### Statement of Deficiencies

**Provider/Supplier/CLIA:**

**Identification Number:** 155704

**Multiple Construction: Building 00**

**Date Survey Completed:** 11/30/2018

**Name of Provider or Supplier:**

**Address:** 505 N MAIN ST, WALDRON, IN 46182

---

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Regulatory or LSC Identifying Information</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0000</td>
<td>Bldg. 00</td>
<td></td>
<td>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00278624.</td>
<td></td>
</tr>
<tr>
<td>F 0656</td>
<td>SS=D Bldg. 00</td>
<td></td>
<td>Complaint IN00278624 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-677 and F-684. Survey dates: November 26, 27, 28, 29 &amp; 30 2018.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Facility number: 000423 Provider number: 155704 AIM number: 100290450</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Census Bed Type: SNF/NF: 50 Total: 50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Census Payor Type: Medicare: 3 Medicaid: 38 Other: 9 Total: 50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 5, 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>§483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable goals and objectives.</td>
<td></td>
</tr>
</tbody>
</table>

---

**Laboratory Director’s or Provider/Supplier Representative’s Signature:**

__________________________________________________________________________

---

**Event ID:** 3PKF11

**Facility ID:** 000423

---

**Note:** Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

---

**Page 1 of 22**
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY ID</th>
<th>PROVIDER'S PLAN OF CORRECTION COMPLETION DATE</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0656</td>
<td>F</td>
<td>Preparation, submission and implementation of this Plan of Correction does not constitute an</td>
<td>12/30/2018</td>
</tr>
</tbody>
</table>

Based on record review and interview the facility

objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv) In consultation with the resident and the resident's representative(s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
failed to create a care plan for an anticoagulant medication for 1 of 2 residents reviewed for anticoagulant medication care plans (Resident 34).

Findings include:

Review of Resident 34's record on 11/27/18 at 12:45 p.m., indicated, diagnoses included, but were not limited to, chronic obstructive pulmonary disease, personal history of pulmonary embolism.

The physician's recapitulation orders dated 11/30/18, indicated, the resident was admitted on 10/26/18, current medications included, warfarin 2 mg, give 2 mg by mouth in the evening for anticoagulant, started 11/13/18.

Review of care plans indicated, no care plan found for anticoagulant medication.

On 11/29/18 at 12:45 p.m., an interview with Director of Nursing indicated, "the resident was started on warfarin 2 days before she discharged, the care plan did not get completed."

Review of the progress notes dated 11/29/18 at 1:28 p.m., indicated, the resident discharged home on 11/20/18.

A policy and procedure for "Comprehensive Care Plan" was provided by the Corporate Nurse Consultant on 11/29/18 at 2:24 p.m., indicated "Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Guidelines: The facility will develop and implement a comprehensive admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

F-656- Ss- D CFR 483.21(b)(1) Development/Implement Comprehensive Care Plan. The facility will develop and implement a comprehensive person-centered care plans for each resident consistent with the residents rights set forth at 483.10 © (2) and 483.10 © (3) that includes measureable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

1. Resident #34 was affected by this deficient practice. Resident #34 no longer resides at the facility.

2. All residents currently on anticoagulant therapy have the potential to be effected by the facilities alleged deficient practice. All residents who are on anticoagulant therapy will be reassessed and any required changes to their Plans of Care will be made.

3. All residents on anticoagulant therapy will be reviewed 5 days per week for the next 30 days.
person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment..."

3.1-35(a)

F 0677 SS=E Bldg. 00

483.24(a)(2) ADL Care Provided for Dependent Residents §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 hygiene;

Based on observation, interview, and record review, the facility failed to ensure 2 residents received showers (Residents J and K) and failed to assist 2 residents with oral care (Residents N and D) for 4 of 7 residents reviewed for Activities of Daily Living.

Findings include:

1. On 11/26/18 at 1:02 p.m., Resident J indicated she has had one shower since admission and would like to have at least two showers a week. She said she didn't think that is asking too much daily at the facilities Morning Stand Up Meetings and any needed care plan changes will be made. The facility DON, or designed, will review all residents on anticoagulant therapies care plans weekly 5 days per week for the next 30 days; then bi-weekly for the following 30 days and monthly thereafter to ensure continued compliance.

4. All significant anticoagulant care plan audit results will be reviewed at the facility monthly QAPI meetings for the next 3 months in order to ensure continued compliance.

5. Compliance Date: 12-30-18

The facility will ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

1. Residents J, K, N, and D were affected by the facilities alleged deficient practice. Residents J, K, N and D will have their ADL needs
and she took more than that at home but would be fine with two a week.

Resident J's record was reviewed on 11/27/18 at 12:29 p.m. The record indicated Resident J had diagnoses that included, but were not limited to, congestive heart failure, arteriosclerotic heart disease with chest pain, chronic obstructive pulmonary disease, high blood pressure, dementia, fibromyalgia, depression, anxiety, osteoarthritis, spinal stenosis of the lumbar region, and chronic tension type headache.

A 5 day Minimum Data Set (MDS) assessment, dated 11/23/18 indicated Resident J was cognitively intact, required extensive assist of one for bathing, and it was very important for her to choose between a tub bath, shower, bed bath or sponge bath.

A care plan dated 11/16/18, indicated: "I have an ADL self-care performance deficit r/t (related to) reduced mobility. Goal: I will assist with bathing and grooming through the review date...bathing/showering: Avoid scrubbing & pat dry sensitive skin...."

Review of ADL care sheets, dated 11/17/18 through 11/28/18, indicated Resident J's shower days are Wednesday and Saturday and she has had one shower, on 11/21/18, since she was admitted.

On 11/30/18 at 10:13 a.m., Resident J indicated she has had one shower since she has been here and said she has not refused a shower. They set her up with a bed bath, she does what she can, and staff haven't washed her back or assisted her with her bath.

reviewed and care plans updated to reflect these ADL needs for the areas of bathing and oral hygiene.

2. All dependent residents have the potential to be affected by this deficient practice. All ADL dependent residents will have their ADL care plans reviewed and revised as needed. Direct care staff will be re-in-serviced on current facility policy and procedures related to bathing and oral hygiene.

3. The DON, or designee, will conduct 5 days per week audits of 10% of dependent residents’ bathing and dental hygiene for the next 30 days; bi-weekly audits on 10% of the residents for the next 30 days and 10% of resident audits monthly thereafter to ensure that residents are receiving proper ADL assistance.

4. All significant ADL audit results for bathing and dental hygiene will be reviewed weekly at the facility Morning Stand Up Meetings for the next 60 days. All significant audit findings will be reviewed at the facility monthly QAPI meetings for recommendations and further action(s) as needed for the next 90 days.

5. Compliance Date: 12-30-18
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**
155704

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

**STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>On 11/30/18 at 10:20 a.m., CNA 12 indicated she has taken care of Resident J often, and the resident can wash her upper part but she can't pull her shirt over her head; she needs help with dressing, she needs stand by assist, hasn't had to wash any part of her, and has not had her on her shower day to see if she refuses showers.</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>COMPLETION DATE</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>2. On 11/27/18 at 2:12 p.m., Resident N indicated staff does not make sure she gets her teeth brushed.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>On 11/29/18 at 11:24 a.m., Resident N's teeth were observed. She has natural teeth and debris were observed in between both her upper and lower teeth. Resident N said she couldn't remember when her teeth were last brushed.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Resident N's record was reviewed on 11/29/18 at 11:27 a.m. The record indicated Resident N had diagnoses that included, but were not limited to, multiple sclerosis, essential tremors, and generalized muscle weakness.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>A 5 day Minimum Data Set (MDS) assessment indicated Resident N was cognitively intact and required extensive assist of 2 for personal hygiene including brushing her teeth.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>A care plan, last revised on 8/16/16, indicated Resident N had a self care deficit and required assistance with activities of daily living (ADL's) due to tremors, multiple sclerosis and weakness. Her goal was to participate with ADL's daily and she required one person physical assist with oral/dental care.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>A dental exam visit, dated 11/1/18, indicated Resident N has her natural teeth, oral hygiene was</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**
APEIRON CARE WALDRON LLC

**STREET ADDRESS, CITY, STATE, ZIP CODE**
505 N MAIN ST
WALDRON, IN 46182
fair, the gum tissue was inflamed with a moderate amount of plaque induced gingivitis (inflamed gums) with a moderate amount of bleeding and debris.

On 11/30/18 at 11:36 a.m., The Director of Nurses (DoN) indicated Resident N's ability to brush her teeth fluctuates from day to day.

3.) During an interview with Resident K's on 11/26/18 at 10:43 a.m., indicated the resident had not been getting enough showers since she had been admitted. The resident normally took at least 5 showers a week when she was at home.

Review with of the Resident K on 11/27/18 2:05 p.m., indicated the resident's diagnoses included, but were not limited to, fracture of the sacrum and pubis sequela, hypertension, diabetes, depression and lack of coordination.

The plan of care for Resident K, dated 11/18/18, indicated the resident had ADL self care performance deficit related to reduced mobility relate to fractured sacrum and pubic ramus.

The Admission Minimum Data Set (MDS) assessment for Resident K, dated 11/21/18, indicated the resident was moderately impaired for daily decision making, it was very important for her to choose between a bed bath, bath and a shower. The resident required extensive assistance of two people for transfer and one person to physically help with bathing. The resident was admitted to the facility on 11/16/18.
The ADL documentation for Resident K indicated the resident received a bed bath on 11/19/18 and 11/29/18. The resident received a shower on 11/22/18. The documentation indicated she received one shower in 15 days.

During an interview on 11/28/18 at 10:17 a.m., with Resident K and Family member 2 indicated when the resident was home she took a shower every day and she had one shower since she had been admitted to the facility.

During an interview with the DON on 11/29/18 at 2:11 p.m., the aide was responsible to ensure Resident K received her showers and the nurse should follow up and ensure the resident's showers were provided.

4.) During an interview with Resident D's family member 1 on 11/26/18 at 1:27 p.m., indicated the resident's teeth were not getting brushed and when they came to visit the resident her teeth would be dirty.

During an observation on 11/26/18 at 218 p.m., Resident D was sitting in her recliner in her room, her teeth had a white thick film over them with debris built up between her teeth.

During an observation 11/27/18 at 9:27 a.m., Resident D was sitting in her wheelchair in the common area. her teeth have a thick film over them are unclean with debris between her teeth.

During an observation on 11/28/18 at 9:52 a.m., Resident D was in activity, her teeth have thick white film and unclean with debris between her teeth.
During an observation on 11/27/18 at 11:15 a.m., Resident D's teeth remained with thick white film and unclean with debris between teeth.

During an observation 11/28/18 at 9:40 a.m., Resident D was sitting in an activity, her teeth had a thick white film on her teeth.

During an interview with CNA 1 on 11/28/18 at 10:03 a.m., indicated she did not provide Resident D with oral care as she was not the person who assisted the resident out of bed. CNA 1 indicated the resident often did have a lot of film on her teeth.

During an interview with Director Of Nursing on 11/28/18 at 10:08 a.m., indicated she had provided Resident D with oral care around 8:30 a.m., and all the film on her teeth did not come off.

During an interview and observation on 11/28/18 at 12:43 p.m., the DON provided Resident D with oral care. The DON indicated it was hard to get Resident D to rinse and spit. The DON provided the resident with tap water to rinse and spit. The resident with a lot of encouragement did spit in the sink. Resident D's teeth did continue to have some film on them, but was a lot cleaner.

Review of the record of Resident D on 11/28/18 01:14 PM indicated the resident's diagnoses included, but were not limited to, malignant brain cancer, depression, seizures, allergic dermatitis, weakness, urge incontinence, Todd's paralysis.

The dental exam for Resident D dated, 4/6/18, indicated the resident had generalized severe gingival inflammation and staff must assist in brushing teeth daily. The resident had a heavy debris level.
The dental exam for Resident D dated, 10/18/18, indicated the resident had poor oral hygiene and heavy debris. The staff must assist in brushing teeth twice daily. MD order written for peridex.

The Quarterly Minimum Data (MDS) for Resident D, dated 11/22/18, indicated the resident had modified independence for daily decision making. The resident required extensive assistance of one person for personal hygiene including brushing her teeth.

The shower policy provided by the Corporate Nurse Consultant on 11/29/18 at 2:24 p.m., indicated the purpose was to ensure resident's cleanliness to maintain proper hygiene and dignity. A shower would be offered according to the resident's preferred frequency.

The oral hygiene policy provided by the Corporate Nurse Consultant on 11/29/18 at 2:24 p.m., indicated the purpose was to provide oral care for the teeth, gums and mouth, remove offensive odors and food debris and promote resident comfort.

This federal tag relates to Complaint IN00278624.

3.1-38(a)(3)

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 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 observation, interview, and record review, the facility failed to provide a resident with his physician ordered medicated cream to treat a rash for 1 of 2 residents reviewed for skin condition non-pressure. (Resident H)

Findings include:

Resident H's record was reviewed on 11/28/18 at 1:29 p.m. His diagnoses included but were not limited to, diabetes and rash. His Quarterly Minimum Data Set assessment dated 10/2/18, indicated he was cognitively intact in his daily decision making skills and had no skin condition other than a surgical wound.

A progress note for Resident H dated 11/12/18 at 10:53 p.m., indicated he had a bright red rash over his torso and his skin was hot to touch. He was transported to a local hospital for evaluation and treatment.

A local hospital note for resident H dated 11/13/18, indicated he had been seen the previous day for upper lip swelling and had returned to the hospital because of an allergic reaction to clindamycin that had been ordered.

A progress note for Resident H dated 11/21/18 at 11:04 p.m., indicated he had returned from a local hospital.

A physician's order for Resident H dated 11/21/18, indicated he would receive triamcinolone acetonide cream 1% to his affected rash areas 2 times a day.

**The facility will ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice.**

1. Resident H was affected by this alleged deficient practice. Resident H's care plan and physician orders will be reviewed and any necessary changes will be made.

2. All residents have the potential to be affected by this deficient practice. The DON, or designee, will review all resident physician treatment orders 5 days per week for the next 30 day; then bi-weekly for the next 30 day and then monthly thereafter to ensure that residents are receiving their treatments per physician orders.

3. The facility DON, or designee, will conduct weekly (5 days per week) reviews of all residents’ physician ordered treatments for the next 30 days; then bi-weekly for the next 30 day and monthly thereafter in order to ensure that the residents are receiving their physician ordered treatments.

4. The results of these audits of physician ordered treatments will be reviewed at the facility daily.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>APERION CARE WALDRON LLC</td>
<td></td>
<td>A plan of care for Resident H initiated 11/26/18, indicated he had an allergic reaction to a medication and developed a rash over his entire body and would receive his treatment as ordered.</td>
<td></td>
<td>APERION CARE WALDRON LLC</td>
<td></td>
<td>Morning Meetings for the next 30 days and all needed action(s) will be taken. All significant audit findings will be reviewed at the facility monthly QAPI meetings for recommendations and additional action(s) as needed for the next 90 days.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident H's treatment record indicated he received his triamcinolone acetonide cream treatment once on 11/21/18, twice on 11/22/18, 11/23/18, 11/24/18, 11/25/18, 11/26/18, 11/27/18, and once on 11/28/18.</td>
<td></td>
<td></td>
<td></td>
<td>5. Compliance Date: 12-30-18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On 11/26/18 at 10:46 a.m., Resident H was observed with 3 scabbed areas on his right arm and a scabbed area on his left arm. His arms and hands had peeling skin. He indicated he had some cream he put on the areas himself but was unable to locate the cream.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On 11/28/18 at 2:33 p.m., LPN 15 indicated Resident H had developed a reaction to a medication and had received triamcinolone cream treatment to the rash. She indicated she had ordered the triamcinolone cream on 11/21/18, but was unable to locate the cream in the treatment cart or Resident H's room. On 11/29/18 at 12:51 p.m., she indicated she had re-ordered his triamcinolone cream on 11/28/18, when she had been unable to locate it in her treatment cart. She had signed the treatment off in error on day shift 11/28/18.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On 11/29/18 at 1:49 p.m., the DON indicated Resident H's triamcinolone cream had originally been ordered from pharmacy on 11/21/18, but it had never been delivered. The triamcinolone cream treatment had been re-ordered 11/28/18, and received by the facility on 11/28/18.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This federal tag relates to Complaint IN00278624.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 155704

**Name of Provider or Supplier:** APERION CARE WALDRON LLC

**Street Address, City, State, Zip Code:** 505 N MAIN ST, WALDRON, IN 46182

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Regulatory or LSC Identifying Information</th>
<th>Provider’s Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0689</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>3.1-37(a) 483.25(d)</td>
<td>12/30/2018</td>
<td></td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiency:**

- Free of Accident Hazards/Supervision/Devices
- §483.25(d) Accidents. The facility must ensure that:
  - §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.

**Findings Include:**

- Resident 26's record was reviewed on 11/27/18 at 10:48 a.m. Her diagnoses included but were not limited to, dementia and neuropathy. Her Significant Change Minimum Data Set assessment dated 10/24/18, indicated she was severely impaired in her cognitive daily decision making skills, required 2 person physical assistance for transfers, and was receiving hospice care.

- A plan of care for Resident 26 revised by the facility on 9/12/18, indicated she was at risk for falls related to weakness. The plan of care did not indicate the amount of assistance she required for transfers.

- On 11/28/18 at 11:48 a.m., Resident 26 was observed being transferred from her wheelchair to bed with the assistance of the Director of Staffing Development and CNA 1, and the use a gait belt.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/CLIA Identification Number</th>
<th>(X2) Multiple Construction A. Building</th>
<th>(X3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>155704</td>
<td>00</td>
<td>11/30/2018</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier**: Aperion Care Waldron LLC

**Address**: 505 N Main St, Waldron, IN 46182

**Event ID**: 3PKF11

---

When Resident 26 was assisted to stand, her knees buckled and she was going toward the floor. The gait belt slid up around her breasts and under her arms. The Director of Staffing Development and CNA 1 pulled up on the back of her slacks, pivoted her, and moved her over and sat her in bed. The Director of Staffing Development indicated she would inform therapy for an evaluation.

The "Manual Gait Belt and Mechanical Lifts" procedure provided by the DON on 11/29/18 at 3:14 p.m., indicated the following: "Purpose: In order to protect the safety and well-being of the Staff and Residents, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of Residents...

Guidelines: 1. Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted. 2. Staff responsible for direct care will be trained in the use of mechanical lifting devices annually and as needed... 5. The transferring needs of residents will be assessed on an ongoing basis and designated into one of the following categories: 0 = Independent, 1 = 1 person transfer (25% or less assistance form the caregiver) with gait belt, 2 = 2 person transfer with gait belt (only when use of mechanical lift is not possible)... 6. Resident transferring and lifting needs shall be documented in care plans and reviewed via care plan time frame and as needed...."

3.1-45(a)(2) 483.45(c)(1)(2)(4)(5) "Drug Regimen Review, Report Irregular, Act days; then 5 audits bi-weekly for the next 30 days and 5 audits per month thereafter in order to ensure that staff is properly using gait belts during all resident transfers.

4. All resident transfer audit results will be reviewed at the facility daily Morning Stand Up meetings for the next 60 days.

All significant transfer audit results will be reviewed at the facility monthly QAPI meetings for the next 90 days for recommendations and additional action(s) as needed.

5. Compliance Date: 12-30-18
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>On §483.45(c) Drug Regimen Review.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>§483.45(c)(2) This review must include a review of the resident's medical chart.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Based on record review and interview the facility failed to have pharmacy reviews for medications completed every 30 days for 4 of 5 residents reviewed for pharmacy reviews for medications (Resident F, Resident 25, Resident 15, and Resident G).

Findings include:

1. On 11/27/18 at 10:16 a.m., review of Resident F's record indicated her diagnoses included, but were not limited to, mood disorder due to known physiological condition with depressive features, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, vascular dementia with behavioral disturbance, and anxiety.

Resident F's Minimum Data Set assessment dated 10/5/18, annual review indicated medications received during last 7 days or since admission/reentry; antipsychotic, antidepressant, antibiotic and diuretic.

Review of the physicians recapitulation orders dated 11/30/18, indicated, her admission date was 10/17/17, current medications included, but were not limited to, zyprexa 5 mg tab, give 1 tablet by mouth at bedtime related to mood disorder due to known physiological condition with depressive features started 7/2/18, zoloft 100 mg, give 1 tablet by mouth in the morning related to mood disorder.
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>due to known physiological condition with depressive features, lasix give 20 mg by mouth one time a day for edema related to unspecified combined systolic (congestive) and diastolic (congestive) heart failure, depakote 125 mg give 1 tablet by mouth two times a day for mood related to vascular dementia with behavioral disturbance, buspar 5 mg give 1 tablet by mouth in the morning for anxiety. Review of the pharmacy reviews indicated, reviews were not completed timely for October or November 2018.</td>
<td></td>
<td>monthly QAPI meetings for recommendations and additional action(s) as required for the next 90 days.</td>
<td>5.Compliance Date: 12-30-18</td>
</tr>
</tbody>
</table>

2. Review of Resident 25's record on 11/28/18 at 10:47 a.m., indicated her diagnoses included, but were not limited to, epilepsy, unspecified, not intractable, without status epilepticus, type 2 diabetes mellitus, other seizures, other recurrent depressive disorders.

Resident 25's Minimum Data Set assessment dated 10/25/18, quarterly review indicated, medications received during last 7 days or since admission/re entry; insulin, antidepressant, hypnotic, antibiotic and opioid.

The physician's recapitulation orders dated 11/30/18, indicated, the resident was admitted on 2/8/18, her current medications included, but were not limited to, klonopin 0.5 mg, give 0.5 mg orally every 12 hours for seizure, lantus, inject 80 unit subcutaneously at bedtime for diabetes mellitus, humalog, inject 14 unit subcutaneously with meals related to diabetes mellitus with diabetic neuropathy, citalopram 40 mg, give 1 tablet by mouth one time a day for depression related to other recurrent depressive disorder, tradjenta 5...
mg, give 5 mg by mouth one time a day for anti-diabetic.

The pharmacy reviews were not completed timely for October or November.

3. Resident 15's record was reviewed on 11/28/18 at 1:13 p.m., indicated, his diagnoses included, but were not limited to, type 2 diabetes mellitus without complications, other recurrent depressive disorders, anxiety disorder, atrial fibrillation, heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris.

Review of Resident 15's Minimum Data Set assessment dated 9/17/18, indicated, medications received during last 7 days or since admission/reentry; insulin, antianxiety, antidepressant, anticoagulant, diuretic and opioid.

Review of the physician's recapitulation orders dated 11/30/18, indicated resident was admitted on 10/7/17, current medication included, but were not limited to, humalog, inject 14 unit subcutaneously with meals related to type 2 diabetes mellitus without complications, lantus pen-injector, inject 90 unit subcutaneously at bedtime for diabetes mellitus without complications, warfarin 3.5 mg, give 3.5 mg by mouth in the evening for treating/preventing blood clots, Clonazepam 0.5 mg, give 1 tablet by mouth three times a day related to anxiety disorder, jardiance 25 mg, give 1 tablet by mouth one time a day for diabetes mellitus, cymbalta 60 mg, give 60 mg by mouth two times a day for depression.

Pharmacy reviews were not completed in timely manner for October or November 2018.
4. On 11/29/18 10:39 a.m., review of Resident G's record indicated, her diagnoses included, but were not limited to, other recurrent depressive disorders, unspecified mood [affective] disorder, delusional disorders.

Resident G's Minimum Data Set assessment dated 8/13/18, quarterly review indicated medications received during last 7 days or since admission/reentry; antipsychotic and antidepressant.

Review of the physician's recapitulation orders dated 11/30/18, indicated, the resident was admitted on 2/2/17, and current medications included, but were not limited to, risperdal 0.5 mg, give 0.5 mg by mouth in the evening for behaviors related to unspecified mood [affective] disorder, wellbutrin 200 mg, give 200 mg by mouth one time a day for depression related to other recurrent depressive disorders, cefalexin 20 mg, give one tablet by mouth one time a day related to other recurrent depressive disorders.

Review of the pharmacy reviews indicated, the reviews were not completed timely for October or November.

On 11/29/18 at 2:10 p.m., an interview with the Corporate Nurse Consultant, indicated, "we changed pharmacies on 10/29/18, Pharmscript is the new pharmacy, they are reviewing residents medications today, on the computer."

An interview with the Director of Nursing on 11/30/18 at 11:17 a.m., indicated, "no residents
have had any interactions from their medications, that I am aware of."

On 11/30/18 at 1:34 p.m., an interview with Administrator indicated, "the old pharmacy thought the new pharmacy was doing reviews for October and the new pharmacy thought the old pharmacy was completing them."

A policy and procedure for "Provider Pharmacy Requirements" was provided by the Corporate Nurse Consultant on 11/29/18 at 2:24 p.m., indicated "Policy Regular and reliable pharmaceutical service is available to provide residents with prescription and non prescription medications, services, and related equipment and supplies..." "Procedures ... 6. Labeling all medications dispensed in accordance with the medication labeling policy and with state and federal requirements..."

3.1-25(i)

3.1-14 Personnel
(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:
(1) Residents' rights.
(2) Prevention and control of infection.
(3) Fire prevention.
(4) Safety and accident prevention.
(5) Needs of specialized populations served.
(6) Care of cognitively impaired residents.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
<td>Bldg. 00</td>
<td>00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F9999</td>
<td>have had any interactions from their medications, that I am aware of.&quot;</td>
<td>F-9999-3.1-25 (i) (k) (l) (v)</td>
<td>Personnel</td>
</tr>
</tbody>
</table>

The facility will ensure that there is an organized ongoing in-service education and training program planned in advance for all personnel.

1. The following staff were affected by this deficient practice:
   - LPN-2; LPN-3; LPN-4; CNA-5;
   - CNA-6; CNA-7; CNA-8; CNA-9;
(l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel.

(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personal assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.

This state rule was not met as evidenced by:

During interview and record review the facility failed to provide dementia training, abuse training and resident rights training as required for 10 of 10 employee records reviewed (Director Of Staffing Development, LPN 2, LPN 3, LPN 4, CNA 5, CNA 6, CNA 7, CNA 8, CNA 9 and CNA 10).

Finding include:

1.) Review of the employee file provided by the Administrator on 11/27/18 at 2:00 p.m., indicated the Director Of Staffing Coordinator did not have dementia training completed, LPN 2 did not have resident rights or dementia training completed, LPN 3 did not have dementia training completed, LPN 4 did not have dementia or resident rights

CNA-10. These aforementioned staff will receive in-servicing training per state requirements.

2. All staff have the potential to be effected by this deficient practice. The facility DSD or designee will conduct monthly in-service training to ensure that all staff receive the required in-services.

3. The facility DON, or designee, and administrator will conduct monthly in-service audits for the next 12 months, to ensure that all staff are properly in-serviced per state requirements.

4. The facility DSD, or designee will review all staff in-service audit results at the facility monthly QAPI meeting for recommendations and additional action(s) as needed.

5. Compliance Date: 12-30-18
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

<table>
<thead>
<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>155704</td>
<td></td>
<td>11/30/2018</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

APERION CARE WALDRON LLC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

505 N MAIN ST
WALDRON, IN 46182

**ID**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
</tbody>
</table>

During an interview with the Director Of Staffing Development 11/30/18 1:14 p.m., indicated she was responsible to provide staff with the required training. The Director of Staffing Development verified she did not have dementia training completed, LPN 2 did not have resident rights or dementia training completed, LPN 3 did not have dementia training completed, LPN 4 did not have dementia training completed, CNA 5 did not have resident rights or resident rights training completed, CNA 6 did not have resident rights or dementia training completed, CNA 7 did not have resident rights or dementia training completed, CNA 8 did not have resident rights or dementia training completed, CNA 9 did not have resident rights or dementia training completed and CNA 10 did not have resident rights or dementia training completed.

During an interview with the Director Of Staffing Development 11/30/18 1:14 p.m., indicated she was responsible to provide staff with the required training. The Director of Staffing Development verified she did not have dementia training completed, LPN 2 did not have resident rights or dementia training completed, LPN 3 did not have dementia training completed, LPN 4 did not have dementia training completed, CNA 5 did not have resident rights or resident rights training completed, CNA 6 did not have resident rights or dementia training completed, CNA 7 did not have resident rights or dementia training completed, CNA 8 did not have resident rights or dementia training completed, CNA 9 did not have resident rights or dementia training completed and CNA 10 did not have resident rights or dementia training completed. The Director of Staffing Development indicated she took over the responsibility of providing required training to the staff in July 2018, it had not been done and she had been trying to catch up on training the staff.