DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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	04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 IN00375458 and IN00376056 Complaint IN00375458 - Unsubstantiated due to lack of evidence. Complaint IN00376056 - Unsubstantiated due to lack of evidence. Unrelated deficiencies are cited at F689. Survey date: April 5, 2022 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census bed type: SNF/NF: 57 Total: 57 Census payor type: Medicare: 8 Medicaid: 35 Other: 14 Total: 57 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 13, 2022.	F 0000		
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

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 determined that other safegaurds 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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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident's plan of care was followed while ADL (Activities of Daily Living) care was being provided for 1 of 1 resident being reviewed for accidents. (Resident C) Resident C sustained a laceration, the size of a pea, on the left side of her forehead just above a raised knot approximately the size of a quarter and an acute displaced oblique fracture of the right fifth finger (a broken right fifth finger). Finding includes: A document, titled "Facility Reported Incident," dated 4/1/22, indicated on 4/1/22 at 1:01 p.m., CNA 1 was providing personal hygiene care for Resident C when the resident slid from the bed and was unable to stop herself and CNA 1 was unable to completely stop the resident. CNA 1 was able to lower the resident to the floor. The resident had a right hand X-ray completed, which indicated she had an acute fracture of the fifth metacarpal. The record for Resident C was reviewed on 4/5/22 at 3:00 p.m. Diagnoses included, but were not limited to, Multiple Sclerosis, tremor, seizures, idiopathic peripheral autonomic neuropathy and restless leg syndrome. A Quarterly MDS (Minimum Data Set) assessment, dated 2/21/22, indicated the	F 0689	**F689** *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.* **1) Immediate actions taken for those residents identified: Resident C was assessed with physician notification of findings. Resident C has a follow up appointment with an orthopedic physician.** **2) How the facility identified other residents: All residents who are a two person assist with mobility have the potential**	04/26/2022

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	resident's functional status for ADL's were scored as follows: - Bed Mobility (how the resident moved to and from a lying position, turned side to side and positioned her body while in bed or an alternative piece of sleep furniture) Self Performance=4 (Total Dependence, full staff performance every time during the entire seven day period) Support=3 (two person physical assist) - Toilet Use (how resident used the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages bosomy or catheter; and adjusts clothes. Did not include emptying of bedpan, urinal, bedside commode, catheter bag or bosomy bag) Self Performance=4 Support=3 - Functional Limitation in Range of Motion: Upper Extremity (shoulder, elbow, wrist and hand)=2 (Impairment on both sides) Lower Extremity (hip, knee, ankle and foot)=2 An EMAR (Electronic Medication Administration Record), dated April 2022, indicated an order was written on 4/1/22 to indicate Care in Pairs every day and night shift scheduled for 12:00 a.m., and 12:00 p.m., and had been signed off in the documentation box for each date and time from 4/1/22 to 4/5/22 to indicate Care in Pairs was being completed from 4/1/22 to 4/5/22. A document, titled "Response History," dated 4/5/22, indicated the following dates and times Resident C was provided the ADL bed mobility with only one staff member's assistance for the time period of 3/23/22 through 4/5/22: On 3/23/22 at 2:54 a.m., and 10:32 p.m. On 3/24/22 at 9:30 a.m. On 3/25/22 at 12:15 a.m., and 8:04 p.m. On 3/26/22 at 7:28 a.m., 8:04 p.m., and 10:46		**to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes: Nursing staff was re-educated relative to Free of Accident Hazards/Supervision/Devices, including but not limited to, accident prevention and provision of ADLs with appropriate number of staff members.** **4) How the corrective actions will be monitored: DON, or designee, will select two residents to ensure ADL care is being provided per the plan of care three times a week X 4 weeks, then twice a week X 4 weeks.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: April**	

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	p.m. On 3/27/22 at 6:40 p.m., and 11:23 p.m. On 3/28/22 at 7:13 a.m. On 3/29/22 at 2:02 a.m., and 4:30 p.m. On 3/30/22 at 3:27 a.m., 8:59 a.m., 3:50 p.m., and 11:05 p.m. On 3/31/22 at 9:35 a.m. On 4/1/22 at 1:39 a.m., 6:53 a.m., 2:55 p.m., and 11:21 p.m. On 4/2/22 at 3:24 p.m. On 4/3/22 at 9:59 p.m., and 11:40 p.m. On 4/4/22 at 6:43 a.m. On 4/5/22 at 5:10 a.m., and 6:55 a.m. The resident had a care plan, which indicated she had a problem with ADL self-care performance deficit, initiated on 8/7/20 and revised on 12/1/21, related to Multiple Sclerosis, COPD (Chronic Obstructive Pulmonary Disease), seizure disorder, tremors, chronic pain and required a Hoyer lift for transfers with a physical assist of two persons. The interventions included, but were not limited to, 2/22/21 with a revision date of 4/1/22, provide Care in Pairs at all times, 8/7/20 with a revision date of 3/9/22, the resident was totally dependent on staff for repositioning and turning in bed every 2 hours and as necessary. 8/11/20, the resident had contractures and tremors of the upper extremities. 8/7/20 with a revision date 5/16/21, the resident was totally dependent on staff for toilet use, peri-care and incontinence care. The resident had a care plan, which indicated she was at risk for falls, initiated on 8/7/20 and revised on 5/18/21, related to she had Multiple Sclerosis, impaired mobility, impaired balance, fall risk medium use, supra catheter, history of tremors and neuropathy. The interventions included, but were not limited to, 8/7/20, Follow		**26, 2022** **We are respectfully asking for a desk review for this tag.**	

the facility fall protocol. 3/24/22, Transfer with two assists and the Hoyer lift to the Broda chair related to resident choice.

A current document, titled "Visual/Bedside Kardex Report," dated 4/5/22, was provided by the DON on 4/5/22 at 4:15 p.m. The DON indicated at that time, this document was the plan of care the CNAs followed to provide care for Resident C. The report included, but were not limited to, the following Special Instructions:

Safety-Follow the facility fall protocol. Monitor the resident for safety. Resident C was prescribed anti-anxiety medication, which were associated with an increased risk of confusion, loss of balance, amnesia and cognitive impairment (which looks like dementia) and an increased risk for falls with broken hips and legs.

Bed Mobility-the resident was totally dependent on staff for repositioning and turning in bed every two hours and as necessary. Utilize pillows for support and padding between bony prominences.

ADL-Care in Pairs at all times

A progress note, dated 4/1/22 at 4:15 a.m., indicated Resident C had a witnessed fall, in her room, while a CNA was providing incontinent care. She was lying on her side and she slid off the bed onto the floor. She was assisted off the floor by three staff members and a Hoyer lift. She complained of right hand fifth digit pain. She had a small abrasion to the left side of her head. The action taken was the resident was assisted up by three staff members with the Hoyer lift and she was provided first aid. The interventions were an X-ray to the right hand and the staff was

educated to "always" do cares in pairs with the resident.

During an interview, on 4/5/22 at 4:25 p.m., Resident C indicated she had fallen out of bed this past Friday (4/1/22) or Saturday (4/2/22) morning at approximately 3:30 a.m. There was only one CNA who provided care for her, which was CNA 1, who frequently provided care for her, by herself. She was laying on her side facing the door and she was holding onto the bed frame like she always did when she laid on her side during ADL care. CNA 1 left her bedside to go to the bathroom to wet another wash cloth, which was something most of the CNAs normally did when there was only one CNA providing care for her because there was no one else to get additional supplies or wet wash clothes if they were needed. The second and third shift CNAs often provided incontinent care for her using only one CNA. CNA 1 was halfway to the bathroom when she began to "fall off" the bed. The resident indicated she yelled out, CNA 1 turned around and looked at her as she was falling off the bed, but CNA 1 was too far away from her to assist her to the floor or to break her fall. By the time CNA 1 got over to the resident, she was already laying on the cement floor between the dresser and the bed. She landed on the cement floor on her stomach and partially on her left side with her right hand caught under her chest and this was how she believed she broke her pinky finger. She hit her left temple area on the floor and sustained a "cut" and "goose egg" above her left eye and a broken right pinky.

At the time of the interview, the following observations were made:
The resident had a scabbed laceration, the size of a pea, on the left side of her forehead just above

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	a raised knot the approximate size of a quarter. She was unable to straighten her bent right pinky. She had slight discoloration to the outside of the right hand by the pinky finger. She complained of pain to her right pinky finger. She attempted to straightened her pinky, but was unable. She was able to straighten the other four digits on the right hand to some degree. She was not able to make a fist with her right hand due to pain in her pinky when she tried to bend it completely in a closed position. An unidentified CNA entered the resident's room carrying a drink in and offered the resident a drink indicating she had brought her drink into her room prior to dinner. The CNA gave the resident a drink indicating to the resident if she needed another drink prior to dinnertime she needed to turn on her light and she would come back in and give her a drink. The CNA indicated to Resident C she would be bringing in her dinner tray shortly to "feed you." During an interview, on 4/5/22 at 12:18 p.m., with the AIT (Administrator in Training), DON (Director of Nursing) and RNC (Regional Nurse Consultant) in attendance, the DON indicated she reported on 4/1/22, Resident C slide out of bed and CNA 1 assisted her to the floor while being provided ADL care. The resident fractured her right pinky. During an interview, on 4/5/22 at 1:36 p.m., the DON and CNA 1 was in attendance. CNA 1 indicated Resident C was lying on her left side leaning over towards the opposite side of the bed (away from CNA 1) while she was providing peri-care for her. She reached for the brief and as she was reaching for the brief, the resident lost her balance and started falling towards the floor			

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	on the opposite side of the bed from where CNA 1 was standing. CNA 1 ran over to, that side of the bed, in an attempt to catch the resident, but she could not catch her. CNA 1 did get her hands under her mid-section before she hit the floor, but she could not assist her to the floor in anyway. Resident C landed on her stomach while hitting her head on the cement floor. CNA 1 indicated that particular day, the resident was leaning to the opposite side of the bed more than she typically did when she provided incontinence care for her. The resident was "gripping" the bed frame with her right hand as she was falling trying to hold herself onto the bed, so that was how she probably broke her finger. CNA 1 was supposed to have another staff member with her while performing care with Resident C because she was one of the residents who was supposed to be cared for by Care in Pairs, but she did not have the second person with her and that was her fault. CNA 1 indicated she had worked at the facility for three years and had cared for this resident the majority of the time and she typically cared for her by herself and she had "never" had a problem with this resident prior to that day. During an interview, on 4/5/22 at 2:58 p.m., the DON indicated CNA 1 was written up for not providing care in "Care in Pairs" while providing ADL care for Resident C. A document, titled "Human Resources Notice of Corrective Action," dated 4/1/22, indicated CNA 1 received a verbal warning on 4/1/22, related to a resident being a Care in Pairs due to false Allegations towards staff and CNA 1 was the only staff member providing care for the resident when this resident fell from bed. CNA 1 was education in Care in Pairs.			

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	A current facility policy, titled "Fall Prevention Program," dated as revised 11/21/17 and provided by the DON on 4/5/22 at 1:00 p.m., indicated "Purpose: To assure the safety of all residents in the facility, when possible...Guidelines...Care plan incorporates...Preventative measures...Standards...Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. Residents at risk of falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care...." 3.1-45(2)			