| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155277 | A. BUILDING 00<br>B. WING | 06/08/2018 |

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| APERION CARE VALPARAISO | 3301 N CALUMET AVE<br>VALPARAISO, IN 46383 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00264621.<br><br>This visit was in conjunction with the Recertification and State Licensure Survey.<br><br>Complaint IN00264621 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558, F686 and F690.<br><br>Survey dates: June 3, 4, 5, 6, 7 and 8, 2018.<br><br>Facility number: 000176<br>Provider number: 155277<br>AIM number: 100288940<br><br>Census Bed Type:<br>SNF/NF: 88<br>Total: 88<br><br>Census Payor Type:<br>Medicare: 11<br>Medicaid: 56<br>Other: 21<br>Total: 88<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 6/13/18. | F 0000 | This Plan of Correction is the Center's credible allegation of compliance.<br><br>Preparation and/or execution of this plan of correction does not constitute admission of 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.<br><br>The facility respectfully requests paper compliance for this survey | |
| F 0558<br>SS=D<br>Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable | | | |

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

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| | accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>Based on observation, record review, and interview, the facility failed to ensure positioning devices were provided related to no trapeze for a resident's bed, and accessible related to a resident's call light not in reach for 2 of 2 residents reviewed for accommodation of needs. (Residents D and C)<br><br>Findings include:<br><br>1. On 6/4/18 at 9:52 a.m., Resident D was observed in bed. The resident had both of his legs amputated below the knee. There was no trapeze noted on his bed.<br><br>Interview with Resident D at that time, indicated he had been asking for trapeze for his bed for months and no one seemed to listen to him.<br><br>On 6/5/18 at 9:56 a.m., the resident was observed in bed. There was no trapeze on his bed.<br><br>The record for Resident D was reviewed on 6/5/18 at 9:58 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, heart failure, heart transplant status, bilateral amputation, muscle weakness, history of falling, and major depressive disorder.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/1/18, indicated the resident was alert and oriented.<br><br>A physician order, dated 2/2/18, indicated trapeze for continuous use. | F 0558 | The facility requests paper compliance for this citation.<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Trapeze was immediately placed in resident D's room.<br><br>Call light was immediately placed in reach for resident C.<br><br>II. How other residents having the | 07/08/2018 |

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| | Interview with the MDS Coordinator on 6/6/18 at 9:15 a.m., indicated the resident had explained to her about the trapeze and she had asked therapy for help in obtaining one for him. She was unaware there was an order for a trapeze since 2/2018.<br><br>2. On 6/6/18 at 9:20 a.m., Resident C was observed sitting in a wheelchair near the foot of his bed. The resident was asked where his call light was located. The resident pointed towards the head of the bed and the call light was observed clipped to itself and out of reach.<br><br>On 6/6/18 at 11:35 a.m., the resident was observed sitting in his room in a wheelchair at the end of his bed. The call light was clipped to itself at the head of the bed and out of the resident's reach.<br><br>On 6/7/18 at 9:16 a.m., the resident was observed lying in bed. The call light was draped over the head of the bed with the button end near the floor. The resident was unable to reach the call light.<br><br>An Admission Minimum Data Set (MDS) assessment, dated 4/25/18, indicated the resident was alert and oriented.<br><br>Interview with the Director of Nursing on 6/7/18 at 11:31 a.m., indicated the resident was able to use the call light. The call light should have been within the resident's reach.<br><br>This Federal tag relates to the Complaint IN00264621.<br><br>3.1-3(v)(1) | | potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;<br><br>All residents have the potential to be affected by the finding. No other resident was found to be without their assistive device or call light within reach.<br><br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>Nursing staff were re-educated on assistive devices and call light positioning on 6/20 – 6/22/18.<br><br>The DON/designee will complete an audit of all physician ordered positioning (change to positioning/ assistive) devices to ensure the devices are in place. Any device found not to be in place will be corrected as appropriate. After initial audit, the DON/designee will complete random audits of 5 residents per week to ensure positioning/assistive devices are in place. The DON/designee will complete random audits of 5 residents per week to ensure call lights are within resident reach.<br><br>IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance | |

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| | | | program will be put into place;<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | |

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| F 0686 SS=D Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>Based on observation, record review, and interview, the facility failed to ensure a resident who entered the facility with no pressure sores received the necessary treatment and services to prevent a pressure sore related to obtaining wound treatments timely and the application of medication to the wound bed for 2 of 2 residents reviewed for pressure areas. (Residents B and E)<br><br>Findings include:<br><br>On 6/3/18 at 3:17 p.m., Resident B was observed in bed. At that time, she had turned on her call light and asked the CNAs to perform incontinence care. The CNAs removed her brief and rolled her on to her left side. There was a foam dressing noted with the date of 6/1/18 to her left inner buttock.<br><br>On 6/7/18 at 10:29 a.m., RN 1 was observed during a pressure ulcer dressing change. CNA 3 was in | F 0686 | The facility requests paper compliance for this citation.<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.* | 07/08/2018 |

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| | the room to help reposition the resident on to her left side. RN 1 washed her hands with soap and water, and donned clean gloves to both hands. She removed the old dressing, removed her gloves and provided hand hygiene with alcohol gel. The RN donned a clean pair of gloves and wiped the pressure area clean with normal saline. She removed her gloves used alcohol gel and donned clean gloves. The RN applied a large amount of Medihoney (a debriding agent) onto her gloved fingers and spread the Medihoney over the wound and on the surrounding (good) skin including part of the left buttock. At that time, the RN was asked to stop what she was doing and was asked why she had spread the Medihoney over the entire buttocks and the wound bed. The RN indicated it was for protection, and was unable to explain what the Medihoney was used for. Nurse Consultant 2, who was in the room at that time, instructed the nurse to remove the Medihoney from the buttock and only apply it to the wound bed.<br><br>Interview with Nurse Consultant 2 at that time, indicated the nurse should not have applied the Medihoney to the entire buttock area, and should have used a tongue depressor or Q-tip to apply the debriding agent to the wound bed instead of her gloved finger.<br><br>The record for Resident B was reviewed on 6/6/18 at 9:57 a.m. Diagnoses included, but were not limited to, stroke with hemiplegia, high blood pressure, type 2 diabetes, heart failure, osteoarthritis, and hypothyroidism.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 5/1/18, indicated the resident was alert and oriented times 3 and was frequently incontinent of urine. The resident had no | | I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Resident B's dressing was immediately changed. RN 1 was immediately re-educated on treatment policy. The pressure ulcer identified on the survey has healed.<br><br>Resident 54 has wound treatments in place.<br><br>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;<br><br>All residents with pressure ulcers were reviewed to ensure treatment orders are in place and applied as ordered.<br><br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>Licensed staff were re-educated | |

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| | pressure areas on admission.<br><br>Nursing notes, dated 6/1/18, indicated a new order for Medihoney and foam to left inner buttocks. The resident and husband were made aware of the new order.<br><br>Nursing notes, dated 6/3/18 at 4:08 p.m., indicated the order was clarified by the wound doctor and a new order for a dressing change every 72 hours was noted.<br><br>Physician order, dated 6/1/18, indicated cleanse left inner buttock with normal saline or wound cleanser. Pat dry, apply Medihoney and cover with foam dressing every day shift and as needed.<br><br>Physician order, dated 6/3/18, indicated cleanse left inner buttock with normal saline or wound cleanser. Pat dry, apply Medihoney and cover with foam dressing every 3 days on day shift and as needed.<br><br>Physician order, dated 4/25/18, indicated barrier cream to be applied as directed every 4 hours and as needed for dry skin and rash to and reddened buttocks.<br><br>The Treatment Administration Records (TARS) for 4/2018, 5/2018 and 6/2018 indicated the barrier cream was not signed out as being applied.<br><br>A wound assessment details report, dated 5/23/18, indicated the resident had a facility acquired stage 2 pressure area to the left inner buttock which measured 1 centimeter (cm) by 1 cm by 0.1 cm and was 100% bright pink or red. The wound had a scant amount of drainage.<br><br>A wound assessment details report, dated 5/29/18, | | on wound treatment procedures and obtaining wound treatments timely on 6/20 – 6/22/18.<br><br>The DON/designee will observe 5 random wound treatments per week to ensure treatment orders are present, proper treatment technique is followed and documentation is present.<br><br>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;<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. | |

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indicated the pressure sore measured 0.5 cm by 0.5 cm by 0.10 cm and was 100% red.

A wound assessment details report, dated 6/5/18, indicated the left inner buttock pressure sore measured 0.6 cm by 0.4 cm by 0.1 cm and 100% red.

Interview with the Director of Nursing on 6/7/18 at 9:15 a.m., indicated a treatment should have been obtained when the pressure area was initially observed on 5/23/18.

2. The record for Resident 54 was reviewed on 6/6/18 at 3:40 p.m. Diagnoses included, but were not limited to, dementia, hypertension, dysphagia, and contractures.

The Significant Change Minimum Data Set (MDS) Assessment, dated 4/26/18, indicated the resident was rarely/never understood and was totally dependent on staff.

The Wound Assessment Details Report, dated 5/29/18, indicated the resident had a facility-acquired unstageable pressure ulcer to the left heel measuring 3.4 by 2.5 cm by 0 cm.

The Wound Physician Assessment, dated 5/29/18, indicated new orders: Betadine (a skin antiseptic) every 1 day and heel protectors.

The 5/2018 and 6/2018 Treatment Administration Record indicated no new treatments were put in place from 5/29/18 - 6/4/18.

Interview with the Director of Nursing on 6/8/18 at 9:48 a.m., indicated the staff should have initiated the treatment as ordered.

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| | This Federal tag relates to the Complaint IN00264621.<br><br>3.1-40(a)(2) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and | | | |

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| | services to restore as much normal bowel function as possible.<br>Based on record review and interview, the facility failed to obtain a urinalysis for a resident who had signs and symptoms of a Urinary Tract Infection (UTI) for 1 of 2 residents reviewed for urinary tract infection. (Resident B)<br><br>Finding includes:<br><br>An interview with Resident B on 6/03/18 at 3:17 p.m., indicated the doctor ordered blood work and a urinalysis last week, but it had not been collected. She did have some burning when she urinated.<br><br>The record for Resident B was reviewed on 6/6/18 at 9:57 a.m. Diagnoses included, but were not limited to, stroke with hemiplegia, high blood pressure, type 2 diabetes, heart failure, osteoarthritis, and hypothyroidism.<br><br>The Admission Minimum Data Set (MDS) assessment, dated 5/1/18, indicated the resident was alert, oriented and was frequently incontinent of urine.<br><br>A Physician progress note by the Nurse Practitioner (NP), dated 5/4/18, indicated "The resident states over active bladder is worsening." The plan was to check urine with culture and sensitivity for UTI.<br><br>Nursing notes, dated 5/4-5/8/18, indicated the record lacked documentation a urine sample was collected.<br><br>Physician progress note by the NP, dated 5/25/18, indicated "The resident has some burning with urination." The plan was to obtain an urinalysis | F 0690 | The facility requests paper compliance for this citation.<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*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.*<br><br>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Resident B's urine specimen was collected and sent to lab for analysis. | 07/08/2018 |

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| | with culture and sensitivity.<br><br>Nursing notes, dated 5/25-5/29/18, lacked documentation a urine sample was collected.<br><br>Physician orders, dated 5/4/18 and 5/25/18, indicated urinalysis with culture and sensitivity.<br><br>Review of lab results indicated there was no urinalysis for review.<br><br>Interview with the Director of Nursing on 6/6/18 at 1:50 p.m., indicated the urinalysis should have been completed as ordered.<br><br>This Federal tag relates to the Complaint IN00264621.<br><br>3.1-41(a)(2) | | 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;<br><br>Review was completed for all residents with UA ordered in the last 30 days, and no other residents were found to be affected .<br><br>III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>Licensed nursing staff were re-educated on obtaining physician ordered UAs on 6/20 – 6/22/18. The DON/designee will audit physician orders at least 3 times per week as follow up to ensure urine specimens are collected timely when ordered.<br><br>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;<br><br>The results of these audits will be reviewed in Quality Assurance Meeting monthly until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify | |

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| | | | any trends or patterns and make recommendations to revise the plan of correction as indicated. | |