STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(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	This visit was for the Investigation of Complaints IN00203595 and IN00204435. Complaint IN00203595 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F314. Complaint IN00204435 - Substantiated. Federal/State deficiency related to the allegation is cited at F309. Survey dates: July 11 and 12, 2016 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Census bed type: SNF/NF: 49 Total: 49 Census payor type: Medicare: 8 Medicaid: 39 Other: 2 Total: 49 Sample: 4 These deficiencies reflects State findings	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on July 14, 2016.			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure a comprehensive plan of care was developed in regards to pressure wounds for 1 of 4 residents reviewed for care	F 0279	**F 279** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	08/05/2016

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	planning. (Resident C) Findings include: The clinical record of Resident C was reviewed on 7/11/16 at 10:40 a.m. Diagnoses for the resident included, but were not limited to, acute kidney failure, bipolar disorder, dysphagia, chronic kidney disease, dementia without behavioral disturbances and difficulty walking. A review of Resident C's Minimum Data Set (MDS) 14-day Review, dated 5/31/16, indicated the resident was moderately cognitively impaired and required extensive assistance and two person physical assistance with bed mobility, transfers and hygiene. Resident C also had bilateral lower limitations. The MDS indicated Resident C was at risk for developing pressure ulcers, but did not currently have any healing pressure ulcers. Resident C was admitted to the facility on 5/17/16. Review of the Admission Skin Assessment, dated 5/17/16, indicated the following skin issues: "a. Sacrum, 5.0 cm x 1.0 cm excoriated area with small open area 0.5 cm x 0.5 cm both areas pink and moist. No drng [drainage]. b. Other (specify) ball of left foot. 0.7		*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 provision of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident C is no longer a resident of Aperion Care Peru. **2) How the facility identified other residents:** An audit was conducted on all residents who were identified as having skin concerns for careplans for the prevention of further skin breakdown, as well as careplans to promote the healing and prevent of complications of current skin concerns. **3) Measures put into place/systems changes:**	

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	cm x 0.7 cm hard scabbed area." The treatment listed indicated the following: "Tx [treatment] to sacrum is cleanse area with NS [normal saline], pat dry. Apply Mupirocin [topical ointment to treat skin infections] and cover with dry drsg [dressing]. Change BID [twice daily] and PRN [as needed]." The Skin Assessment indicated a Health Care Plan had been initiated. A Physician's Order, dated 5/18/16, indicated the treatment to the sacrum twice daily with mupirocin ointment. A Skin Condition report, dated 5/26/16, indicated the following skin issues: "15) Right antecubital 7.5x5cm purple bruising with pink/pale skin center above vein-discoloration surrounding perimeter. 16) Left antecubital 1.5x 1 cm light purple." The report indicated Resident C had a blood draw on 5/26/16. No other skin issues were listed. A review of Resident C's Care Plan indicated the following problem areas: a. "Skin tear to R [right] hand...initiated:		A. Aperion Care of Peru has hired a new nurse responsible for the completion of weekly wound assessments, documentation, and careplanning of wounds. B. Licensed nurses of Aperion Care Peru have been re-educated by Aperion Care's Regional Educator on documentation, including skin assessments. C. Additional training for nurse managers to be held for careplanning and weekly wound documentation. D. Weekly audits will be conducted by DON or designee for all identified pressure wounds to ensure weekly assessments completed and careplans developed and updated, as needed, for the prevention of further skin issues, and to promote healing of currently identified pressure areas.	

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	06/06/2016...Interventions: Assess wound(s) weekly... b. Skin Condition: Bruise...initiated: 05/26/2016...Interventions: Measure bruised area upon initial observance and weekly til healed...." No Health Care Plan for pressure wounds was initiated following the Admission Skin Assessment dated 5/17/16. During review of the May Medication Administration Record (MAR), mupirocin ointment 2% was ordered to be applied to the sacrum and was started on 5/19/16. An order for zinc sulfate 220 mg daily was ordered on 5/20/16 for 10 days for wound healing. An order for vitamin C 500 mg twice daily was ordered on 5/19/16 for 10 days for wound healing. An order for an absorbent dressing to right heel was received on 6/3/16. The dressing was to be applied three times daily until fluid-filled blister resolved. During an interview on 7/11/16 at 4:40 p.m., the Director of Nursing (DON) indicated "they are missing some skin		Any concerns identified will be addressed immediately and reported to Administrator and DON/ designee and wound nurse, and noted for further follow up, as merited. The Administrator or designee will be responsible for oversight of these audits **4) How the corrective actions will be monitored:** The results of these audits will be given to the Administrator weekly and reviewed by the Quality Assurance Committee at the monthly Quality Assurance Meeting for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **8/5/2016**	

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	assessments." During an interview on 7/12/16 at 11:30 a.m., the Corporate Nurse indicated the former Assistant Director of Nursing (ADON) did not stage the pressure areas on the initial Admission Skin Assessment dated 5/17/16. No additional information was provided related to the pressure areas. This Federal tag relates to Complaint IN00203595. 3.1-35(a)			
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on interview and record review, the facility failed to ensure a resident received prompt medical attention regarding increased pain for a fracture following a fall for 1 of 3 residents reviewed for falls. This resulted in the resident lying in pain until further evaluated 2 days later. (Resident B) Findings include:	F 0309	**F 309** **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*	08/05/2016

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	The clinical record for Resident B was reviewed on 7/11/16 at 8:45 a.m. Diagnoses for Resident B included, but were not limited to, Alzheimer's disease, pseudobulbar affect, hypertension and hypothyroidism The most recent Annual Minimum Data Set (MDS) assessment, dated 4/18/16, indicated Resident B was severely cognitively impaired. Resident B received the following Activities of Daily Living (ADL) assistance; transfer-extensive assist with 1 person physical assist, dressing, bathing and eating- extensive assist with 1 person physical assist. Resident B had bilateral lower extremities impairment. Review of a Current Care plan, dated 6/29/16, indicated the following: "Focus [name of resident] had a fall characterized by multiple risk factors...Interventions chair alarm...Ensure environment is free of clutter...Trial of self releasing velcro alarming seat belt...." Review of a "Witnessed Fall" investigation, dated 6/28/16 at 4:00 p.m., indicated LPN #1 was notified by staff that Resident B had fallen and upon entering the unit, she noted the resident		*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 provision of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B is no longer a resident of Aperion Care Peru. **2) How the facility identified other residents:** Aperion Care of Peru conducted a review of all residents who had fallen in facility for past 30 days to ensure pain assessments had been completed and if new pain noted, physician notification and follow up completed. **3) Measures put into place/systems changes:** A. An inservice by Aperion Care Regional Clinical Educator has been scheduled for all nursing,	

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	was on the floor, facing up. Resident B was assessed and found to have bilateral lower extremities within normal range of motion. She showed no facial discomfort or voiced any discomfort, according to the investigation. A Pain Screen assessment, done on 6/28/16 at 4:00 p.m., indicated an "After Fall/incident." The assessment included the following: "...B. New pain - 5. Any new pain... F. Frequency of pain - 1. Intermittent/Occasional H. Intensity of pain - 1. Moderate pain I. Observation of pain - 2. Other pain (facial expressions, guarding, moaning, restlessness, rubbing area)." A 72- hour Occurrence Follow-up Charting, dated 6/29/16 at 11:00 a.m., indicated the following: "...E. PAIN ...b. Location/Description of Pain: sl [slight] guarding r [right] leg... ...G. POST-FALL RANGE OF MOTION 1. RANGE OF MOTION: ...New Limitations: 2. Describe Change in ROM: ...sl guarding r leg...."		both licensed and non-licensed nursing staff to address pain and identifying pain in cognitively impaired residents, as well as fall protocol. B. All residents who fall while residing at Aperion Care of Peru shall have a pain assessment completed along with head to toe assessment, upon occurrence. Any concerns identified will be addressed immediately and reported to Administrator and DON/ designee and physician. C. All falls from residents at Aperion Care of Peru will be reviewed the following business day to ensure completion of documentation, including appropriate pain assessment and follow up, as needed, during clinical meeting. Any concerns from these audits will be forwarded to the Administrator, DON/ designee for follow up. Issues with non-compliance with	

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	During an interview on 7/12/16 at 10:39 a.m., Unit Manager #2 indicated she put in the initial x-ray order in the computer for the wrong leg and hip. She then put in the correct order for the right leg and hip on 6/29/16. She indicated the x-ray was not done on 6/28/16 because the resident had vomited. During an interview on 7/12/16 at 3:07 p.m., LPN #1 indicated she told the CNA not to move Resident B after she was back in bed. She indicated when they rolled Resident B onto her side, she got sick (vomited). She indicated she was not able to get back to the locked unit every 15 minutes to complete the neurological assessments so they were not done. During a second interview on 7/12/16 at 3:16 p.m., Unit Manager #2 indicated she was in the building late on 6/28/16 and was assisting with another fall. She indicated a CNA said something about pain, so they [herself and LPN #1] stood Resident B up. Review of the Medication Administration Record (MAR) for June 2016, no pain was documented from 6/28-6/29/16. The MAR also indicated an x-ray to the left leg, hip, knee, tibia and fibula was done 6/28/16 at 9:38 p.m. The order was then		documentation will be addressed on an individual basis by re-education and/or disciplinary action as deemed appropriate. **4) How the corrective actions will be monitored:** The results of these audits will be given to the Administrator weekly and reviewed by the Quality Assurance Committee at the monthly Quality Assurance Meeting for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **8/5/2016**	

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	entered on 6/29/16 for the right leg, hip, knee, tibia and tibia to be x-rayed. The x-ray was charted as done at 6:01 p.m. Resident B received Norco (an opioid pain medication) 10-325 mg three times daily for pain at 8:00 a.m., 12:00 p.m. and 4:00 p.m. The pain medication was unavailable on 6/29/16 at 12:00 p.m. A Progress Note, dated 6/28/16 at 10:58 p.m., indicated "Resident has had emesis x 1 for shift during x-ray which will be done in the am. RT [related to] hip and lower extremity assessed for any bruising or swelling and none was noted...." A Progress Note, dated 6/29/16 at 8:00 a.m., indicated Resident B had a temperature of 100.3 Fahrenheit. An x-ray done in the facility on 6/29/16 at 10:26 am., indicated "suspicious deformity of the basicervical region of the right femoral neck...possible fracture." A Progress Note, dated 6/29/16 at 3:11 p.m., indicated the following: "X-ray results received today and forwarded to medical director. [Name of physician] gives new order to send res to [name of hospital] ER...."			

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	Review of the hospital records began on 7/12/16 at 12:30 p.m. It indicated a computed tomography (CT) scan was done on 6/29/16 at 5:10 p.m. The CT scan indicated an impacted fracture involving the intertrochanteric region. On 7/1/16, Resident B had surgery to repair the fracture. Confidential CNA and Nurse interviews for staff working 6/28-6/29/16 and 7/11-7/12/16 were completed. Exact times and dates withheld to maintain anonymity. Staff #3 indicated when they [staff] laid the resident down, she vomited 2-3 times and at dinner she was putting her hand on her hip. She indicated there was usually only one CNA in the locked unit to care for the residents. Staff #4 indicated when Resident B was weight bearing, she would say "oh, oh oh." Staff #5 indicated she was told to not get Resident B out of bed. When Resident B was being assisted, she would "growl when they moved her. They knew it hurt her." Staff #6 indicated Resident B was in a lot of pain. She had a history of falling. She			

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	indicated nursing staff knew she was in pain, but indicated the nursing staff were overwhelmed. Staff #7 indicated Resident B was in a lot of pain. She indicated the facility could not get nurses to work. When they did, the nurses were overwhelmed and too busy to reorder medication or chart correctly. She indicated management was aware Resident B's hip and/or leg was probably broken, but management was worried about losing money by sending residents out. This Federal tag relates to Complaint IN00204435. 3.1-37(a)			
F 0314 SS=D Bldg. 00	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			

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	developing. Based on interview and record review, the facility failed to identify and prevent the development and progress of multiple pressure ulcers for 1 of 4 residents reviewed. (Resident C) Findings include: The clinical record of Resident C was reviewed on 7/11/16 at 10:40 a.m. Diagnoses for the resident included, but were not limited to, acute kidney failure, bipolar disorder, dysphagia, chronic kidney disease, dementia without behavioral disturbances and difficulty walking. A review of Resident C's Minimum Data Set (MDS) 14-day Review, dated 5/31/16, indicated the resident was moderately cognitively impaired and required extensive assistance and two person physical assistance with bed mobility, transfers and hygiene. Resident C also had bilateral lower limitations. The MDS indicated Resident C was at risk for developing pressure ulcers, but did not currently have any healing pressure ulcers. Resident C was admitted to the facility on 5/17/16. Review of the Admission Skin Assessment, dated 5/17/16, indicated the following skin issues:	F 0314	**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 provision of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident C is no longer a resident of Aperion Care Peru. **2) How the facility identified other residents:** An audit was conducted on all residents who were identified as being at high risk for pressure ulcer development, utilizing the standardized Braden Scale Assessment for careplans to	08/05/2016

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	"a. Sacrum, 5.0 cm x 1.0 cm excoriated area with small open area 0.5 cm x 0.5 cm both areas pink and moist. No drng [drainage]. b. Other (specify) ball of left foot. 0.7 cm x 0.7 cm hard scabbed area." The treatment listed indicated the following: "Tx [treatment] to sacrum is cleanse area with NS [normal saline], pat dry. Apply Mupirocin [topical ointment to treat skin infections] and cover with dry drsg [dressing]. Change BID [twice daily] and PRN [as needed]." The Skin Assessment indicated a Health Care Plan had been initiated. A Physician's Order, dated 5/18/16, indicated the treatment to the sacrum twice daily with mupirocin ointment. A Skin Condition report, dated 5/26/16, indicated the following skin issues: "15) Right antecubital 7.5x5cm purple bruising with pink/pale skin center above vein-discoloration surrounding perimeter. 16) Left antecubital 1.5x 1 cm light purple." The report indicated Resident C had a blood draw on 5/26/16. No other skin		address the promotion of any healing wounds, prevention of infection and prevention of further skin breakdown. **3) Measures put into place/systems changes:** A. Aperion Care of Peru has hired a new nurse responsible for the completion of weekly wound assessments, documentation, and careplanning of wounds. B. Licensed nurses of Aperion Care Peru have been re-educated by Aperion Care's Regional Educator on Documentation, including skin assessments. C. Additional training for nurse managers to be held for careplanning and weekly wound documentation. D. Weekly audits will be conducted by DON or designee for all identified pressure wounds to ensure weekly assessments	

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	155702	A. BUILDING 00 B. WING	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

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	issues were listed. Resident C was discharged to the local hospital on 6/4/16. No skin assessment was completed before discharge. Review of the hospital records began on 7/12/16 at 12:30 p.m. It indicated a nursing assessment dated 6/4/16 at 2:31 p.m. The assessment indicated the following skin wounds: a. Wound #1-coccyx-redness and non-blanchable b. Wound #2-right hip-abrasion with no drainage c. Wound #3-left great toe-scabbed and crusted with serosanguineous drainage d. Wound #4-left heel-redness, open with serosanguineous drainage e. Wound #5-right heel-redness and non-blanchable No measurements were listed on the hospital flowsheet. A hospital order, dated 6/4/16 at 4:08 p.m., indicated to apply Bacitracin ointment to the left toe. A hospital flowsheet dated 6/5/16 indicated the following: "has several heel sores on bilateral feet...three bed sores 2 on heel...one on		completed and careplans developed and updated, as needed, for the prevention of further skin issues, and to promote healing of currently identified pressure areas. Any concerns identified will be addressed immediately and reported to Administrator and DON/ designee and wound nurse, and noted for further follow up, as merited. The Administrator or designee will be responsible for oversight of these audits **4) How the corrective actions will be monitored:** The results of these audits will be given to the Administrator weekly and reviewed by the Quality Assurance Committee at the monthly Quality Assurance Meeting for 6 months or until 100% compliance is achieved x3 consecutive months.	

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	sacrum...facial grimacing with rolling in bed due to bed sore...bed sores with altered mental and unstable vitals...." An unrelated procedure done on 6/8/16, also included a 3 cm excision of eschar tissue on the right heel. A facility progress note, dated 6/9/16 at 1:03 p.m., indicated "Dr [name of physician] debrided res [resident] heels...." A facility Re-admission Observation Assessment, dated 6/11/16 at 12:05 p.m., indicated the following skin issues: "49) Right heel pressure area to heel 6 cm x 6 cm, old blister area 50) Left heel pressure area 4 cm x 1 cm dark and dry 52) Left toe(s) pressure area to tip, 1 cm [sic] 0.5 dark and dry 53) Sacrum pressure area 4 cm x 5 cm pink dry A review of Resident C's MDS Discharge Assessment, dated 6/13/16, indicated Resident C was admitted with 4 unstageable pressure ulcers. A review of Resident C's Care Plan indicated the following problem areas:		**5) Date of compliance:** **8/5/2016**	

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	a. "Skin tear to R [right] hand...initiated: 06/06/2016...Interventions: Assess wound(s) weekly... b. Skin Condition: Bruise...initiated: 05/26/2016...Interventions: Measure bruised area upon initial observance and weekly til healed...." No Health Care Plan for pressure wounds was initiated following the Admission Skin Assessment dated 5/17/16. During review of the May Medication Administration Record (MAR), mupirocin ointment 2% was ordered to be applied to the sacrum and was started on 5/19/16. An order for zinc sulfate 220 mg daily was ordered on 5/20/16 for 10 days for wound healing. An order for vitamin C 500 mg twice daily was ordered on 5/19/16 for 10 days for wound healing. An order for an absorbent dressing to right heel was received on 6/3/16. The dressing was to be applied three times daily until fluid-filled blister resolved. Following readmission on 6/11/16, an order for Granulex Aerosol solution			

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	[topical aerosol which stimulates the vascular bed] to be applied to heels, toes and coccyx twice daily. The order was received on 6/12/16. During an interview on 7/11/16 at 4:40 p.m., the Director of Nursing (DON) indicated "they are missing some skin assessments." During an interview on 7/12/16 at 11:30 a.m., the Corporate Nurse indicated the former Assistant Director of Nursing (ADON) did not stage the pressure areas on the initial Admission Skin Assessment dated 5/17/16. No additional information was provided related to the pressure areas. Resident C's initial admission weight on 5/18/16 was 149.6 lbs. On 5/23/16, her weight was 141.6. On 6/2/16, Resident C's weight was 132.4 lbs. Resident C had over an 11% weight loss during her admission. An order for Remeron (appetite stimulant) 7.5 mg was received on 5/24/16. On 5/30/16, health shakes were added to be given with meals. During an interview on 7/12/16 at 2:53 p.m., Dietary Manager #8 indicated the nursing staff did not contact her related to Resident B's weight loss. She indicated the dietician had been in a couple weeks ago and informed her of a few residents who had weight loss or weight gain. She indicated she did put those residents into			

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	her computer. Review of a current, undated facility policy, titled "Wound Care Skin Inspection and Care Table" was provided by the Corporate Nurse on 7/12/16 at 3:15 p.m., indicated the following: "Documentation of weekly head to toe skin assessment by licensed nurse in the resident's chart or on a facility approved form...Staff should change the resident's position approximately every two hours...Completely offload heels while in bed...apply heel protectors...minimize skin exposure to moisture due to wound drainage...Notify Dietician of residents being identified as (Moderate, High, or Severe Risk)...Nutritional assessment to be performed and documented within 24 hours for residents with multiple Stage II, and any Stage III or IV...." This Federal tag relates to Complaint IN00203595. 3.1-40(a)(1) 3.1-40(a)(2)			