a pink intact area per 07-20-15 skin note, not new. However orders indicate area to coccyx is open. Will ask nurse to clarify coccyx."</p> <p>"07-22-15 14:57 [2:57 p.m.]- DON [Director of Nurses] said coccyx is open, superficial. Treatment ordered. Will review upcoming wound reports, expect it will heal quickly."</p> <p>"07-23-15 05:28 [5:28 a.m.]- ...Tx [treatment] to coccyx, drsg [dressing] intact, no further areas noted."</p>		<p><b>2) How the facility identified other residents:</b></p> <p>Residents with pressure ulcers were assessed and documentation reviewed.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Licensed nurses will be re-educated regarding policy for timely notification of physician and responsible party for change in condition.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>Documentation will be reviewed at least 3-5 times per week to ensure physician and responsible party were notified of change in condition in a timely manner.</p>	

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	<p>"07-23-15 12:15 [12:15 p.m.] - Skin condition: superficial."</p> <p>"07-24-15 02:26 [2:26 a.m.] - Coccyx continues with tx. as ordered, no redness, or drainage to or around dressing, no c/o [complaints of] verbally, pleasant."</p> <p>"07-28-15 02:39 [2:39 a.m.] - Tx. to coccyx continues as ordered, no bleeding, mild drainage clear/light yellow, are cleaned and dried sterile technique/clean technique, tender to touch area, applied foam derma as ordered, tolerated."</p> <p>"07-29-15 01:28 [1:28 a.m.] - Skin concerns observed: coccyx - treatment in progress. Moist to dry dressing."</p> <p>"07-29-15 05:45 [5:45 a.m.] - Treatment continues to coccyx. Cleansed, applied moist dressing and covered with transparent dressing. Small amount of bloody drainage noted. Complaint of tenderness with touch. Slight odor noted."</p> <p>"07-31-15 02:50 [2:50 a.m.] ...coccyx area pink with dk. [dark] brown area by open area, cleansed, wet to dry drsg. [dressing] and covered, tender to touch...."</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 x3 months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 9-21-15</b></p>	

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	<p>A review of the "Skin/Pressure Report dated 07-21-15 indicated, "new wound development, open area to coccyx - abrasion 7.0 cm [centimeters] by 2.0 cm. Acquired in house/pressure. Date first observed 07-20-15 - epithelial, granulation with no signs or symptoms of infection. Periwound intact. Treatment - Calmoseptine and foam."</p> <p>A physician order, dated 07-21-15 indicated, "cleans [sic] open area to coccyx with Normal Saline, pat dry. Apply small amount of Calmoseptine [a skin barrier treatment] ointment BID [two times a day] and PRN [as needed] for soilage until healed every day and night shift for open area." The order did not indicate the use of a foam dressing, wet to dry dressing or transparent dressing.</p> <p>Further review of the Skin/Pressure Reports indicated on 07-24-15 the area measured .5 cm by .2 cm by .1 cm and was assessed as a Stage Two [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough] pressure area.</p> <p>A review of the Skin/Pressure report dated 07-31-15, 7 days later, indicated the area was now assessed as a "Stage 4</p>			

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	<p>[Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed and often include undermining and tunneling] pressure ulcer and measured 4.6 cm by 3.4 cm by .3 cm." The assessment indicated the area was "worsening, had granulation, with slough and was necrotic." The drainage was identified as "serosanguinous" and the "periwound was discolored."</p> <p>A subsequent review of the Skin/Pressure report, dated 08-07-15 indicated the pressure ulcer increased in size to "4.8 cm by 4.2 cm by .3 cm" and was assessed as a "Stage Four" pressure ulcer. The assessment indicated the area was "worsening, had slough and eschar with moderate amount of purulent drainage, discoloration and edema to the periwound and displayed with signs and symptoms of infection."</p> <p>The nursing staff failed to notify the physician for medical intervention, on 07-28-15 when the area was first noted with mild drainage, and then on 07-29-15 when the area was noted with bloody drainage, a slight odor and complaints of tenderness by the resident to the area, and subsequently did not report the area until it was assessed on 07-31-15 as a Stage</p>			

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	<p>Two pressure ulcer when the nurse documented the area had a dark brown area adjacent to the open area and the resident continued to complain of tenderness.</p> <p>Further review of the resident's clinical record indicated the resident had a change in condition and was transported to the local area hospital on 08-08-15.</p> <p>On 8-31-15 at 9 a.m., the ambulance report dated 8-8-15 was reviewed and indicated the resident had a temperature of 101.9 Fahrenheit, a pulse of 115 and respiration rate of 24. The report indicated that when the ambulance crew arrived at the facility, four nurses were "holding his hands to prevent them from shaking."</p> <p>A review of the Hospital record on 08-31-15 at 8:30 a.m., for the dates 8-8-15 through 8-19-15 indicated that upon arrival at the local hospital Emergency Room, the resident's white blood cell count was 19.8 (with a normal range of 3.3 to 10.5) and diagnosed with "multi organism sepsis with fever and decubitus ulcer overlying the lower sacrum and coccyx."</p> <p>A review of the hospital "Wound Care,"documentation indicated the</p>			

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	<p>resident "came from Aperion nursing facility and had decubitus ulcer to coccyx upon arrival to [name of local area hospital]. The wound has a strong odor and has eschar on it." The Wound Nurse indicated there was a "Large amount of purulent drainage. Photo and measurements completed." The documentation indicated the pressure ulcer measured "5 cm long by 3 cm wide and 5 cm deep with necrotic tissue."</p> <p>The hospital physician notation indicated, the resident presented to the hospital with a "deep infected sacral decubitus ulcer" and underwent a debridement procedure to the wound. "The size of the area treated [by debridement] was approximately 10 cm long by 7 cm wide by 3 cm deep with all necrotic devitalized tissue removed."</p> <p>During an interview on 09-02-15 at 2:00 p.m., the Wound nurse indicated the legal representative for the resident had not been notified of the pressure area, and the nursing staff had been communicating with the resident's spouse. "We thought she [in regard to the spouse] was the contact person and didn't know she had some dementia until later on. We talked with her almost daily."</p> <p>During a further interview on 09-03-15 at</p>			

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	<p>10:00 a.m., the Wound Care Nurse verified the nursing staff did not follow the physician orders dated 07-21-15, "There are some areas that need to breath and not be covered."</p> <p>A review of the facility policy on 09-02-15 at 11:30 a.m., titled, "Change in Condition Physician Notification Overview Guidelines," and dated 01-01-2014, indicated the following:</p> <p>"These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. 2. Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner."</p> <p>"Nurse Responsibilities - The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention."</p> <p>A review of the facility policy on 09-02-15 at 11:30 a.m., titled "Pressure Ulcer and Skin condition Assessment Policy," dated 01-01-2015, indicated the following:</p>			

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	<p>"Policy: It is the policy of this facility that pressure and other ulcers, (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse, and recorded on the facility approved wound assessment form."</p> <p>"Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented."</p> <p>"Standards: ... 2. Residents identified by the Braden scale of being at risk of a skin breakdown will have a weekly skin assessment by a licensed nurse. 7. At the earliest sign of a pressure ulcer or other skin problem, the resident, legal representative and attending physician will be notified.... 14. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. ... 18. The licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative of any suspected wound infection. ... 21 A licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. observations such as drainage,</p>			

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	<p>dehiscence, redness, swelling, or pain will be documented in the nurse's notes. If observations are acute, physician and responsible party will be notified by change nurse."</p> <p>The Federal tag relates to Complaint IN00180682.</p> <p>This deficiency was cited on 7/17/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-5(a)</p>				