STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE KOKOMO	**3518 S LAFOUNTAIN ST KOKOMO, IN 46902**

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 a resident's emergency contact regarding a change in condition, which resulted in her admission to the hospital for surgery for [REDACTED]. Finding includes: During a phone interview, on 7/23/2020 at 2:03 p.m., a family member indicated she did not know the resident fell on [DATE] or had to be taken to the hospital for treatment until the surgeon called her to ask her for consent to operate on Resident E. She had fractured her lower leg bone when she fell at the facility. Resident E was unable to sign the surgery consent due to being medicated for pain, so the Surgeon had to call a family member to get consent for surgery. A document, titled Concern/Compliment Form dated as revised on 10/2017, provided by the DON (Director of Nursing) on 7/23/2020 at 3:51 p.m., indicated the concern was taken over the phone. (Name of Family Member) filed the form, dated 6/3/2020, as the family member was upset because there was a lack of communication between her and the facility. She indicated she was not notified of the last falls or the hospitalization . The summary of Pertinent Findings indicated these concerns were partially substantiated by the facility. The DON was aware of the notification issues and education would be provided to the staff. Corrective action taken did not indicate what corrective action was taken to prevent the reoccurrence of the (Name of family member) not being notified of Resident E's change in condition, falls or hospitalization s. The record for Resident E was reviewed on 7/22/2020 at 4:10 p.m. [DIAGNOSES REDACTED]. A Quarterly MDS (Minimum Data Set) Assessment, dated 4/23/2020, indicated the resident's BIMS (Brief Interview Mental Status) was a score of four, which indicated the resident was cognitively impaired. A document, titled Fall-Initial Occurrence Note, dated 5/22/2020, indicated Resident E had a witnessed fall on 5/22/2020 at 10:30 a.m. A new injury was observed when the resident was assessed by the nurse. She had a small abrasion on her right knee and an area of swelling below her right knee. The area for the Family/Responsible Party Notified indicated the person notified was Resident E (Name of Resident E) and Do not Use was typed next to her name. Contact type: Emergency Contact box was checked. The telephone information was blank and the date and time the family or responsible party was notified was blank. A Care Plan, dated 10/24/17 with a revised date of 2/5/2020, addressed the problem she had a progressive decline in her intellectual functioning characterized by dementia, deficit in her memory, judgment, decision making and thought processes related to a mental illness diagnosis, short term memory loss and forgetfulness. A Care Plan, dated 9/19/19 with a revised date of 7/15/2020, addressed the problem she had an impaired cognitive function related to dementia with behavioral disturbance. Interventions included, but were not limited to, 9/19/19--Cue, reorient and supervise as needed. A document, titled Comprehensive Clinical Review Meeting Note dated 6/24/2020, indicated she returned from the hospital on [DATE] after a post surgical repair to her leg. In the Family/Responsible Party section the person listed as the responsible party was Resident E. Next to her name was (Do not use) and she was the person listed as the responsible party to call for changes in condition. A document, titled Transfer/Discharge Report, dated 7/23/2020, indicated (Name of family member) (Relationship of individual) was Resident E's primary contact. During an interview, on 7/23/2020 at 4:45 p.m., the Social Service Director indicated Resident E's (Name of Family Member) did voice concerns related to she was not notified Resident E fell at the facility and was sent to the hospital for a fracture of her leg. The family member was notified of the fall and the surgery by the hospital when they needed consent for surgery. The facility failed to notify her of the resident's fall and when she was sent to the hospital. Even if the resident was her own responsible party, an emergency contact should have been notified when she was sent to the hospital. A current policy, titled Physician-Family Notification-Change in Condition, dated 10/1/15, provided by the DON on 7/23/2020 at 3:44 p.m., indicated .Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient and effective manner . Guidelines: The facility will inform the resident' .notify the resident's legal representative and interested family member when there is: (A) an accident involving the resident which results in injury and has the potential for requiring physician intervention (B) A significant change in the resident's physical, mental, psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) .(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new for of treatment); A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before). (D) A decision to transfer or discharge the resident from the facility. This policy is a guideline only. Each Resident has his or her own set of circumstances which may require that this policy not be followed. The needs of each resident supersede this policy This Federal tag relates to Complaint IN 816. 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(4)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were properly supervised to prevent a choking episode during a meal and to ensure a resident did not hoard medications and potentially injure herself or another resident for 2 of 5 residents reviewed for accidents (Residents G and H). Findings include: 1. During an interview, on 7/23/2020 at 9:53 a.m., Resident G indicated she did not take her antibiotics this morning which the nurse left at her bedside. There were certain nurses who left her medications at the bedside especially in the mornings when she was asleep and when she woke up, she would take them. She did not ask to have them left, these nurses left them on their own. Resident G indicated she had the medication in her room because she was not taking the antibiotics for her leg because she did not need them. As the resident was talking, the Nurse Consultant came into her room to check on her. The DON (Director of Nursing) joined Resident G and the Nurse Consultant in Resident G's room. At this time, Resident G retrieved three green and white capsules and a plain white capsule from her purse. She indicated the green and white capsules were her antibiotics and the plain white capsule was her [MEDICATION NAME] (an antidepressant medication) from this morning, which she did not take. She indicated the nurse left her cup of medications at her bedside, while she was sleeping, then when she woke up she took all her medications, except those four. The record for Resident G was reviewed on 7/23/2020 at 3:00 p.m. [DIAGNOSES REDACTED]. The EMAR (Electronic Medication Administration Record) dated July 2020, included, but were not limited to, the following orders: 7/2/2020--[MEDICATION NAME] Capsule 10 mg (milligrams), give one capsule by mouth one time a day related to [MEDICAL CONDITION] disorder. The box for 7/23/2020 was initialed off as administered for the 8:00

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) a.m. dose. 7/22/2020--[MEDICATION NAME] tablet (a medication used to treat an infection) 250 mg, give three tablets by mouth two times a day for [MEDICAL CONDITION] of the left leg for ten days (total dose-750 mg). The box for 7/23/2020 was initialed off as administered for the 7:00 a.m. dose. 2. On 7/22/2020, while touring the Harmony unit from 12:39 p.m., to presently at 12:58 p.m., there was no staff observed on the unit except two CNA's who were answering call lights. While walking past the dining room on the 200 unit with the Wound Nurse at 12:58 p.m., Resident H was heard coughing. There was no staff member in attendance of the dining room while he ate his lunch. The Wound Nurse asked Resident H if he was alright, he shook his head no and continued to cough. He was able to get his breath during this time. Resident H started coughing harder, his face turned red and he was no longer able to express himself orally. At this time, the Wound Nurse got behind the resident. As she was stepping behind him, a piece of food flew out of his mouth. He picked up a green pea pod up off his thigh and placed it on a piece of paper on the table. The Wound Nurse asked him if this piece of food came from his mouth or if it was in his throat. Resident H indicated it came from his throat and he was choking on it. The resident had a glass with regular consistency milk, which the Wound Nurse handed him as she was wheeling him out of the dining room with her. He had a pot pie three fourths of the way eaten, a salad with dressing on it, which had not been eaten and a bowl with cooked cauliflower and broccoli, which was one fourth of the way eaten. After the Wound Nurse removed the resident from the dining room, he came back to the dining room and began to eat his salad left on his tray on the table. She explained to him she did not feel comfortable with him eating the salad after he had choked and asked if he would eat an alternative for the salad and he agreed. The Wound Nurse stayed with the resident until a nurse from another unit came to assess him. During an interview, on 7/22/2020 at 1:09 p.m., CNA 4 indicated the CNA's usually assist the residents who need help eating in the dining room while the nurse sat at the nurses station across the hallway. When they were finished, they went out on the hallway and answered lights and picked up the meal trays. The nurse was supposed to sit at the nurses station to be available in case she was needed in the dining room. She did not know where the nurse was during this time. On 7/22/2020 at 1:16 p.m., the Wound Nurse reviewed Resident H's diet orders. He was ordered a regular diet with mechanical soft consistency, pureed meat texture and necture thickened consistency liquids. The resident was ok to have a peanut butter and jelly sandwich, add gravy to the meats and recommend supervision with all meals. When the Wound Nurse left the 200 unit, on 7/22/2020 at 1:24 p.m., the nurse assigned to the Harmony unit had not returned to the unit. The Wound Nurse indicated the nurse assigned to the unit had indicated she was going to take a lunch after the residents had finished eating. She did not know if the nurse had left for lunch or not. The record for Resident H was reviewed on 7/23/2020 at 4:00 p.m. [DIAGNOSES REDACTED]. A ST (Speech Therapist)--Therapist Progress & Discharge Summary dated 4/23/2020, indicated training was completed on safe swallow techniques of sitting upright and supervised for meals, small bite sizes, do not drink unless oral cavity was clear of residue. Use finger sweep to dislodge food which gets stuck on ill fitting upper dentures. Training to staff on need for resident to be in an upright position for all meals and supervised. Resident with noted increased coughing, loss of breath and increased with uncoordinated swallow function. discharged on a mechanical soft diet with pureed meats. Staff were aware the resident was to be out of bed for all meals and supervised at meals secondary to his high risk of penetration, aspiration and choking. The Physician orders [REDACTED]. The resident should not have received the salad. Residents who receive a mechanical diet were not allowed to receive the salads. Any resident on a mechanical soft diet should have received a soft cooked hot vegetable with lunch today. During an interview, on 7/23/2020 at 5:35 p.m., the Nurse Consultant indicated the facility did not have a dining room policy. She indicated a staff member must be in the dining room during meals at all times. A current policy, titled Medications Administration Oral and undated, provided by the DON on 7/23/2020 at 3:56 p.m., indicated .Purpose: To safely administer medications as prescribed .Important Points: Procedure .8. Administer oral medication and remain with resident while he/she takes the medication Rationale/Amplification: Never leave a drug in resident's room .14. If a resident refuses or is unable to take a medication indicate by initialing and circling the space and write note as to reason in the nurses' notes and/or on the reverse side of the medication record. Rational/Amplification: Licensed Nurse to assess resident and notify physician of any changes in condition, resident inability to take medications or adverse reactions and refusals. Document in the medical record and on the 24 Hour Report .Licensed nurse is to instruct resident of implications of refusals and non-compliance This Federal tag relates to Complaint IN 286. 3.1-45(a)(2)
F 0808 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the dietary department delivered the correct therapeutic diets to 2 of 3 residents being reviewed for the appropriate therapeutic diets being served (Residents H and J). Findings include: 1. On 7/22/2020, while touring the Harmony unit from 12:39 p.m., to presently at 12:58 p.m., there was no staff observed on the unit except two CNA's who were answering call lights. While walking past the dining room on the 200 unit with the Wound Nurse at 12:58 p.m., Resident H was heard coughing. There was no staff member in attendance of the dining room while he ate his lunch. The Wound Nurse asked Resident H if he was alright, he shook his head no and continued to cough. He was able to get his breath during this time. Resident H started coughing harder, his face turned red and he was no longer able to express himself orally. At this time, the Wound Nurse got behind the resident. As she was stepping behind him, a piece of food flew out of his mouth. He picked up a green pea pod up off his thigh and placed it on a piece of paper on the table. The Wound Nurse asked him if this piece of food came from his mouth or if it was in his throat. Resident H indicated it came from his throat and he was choking on it. The resident had a glass with regular consistency milk, which the Wound Nurse handed him as she was wheeling him out of the dining room with her. He had a pot pie three fourths of the way eaten, a salad with dressing on it, which had not been eaten and a bowl with cooked cauliflower and broccoli, which was one fourth of the way eaten. After the Wound Nurse removed the resident from the dining room, he came back to the dining room and began to eat his salad left on his tray on the table. She explained to him she did not feel comfortable with him eating the salad after he had choked and asked if he would eat an alternative for the salad and he agreed. The Wound Nurse stayed with the resident until a nurse from another unit came to assess him. On 7/22/2020 at 1:16 p.m., the Wound Nurse reviewed Resident H's diet orders. His diet order was a regular diet with mechanical soft consistency, pureed meat texture and necture thickened consistency liquids. The resident was ok to have a peanut butter and jelly sandwich, add gravy to the meats and recommend supervision with all meals. The record for Resident H was reviewed on 7/23/2020 at 4:00 p.m. [DIAGNOSES REDACTED]. A ST (Speech Therapist)--Therapist Progress & Discharge Summary dated 4/23/2020, indicated the resident was discharged on a mechanical soft diet with pureed meats. Staff were aware the resident was to be out of bed for all meals and supervised at meals secondary to his high risk of penetration, aspiration and choking. The Physician orders [REDACTED]. The resident should not have received the salad. Residents who receive a mechanical diet were not allowed to receive the salads. Any resident on a mechanical soft diet should have received a soft cooked hot vegetable with lunch today. 2. On 7/22/2020 at 12:30 p.m. with the Wound Nurse in attendance, Resident J indicated she was finished with her lunch tray. She could not eat the salad on her tray because she was not supposed to have raw vegetables to eat. The Wound Nurse reviewed her meal tray ticket and indicated the resident was to have a mechanical soft diet with no raw vegetables. Resident J's tray was observed to have a salad with two whole tomato halves. The record for Resident J was reviewed on 7/23/2020 at 3:45 p.m. [DIAGNOSES REDACTED]. The Physician orders [REDACTED]. A Care Plan, dated 11/20/18 with a revised date of 7/23/2020, addressed the problem she had a regular mechanical soft diet with thin liquids and difficulty swallowing. The interventions included, but were not limited to, 11/20/18--Provide diet as ordered. A Care Plan, dated 12/16/19, addressed the problem she was at risk for aspiration related to dysphagia. The interventions included, but were not limited to, 12/16/19--Provide diet as ordered. During an interview, on 7/22/2020 at 2:02 p.m., the Dietary Manager indicated according to Resident J's meal card tray she should have received a mechanical soft diet and she should not have received the salad. Any resident on a mechanical soft diet should have received a soft cooked hot vegetable with lunch today. During an interview on 7/23/2020 at 5:35 p.m., the Nurse Consultant indicated the facility did not have a dining room or meal policy. This Federal tag relates to Complaint IN 286. 3.1-21(b)