| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **155446** | A. BUILDING _____ B. WING _____ | **08/31/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **APERION CARE FORT WAYNE** | **5700 WILKIE DR FORT WAYNE, IN 46804** |

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) |
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| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to follow Physician Orders for wound care, for 1 of 3 resident's reviewed. (Resident L) Findings include: A review of Resident L's record on 8/28/2020 at 12:50 p.m., indicated [DIAGNOSES REDACTED]. Resident L was identified by the facility as being alert, oriented, and interviewable . Physician's Progress Notes documented by the Wound Physician, dated 8/26/2020 indicated the following 5 wounds: The wound, documented as Site 1, located on the right lower buttock exhibited no change. The measurements were 11.5 cm (centimeters) in length by 2.5 cm in width, and there was no measurable depth. There was no drainage and there was 100% granulation (new) tissue. The treatment plan indicated the following orders documented by the Wound Physician: A Xeroform (occlusive dressing) sterile gauze, apply to the wound twice daily for 9 days, cover with a secondary foam dressing twice daily for 9 days, then apply a [MEDICATION NAME] (transparent adhesive film) to cover the foam twice daily for 9 days. The wound, documented as Site 2, located on the right medial thigh, exhibited no change. The measurements were 9.5 cm in length by 10.5 cm in width, and there was no measurable depth. There was light serous (clear, watery) drainage, and there was 50% granulation tissue, and 50% skin. The treatment plan indicated the following orders documented by the Wound Physician: A Xeroform, sterile gauze, apply to the wound twice daily for 9 days, cover with a secondary foam dressing twice daily for 9 days, then apply a [MEDICATION NAME] to cover the foam twice daily for 9 days. The wound, documented as Site 3, located on the left posterior leg, exhibited no change. The measurements were 5 cm in length by 5.5 cm in width, and the depth was not measurable. There was light serous drainage, and there was 10% slough (yellow, stringy, thick) devitalized (dead) tissue, 40% granulation tissue, and 50 % skin. The documentation indicated that this wound was in an [MEDICAL CONDITION] stage and was unable to progress to a healed phase, because of the presence of a biofilm (thin, slimy film of bacteria that sticks to the wound surface). The treatment plan indicated the following orders documented by the Wound Physician: A Xeroform, sterile gauze, apply to the wound twice daily for 9 days, cover with a secondary foam dressing twice daily for 9 days, then apply a [MEDICATION NAME] to cover the foam twice daily for 9 days. During the visit the Physician performed a debridement of this wound, and surgically excised 2.75 cm of devitalized tissue that included slough, biofilm, and non-viable fatty tissue and surrounding connective tissues were removed. A clean dressing was applied following the procedure. The wound, documented as Site 5, located on the right flank area, and referred to as an [DIAGNOSES REDACTED] disease induced wound and has exhibited no change. The measurements were 20 cm in length by 25 cm in width, and the depth was not measurable. There was moderate sero-sanguinous(clear and red) drainage, and there was 80% thick adherent devitalized necrotic (black) tissue, and 20% slough. The treatment plan indicated the following orders documented by the Wound Physician: apply Alginate calcium w/silver(gel like covering) apply twice daily with a gauze dressing for 9 days, and moisturizer was to be applied around the wound twice daily for 9 days. During the visit the Physician performed a debridement of this wound, and surgically removed necrotic tissue and established margins of viable tissue. The wound was cleansed and 500 cm of devitalized tissue and necrotic fatty tissue and slough was removed. A clean dressing was applied following the procedure. The wound, documented as Site 6, located on the right groin area, measured 10 cm in length by 1 cm in width, and the depth was not measurable. There was moderate serous drainage, 90% slough, and 10 % skin. The treatment plan indicated the following orders documented by the Wound Physician: apply Alginate calcium w/silver once daily for 30 days, cover with an ABD(abdominal absorbing) pad and sterile gauze sponges once daily for 30 days. House barrier cream to be applied around the wound once daily for 30 days. A review of Resident L's Active Orders indicated the following Treatment Orders: Cleanse area to upper right upper buttock with theraworx, pat dry, apply Xeroform, cover with foam and [MEDICATION NAME] qd (every day), two times a day for open area. The order was dated 8/15/2020, with a start date of 8/16/2020. Wound site: Cleanse right posterior upper legs with mild soap and water, pat dry, apply Xerform, cover with foam and [MEDICATION NAME], two times a day for sheering. During an interview on 8/28/2020 at 11:05 a.m., the DON (Director of Nursing) indicated that the ADON (Assistant Director of Nursing) had recently taken over the Wound Care Program and rounds with the Wound Physician weekly. During an interview on 8/28/2020 at 3 p.m., the DON indicated Resident L had her dressings changed. During an interview on 8/28/2020 at 4:25 p.m., Resident L indicated they had not had their dressings changed. On 8/28/2020 at 4:25 p.m., Resident L was observed in their room, sitting up in bed. The sponge dressings on her right upper buttocks were not dated and there was brownish colored drainage observed on the sponges. The resident was observed to have a large disposable soaker pad folded beneath the right abdominal fold that had bright red drainage on it. During an interview on 8/28/2020 at 4:45 p.m., in the DON's the ADON indicated Resident L often refused their dressing changes, and that they get them once a day.At this same time the DON indicated the Orders were in the computer. A review of Resident L's record on 8/28/2020 at 4:50 P.M. indicated no refusal had been documented in the Progress Notes. There were no orders dated 8/26/2020 regarding wound care in the record. During an interview on 8/28/2020 at 4:55 p.m., LPN(Licensed Practical Nurse) 1 indicated Resident L was to have their dressing changed once a day. During an interview on 8/31/2020 at 12:10 p.m., the ED(Executive Director) indicated Resident L refused their dressing change that morning. During an interview on 8/31/2020 at 1:15 p.m., the DON indicated that the ADON, had said the Wound Physician had not taken the dressings off or debrided the wounds on 8/26/2020. The DON indicated the Physician tended to give verbal orders all at once while doing rounds. The DON further indicated Resident L had not liked the Alginate cream and indicated it burned when the treatment was completed. During an interview on 8/28/2020 at 1:33 p.m., the Wound Physician indicated he had measured, debrided, and him or the nurse had dressed the wounds of Resident L during rounds on 8/26/20. He indicated his treatment orders were documented at the end of each wound progress note. There were no Nursing Progress Notes of wound rounds or new orders documented in Resident L's record dated 8/26/20. During an interview on 8/31/2020 at 3:10 p.m., the DON indicated the treatment orders should have been put in Resident L's active orders, and they were not. A current facility policy, Physician Orders- Entering and Processing, dated 1/31/2018, provided by the ED on 8/31/2020 at 3:05 p.m., indicated the following: .Following a physician visit, a licensed nurse will check for any orders that require confirmation under Clinical>orders>pending orders. The orders will be confirmed by the nurse and the instructions for the order will be completed . This Federal citation is related to Complaint IN 927. 3.1-40 |

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.