

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2019
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NAME OF PROVIDER OR SUPPLIER  APERION CARE MARION LLC	STREET ADDRESS, CITY, STATE, ZIP COD 614 WEST 14TH STREET MARION, IN 46953
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F 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 31, 2019. This visit included the PSR to the Investigation of Complaint IN00283644 completed on January 31, 2019. This visit included a PSR to the State Residential Licensure Survey completed on January 31, 2019.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00284622 and IN00285106 completed on January 31 2019.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00286201 and IN00286392 completed on February 7, 2019.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00289877.</p> <p>Complaint IN00286201 - Not Corrected.</p> <p>Complaint IN00286392 - Not corrected.</p> <p>Complaint IN00283644 - Not corrected.</p> <p>Complaint IN00284622 - Not corrected.</p> <p>Complaint IN00285106 - Not corrected.</p> <p>Complaint IN00289877 -Substantiated. Federal/State and Residential deficiencies related to the allegations are cited at F684, F727, F755, F761, and R117.</p> <p>Survey dates: March 21, 22, and 25, 2019.</p> <p>Facility number: 012809</p>	F 0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 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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F 0677 SS=D Bldg. 00	<p>Provider number: 155799 AIM number: 201136580</p> <p>Census Bed Type: SNF/NF: 39 SNF: 19 Residential: 12 Total: 70</p> <p>Census Payor Type: Medicare: 19 Medicaid: 33 Other: 12 Total: 70</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed March 28, 2019.</p> <p>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;</p> <p>Based on observation, interview, and record review, the facility failed to meet the residents' need for assistance with toileting for 1 of 3 residents reviewed for ADL's (Activity of Daily Living) (Resident 26) .</p> <p>Findings include:</p> <p>During an observation, on 3/21/19 at 10:41 a.m., Resident 26 was sitting in the recliner, her right forearm had a bulky dressing that was visible through her sweater sleeve. She indicated she had</p>	F 0677	<p><b>F677 – ADL Care Provided for Dependent Residents</b> <b>The facility requests paper compliance for this citation.</b> <i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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</i></p>	04/10/2019

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	<p>fallen the day before because there was one staff member assisting her to the bathroom and she required assistance of two.</p> <p>The resident's clinical record was reviewed on 3/21/19 at 3:34 p.m. Diagnoses included, but were not limited to, unspecified osteoarthritis, unspecified site, age-related debility, and frequency of micturition.</p> <p>Physician orders included, but were not limited to the following: Apply kerlix every evening to skin tear to right forearm every night, monitor for signs/symptoms of infection while changing dressing until healed, order date 3/20/19</p> <p>Meloxicam (non-steroidal anti-inflammatory) 7.5 mg (milligram), give one tablet by mouth in the morning for osteoarthritis, order date 1/20/18</p> <p>A 3/12/19, annual, Minimum Data Set (MDS) assessment, indicated the resident had moderate cognitive impairment. She required extensive assistance of two staff members with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. She had frequent episodes of incontinence with bowel and bladder.</p> <p>A current care plan, revised on 6/27/17, indicated the resident needed assistance with ADL's related to decreased mobility, weakness, age-related debility, and hypertension. The interventions included, but were not limited to, toilet use- extensive two person physical assist required.</p> <p>A progress note, dated 3/20/19 at 10:15 a.m., indicated the resident had fallen at 10:15 a.m. in</p>		<p><i>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.</i></p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Due to confidential resident roster residents are unknown. All residents ADL status were updated and added to Kardex and C.N.A task list</p> <p><b>2. 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?</b> All residents transfer methods were reviewed and added to C.N.A task for transfer and bed mobility to ensure clear communication.</p> <p><b>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</b> Nursing staff will be re-educated on how to find information transfer, bed mobility and ambulation assistance for the residents. DON or designee will audit new admissions within 1 business day to ensure method of transfer is added to C.N.A task list. Task list will be updated with</p>		

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F 0684 SS=D Bldg. 00	<p>the bathroom when C.N.A. 14 (Certified Nursing Assistant) was attempting to stand the resident to pull her pants up.</p> <p>A review of the facility's plan of correction indicated it had been completed as of 3/9/19. The plan indicated a facility audit had been completed on those residents that were dependent on staff for toileting, and ADL care. Ongoing audits were to be conducted by the Director of Nursing/designee on two residents weekly to determine appropriate ADL had been provided specifically for dependent residents. The facility was not able to provide documentation of the facility-wide audit being completed.</p> <p>During an interview, on 3/22/19 at 2:15 p.m., CNA 14 indicated she was in training, the person training her told her how much care a resident would need, she learned 3/20/19 that Resident 26 required assistance of two with transfers and toileting.</p> <p>This deficiency was cited on January 31, 2019. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-38(a)(3)</p> <p>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</p>		<p>care plan review and change in condition. Executive Director /designee will be responsible for compliance.</p> <p><b>4. 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?</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. <b>Date of compliance:</b> 4/10/19</p>		

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	<p>comprehensive person-centered care plan, and the residents' choices.</p> <p>Based on record review and interview, the facility failed to monitor overall medical condition and follow physician orders for 3 of 6 residents reviewed for bowel monitoring and nursing services (Residents C, Resident D and Resident F).</p> <p>Findings include:</p> <p>1. Review of Resident C's clinical record was completed on 3/21/19 at 11:45 a.m. Diagnoses included, but were not limited to, failure to thrive and dysphagia.</p> <p>A 3/1/19, admission, Minimum Data Set (MDS) assessment indicated she was cognitively intact, required extensive assistance with transfers and toileting, and was incontinent of bowel.</p> <p>Review of bowel and bladder documentation for March 2019 indicated she had a large bowel movement (BM) on 3/10/19. She did not have another bowel movement until 3/15/19, when she had a small BM.</p> <p>Review of a 3/17/19 progress note indicated she had verbalized having a BM on 3/16/19.</p> <p>There was no indication in the clinical record she had received any intervention or assessment for constipation.</p> <p>2. Review of Resident F's clinical record was completed on 3/22/19 at 11:15 a.m. Diagnoses included, but were not limited to, pulmonary hypertension, diabetes type 2, hypothyroidism, and hypertension.</p>	F 0684	<p><b>F684 – Quality of Care</b>  <b>The facility requests paper compliance for this citation.</b>  <i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b>  Resident D was assessed and had no adverse reaction to the alleged deficient practice. All wound care supplies are in house currently. Residents C, D, F were assessed and had no adverse effects related to abnormal bowel movement schedule.</p> <p><b>2. 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?</b>  All residents with bowel movement</p>	04/10/2019

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	<p>A 3/4/19, 14 day, MDS assessment indicated she was cognitively intact, required extensive assistance with transfers and toileting, did not walk, and was incontinent of bowel.</p> <p>Review of bowel and bladder documentation for March 12 - 25, 2019, indicated she had a medium BM on 3/15/19. She had not had another documented BM since 3/15/19.</p> <p>There was no indication in the clinical record she had received any intervention or assessment for constipation.</p> <p>During an interview, on 3/25/19 at 10:41 a.m., RN 11 indicated the electronic health record alerted nursing staff when a resident had not had a BM in 48 hours and again at 72 hours. She reviewed Resident F's clinical record and could not identify a laxative order, nor could she identify when the resident had last had a BM.</p> <p>Review of an undated, current facility protocol titled Bowel Elimination Protocol, provided by the Administrator on 3/25/19 at 2:07 p.m., indicated CNAs were responsible for documenting all BMs and for asking alert residents about their elimination each shift. The results were to be given to the charge nurse to document. Residents who have had no BM for six shifts would be offered prune juice. Residents who had no BM for 9 shifts would be assessed for the possibility of impaction. If no fecal impaction was found, a laxative would be administered. If there was no order for a laxative, the physician would be notified.</p> <p>3. During an interview with Resident D, on 3/21/19 at 2:23 p.m., he indicated he had a diabetic</p>		<p>pattern greater than 72 hours will be assessed and addressed as needed. All residents receiving wound care will have treatment reviewed and ensure wound care supplies are available.</p> <p><b>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</b> Nursing staff will be reeducated on the appropriate action for missing treatment or medical supplies. Nursing staff will be reeducated on bowel movement tracking on dashboard and proper documentation of bowel records. DON/designee will audit 5 residents per week for availability of medical supplies and treatments. DON/designee will audit 5 residents per week to ensure residents with no documented BM for 72 hours is addressed. The Executive Director /designee will be responsible for compliance.</p> <p><b>4. 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?</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends</p>		

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	<p>ulcer on his right heel, and he went to the wound clinic every Thursday. On 3/14/19, the wound clinic ordered an Unna Boot to his right foot and it was to be changed every Monday, Wednesday and Friday. On Friday, 3/15/19, Resident D indicated the Unna Boot was not changed. On Saturday, 3/16/19, the resident said the nurse told him, it was a bad day on Friday, she changed the dressing and applied an ace wrap because the Unna Boot supplies had not arrived at the facility. On Monday, 3/18/19, the Unna Boot supplies had not arrived. On Wednesday, 3/19/19, a nurse had indicated to him they had found the Unna Boot supplies somewhere near the front of the facility. The Unna Boot was applied to his right foot on 3/20/19.</p> <p>Resident D's clinical record was reviewed, on 3/21/19 at 3:30 p.m. Diagnoses included, but were not limited to, acute osteomyelitis in the right ankle and foot, pain in right ankle and joints of right foot, type 2 diabetes mellitus with hyperglycemia, long term use of insulin, and peripheral vascular disease.</p> <p>A quarterly MDS (Minimum Data Set), dated 1/24/19, indicated the resident was cognitively intact, he required extensive assist of two staff members for bed mobility, transfers, dressing and personal hygiene. He had a diabetic foot ulcer, received surgical wound care and an application of dressing to his feet.</p> <p>A care plan, dated 10/24/18, indicated Resident D had a surgical incision/wound to his right posterior foot, and amputation. Interventions included, but were not limited to, treatment as ordered.</p> <p>A physicians order with a start date of 3/15/19 and</p>		<p>or patterns and make recommendations to revise the plan of correction as indicated. <b>5. Date of compliance: 4/10/19</b></p>		

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

PRINTED: 04/08/2019

FORM APPROVED

OMB NO. 0938-039

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	<p>an end date of 3/21/19, indicated the right lateral ankle was to be cleansed with sterile water, covered with Aqacel AG (silver), then apply Unna boot and Calamine, change 3 times weekly, every day shift on Monday, Wednesday and Friday.</p> <p>A review of the MAR (Medication Administration Record) indicated, on 3/15/19, the Unna Boot was applied. On 3/18/19, it indicated to see the progress note. On 3/20/19, it indicated the Unna Boot was applied.</p> <p>During an interview with RN 73, on 3/21/19 at 4:01 p.m., she indicated there was an ordering issue with the Unna Boot, facility management normally ordered the supplies, it was communication breakdown and she was not really sure what happened.</p> <p>During an interview with LPN 79, on 3/25/19 at 2:28 p.m., she indicated last month the wound nurse position had been eliminated, now the nurses are supposed to be doing the wound treatments, and they would normally do measurements every week on a certain day. She had no wound training whatsoever, they keep telling her they will be doing inservices but they have not have had one on wounds since the wound nurse had been eliminated.</p> <p>This Federal tag is related to Complaint IN00289877.</p> <p>This deficiency was cited on 2/7/19. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-37(a)</p>				

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F 0689 SS=D Bldg. 00	<p>483.25(d)(1)(2) 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</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a fall was adequately assessed, documented, and investigated for 1 of 3 residents reviewed for assessments (Resident M).</p> <p>Findings include:</p> <p>During an interview, on 3/25/19 at 10:54 a.m., Resident M indicated she had fallen the previous month, when a staff member had let go of her. The staff member had taken her hand to pull her up and the wheelchair had gone out from behind her, and she had fallen to the floor. Her back had hit the wall and had been scratched up. She indicated to a marred area on the wall, where her back had hit it and the wheelchair had scratched it.</p> <p>Resident M's clinical record was completed on 3/25/19 at 11:00 a.m. Diagnoses included, but were not limited to, hypertension, dementia, anxiety, and depression.</p> <p>A 3/5/19 Minimum Data Set (MDS) assessment indicated she was cognitively intact and required extensive assistance with transfers. She had</p>	F 0689	<p><b>F689 – Free of Accidents/Hazards/Supervision/ Devices</b> <b>The facility requests paper compliance for this citation.</b> <i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Due to confidential nature of complaints the roster was not made available. All transfer</p>	04/10/2019	

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	<p>experienced no falls since admission to the facility.</p> <p>She had a current, 2/6/19, care plan problem of risk for falls related to unsteady gait and muscle weakness. Interventions included, but were not limited to, ensure the call light was in reach, prompt response to requests for assistance, remove any potential causes if possible, and educate the resident/family/caregivers/IDT as to causes.</p> <p>Review of a 2/5/19 Fall Risk assessment indicated she was at risk for falls.</p> <p>Review of a 2/10/19 progress note indicated she had fallen after losing her balance while transferring from her recliner to her wheelchair to go to the bathroom. She had fallen backward and hit her back, resulting in a 2.5 centimeter (cm) long x 5.0 cm wide abrasion. Interventions to prevent recurrence included, but were not limited to, ensure proper footwear, ensure CNA uses gait belt, and give the resident time for transfers.</p> <p>Review of facility audits, for the weeks ending both 3/16/19 and 3/23/19, indicated there were no residents with falls reviewed for the facility audits. The boxes designated for falls were marked as not applicable or no falls.</p> <p>During an interview, on 3/21/19 at 11:11 a.m., the Administrator indicated there had been different Nurse Consultants helping out with the audits, since the DON had left employment the weekend of 3/10/19.</p> <p>During an interview, on 3/22/19 at 12:26 p.m., Nurse Consultant 13 indicated she had completed most of the audits, but was waiting on information</p>		<p>statuses were updated and added to C.N.A task list.</p> <p><b>2. 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?</b> An audit was completed on all residents with an incident or accident in the last 14 days were assessed for complete investigation and interventions were updated as needed.</p> <p><b>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?</b> Nursing staff will be reeducated on investigating and implementing interventions post incident. DON/designee will audit 5 residents per week to ensure appropriate intervention and complete investigation. The Executive Director /designee will be responsible for compliance.</p> <p><b>4. 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?</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and</p>	

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	<p>from another Nurse Consultant, who had also completed some reviews.</p> <p>During an interview, on 3/25/19 at 11:12 a.m., the Administrator indicated she had not reported Resident M's fall to ISDH, since the DON had reported to her there had been no injury.</p> <p>Review of a Fall Investigation document, provided by Nurse Consultant 13 on 3/25/19 at 2:07 p.m., indicated the resident was being helped out of a recliner by a CNA, when she had lost her balance and fell, resulting in an abrasion to her lower back. There were no environment factors and the resident's gait imbalance contributed to the fall.</p> <p>During an interview, on 3/25/19 at 11:36 a.m., Nurse Consultant 13 indicated the fall and injury were not reported to the state agency due to the injury did not impede her daily activities.</p> <p>During an interview, on 3/25/19 at 3:26 p.m., Nurse Consultant 13 indicated there was no IDT follow up for the fall in the resident's clinical record.</p> <p>Review of a current facility policy, titled "Fall Prevention Program," revised 11/21/17 and provided by Nurse Consultant 13 on 3/25/19 at 2:07 p.m., indicated the program would include measures which determine the individual needs of the resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices were utilized as necessary. Quality Assurance Programs would monitor the program to assure ongoing effectiveness. Safety interventions would be implemented for each resident identified at risk. Accident/Incident reports involving falls would be reviewed by the IDT to ensure appropriate care and services were</p>		<p>make recommendations to revise the plan of correction as indicated.</p> <p><b>5. Date of compliance: 4/10/19</b></p>		

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F 0692 SS=D Bldg. 00	<p>provided and determine possible safety interventions.</p> <p>This deficiency was cited on 2/7/19. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-37(a)</p> <p>483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview the facility failed to monitor significant weight gains for 2 of 3 residents reviewed for weight changes (Resident 26 and Resident B).</p> <p>Findings include:</p>	F 0692	<p><b>F692 – Nutrition/Hydration Status Maintenance</b> The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	04/10/2019

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	<p>1. Resident 26's clinical record was reviewed on 3/21/19 at 3:34 p.m. Diagnoses included, but were not limited to, gastro-esophageal reflux disease (GERD) without esophagitis and essential (primary) hypertension (HTN), unspecified.</p> <p>Physician orders included, but were not limited to the following: regular diet, order date 1/20/18 ensure (nutritional supplement) three times a day for supplement, give 240 ml's (milliliters), order date 2/9/19 hydrochlorothiazide (water pill) 25 mg, give one tablet by mouth one time a day for HTN, hold for systolic blood pressure less than 110 or pulse less than 60, order date 7/9/18 furosemide solution (water pill), inject 40 mg (milligram) intramuscularly one time a day for congestive heart failure exacerbation, wet lungs, for three days, first dose 3/25/19, order date 3/25/19 norvasc (anti-hypertensive) 2.5 mg, give one tablet by mouth at bedtime for HTN, hold for systolic blood pressure less than 110 or pulse less than 60, order date 7/9/18 omeprazole (antacid) delayed release 20 mg, give one tablet by mouth at bedtime for acid indigestion, order date 1/20/18.</p> <p>A 3/12/19, annual, Minimum Data Set (MDS) assessment, indicated the resident had moderate cognitive impairment. She required extensive assistance of two staff members with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. Her active diagnoses included, but were not limited to, HTN, GERD, thyroid disorder, and arthritis. She had received a diuretic three days and an opioid seven days during the assessment period.</p> <p>A current care plan, with a revision date 12/10/18, indicated she had altered nutrition and hydration</p>		<p><i>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.</i></p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident 26 was assessed, and MD was notified of weight variation of 5%, 7.5% or 10% according to MDS guidelines. Resident had no adverse effects related to alleged deficient practice. Due to confidential nature of complaints the roster was not made available house wide audit was completed.</p> <p><b>2. 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?</b> All current residents weight records will be reviewed, and notification of the MD and dietician will be completed as needed. Interventions will be updated accordingly.</p> <p><b>3. What measures will be put into place and what systemic</b></p>		

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	<p>risk related to GERD and HTN. The goal indicated she would have no unintended weight (loss/gain) through next review date of 3/28/19. The interventions included, but were not limited to, notify medical doctor of significant weight change.</p> <p>Review of the resident's weights indicated the following:</p> <p>On 3/14/19 her weight was 115.4 lbs (pounds).</p> <p>On 3/16/19 her weight was 114.8 lbs.</p> <p>On 3/17/19 her weight was 133.4 lbs.</p> <p>On 3/18/19 her weight was 132.4 lbs, this was a 17 lb gain from her weight on 3/14/19.</p> <p>Prior to the progress note, dated 3/22/19 at 4:40 p.m., the record lacked notification to the medical doctor.</p> <p>A progress note, dated 3/22/19 at 4:40 p.m., indicated the resident's weight on 3/14/19 was 115 lbs, 3/22/19 weight was 121.4 lbs, she did not have a diagnosis of heart failure and had no signs/symptoms of recent increase in edema. The resident's daughter and the Nurse Practitioner were notified.</p> <p>During an interview, on 3/22/19 at 2:47 p.m., LPN 15 indicated she was not aware of the resident's weight gain.</p> <p>2. Resident B's clinical record was reviewed on 3/22/19 at 4:11 p.m. Diagnoses included, but were not limited to, hypertensive heart disease, GERD, and other recurrent depressive disorders.</p>		<p><b>changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Nursing staff will be re-educated on daily and weekly weight requirements and following MD orders, MDS guidelines for MD notification. DON/designee will audit 5 records per week for weight loss, MD notification and appropriate action. Executive Director /designee will be responsible for compliance.</p> <p><b>4. 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?</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.</p> <p><b>5. Date of compliance: 4/10/19</b></p>		

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	<p>Physician orders included, but were not limited to the following: no added salt diet, order date 2/22/19; daily weight, notify Medical Doctor/Nurse Practitioner (MD/NP) if the resident had a weight gain of 3.0 lbs in a day or 5.0 lbs in a week, for congestive heart failure program, order date 2/23/19; aspirin (blood thinner) 81 mg, give one tablet by mouth in the morning related to chronic atrial fibrillation, order date 2/22/19; digoxin (antiarrhythmic) 125 mcg (microgram), give one tablet by mouth in the evening for atrial fibrillation, order date 2/22/19; diltiazam HCL (antihypertensive) 240 mg, give one tablet by mouth in the morning for hypertension, order date 2/22/19 furosemide (diuretic) 40 mg, give one tablet by mouth every day and evening shift for edema related to unspecified diastolic (congestive) heart failure, order date 2/22/19.</p> <p>A 2/12/19, quarterly, MDS assessment indicated the resident was cognitively intact. She had a 5% or more weight gain in the last month or a 10% or more weight gain in the last six months, and was not on a physician's prescribed weight-gain regimen. Active diagnoses included, but were not limited to, heart failure, hypertension, and depression.</p> <p>A current care plan, with a revision date 8/31/18, for altered nutrition and hydration risk related to atrial fibrillation, anemia, chronic obstructive pulmonary disease, edema, expected weight fluctuations due to edema and diuretic use, GERD, heart disease, hypo-thyroidism, hypertension, and kidney disease. The goal indicated she would have no unintended weight (loss/gain) through next review date of 5/7/19. The interventions included, but were not limited to, monitor weights daily.</p>				

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F 0755 SS=D	<p>Review of the resident's weights indicated the following:</p> <p>On 3/18/19 her weight was 154.4 lbs.</p> <p>On 3/19/19 her weight was 155.0 lbs.</p> <p>On 3/20/19 her weight was 149.8 lbs.</p> <p>On 3/21/19 her weight was 158.2 lbs., this was a 8.4 lb weight gain in one day.</p> <p>As of 3/24/19 at 4:22 p.m., the record lacked notification to the MD/NP.</p> <p>During an interview, on 3/25/19 at 10:50 a.m., LPN 15 indicated she was aware of the resident was weighed daily, that there were parameters for physician notification with the daily weight order, and the notification would have been charted in the progress notes.</p> <p>Review of a current facility policy titled, "Nutritional Monitoring," provided by the Administrator on 3/25/19 at 2:07 p.m., indicated, undesired or unanticipated weight losses or weight gains of 2 1/2% in one week, 5% in one month, or 10% in 180 days shall be reported to the physician, dietary manager, and registered dietician.</p> <p>This deficiency was cited on January 31, 2019. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-46</p> <p>483.45(a)(b)(1)-(3) Pharmacy</p>						

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Bldg. 00	<p>Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Based on observation, interview, and record review the facility failed to ensure parameters were monitored with medication administration for 2 of 2 residents reviewed during observation of medication administration. (Resident B and</p>	F 0755	<b>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.</b>	04/10/2019	

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	<p>Resident E)</p> <p>Findings include:</p> <p>1. Resident B's clinical record review was reviewed, on 3/21/19 at 3:30 p.m. Diagnoses included, but were not limited to, acute respiratory failure with hypercapnia, cognitive communication deficit, acute myocardial infarction, unspecified, hypertensive heart disease with heart failure, chronic kidney disease, stage 3 (moderate), nonrheumatic aortic valve disorder, unspecified, chronic atrial fibrillation.</p> <p>An order, dated 2/23/19, indicated the resident was to receive digoxin tablet 125 mcg, give one tablet by mouth in the evening for atrial fibrillation, hold if pulse is less than 60.</p> <p>During an observation of a medication pass with QMA 23, on 3/21/19 at 3:04 p.m., she prepared the following medications: digoxin (antirhythmic) 125 mcg (microgram), doxycycline hyclate (antibiotic) 100 mg, Lasix (water pill) 40 mg, gabapentin (nerve pain) 400 mg, Preservision areds (eye vitamin). The label of the digoxin indicated to hold medication if the resident's pulse was below 60. QMA 23 did not obtain a pulse prior to administration of the medication, digoxin. She indicated at her previous job she looked for the red heart on the MAR (Medication Administration Record) to indicate she needed to take a pulse prior to administration and she did not realize the MAR indicated to hold medication if the resident's pulse was less than 60.</p> <p>2. Resident E's clinical record was reviewed, on 3/21/19 at 3:30 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, essential hypertension, dysphagia ,oropharyngeal phase.</p>		<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the F755 – Pharmacy Services/Procedures/Pharmacist/Records 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.</i></p> <p><b>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Due to confidential nature of complaints the roster was not made available. House wide audit was completed, and meds requested from pharmacy.</p> <p><b>2. 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?</b> All residents with medication parameters will be reviewed for compliance with monitoring for last 7 days. Report of “omitted” drugs for the last 7 days will be reviewed and medications will be requested from pharmacy.</p> <p><b>3. What measures will be put into place and what systemic changes will be made to</b></p>	

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	<p>An order with a start date of 3/5/19 and an end date of 3/17/19, indicated the resident was to receive Chlorophyll (odor reducer) tablet, 3 mg by mouth every morning and at bedtime for odor reducer.</p> <p>Review of the MAR (Medication Administration Record) indicated, the medication was given in the morning, on 3/9/19, 3/10/19, 3/12/19, 3/13/19, 3/14/19, and in the evening on 3/16/19, and to see the progress notes on 17 of the 23 administration times.</p> <p>Review of the nurses notes indicated, the medication was not available, from 3/5/19 through 3/16/19.</p> <p>During an interview, on 3/21/19 at 3:59 p.m., RN 73 indicated the Chlorophyll was from the hospital, it was a special mixture, and was unable to retrieve it from the pharmacy so doctor discontinued it. The resident had went so long without it and she had no adverse effects from not getting it, so they decided to get rid of it.</p> <p>During an interview with the Nurse Consultant, on 3/25/19 at 4:23 p.m., she indicated the facility did not have a policy regarding medication with parameters and they go by the physician orders.</p> <p>This Federal tag is related to Complaint IN00289877.</p> <p>This deficiency was cited on 1/31/19. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25</p>		<p><b>ensure that the deficient practice does not recur?</b> Nursing staff will be reeducated on medication parameters and proper procedure for unavailable medications. DON/designee will audit 5 records per week to ensure med availability and proper dosing according to MD orders. Executive Director/designee will be responsible for compliance.</p> <p><b>4. 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?</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.</p> <p><b>5. Date of compliance: 4/10/19</b></p>	

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R 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on January 31, 2019. This visit included the PSR to the Investigation of Complaint IN00283644 completed on January 31, 2019. This visit included a PSR to the Recertification and State Licensure Survey completed on January 31, 2019.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00284622 and IN00285106 completed on January 31 2019.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00286201 and IN00286392 completed on February 7, 2019.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00289877.</p> <p>Complaint IN00286201 - Corrected.</p> <p>Complaint IN00286392 - Not corrected.</p> <p>Complaint IN00283644 - Not corrected.</p> <p>Complaint IN00284622 - Not corrected.</p> <p>Complaint IN00285106 - Not corrected.</p> <p>Complaint IN00145184-Substantiated. Federal/State and Residential deficiencies related to the allegations are cited at F684, F727, F755, F761, and R117.</p> <p>Survey dates: March 21, 22, and 25, 2019.</p> <p>Facility number: 012809</p>	R 0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p>	

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

PRINTED: 04/08/2019

FORM APPROVED

OMB NO. 0938-039

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	<p>Provider number: 155799 AIM number: 201136580</p> <p>Census Bed Type: SNF/NF: 39 SNF: 19 Residential: 12 Total: 70</p> <p>Census Payor Type: Medicare: 19 Medicaid: 33 Other: 12 Total: 70</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p>				