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	155799	A. BUILDING 00 B. WING	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00421071 and IN00421177. Complaint IN00421071 - Federal/State deficiencies related to the allegations are cited at F656. Complaint IN00421177 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: November 8 and 9, 2023. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 40 SNF: 4 Total: 44 Census Payor Type: Medicare: 4 Medicaid: 27 Other: 13 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 15, 2023.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tamera Shirels	ED	11/28/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable 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. §483.21(b)(3) The services provided or			

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	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	A. Based on interview and record review, the facility failed to develop a care plan to prevent further falls for 1 of 3 residents reviewed for falls. (Resident C) B. Based on observation and interview, the facility failed to develop care plans for residents with pressure related wounds for 3 of 3 residents reviewed for wounds (Resident B, D and F). Findings include: A. Resident C's clinical record was reviewed on 11/8/23 10:52 a.m. Diagnoses included type 2 diabetes mellitus without complications, essential (primary) hypertension, epilepsy, unspecified, intractable, with status epilepticus, Parkinson's disease, other abnormalities of gait and mobility, muscle weakness (generalized), aftercare following joint replacement surgery, cognitive communication deficit, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. An admission Minimum Data Set (MDS) assessment, dated 7/25/23, indicated she was severely cognitively impaired. She required extensive assistance of two staff members for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. She had two or more falls with no injury since admission/entry, re-entry, or the prior assessment (OBRA or Scheduled PPS). She had current care plan problem of risk for	F 0656	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Inter Disciplinary Team was educated on care plans for falls and wounds II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents with falls or wounds will be discussed in daily (Monday-Friday) and care plans will be developed/updated at that time. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff involved with developing resident care plans were educated on the process. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit 6 resident care plans daily(Monday-Friday) for 4 weeks, then audit 4 resident	11/28/2023

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	fall/injury from weakness and tiredness (7/18/23). Interventions included administer medications as ordered (7/18/23), bed height to be placed where my feet are flat on the floor (7/18/23), notify physician as needed of any changes (7/18/23), observe effectiveness of medications (7/18/23) and obtain labs as ordered and notify the physician of results (7/18/23). An admission fall assessment, dated 7/14/23, indicated she was at risk for falling. Review of her nurses notes indicated the following: On 7/18/23 at 3:48 p.m., she was found on the floor on her left side in front of the recliner. She was assisted into the wheelchair and brought out to the lounge. Neurological checks were initiated. On 7/24/23 at 6:35 p.m., she was found lying on her side on the mat next to her bed. She stated she was trying to go to the bathroom. Her care plan lacked a new intervention to prevent further falls. On 7/30/23 at 11:00 a.m., she was found lying on the floor next to her bed on the floor mat at 10:15 a.m. Her bed was in the lowest position. She was moaning in pain and holding her head. She had a small laceration to the top of her right side of scalp. Area was cleansed with wound cleanser and pressure dressing applied to cease bleeding. A new order was received to send her to the emergency room. Her care plan lacked a new intervention to prevent further falls.		care plans daily for 4 weeks and then 2 resident care plans weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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During an interview, with the DON, on 11/9/23 at 12:58 p.m., she indicated falls were reviewed in the morning meetings and interventions would be put into place and put in the resident's care plan.

During an interview, with the MDS Coordinator, on 11/9/23 at 1:49 p.m., she indicated they reviewed falls in the morning meeting. She would update the care plan if she was asked to. She completed a baseline care plan for new admissions, she reviewed and updated the care plan during the resident's quarterly and annual assessments.

A current facility policy, revised on 11/21/17, titled "Fall Prevention Program," provided by the Regional Vice President, on 11/9/23 at 2:14 p.m., indicated the following: "Guidelines: The Fall Prevention Program includes the following components... Care plan incorporates: Identification of all risk/issue, addresses each fall, interventions are changed with each fall, as appropriate, and preventative measures...."

B. 1. During a facility tour, with the ADON, on 11/8/23 at 9:01 a.m., she indicated Resident B had a colostomy reversal and a hernia repair. She had 26 staples and an egg-sized wound that had dehisced (separated) on the inside. They were doing wet to dry dressings until her wound vacuum (wound VAC) came. She had a follow up surgical appointment last week and was sent to the hospital from the appointment.

Resident B's clinical record was reviewed on 11/8/23 at 9:47 a.m. Diagnoses included heart failure, chronic kidney disease, unspecified severe protein-calorie malnutrition, and other specified postprocedural states.

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A significant change MDS assessment, dated 10/24/23, indicated she was cognitively intact and she had a surgical wound.

On 10/20/23 at 5:34 p.m., she returned from the hospital from a planned colostomy takedown with low anterior resection and ureteral stent placement. She also underwent exploratory laparotomy (surgical incision into the abdominal cavity) with lysis (destruction) of adhesions. She had an abdominal wall closure and hernia repair with mesh. A wound VAC hose and dressing was intact to the abdominal surgical site. Orders for a wet to dry dressing was being placed on the surgical site until the wound VAC arrived at the facility. She was alert and oriented, was able to voice her needs, and she requested to go outside to smoke. She voiced mild pain to her abdominal area. She ambulated with a walker with supervision.

Her clinical record lacked a care plan related to her colostomy reversal.

During an interview, with the DON, on 11/9/23 at 12:58 p.m., she indicated Resident B should had a care plan related to her surgical wound.

B.2. During a facility tour, with the ADON, on 11/8/23 at 9:01 a.m., she indicated Resident D received hospice services and had a facility-acquired stage 3 (full-thickness skin loss) wound to her coccyx. Interventions included a low air loss mattress, pressure boots, and she was checked hourly and turned/repositioned every two hours.

Resident D's clinical record was reviewed on 11/8/23 at 3:02 p.m. Diagnoses included iron deficiency anemia, broken internal left hip

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prosthesis, subsequent encounter, adult failure to thrive, chronic diastolic (congestive) heart failure, and chronic kidney disease, stage 3.

A quarterly MDS assessment, dated 11/5/23, indicated she was severely cognitively impaired. She required extensive assistance of two staff members for bed mobility and toilet use. She required total assistance of two staff members for transfers. She had one unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. She had a pressure reducing device to her chair and bed. She had applications of ointments/medications other than to her feet.

A skin assessment, dated 7/27/23, indicated she was at a moderate risk for developing pressure ulcers.

A skin assessment, dated 9/12/23, indicated she was at a high risk for developing pressure ulcers.

She had a care plan for potential for impairment to skin integrity related to impaired mobility, status post total left hip arthroplasty revision, anemia, cardiac/cardiovascular disease that may affect tissue perfusion, adult failure to thrive, at risk for malnutrition, and incontinence (5/10/22). Her interventions included administer/monitor effectiveness of medications as ordered (5/10/22, assess/record changes in skin status (5/10/22), avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short (5/10/22), avoid shearing: use lift sheet for repositioning (5/10/22), avoid skin-to-skin contact (5/10/22), ensure linens are wrinkle free (5/10/22), follow facility protocols for treatment of injury (5/10/22), keep skin clean and dry, use lotion on dry skin (5/10/22), minimize pressure over boney prominences (5/10/22), protective skin barrier

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cream as ordered (5/10/22), provide diet as ordered and monitor nutritional status and dietary needs (5/10/22), report pertinent changes in skin status to physician (5/10/22), treatment as ordered (5/10/22), use a draw sheet or lifting device to move resident (5/10/22), use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface (5/10/22).

A nurses note, dated 9/8/23 at 2:12 p.m., indicated she had developed a pressure wound to her coccyx and measured 1 cm x 2 cm. The area was cleansed, Medihoney was applied, and covered with a foam border. Hospice was notified of area and treatment. An air mattress was requested.

A skin and wound evaluation, dated 9/12/23, indicated she developed a facility acquired stage 2 (partial-thickness skin loss with exposed dermis) pressure ulcer on her coccyx and measured 1.2 cm (centimeters) x 0.9 cm (length x width).

The clinical record lacked a care plan for her pressure ulcers.

During an interview, with the DON, on 11/9/23 at 12:58 p.m., she indicated the ADON/Wound nurse would be notified of a new wound and she would double check to make sure a treatment and interventions were put into place. She provided the MDS Coordinator a weekly list of residents with wounds and she would update the care plans. She did not see a care plan for wounds for Resident D.

B.3. During a facility tour, with the ADON, on 11/8/23 at 9:01 a.m., she indicated Resident F had Methicillin-resistant Staphylococcus aureus (MRSA) in a wound. She received vancomycin

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(antibiotic) until 11/21/23 and she was being seen by an infectious disease physician. She received IV (intravenous) fluids, she was non-compliant. She had an unstageable wound to her coccyx, a scab to her right great toe and a deep tissue injury (DTI) (persistent non-blanchable deep red, maroon or purple discoloration) to her right heel. Interventions were to float her heels which she was non-compliant with. She refused to walk and refused therapy. She received tube feeding.

Resident F's clinical record was reviewed on 11/9/23 9:43 am. Diagnoses include other abnormalities of gait and mobility, type 2 diabetes mellitus without complications, acute kidney failure, cerebral infarction, acute respiratory failure with hypoxia, and need for assistance with personal care.

An admission MDS assessment, dated 9/30/23, indicated she was cognitively intact. She required extensive assistance of two staff members for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene. She had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. She was at risk for developing pressure ulcers. She had an unstageable pressure ulcer, due to coverage of wound bed by slough and/or eschar, that was present on admission/entry or re-entry and one unstageable pressure injury presenting as a deep tissue injury. She had a surgical wound and she received pressure ulcer/injury care.

An admission skin assessment, dated 9/26/23, indicated she was at risk for developing pressure ulcers.

Her skin and wound evaluations indicated the following:

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On 10/3/23, she developed a facility acquired unstageable pressure ulcer measuring 4.1 cm x 3.2 cm.

On 10/3/23, she admitted to the facility with a DTI that measured 2.1 cm x 1.5 cm.

On 10/10/23, she admitted to the facility with an arterial wound measuring 1.2 cm x 1 cm.

The clinical record lacked a care plan for her pressure ulcers.

During an interview with CNA 12, on 11/8/23 at 3:04 p.m., she indicated the CNAs did not have access to the Kardex or the resident's care plans. Normally the new interventions were communicated during shift change.

During an interview, with the DON, on 11/9/23 at 12:58 p.m., she indicated the ADON/Wound nurse would be notified of a new wound and she would double check to make sure a treatment and interventions were put into place. She provided the MDS Coordinator a weekly list of residents with wounds and she would update the care plans. She did not see a care plan for wounds or non-compliance for Resident F.

During an interview, with the MDS Coordinator, on 11/9/23 at 1:49 p.m., she indicated the ADON/Wound nurse updated the wound care plans. She would update the care plan if she was asked to. She completed a baseline care plan for new admissions, she reviewed and updated the care plan during the resident's quarterly and annual assessments.

A current facility policy, revised on 1/17/18, titled

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	"Pressure Injury and Skin Condition Assessment," provided by the Regional Vice President, on 11/9/23 at 2:14 p.m., indicated the following: "...17. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care...." This citation relates to Complaint IN00421071. 3.1-35(a)			
F 0684 SS=D Bldg. 00	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 interview and record review, the facility failed to ensure a wound VAC (Vacuum - Assisted Closure) was placed on a resident's wound after a surgical procedure in a timely manner for 1 of 3 residents reviewed for wounds (Resident B). Findings include: Resident B's clinical record was reviewed on 11/8/23 at 9:47 a.m. Diagnoses included chronic viral hepatitis, essential (primary) hypertension, heart failure, unspecified, chronic kidney disease, unspecified severe protein-calorie malnutrition, and other specified postprocedural states. A significant change Minimum Data Set (MDS) assessment, dated 10/24/23, indicated she was	F 0684	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Executive Director and DON were educated on following through with the ordering of equipment. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Order forms for equipment will be printed off at the time of ordering and given to the DON and nurse for the resident.	11/28/2023

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cognitively intact. She required supervision for bed mobility, transfers, and toilet use. She had a surgical wound.

A hospital discharge summary, dated 10/20/23, indicated Resident B had a history of a bowel obstruction and diverticular stricture which resulted in multiple bowel resections with end colostomy. She underwent colostomy reversal. She had minimal pain and tolerated her diet. She denied any nausea, vomiting or diarrhea. She passed flatus and had bowel movements. She had a wound VAC and it was changed this day. She was returning to a nursing home that could care for the wound VAC. She would need the wound VAC changed on Mondays, Wednesdays, and Fridays.

Her orders indicated the following:

Wound VAC site - abdominal surgical site with normal saline, pat dry with gauze, protect the peri skin with skin prep and drape, pack the wound with black foam, the setting was 125 mmHg (millimeters of mercury) continuously, change the wound VAC dressing and canister every day shift on Monday, Wednesday and Friday for post operation of bowel resection (10/20/23), wet to dry dressing if wound VAC was unable to be applied to abdominal surgical site, change the dressing daily and as needed (PRN), every night shift and upon readmission from the hospital, keep in place until wound VAC arrived (10/20/23), notify the colorectal surgeon if she had any of the following symptoms; fever (101 degree or higher), severe redness or drainage from her incision, nausea or vomiting, watery diarrhea, or any concerning change in condition (10/20/23).

Review of her nurses notes indicated the

III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;
All order forms will be printed off at time of order and will be followed up daily by Executive Director.

IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;
Executive Director/designee will audit equipment order forms daily(Monday-Friday), until equipment has been delivered.

The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.

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following:

On 10/20/23 at 5:34 p.m., she returned from the hospital from a planned colostomy takedown with low anterior resection and ureteral stent placement. She also underwent exploratory laparotomy (surgical incision into the abdominal cavity). A wound VAC hose and dressing was intact to the abdominal surgical site. Orders for a wet to dry dressing was being placed on the surgical site until the wound VAC arrived at the facility. She was alert and oriented and she was able to voice her needs, she requested to go outside to smoke. She voiced mild pain to her abdominal area. She ambulated with a walker with supervision.

A Nurse Practitioner (NP) progress note, dated 10/23/23 at 7:35 a.m., indicated it was recommended to obtain the wound VAC per orders.

On 10/25/23 at 11:34 a.m., the surgeon's office was notified of diarrhea.

The nurses note lacked notification to the surgeon's office that the wound VAC had not been obtained.

On 10/27/23 at 1:03 p.m., the surgeon's office was updated about the resident's diarrhea improving.

The nurses note lacked notification to the surgeon's office that the wound VAC had not been obtained.

A NP wound care progress note, dated 10/27/23 at 6:27 p.m., indicated the surgical incision was to be cleansed daily, pat dry, pack with Dakin soaked gauze while awaiting the wound VAC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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	A late entry nurses note, dated 10/31/23 at 9:37 a.m. and created on 11/1/23 at 9:43 a.m., indicated a wound assessment was completed. A moderate amount of drainage was noted to the dressing. There was no signs or symptoms of infection. The area was cleansed and the wound VAC was placed per order. On 11/1/23 at 11:33 a.m., the colorectal surgical specialist office indicated Resident B was being sent to the hospital to be admitted for wound dehiscing, work up, and a consultation with a plastic surgeon. A review of a fax sent to the facility from the colorectal surgical specialist office, on 11/8/23 at 3:27 p.m., indicated the following: An email sent to the surgeon, by the surgeon's nurse, dated 11/2/23, indicated a corporate staff member from the facility called the surgeons office and asked to speak to the surgeon about an error that was made related to Resident B. She wanted to apologize to the doctor for "dropping the ball" and took full responsibility for the error. After Resident B came back to the nursing facility, after being discharged from the hospital, they ordered a wound VAC. A few days later the wound VAC was delivered but delivered without canisters. The canisters were ordered and were delivered the next day to the back door and whoever picked them up, put them in storage. When they were found, the wound VAC was placed on Resident B the day before her follow up appointment, which made it two weeks after she was supposed to have the wound VAC on. She again apologized and stated that when she was sent back to the facility, she would make sure the wound VAC and all parts of the wound VAC were readily available			

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before she got there.

The impression from a Computed Tomography (CT) scan, dated 11/1/23 at 4:45 p.m., indicated a large fluid collection with air bubbles seen due to dehiscence of the skin adjacent to that area along the anterior abdominal wall, underlying constipation was noted and cholelithiasis (formation of gallstones) without CT evident of acute cholecystitis (inflammation of the gallbladder).

An operative report, dated 11/3/23 at 4:38 p.m., indicated the indication for surgery was she had recently undergone a complicated colostomy closure due to ventral hernia. The operation consisted of wound exploration and drainage of wound seroma and the placement of a wound VAC.

During an interview with the DON, on 11/8/23 at 12:57 p.m., she indicated Resident B came back to the facility after being released from the hospital, the wound VAC was ordered and delivered to the back dock door and was found on Tuesday, but the canisters were not sent with the wound VAC. They would normally deliver items to the front door. They called the company and told them they needed the canisters ASAP. Resident B wanted a shower two days prior to appointment because she didn't want to carry the VAC around and it was explained to her the wound VAC was an order from her surgeon.

During an interview with the ADON/Wound nurse, on 11/8/23 at 1:27 p.m., she indicated Resident B had her follow up appointment on 11/1/23, the wound VAC was placed on 10/31/23. They had all the equipment for the wound VAC on Monday (10/30/23), but Resident B wanted to

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	wait until after her shower on Tuesday morning (10/31/23). The Administrator had ordered the wound VAC and the NP gave the order for a wet to dry dressing until the wound VAC arrived at the facility. The wound VAC was delivered with no canisters. They called the company back and they indicated they would send it through FedEx, which could take three to five days. During an interview with a customer service agent at the equipment company used by the facility, on 11/8/23 at 1:41 p.m., he indicated a wound pump, and a foam dressing was ordered on 10/23/23 at 4:18 p.m. and delivered on 10/24/23 at 3:00 p.m. A canister with tubing was ordered on 10/25/23 at 11:30 a.m. and was delivered to the facility on 10/27/23. During an interview with the Regional Vice President, on 11/9/23 at 4:17 p.m., he indicated the wound VAC placement was considered a standard practice and they did not have a policy for standard practices. This citation relates to Complaint IN00421177. 3.1-37(a)			