STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00368179 and IN00370095 Complaint IN00368179 - Unsubstantiated due to lack of evidence. Complaint IN00370095 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: January 7 and 10, 2022 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census bed type: SNF/NF: 58 Total: 58 Census payor type: Medicare: 13 Medicaid: 28 Other: 17 Total: 58 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 19, 2022.	F 0000	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. The facility respectfully requests a desk review.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility lacked non-pressure skin condition assessments to determine the progress of diabetic ulcers during a resident's admission for 1 of 1 resident reviewed for assessment of non-pressure wounds (Resident B). Finding includes: A document, titled "Intake Information," dated 12/30/21, indicated an anonymous person voiced a concern regarding the manner the facility was providing care to Resident B's wounds. The anonymous person indicated the left foot wound was expected to worsen. Resident B's record was reviewed on 1/10/22 at 3:30 p.m. Diagnoses included, but were not limited to, persistent vegetative state, metabolic Encephalopathy, chronic kidney disease stage 3, type 2 diabetes mellitus, encounter for palliative care, personal history of diabetic foot ulcer and combined systolic (congestive) and diastolic heart failure. The resident's census history of admissions, readmissions and discharges were reviewed, which indicated he was in and out of the facility on the following dates: On 12/2/21 at 5:45 p.m., Admitted to the facility. On 12/3/21 at 1:51 p.m., Admitted to the hospital. On 12/6/21 at 6:37 p.m., Readmitted back to the facility.	F 0684	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident B no longer resides at the facility**. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Residents with wounds have the potential to be affected by this alleged deficient practice. All residents with wounds charts were audited to ensure accurate and timely assessments were **completed. Any needed assessments were completed.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **Licensed nurses have been re-educated relative to Quality of Care, including but not limited to, skin condition assessments and accurate completion of documentation**	02/04/2022

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	On 12/7/21 at 2:04 p.m., Admitted to the hospital. On 12/9/21 at 7:38 p.m., Readmitted back to the facility. On 12/15/21 at 8:40 p.m., Admitted to the hospital. A facility admission observation note, dated 12/2/21, indicated the resident had a diabetic ulcer on his left heel. A Physician progress note, dated 12/3/21 at 9:45 a.m., indicated the resident had a wound to his left foot and he was a hospice candidate, but the family did not want to pursue a hospice referral. A hospital "Inpatient consult to Wound Care" note, dated 12/8/21 at 3:35 p.m., indicated Resident B had bilateral feet wounds. He continued to have a "gangrenous-appearing" left dorsal foot with dried black eschar (thick, leathery necrotic or dead tissue, which was frequently black or brown in color and crusty.) A facility progress note, dated 12/9/21 at 5:45 p.m., indicated there was an open lesion (two of them) to the right foot and the left foot had cracking skin with an indentation from the cracked skin, which was not new. A dressing was intact and dry to his feet. A hospital 72 hour admission/readmission document, with an effective date 12/10/21 at 8:15 a.m., indicated Resident B had wound and skin concerns present with no changes in his skin integrity. He had fluctuance (a gas-forming infection present usually due to an anaerobic microorganism or one of the aerobic coliforms) with eschar at the proximal aspect (nearer the center of the foot) and periwound area. There was a significantly less malodorous (foul smelling) odor than previous assessments completed on		**relative to skin assessments.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON, or designee, will review the documentation relative to skin condition assessments of all residents with wounds weekly x 4 weeks and then monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	previous hospitalizations in the previous month, but the odor was still present. Healing of the left foot was not realistic, so Betadine soaks twice daily to keep the wound dry and intact would be recommended. The wound assessment for the bilateral feet wounds were as follows: Right Medial Ankle: Venous Wound Yellow wound bed Measurements: 2 cm (centimeters) x 2 cm x 0.1 cm Periwound was normal The wound edges were not approximated Right Lateral Foot: Venous Wound Wound bed was dry Measurements: 1 cm x 1 cm x 0.2 cm Periwound was normal The wound edges were not approximated Left Anterior Foot: Other Wound Type Wound bed was Black Measurements: 17 cm x 8 cm Periwound was fluctuance The wound edges were not approximated A facility 72 hour admission/readmission document, with an effective date of 12/11/21 at 12:15 p.m., indicated the resident had wounds and skin concerns present with no changes in his skin integrity. He did not require dressing changes. A facility "Weekly Skin Observations" document, signed by RN 2 on 12/13/21, with an effective date of 12/9/21 at 5:45 p.m., indicated the resident had two wounds on his right foot and the top of his left foot had cracking skin with an indentation from the cracked skin. This observation lacked wound measurements or an assessment of the			

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	wound beds. A hospital "Infectious Disease Initial Consultation Note," dated 12/21/21 at 4:44 p.m., indicated the reason for the consult was antibiotic recommendations for a diabetic left foot infection with gangrene with suspected underlying osteomyelitis, recent ESBL (Extended Spectrum Beta-Lactamase) (an enzyme found in some bacteria's, which could not be killed by many of the antibiotics used to treat infections, therefore it made it harder to treat) Klebsiella bacteremia/sepsis (a very serious infection which could be life threatening). He was admitted on 12/15/21, with acute respiratory failure concerning aspiration, pneumonia and sepsis. Resident B underwent an Incision and Drainage of an abscess with gangrene of his left foot on 11/19/21. He was evaluated by ortho during his last admission and was considered not a candidate for an amputation of his left foot due to poor cardiac health and other severe comorbidities. His left foot ulcer probed to the bone. The Physician was unable to palpate any pulses. His foot was examined on 12/21/21, the left foot dorsum had a large necrotic, gangrenous wound with foul odor with two lateral ulcerations. The distal one was probed to the bone. The proximal ulcer was a stage 4 and did not probe to the bone. The right foot had multiple superficial ulcerations. His foot was nonhealing going on three months and it was likely not to heal despite the continued antibiotic therapy. Due to his poor health, recurrent strokes and his other concurrent multiple medical problems, his prognosis was very poor regarding saving his left foot and there was a high risk of progression of the infection into the left leg. The Physician agreed with the ethics discussions with the family to make a decision for the resident to be placed on hospice. During his admission on			

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	11/19/21, he had an Incision and Drainage of a nonhealing necrotic wound smelling left dorsum wound. The facilities Admission/Readmission notes and weekly skin observations were reviewed for assessments of the wound beds and measurements of the resident's wounds, however these documents lacked the assessments and measurements. The "Progress Notes" during the resident's admission until discharge were reviewed for assessment of his bilateral feet wounds, but these notes lacked completed wound assessments to indicate he had received assessments of his wounds on his feet. During an interview, on 1/10/22 at 5:25 p.m., the Director of Nursing (DON) and RN 3 were in attendance. The DON indicated there were no further wound assessments or wound measurements available for Resident B. He did not see a wound care Physician during his admission. RN 3 indicated the resident was in and out of the facility being sent to the hospital with brief stays in the facility. During an interview, on 1/10/22 at 5:46 p.m., RN 1 indicated she admitted Resident B to the facility on 12/2/21. She assessed his wounds and he only had an ulcer to one of his heels. She did not measure the wound, but she did ask the next shift to measure the wound and she thought the nurse had measured it. She should have measured it herself. A current facility policy, titled "Pressure Injury and Skin Condition Assessment," dated 1/17/18 and provided by the DON on 1/10/22 at 5:46 p.m.,			

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	indicated "Purpose...Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse, and documented in the resident's clinical record...." This Federal tag relates to Complaint IN00370095. 3.1-37(a)			