STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155596	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE ANGOLA	**500 N WILLIAMS ST ANGOLA, IN 46703**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify family of a resident's fall and significant change in condition for 1 of 1 resident's reviewed. (Resident J). Findings include: On 9/3/20 at 1:00 P.M., Resident J's record was reviewed. [DIAGNOSES REDACTED]. The resident admitted to the facility following surgery for [REDACTED]. A Social Service note, dated 7/8/20 at 2:37 p.m., indicated the resident had been assessed on admission, to have no memory issues or impaired decision making. 72 hour Admission documentation, dated 7/9/20 at 6:15 a.m., indicated Resident J was alert. She had an unsteady gait that required supervision. She had impaired balance and weakness. A Fall-Initial Occurrence Note, dated 7/11/20 at 8:00 p.m., indicated the resident had an un-witnessed fall. The resident was found next to her bed. She had attempted to self transfer and hadn't used the call light for help.The staff interviewed Resident J. She indicated she hadn't known what she was trying to do. She had an abrasion noted to the back of her left hip. Neurological checks were initiated. The note indicated the resident was notified of the fall but not her family. On 9/3/20 at 12:13 P.M., Resident J's family member was interviewed by phone. During the interview, they alleged the facility had not contacted them timely after sending the resident to the hospital for a significant change in her condition. The family member indicated they were contacted by the hospital , located a quarter mile from the facility, and told by the ER that family needed to go to the hospital immediately because the resident had no pulse or blood pressure. The resident had been intubated and was going to be airlifted to a trauma center for further care. A Nurse Note, dated 7/13/20 at 9:08 a.m., indicated the resident was found lying in bed sideways and calling out. The resident verbalized delusional statements. She was assisted into her chair as requested and was observed to have posturing of head and neck, started with arms and legs, rigid and wiggling. The nurse was unable to obtain the resident's blood pressure. Her pulse was irregular and her oxygen saturation was 76% (normal is above 90%). The resident was assisted back into bed for safety. The EMS was called and she was transported to the hospital for evaluation and treatment. A Nursing Home to Hospital Transfer Form (Interact), dated 7/13/20, indicated the resident had been transferred to the hospital for a [MEDICAL CONDITION]. The form indicated the resident and her family member had been notified of her clinical condition. The form listed the name of the family member and their contact number. The contact number was the resident's home phone number. This number was not the emergency contact's phone number. The emergency contact did not live with the resident and couldn't be reached on the resident's home phone. The transferring nurse signed her name on the form on 7/13/20 at 10:13 a.m. A Nurse Note, dated 7/13/20 at 10:14 a.m., indicated the hospital emergency room called the facility and requested another copy of the resident's Medication list which was faxed to the hospital. The note indicated the facility notified the family member On 9/4/20 at 12:20 P.M., the Administrator provided a current copy of the facility's policy titled Physician-Family Notification-Change in Condition which stated the following: Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner .The facility will inform the resident .resident's legal representative or an interested family member when there is: An accident involving the resident which results in injury and has the potential for requiring physician intervention; A significant change in the resident's physical, mental, or psychosocial status; Life threatening conditions are such things as a [MEDICAL CONDITION] or stroke .A decision to transfer or discharge the resident from the facility. This Federal tag relates to Complaint IN 394. 3.1-5(a)(1)(2)(4)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders [REDACTED]. Findings include: On 9/3/20 at 1:00 P.M., Resident J's record was reviewed. [DIAGNOSES REDACTED]. The resident admitted to the facility following surgery for [REDACTED]. The Plan of Care did not specify the site of the incision nor did it have any interventions for care of the surgical incision. Hospital discharge summary and orthopedic orders, dated 7/8/20 at an unknown time, were as follows: 1. Cleanse knee incision daily with [MEDICATION NAME] (antibacterial cleanser). 2. Apply ACE wrap to the LLE (left lower extremity)-toes to thigh-every night for 2 weeks. 3. Remove ACE wrap and apply TED hose (compression stockings) after skin care every morning for 2 weeks. Review of Nurse Notes indicated the resident received surgical wound care on 7/9 at 6:15 a.m., 2:15 p.m., and 10:15 p.m.; 7/10 at 1:57 a.m., 9:23 a.m., and 3:50 p.m.; 7/11 at 6:05 p.m. and 6:15 p.m.; and 7/12/20 at 6:15 p.m. A TAR (Treatment Administration Record) dated July 2020 for Resident J was not available for review and there was no documentation in the records reviewed to indicate what kind of surgical wound care had been or was ordered to have been provided. There was no documentation of the status of the surgical wound site completed nor documentation of any dressing changes found. There was no documentation on the healing status of the wound, monitoring for infection, or any documentaion the ACE wraps and TED hose had been applied. On 9/3/20 at 3:11 P.M., LPN 5 was interviewed. During the interview, she indicated she couldn't recall if the resident had any dressing changes ordered for her surgical wound. Upon review of the resident's chart, LPN 5 indicated she couldn't find any orders for dressing changes and she wasn't aware of the orders for ACE wraps and TED hose. She indicated some surgeons prefer to keep wound dressings in place until they are seen for a follow up visit and the surgeon removes the dressing. LPN 5 indicated if staff were to leave a dressing in place until a surgeon removed them, nurses would still document daily that the dressing was clean, dry and intact and would monitor and document on the skin around the dressing to observe for signs of infection. On 9/3/20 at 3:30 P.M., the DON (Director of Nursing) was interviewed. During the interview, she indicated Resident J should have had treatment to her surgical wound as ordered and the wound site monitored daily for healing and signs of infection. This Federal tag relates to Complaint IN 394. 3.1-37

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.