| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155799 | A. BUILDING 00<br>B. WING | 12/12/2018 |

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| APERION CARE MARION LLC | 614 WEST 14TH STREET<br>MARION, IN 46953 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00281076.<br><br>Complaint IN00281076 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677 and F684.<br><br>Unrelated deficiency was cited.<br><br>Survey date: December 12, 2018<br><br>Facility number: 012809<br>Provider number: 155799<br>AIM number: 201136580<br><br>Census Bed Type:<br>SNF: 23<br>NF: 15<br>Residential: 22<br>NCC: 7<br>Total: 67<br><br>Census Payor Type:<br>Medicare: 23<br>Medicaid: 15<br>Other: 7<br>Total: 45<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 | F 0000 | This plan of correction constitutes the facility's written credible allegation. 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 the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and / or executed solely because required by the provisions of health and safety code section 1280 and 42 CFR 483. Provider desires that this plan of correction serve as our credible allegation of compliance and **respectfully requests a Desk Review** in lieu of a re-visit.<br><br>Brenda Alfrey, HFA<br>Executive Director | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral | | | |

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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| | hygiene;<br>Based on interview and record review, the facility failed to ensure residents who were dependent on staff for transfers and mobility and Activities of Daily Living (ADL), received those services for 1 of 5 residents reviewed for Activities of Daily Living (ADL) assistance (Resident B).<br><br>Findings include:<br><br>The closed clinical record for Resident B was reviewed on 12/12/18 at 10:21 a.m. Diagnoses included, but were not limited to, artificial left knee, aftercare following joint replacement surgery and morbid obesity.<br><br>The 5-day Minimum Data Set (MDS) assessment, dated 11/19/18, indicated the resident was moderately cognitively impaired. He was admitted from an acute hospital on 11/18/18 and discharged to home on 11/19/18. He required two person assistance for bed mobility and toilet use.<br><br>A current health care plan, dated 11/19/18, indicated the resident had limited physical mobility related to knee surgery. Interventions included, but were not limited to, provide supportive care and assistance with mobility.<br><br>A progress note, dated 11/18/18, indicated the resident arrived to the facility around 4:30 p.m.<br><br>An Admission Assessment on 11/18/18 at 4:30 p.m., indicated the resident had a surgical incision .<br><br>Review of the CNA documentation from 11/17/18 through 11/18/18, Resident B was toileted on 11/18/18 at 11:37 p.m.. He was moved in his bed on 11/18/18 at 11:36 p.m. by two person staff | F 0677 | F677 ADL Care Provided for Dependent Residents<br><br>1.) What corrective actions will be accomplished for those residents found to be affected?<br>Resident #B no longer resides within the facility<br>Licensed nursing staff and C.N.A's were re-educated on provision of ADL care.<br>**2.) How will the facility identify other residents?**<br>A facility audit was completed on those residents that are dependant on staff for transfers, mobility and ADL care. Those residents identified were assessed and ADL care plan revisions were completed.<br><br>**3.) What measures will be put into place to ensure the practice does not recur?**<br>Nursing staff was re-educated on the provision of ADL care, i.e. transfers, mobility, hygiene and eating<br>Director of Nursing/ designee will randomly interview 2 residents weekly that require assistance with ADL's.<br>Any issue identified will be immediately addressed.<br><br>**4.) How will the corrective actions be monitored?**<br>The responsible party for this plan of correction is the Director of | 01/11/2019 |

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| | assistance.<br><br>The documentation lacked any information related to the resident being transferred, provided with hygiene or fed a meal.<br><br>A 72 hour Admission Charting, dated 11/19/18 at 12:30 a.m., indicated the resident was unsteady with gait, weakness and imbalance was noted. He required one person assistance with toileting, bed mobility and transfers. The resident was unable to walk and did not use a wheelchair or a scooter.<br><br>A progress note, dated 11/19/18 at 12:22 p.m., indicated the Social Service Director visited with the resident and he stated he was going to discharge today. He stated his wife was a nurse and could assist with his care at home.<br><br>During an interview on 12/12/18 at 2:20 p.m., the Director of Nursing indicated if a resident was admitted without a wheelchair, the facility kept wheelchairs in the basement they would provide them with one. The therapy department would then fit them when they were available. She did not provide any information as to why the resident was not moved and/or transferred during his admission or provided with a wheelchair.<br><br>During an interview on 12/12/18 at 2:25 p.m., the SSD indicated she did not have any additional documentation as to why Resident B left other than his wife was a nurse and she could care for him at home.<br><br>Review of a facility policy, dated 1/15/18, titled,"Pressure Ulcer Prevention," which was provided by the Director Of Nursing (DON) on 12/12/18 at 4:23 p.m. The policy indicated the following: | | Nursing/designee with administrative oversight.<br>Audits will be conducted by the Director of Nursing/designee on 2 residents weekly to determine appropriate ADL has been provided specifically for dependent residents.<br>Identified concerns will be addressed timely.<br>The results of these audits will be reviewed in Quality Assurance Performance Improvement Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5.) Date of Correction**<br>01/11/2019 | |

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| | "Purpose:<br>...5. Turn dependent resident approximately every two hours or as needed....<br>7. Whenever possible, encourage resident to change position at regular intervals as able to promote circulation....<br>12. Encourage resident to maintain proper nutrition...assistance at mealtime as needed."<br><br>This Federal Tag relates to complaint IN00281076.<br><br>3.1-50(a)(2) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to 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.<br>Based on interview and record review, the facility failed to ensure a physician's order was in place for a surgical dressing change and/or wound care for 1 of 5 residents reviewed for physician orders (Resident B).<br><br>Findings include:<br><br>The closed clinical record for Resident B was reviewed on 12/12/18 at 10:21 a.m. Diagnoses included, but were not limited to, artificial left knee, aftercare following joint replacement surgery and morbid obesity.<br><br>The 5-day Minimum Data Set (MDS) assessment, | F 0684 | **The facility requests paper compliance for this citation**<br><br>**F684 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<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* | 01/11/2019 |

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| | dated 11/19/18, indicated the resident was moderately cognitively impaired. He was admitted from an acute hospital on 11/18/18 and discharged to home on 11/19/18. He required two person assistance for bed mobility and toilet use.<br><br>A current health care plan, dated 11/19/18, indicated the resident had a surgical incision to the left knee. Interventions included, but were not limited to, keep incision site clean and treatment as ordered.<br><br>A progress note, dated 11/18/18, indicated the resident arrived to the facility around 4:30 p.m.<br><br>An Admission Assessment on 11/18/18 at 4:30 p.m., indicated the resident had a surgical incision and the nurse was unable to measure related to a dressing covering the incision. The focus indicated to keep the incision site clean and monitor for signs and symptoms of infection such as increased drainage, redness or warmth.<br><br>A 72 hour Admission Charting, dated 11/19/18 at 12:30 a.m., indicated the resident had a wound present with no change in skin integrity. The assessment indicated the resident received "surgical wound care."<br><br>During an interview on 12/12/18 at 2:20 p.m., the Director of Nursing (DON) indicated if a resident was admitted without orders for a wound care, the staff would attempt to call the physician. If they did not hear back from the physician, they would contact the house physician for orders. She did not find where the nurse attempted to call the surgeon or house physician. She did not find any orders for wound care.<br><br>Review of an undated facility policy, | | *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>**1) Immediate actions taken for those residents identified:**<br>Resident B no longer resides within the facility.<br>Licensed staff were educated to ensure physicians orders are in place for needed treatments.<br><br>**2) How the facility identified other residents:**<br>Facility treatment audit was completed to determine orders were appropriate for wound care and administered as ordered. Care plans were reviewed and updated as needed. Any issues identified were immediately addressed.<br><br>**3) Measures put into place/ System changes:**<br>Monitor daily during clinical review, utilizing the Order Listing report to identify any residents that have had treatment changes to ensure the correct treatment is in place as well as reviewing the treatment administration record to ensure treatments have been completed as ordered. DNS\designee will randomly observe 3 dressing changes/treatments weekly to determine orders are followed. Any | |

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| | titled,"Documentation," which was provided by the Director Of Nursing (DON) on 12/12/18 at 3:50 p.m. The policy indicated the following:<br>"Purpose:<br>...10. Verbal and telephone communication with all parties concerning the care and treatment of the resident will be entered into the clinical record."<br><br>This Federal Tag relates to complaint IN00281076.<br><br>3.1-37(a) | | identified issue will be addressed promptly through re-education.<br><br>**4) How the corrective actions will be monitored:**<br>The facility Director of Nursing/Designee will monitor TAR and the Order Listing report 3 times weekly to ensure treatments/dressing changes are appropriate and being administered as ordered.<br>Additional education will be provided with any identified issues.<br>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.<br><br>**5) Date of compliance**:01/11/2019 | |
| F 0842<br>SS=D<br>Bldg. 00 | 483.20(f)(5); 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on | | | |

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| | each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,<br>regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law. | | | |

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| | §483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>Based on observation, interview and record review, the facility failed to ensure resident clinical records were accurately documented related to medication administration to show correct dates for 1 of 5 residents who were reviewed for medication administration. (Resident C)<br><br>Findings include:<br><br>The clinical record for Resident C was reviewed on 12/12/18 at 11:48 a.m. Diagnoses included, but were not limited to, peripheral vascular disease, malignant neoplasm of kidney and diabetes mellitus.<br><br>A current health care plan initiated 12/7/18, indicated the resident was at risk for decreased cardiac output related to atrial fibrillation. Interventions included, but were not limited to, administer medications as ordered and observe for effectiveness.<br><br>During an interview on 12/12/18 at 11:28 a.m., the resident indicated she had just received one of her medications this morning. She was admitted to the facility on 12/7/18. | F 0842 | F842 Resident Records/Identifiable Information<br>**The facility requests paper compliance for this citation.**<br>*This Plan of Correction is the center's credible allegation of compliance.*<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>1. Resident #C is receiving and has appropriate orders for anticoagulation. Orders are reviewed daily during clinical meeting via the order listing report per DNS/designee. Primary physician and responsible parties | 01/11/2019 |

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| | A discontinued physician order, dated 12/7/18, indicated to give apixaban (anticoagulant) 5 mg, give two tablets twice daily.<br><br>A progress note, dated 12/7/18 at 9:33 p.m., indicated the medication had not been received from pharmacy.<br><br>A new physician order, dated 12/9/18, indicated to give the resident apixaban 5 mg, give one tablet twice daily.<br><br>Review of the Medication Administration Record (MAR), on 12/8/18 at 8:00 a.m., a nurse documented the medication, apixaban, had been given.<br><br>On 12/8/18 at 8:00 p.m., a nurse documented on the MAR the medication was not yet available.<br><br>A progress note, dated 12/8/18 at 9:43 p.m., indicated the medication was not available.<br><br>A progress note, dated 12/9/18 at 7:47 a.m., indicated the medication was not available.<br><br>A progress note, dated 12/9/18 at 9:36 p.m., indicated the medication was not available.<br><br>A progress note, dated 12/10/18 at 8:39 a.m., indicated "out of medication."<br><br>A progress note, dated 12/10/18 at 7:26 p.m., indicated the medication was not available and the nurse and pharmacy were aware.<br><br>On 12/11/18 at 8:00 a.m., a nurse documented on the MAR apixaban had been given. | | were notified of the issues revolving around Resident C's anticoagulant. Care Plan was reviewed and updated. No adverse outcome was identified.<br>2. A full review of physician orders and medication administration records for those residents receiving anticoagulants was completed to determine medications were available and administered as ordered. Any identified area of concern was immediately corrected.<br>3. Licensed nursing staff will be educated on medication administration, documentation, and procedures required to obtain any medication noted to be unavailable for administration. Licensed Nursing staff will review admission orders within twenty-four hours of admission to determine admission orders are present and medications are available. Identified areas of concern will result in additional education.<br>4. The responsible party for this monitoring will be the Facility Executive Director\DON and or the designee. The DNS\ designee will audit three resident admission records weekly to determine administration occurred as ordered and medications were available for administration. Results of the audits will be taken to Quality Assurance/Performance Improvement meetings monthly for | |

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| | On 12/11/18 at 8:00 p.m., a nurse documented on the MAR apixaban had been given.<br><br>During an observation and interview on 12/12/18 at 12:05 p.m., the Qualified Medication Aide (QMA) 2 pulled out the apixaban medication punch card. The initial amount of pills sent was 28 and the card had 27 unused pills. The QMA indicated the resident received her first dose of medication with morning medication administration on 12/12/2018.<br><br>During an interview on 12/12/18 at 3:31 p.m., the Administrator was provided an explanation as to the MAR documentation and the medication could not have been given since the first pill was given today.<br><br>Review of an undated facility policy, titled,"Documentation," which was provided by the Director Of Nursing (DON) on 12/12/18 at 3:50 p.m. The policy indicated the following:<br>"Purpose:<br>...1. Each health care professional shall be responsible for making their own prompt...concise, complete, appropriate, and legible entries."<br><br>3.1-50(a)(2) | | 6 months and or until 100% compliance has been achieved for 3 months and the interdisciplinary team recommends discontinuing.<br>5. 1-11-2019 | |