| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155702 | A. BUILDING 00<br>B. WING | 07/29/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| APERION CARE PERU | 1850 WEST MATADOR ST<br>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 |
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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00176314, Complaint IN00177350, Complaint IN00177657, Complaint IN00178351, and Complaint IN00178525.<br><br>Complaint IN00176314 - Substantiated. No deficiency related to the allegation is cited.<br>Complaint IN00177350 - Substantiated. No deficiencies related to the allegations are cited.<br>Complaint IN00177657 - Substantiated. No deficiencies related to the allegations are cited.<br>Complaint IN00178351 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309 and F314.<br>Complaint IN00178525 - Substantiated. No deficiency related to the allegation is cited.<br><br>Unrelated deficiencies are cited at F323.<br><br>Survey dates: July 27-29, 2015<br><br>Facility number: 003130<br>Provider number: 155702<br>AIM number: 200386750 | F 0000 | Preparation, submission and 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. Rather, this Plan of Correction is prepared, submitted and executed in compliance with State and Federal Regulations. | |

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

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| | Census bed type:<br>SNF/NF: 54<br>Total: 54<br><br>Census payor type:<br>Medicare: 10<br>Medicaid: 37<br>Other: 7<br>Total: 54<br><br>Sample: 6<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. | | | |
| F 0309<br>SS=D<br>Bldg. 00 | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>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.<br>Based on observation, record review and interviews, the facility failed to accurately assess and identify an injury resulting in an open area on the (R) (Right) 2nd toe for 1 of 4 residents reviewed for skin areas in a sample of 6. (Resident "C") | F 0309 | **F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**<br><br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: | 08/21/2015 |

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| | Finding includes:<br><br>The record of Resident "C" was reviewed on 07/27/15 at 10:20 a.m. Resident "C" was admitted to the facility on 06/25/15 with diagnoses including, but not limited to, MS (Multiple Sclerosis), neurogenic bladder, HTN (hypertension), chronic pain, and obesity. Review of the most recent Annual MDS (Minimum Data Set: an assessment tool), dated 05/01/15, indicated Resident "C" was cognitively intact, required extensive assistance of 2 or more for toileting, bed mobility (moving to and from lying position, turning side to side, and positions body while in bed), was always incontinent of bladder and frequently incontinent of bowel.<br><br>Resident "C" was interviewed on 07/27/15 at 9:55 a.m. Resident "C" indicated staff checks and changes her as able but due to minimal feeling from the waist down.<br><br>"WEEKLY SKIN OBSERVATION" forms, from 05/2015 to 07/22/15 were reviewed. The form, dated 07/01/15, indicated:<br>"FOOT PROBLEMS/CARE:...Open lesion(s). Are any of these foot concerns new? No. "The area noting:<br>"Location/description of any open | | a. Treatment of injury to "Resident C"s Left 2ndtoe continues per Physician's order. Area is being assessed weekly by Wound Nurse/ Wound Physician.<br><br>2. How are other residents having the potential to be affected by the same deficient practice being identified, and what corrective action(s) will be taken:<br><br>a. All residents residing in facility have the potential to be affected.<br><br>b. Complete skin assessment will be performed on each resident, to ensure that no wound or area of injury exists that has not previously been reported and treated.<br><br>c. Any new areas of skin concern will handled per facility policy, | |

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| | lesions/blister/calluses on foot(s)" was blank.<br>The other weekly forms did not note any open lesions on the foot/feet and were noted to be checked, "No Concerns".<br><br>Review of the "WEEKLY SKIN OBSERVATIONS", dated 07/15/15, indicated:<br>"FOOT PROBLEMS/CARE:...Open lesion(s). Are any of these foot concerns new? Yes." The area noting: "Location/description of any open lesions/blister/calluses on foot(s)" indicated: "wound care notified and assessing for treatment to be ordered." The form indicated the physician was notified and orders were received.<br><br>The SKIN-PRESSURE/DIABETIC/STASIS/ ARTERIAL WOUND REPORT", dated 07/15/15, indicated:<br>"New wound...MEASUREMENT/TYPE/STAGE:...Units of measure: centimeters:...Site: Left [sic: right toe] Type: Pressure; Length 1.5; Width: 1.5; Depth: 0.2; Stage: Suspected Deep Tissue Injury."<br><br>The open area of the affected toe was observed, accompanied by the wound nurse, on 07/28/15 at 10:10 a.m. The wound nurse indicated the wound | | including Assessment, Notifications, Investigation, Treatment, Interventions and Documentation.<br><br>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br><br>a. All Nursing Staff will receive additional education regarding Skin Assessment and Aperion Policy and Procedure relating to the Identification of new skin issues, including investigation, notifications, treatment, interventions and documentation. This education will be performed by the Director of Nursing, or her designee.<br><br>b. All new skin issues will be reviewed daily, Monday through Friday, by Interdisciplinary Team. "Daily Wound Documentation", and either the "Skin-Other Condition Report" or the "Skin-Pressure/Diabetic/Stasis/Arterial Wound Report" will be reviewed in Electronic Medical Record (Point Click Care). "Alert Listing Report" (Point Click Care) will also be reviewed for any new skin concerns. This review will be coordinated and documented by the Director of | |

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| | physician had examined and debrided the toe on 07/29/15. The open area was noted to be approximately 0.6 cm (centimeter) in length by 1.5 cm in width with healthy pink tissue viewed and light serous (clear-pink) drainage noted.<br><br>The wound nurse indicated, during the 07/27/15 physician's visit, the physician had engaged the resident in conversation and indicated the area was not due to pressure but from an injury. The wound nurse indicated Resident "C" told the physician the injury occurred while she was being transferred from the bed to the wheelchair, when her right foot caught and bent back against the foot pedal. The wound nurse indicated the area, when discovered on 07/01/15 had not been reported to her. In addition the wound nurse indicated, when notified of the area on 07/15/15, the area was not investigated as an accident as it was thought to be pressure until the physician/resident conversation the previous day.<br><br>On 07/29/15, at 12:45 p.m., the DNS (Director of Nursing Services) provided a copy of the current facility Policy & Procedure, "Skin Condition and Pressure Ulcer Assessment: 06/2012", which indicated: | | Nursing, or her designee.<br><br>c. With all newly identified wounds /injuries, the Wound Nurse or Wound Physician will complete an assessment of area at first availability to ensure that initial assessment is accurate and treatment is appropriate. This review will be coordinated and documented by the Director of Nursing, or her designee<br><br>4. How will the corrective actions be monitored to ensure the deficient practice will no recur, i.e, what Quality Assurance Program will be put into place:<br><br>a. In order to monitor that all injuries of unknown origin are properly assessed and treated, "INJURY OF UNKNOWN ORIGIN" QAPI Tool (Attachment B) will be utilized monthly for a period of 6 months with results of the review reported to QAPI monthly during that time period. Review will continue past that point as directed by QAPI Team, based on results of | |

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| | "Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and pressure ulcers and assuring interventions are implemented....<br><br>Frequency: Pressure ulcers and/or skin problems will be assessed and measured at least every seven (7) days by a licensed nurse and documented....<br><br>Standards:<br>1. All residents known or not known to have skin problems, will have a body check/assessment by a licensed nurse at least weekly....<br><br>4. Skin observations are made daily, during the performance of bathing and dressing residents and administering treatment procedures.<br><br>5. Each resident will be observed for skin breakdown or problems on their scheduled shower/bath days by the CNAs. Changes are to be promptly reported to a licensed nurse who will then perform a complete assessment, as appropriate...."<br><br>This Federal tag relates to Complaint IN00178351.<br><br>3.1-37(a) | | the audits.<br><br>b. Director of Nursing, or her designee, will report on the Review of all New Skin Issues (As outlined in 3b of this Plan of Correction) to the QAPI team. This report will include information regarding any new skin issue that was not properly identified, assessed, or treated. This will occur monthly for a period of 6 months, and continue past that point as directed by the QAPI Team, based on results of the review.<br><br>5. By what date will the systemic changes be completed:<br><br>August 21, 2015 | |

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| F 0314<br>SS=G<br>Bldg. 00 | 483.25(c)<br>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br>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.<br><br>Based on observation, record review and interviews, the facility failed to provide pressure reducing interventions for a dependent resident which resulted in 2 stage III (full thickness tissue loss) pressure areas for 1 of 4 residents reviewed for skin issues in a sample of 6. (Resident "C")<br><br>Finding includes:<br><br>The record of Resident "C" was reviewed on 07/27/15 at 10:20 a.m. Resident "C" was admitted to the facility on 06/25/14 with diagnoses including, but not limited to, MS (Multiple Sclerosis), neurogenic bladder, HTN (hypertension), chronic pain, and obesity. The most recent Annual MDS (Minimum Data Set) | F 0314 | **Please note:** We are respectfully requesting Informal Dispute Resolution for the following alleged deficiencies, and for the following reasons:<br><br>**F282 and F314:** It is alleged in Statement of Deficiencies that, prior to Resident C acquiring the pressure areas, she was not on the mattress that had been deemed appropriate in her individualized plan of care. We refute these allegations based on the fact that, prior to the discovery and assessment of the pressure areas, she was on the mattress that had been care-planned for her: A pressure reducing mattress.<br><br>**F314 TREATMENT/SERVICES TO** | 08/21/2015 |

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| | assessment, dated 05/01/15, indicated Resident "C" was cognitively intact, required extensive assistance of 2 or more for toileting, bed mobility (moving to and from lying position, turning side to side, and positions body while in bed), was always incontinent of bladder and frequently incontinent of bowel.<br><br>A Care Plan, initiated 06/25/14 and revised 11/14/14, indicated:<br>"Focus: Potential for pressure ulcers related clinical complicating factors, MS HTN [hypertension], weakness, ...obesity, history of pressure ulcers...Goal: Will not develop new open areas related to pressure...Interventions/Tasks:...Pressure reducing mattress, Turn and reposition every two hours..."<br><br>The "WEEKLY SKIN OBSERVATIONS" for Resident "C" indicated:<br>"07/01/15..SKIN PROBLEMS...SKIN INTACT- NO CONCERNS."<br>"07/15/15..SKIN PROBLEMS...2. Are any of the areas observed NEW?...YES."<br><br>The "SKIN-PRESSURE/DIABETIC/STASIS /ARTERIAL WOUND REPORT," dated 07/15/15, indicated:<br>"...New Wound Development...SKIN | | **PREVENT/HEAL PRESSURE SORES**<br>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>a. On 7-28-15, a specialty air mattress was placed on "Resident C"s bed.<br><br>2. How are other residents having the potential to be affected by the same deficient practice being identified, and what corrective action(s) will be taken:<br><br>a. All residents in facility whose Plan of Care calls for a Specialty Mattress or Pressure Reduction Device have the potential to be affected.<br><br>b. A review of Care plans for all residents with Pressure Wounds or who's Plan of Care includes a Specialty Mattress or Pressure Reduction Mattress will be completed and a visual inspection will be completed to ensure that all such interventions are in place. This review will be completed by the Director of Nursing or her designee.<br><br>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br><br>a. All new Pressure Reduction | |

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| | PROBLEMS...open area to posterior thighs...<br>MEASUREMENT/TYPE/STAGE...Site: Right thigh (rear) Type: Pressure Unit of measure: centimeters: Length 3.0 Width 15 Depth 0.2 Stage: III<br>Left thigh (rear) Type: Pressure Unit of measure:... Length 0.7 Width 4.0 Depth 0.2 Stage: III..."<br>The form indicated the wounds were required in house. The physician was notified and orders were received.<br><br>The measurements from the 07/27/15 visit, when the resident was seen by the wound physician, indicated the area measurements as:<br>The measurements from the 07/27/15 visit, when the resident was seen by the wound physician, indicated the area measurements as:<br>"Right thigh (rear) Type: Pressure; Unit of measure: centimeters: Length 2.0 Width 2.5, Depth 0.2 Stage: III<br>Left thigh (rear) Type: Pressure Unit of measure:...Length 0.6 Width 6.0 Depth 0.2 Stage: III."<br><br>Resident "C" was interviewed on 07/27/15 at 9:55 a.m. Resident "C" indicated staff checks and changes her as able but due to minimal feeling from the waist down, she is not always aware | | interventions will be reviewed daily, Monday through Friday, by Interdisciplinary Team, with a visual inspection at that time to ensure that intervention was put in place, in accordance with Plan of Care. The "Plan of Correction Audit Tool" will be used to document this audit. (See Attachment D) This review will be coordinated and documented by the Director of Nursing, or her designee.<br><br>b. All Nursing Staff will receive additional education regarding Pressure Ulcer Prevention, including use of Pressure Reduction Devices, where they are stored in our facility, and how to properly place / use them. This education will be performed by the Director of Nursing, or her designee.<br><br>4. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e, what Quality Assurance Program will be put into place:<br><br>a. RESSURE ULCER QAPI TOOL (see attachment A) will be utilized for any resident with a Pressure Wound, to ensure that all interventions were put in place per Plan of Care. This will be completed by the Interdisciplinary Team with any new Facility-Acquired or Present upon- Admission Pressure | |

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| | when she has been incontinent to call for assistance. Resident "C" was observed lying in bed on a regular mattress.<br><br>The skin areas were observed on 07/28/15 at 10:10 a.m., while accompanied by the wound nurse. The open areas were noted to be ruddy (rosy red) granulating (filling in with normal skin tissue), oblong in shape and to have a small amount of serous (clear to pink) drainage. The wound nurse was queried regarding Resident "C" being on a regular mattress. The nurse indicated the resident was supposed to be on a specialty mattress. The wound nurse indicated the staff nurse does weekly skin assessments. If an area was noted, the staff nurse is to notify the wound nurse who in turn notifies the physician and obtains treatment orders if indicated. The wound nurse indicated the staff nurse's weekly skin assessments are to address any new skin issues and do not include any previous identified skin areas already being monitored.<br><br>On 07/29/15, at 12:45 p.m., the DNS (Director of Nursing Services) provided a copy of the current facility Policy & Procedure, "Skin Condition and Pressure Ulcer Assessment: 06/2012," which indicated: | | Wound for a period of 6 months, with results of the review to be reported to QAPI Team monthly for 6 months.<br><br>b. After the initial 6 month review period, the PRESSURE ULCER QAPI TOOL (see Attachment A) will be used according to instructions on tool, every other month, with results reported to QAPI team. If threshold of 100% is not met, an Action Plan will be created and monitored by QAPI team until such time that QAPI team is satisfied with results of audit.<br><br>5. By what date will the systemic changes be completed:<br>August 21, 2015 | |

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| | "Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and pressure ulcers and assuring interventions are implemented....<br><br>Frequency: Pressure ulcers and/or skin problems will be assessed and measured at least every seven (7) days by a licensed nurse and documented....<br><br>Standards:<br>1. All residents known or not known to have skin problems, will have a body check/assessment by a licensed nurse at least weekly....<br><br>4. Skin observations are made daily, during the performance of bathing and dressing residents and administering treatment procedures.<br><br>5. Each resident will be observed for skin breakdown or problems on their scheduled shower/bath days by the CNAs. Changes are to be promptly reported to a licensed nurse who will then perform a complete assessment, as appropriate...."<br><br>This Federal tag relates to Complaint IN00178351.<br><br>3.1-40(a)(1) | | | |

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| | 3.1-40(a)(2) | | | |
| F 0323<br>SS=D<br>Bldg. 00 | 483.25(h)<br>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interviews, the facility failed to provide assistance of 2 or more while turning a resident, resulting in the resident rolling out of bed and onto the floor. This finding effected 1 of 4 residents in a sample of 6 reviewed for falls or injuries. (Resident "C")<br><br>Finding includes: | F 0323 | **F323:** It is alleged in the Statement of Deficiency that the facility failed to provide assistance of 2 or more while turning a resident, resulting in the resident rolling out of bed and onto the floor. While it is true that the resident did roll from bed during repositioning, she only required extensive assist at times, and it was not a part of her individualized plan of care to utilize 2 caregivers for bed | 08/21/2015 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155702 | A. BUILDING 00<br>B. WING | 07/29/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APERION CARE PERU | 1850 WEST MATADOR ST<br>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 |
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| | The record of Resident "C" was reviewed on 07/27/15 at 10:20 a.m. Resident "C" was admitted to the facility, on 06/25/14, with diagnoses including, but not limited to, MS (Multiple Sclerosis), neurogenic bladder, HTN (hypertension), chronic pain, and obesity. The most recent Annual MDS (Minimum Data Set) assessment, dated 05/01/15, indicated Resident "C" was cognitively intact, required extensive assistance of 2 or more for toileting, bed mobility (moving to and from lying position, turning side to side, and positions body while in bed), was always incontinent of bladder and frequently incontinent of bowel.<br><br>Resident "C" was observed during wound care on 07/28/15 at 10:10 a.m. The resident was positioned in the middle of the bed and on direction from the wound nurse, turned onto her right side and held onto the enabler bar (a short bar approximately 18 inches in length) to turn, resulting in the resident being on the right edge of the bed. The resident stated, "I don't want to fall." The wound nurse assisted the resident to roll back and called for a CNA to assist to reposition and realign Resident "C." The resident was then turned again to her right side, holding onto the enabler bar, and was noted to be approximately 6 inches from | | mobility, as she is able to assist with the use of enabler bars.<br><br>**F323 FREE OF ACCIDENT/HAZARDS/SUPERVISION /DEVICES**<br><br>1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br><br>a. Resident is being assisted with bed mobility per Plan of Care.<br><br>2 How are other residents having the potential to be affected by the same deficient practice being identified, and what corrective action(s) will be taken:<br><br>a. All residents requiring the assistance of 2 caregivers have the potential to be affected.<br><br>b. Review of Resident Care plans and MDS will be performed to identify which residents require the assistance of 2 caregivers for bed mobility.<br><br>c. For all residents identified as requiring the assistance of 2 caregivers for bed mobility, the following audit will be performed. This audit will confirm that:<br><br>1. The resident's level of required assistance for bed | |

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| | the right edge of the bed.<br><br>Resident "C's" record indicated a fall incurred on 05/22/15 at 8:00 p.m. The fall investigation indicated: "Resident was rolled for care during cleaning and rolled off the bed onto the floor to knees." The report indicated the fall was witnessed by the CNA providing care. The report indicated the resident landed on her knees and did not show signs of injury.<br><br>The DNS (Director Nursing Services) was interviewed on 07/29/15 at 11:30 a.m. The DNS indicated the resident was being provided care by 1 CNA when the fall occurred. The CNA is no longer employed at the facility. The DNS indicated the facility does not utilize half rails and only uses enabler bars.<br><br>The wound nurse was interviewed on 07/29/15 at 12:30 p.m. and indicated the resident could roll to her right side and did not require additional assistance to turn. The MDS Coordinator was interviewed on 07/29/15 at 12:35 p.m. and indicated the resident's most current MDS assessment, dated 05/01/15, was correct and the resident requires extensive assistance of 2 or more to reposition and turn in bed. | | mobility is documented in the Plan of Care.<br><br>2. The resident's Kardex, which communicates this information to the Certified Nurse's Aides, is updated to reflect the needed level of assistance for bed mobility.<br><br>3. If any resident identified as requiring the assistance of 2 caregivers does NOT have the needed intervention listed in the resident's Plan of Care or on the Resident's Kardex, it will be immediately added as appropriate.<br><br>d. The "Plan of Correction Audit Tool" will be used for this audit. (See Attachment D)<br><br>3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br><br>a. All Nursing Staff will be provided additional education regarding bed mobility, Resident Kardex accessibility, and adherence to individualized Plans of Care. This education will be provided by the Director of Nursing, or her designee.<br><br>b. Members of Nursing Team responsible for editing Plans of Care and the Kardex will be | |

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| | A care plan, initiated 06/25/14, indicated: "FOCUS: Potential for falls...Interventions: 0708/14 Half rails to assist with transfers...." The care plan did not address assistance for turning in accordance with the MDS.<br><br>3.1-45(a)(2) | | provided additional education regarding editing of the Kardex and Careplan to reflect current levels of required assistance.<br><br>4 How will the corrective actions be monitored to ensure the deficient practice will no recur, i.e, what Quality Assurance Program will be put into place:<br><br>a. FALL RISK MANAGEMENT QAPI Tool (See Attachment C) will be utilized for any fall involving a resident that requires the assistance of 2 caregivers for bed mobility to ensure that care was being provided in a manner consistent with the resident's plan of care and individualized interventions. This will continue for a period of 6 months with results of the audit reported to QAPI monthly during that time.<br><br>b. After the initial 6 month review period, the FALL RISK MANAGEMENT QAPI TOOL (see Attachment C) will be used according to instructions on tool, every other month, with results reported to QAPI team. If threshold of 95% is not met, an Action Plan will be created and monitored by QAPI team until such time that QAPI team is satisfied with results of audit.<br><br>5 By what date will the systemic changes be completed: | |

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| | | | August 21, 2015 | |