

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2017
NAME OF PROVIDER OR SUPPLIER APERION CARE VALPARAISO		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383		
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00239302.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 7/17/17.</p> <p>Complaint IN00239302 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314.</p> <p>Survey dates: August 29 & 30, 2017</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Census Bed Type: SNF/NF: 94 Total: 94</p> <p>Census Payor Type: Medicare: 13 Medicaid: 71 Other: 10 Total: 94</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0314 SS=G Bldg. 00	<p>Quality review completed on 9/5/17.</p> <p>483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -</p> <p>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>Based on record review and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to not staging the pressure ulcers appropriately and providing the correct treatment for areas with necrotic tissue which resulted in the worsening of an unstageable pressure ulcer and hospitalization for 1 of 4 residents reviewed for pressure ulcers.</p>		F 0314	<p>F 314</p> <p>The facility requests paper compliance for this citation.</p> <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</i></p>	09/14/2017

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	<p>(Resident B)</p> <p>Finding includes:</p> <p>The closed record for Resident B was reviewed on 8/30/17 at 8:28 a.m. The resident was admitted to the hospital on 8/24/17 and was currently still there. Diagnoses included, but were not limited to, chronic respiratory failure, hypoxia, coma, tracheostomy, gastrostomy, high blood pressure, convulsions, contractures right foot and left foot, retention of urine, contractures of elbow and pemphigus.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/17, indicated the resident was in a vegetative state. The resident was totally dependent on staff for all of his activities of daily living including bed mobility, transfers, toilet use, dressing, and eating. The resident was at risk for pressure ulcers and currently had a Stage 2 pressure ulcer that originated on 5/18/17. The resident received enteral feeding via the gastrostomy tube for nutrition and had a tracheostomy.</p> <p>A Braden scale pressure ulcer risk assessment, dated 8/15/17, indicated the resident was a high risk for pressure ulcers.</p>		<p><i>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>1) Immediate actions taken for those residents identified: Resident B has been discharged</p> <p>2) How the facility identified other residents: All resident have the potential to be affected and were audited for skin assessments and correct treatments in place</p> <p>3) Measures put into place/ System changes: In-service nursing regarding pressure ulcer assessment, prevention, treatments and signing out of treatments.</p> <p>4) How the corrective actions will be monitored: Audits will be performed on timeliness and accuracy of wound assessments, treatment sign out and correct treatment in place on 3 residents per unit per week. The results of these audits will be reviewed in Quality Assurance</p>	

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	<p>A care plan, updated 6/2017, indicated the resident was at risk for pressure ulcers related to unable to make independent movements, bowel incontinence and a history of pressure ulcers.</p> <p>A Nurse's note, dated 7/25/17, indicated a weekly skin observation was completed. The resident's skin was intact. There were blisters to his feet but they were not new.</p> <p>A Nurse's note, dated 8/8/17, indicated a weekly skin observation was completed and the resident's skin was intact, with no foot concerns.</p> <p>A Nurse's note, dated 8/11/17 at 10:07 a.m., indicated the Physician was made aware of areas to the resident's bilateral buttock and new orders were received to cleanse with wound cleanser and apply Anasept (an antimicrobial gel) and foam dressing every Monday and Thursday and as needed. The resident's wife was made aware.</p> <p>Physician orders, dated 8/11/17, indicated cleanse bilateral buttocks with wound cleanser and apply Anasept gel and foam dressing. Change every Monday and Thursday and as needed.</p>		<p>Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.</p> <p>5) Date of compliance: 9/14/2017</p>	

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	<p>The Treatment Administration Record (TAR), dated 8/2017, indicated the Anasept treatment was not signed out as being completed on 8/11/17 when ordered. The treatment was signed out 1 time on 8/14/17. It was discontinued on 8/16/17.</p> <p>There was no evidence the pressure ulcers to the right and left buttocks were assessed, measured, and documented on the Wound Assessment Details report.</p> <p>A Nurse's note, dated 8/15/17 at 12:39 a.m., indicated the resident had abnormal labs. A Complete Blood Count (CBC) with differential was completed and the White cell Blood Count was 22.8 (a high value indicating infection). The Physician was notified and new orders were obtained for Levaquin (an antibiotic) 500 milligrams (mg) 1 every day for 10 days for an urinary tract infection.</p> <p>A Nurse's note, dated 8/15/17 at 8:43 p.m., indicated a weekly skin observation had been completed. The skin concerns observed were left buttock open area 2 centimeters (cm) in diameter and right buttock open area 2 cm diameter. The areas were not new.</p> <p>A Nurse's note, dated 8/16/17 at 11:44</p>			

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	<p>a.m., indicated new orders for Cavilon Skin Prep (a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films) spray to bilateral buttocks every day.</p> <p>A Physician order, dated 8/16/17, indicated Cavilon no sting barrier film-liquid. Apply to both buttocks topically one time a day for wound care after cleansing with wound cleanser. Cover with dry dressing and change daily and as needed.</p> <p>The 8/2017 TAR indicated the treatment had been signed out as being completed on 8/16-8/18, and 8/21-8/22/17. The treatment was not signed out on 8/19 and on 8/20 the code which was documented indicated to see Nurse's notes.</p> <p>A Wound Assessment Details Report, dated 8/15/17, indicated the resident had pressure ulcers. The site was left lower leg back, the clinical Stage was a 2 and the tissue was 100% non-blanchable erythema (red intact skin). There was scant amount of serous drainage. The wound measured 9 cm by 11 cm by .1. The other pressure ulcer was identified as the right back of the thigh, the clinical Stage was a 2 and the tissue was 100%</p>			

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	<p>non-blanchable erythema. There was scant amount of serous drainage. The wound measured 3.2 cm by 3.2 cm by .1. Both pressure ulcers were originally identified on 8/11/17.</p> <p>A Nurse's note, dated 8/22/17 at 3:35 p.m., indicated a new order was received for Santyl ointment (a debriding agent used for necrotic tissue) to the wound on the coccyx and cover with dry dressing daily.</p> <p>The 8/2017 TAR indicated the Santyl ointment had not been signed out as being completed for 8/22/17.</p> <p>A Physician Progress note, dated 8/23/17, indicated the resident had a urinary tract infection and was currently on Levaquin. "I was asked to look at the decubitus ulcer, it was draining. Refer to wound care clinic."</p> <p>A Nurse's note, dated 8/23/17 at 2:36 p.m., indicated new orders received for coccyx wound. Clean area and apply Santyl to yellow slough, pack wound with Alginate, use skin prep to peri area, cover with foam dressing daily and as needed for soiling.</p> <p>The 8/2017 TAR indicated the Santyl ointment and Alginate packing had been</p>				

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	<p>signed out for the first time on 8/24/17.</p> <p>The Wound Assessment Details Report dated 8/22/17 indicated the right thigh back and left lower leg back were now combined into one large area called the coccyx. The pressure ulcer was now a Stage 4 with 25% slough (necrotic tissue) with moderate amount of serous drainage, measuring 14.2 cm by 7.5 cm by 6 cm.</p> <p>The Wound Assessment Details Report, dated 8/23/17, indicated the coccyx pressure ulcer was now classified as a deep tissue injury with 75% slough, moderate serous drainage, and measured 16 cm by 8 cm by unknown.</p> <p>A Nurse's note, dated 8/24/17 at 8:56 p.m., indicated the resident's blood pressure had dropped to 87/53 and his heart rate was 123. The Physician and wife were notified and new orders to send to the hospital were obtained.</p> <p>The resident was admitted for renal insufficiency, pneumonia, and severe sepsis.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 8/30/17 at 11:00 a.m., indicated she was asked to help out with wounds when the wound nurse left</p>			

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	<p>about 3 weeks ago. She had no prior experience working with pressure ulcers, did not know how to stage wounds, and had to get an application on her phone to help her stage the wounds. The ADON indicated Resident B's areas were actually to the lower buttocks, but the computer wound program would not allow her to pick that option, so she was told by the old wound nurse to pick an area in the computer that the wounds were closer to. After measuring and seeing the pressure ulcers for the first time on 8/15/17, she staged both areas as a Stage 2, but she had no idea there was necrotic tissue on both of the areas. She had chosen the skin prep spray because she remembered another nurse who she had worked with had used the spray before on wounds.</p> <p>The Vice President (VP) of Clinical Services brought in her computer on 8/30/17 at 11:17 a.m. so the pressure ulcers could be viewed in color. At that time, she was asked to describe the left lower leg back pressure ulcer that was assessed on 8/15/17. The left lower leg back pressure ulcer was not 100% Erythema as indicated in the weekly wound documentation. She would not have staged the wound as a stage 2 either because, in the color picture, there were many areas of yellow slough throughout the wound. The VP of Clinical Services</p>				

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	<p>indicated the pressure ulcer to the left lower leg back would be unstageable. The color picture for the right thigh back was viewed. The VP indicated there was slough on that wound as well, however, with the picture alone she would not be able correctly stage the wound. She indicated for both wounds, 100% Erythema would not have been her assessment. The Caviton Skin Prep spray would not have been the treatment of choice for both pressure areas as well.</p> <p>Interview with the Administrator on 8/30/17 at 11:25 a.m., indicated he had spoken to the nurse who originally assessed the wounds on 8/11/17. She remembered the pressure ulcers, and getting a treatment for them, however, she did not know if she measured the areas or where that documentation would currently be located.</p> <p>This Federal tag relates to Complaint IN00239302.</p> <p>3.1-40(a)(2)</p>				