STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE WALDRON LLC	**505 N MAIN ST WALDRON, IN 46182**

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure follow-up and initiation of treatment to an identified skin impairment that was later identified as an unstageable pressure ulcer that resulted in a wound infection, hospitalization , and surgical intervention for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/29/20 at 12:48 p.m. The [DIAGNOSES REDACTED]. An Admission Minimum Data Set (MDS) assessment, dated 5/6/20, indicated a surgical wound was present. There were no pressure or arterial ulcers marked on the admission MDS. He was marked to need extensive assistance with 2 staff person with transfers and bed mobility. A hospital discharge summary, dated 4/30/20, indicated Resident B had surgical wounds to left lower extremity related to the repair of a left femoral fracture. There was no indication of pressure or arterial wounds noted for Resident B upon discharge from the hospital. An admission observation, dated 4/30/20, indicated the following, .left heel .DTI (deep tissue injury) 4cm (centimeters) diam. (diameter) The admission observation was opened with a locked date of 7/29/20. A Braden Assessment, dated 4/30/20, indicated Resident B was at moderate risk for pressure ulcer development. An activities of daily living (ADL) care plan, undated, indicated the following, .I have an ADL self-care performance deficit r/t (related to) recent surgery to hip from fracture (sic) .Interventions .Skin Inspection: The resident requires SKIN inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes to the NURSE A care plan pertaining to skin, undated, indicated the following, .I have a potential for impairment to skin integrity r/t (related to) aging/disease process, decreased mobility, fragile skin, impaired mobility, incontinence .Interventions .Assess/record changes in skin status .Follow facility protocols for treatment of [REDACTED]. A weekly skin observation, dated 5/8/20, indicated the following, .NO FOOT CONCERNS A weekly skin observation, dated 5/15/20, indicated the following, .NO FOOT CONCERNS A physician order, dated 5/21/20, indicated the following, .Venelex Ointment .Apply to back of left thigh topically two times a day A physician order, dated 5/21/20, indicated the following, .Resident to not wear shoes until area on feet have healed A weekly skin observation, dated 5/22/20, indicated the following, .a. Describe any foot problems: .(checkmark) 10 Open Lesion(s) .left heel redness, pressure area dorsum (area facing upwards while standing) of left foot There were no further description and/or measurements to the skin concerns identified to Resident B's left foot and heel. A Skin & Wound Evaluation, dated 5/28/20, indicated a deep tissue injury was noted to Resident B's left heel that was marked present upon admission. The wound measured 2.6 centimeters x 4.4 centimeters and contained 40 percent of eschar (dead tissue) to the wound bed. A Skin & Wound Evaluation, dated 5/28/20, indicated an arterial wound was noted to Resident B's dorsum left foot that was marked present upon admission. The wound measured 2.3 centimeters x 5.6 centimeters and marked as a scab. A weekly skin observation, dated 5/29/20, indicated the following, .Left heel redness, pressure area to dorsum of left foot All physician orders [REDACTED]. A Skin & Wound Evaluation, dated 6/4/20, indicated a blister to Resident B's dorsum left foot that was in-house acquired and measured 4.0 centimeters x 5.2 centimeters. The wound contained 30% of slough to the wound bed. A Skin & Wound Evaluation, dated 6/4/20, indicated an arterial ulcer was noted to Resident B's left lateral malleolus (bony prominence on the ankle) that was present upon admission. The wound measured 1.8 centimeters x 4.9 centimeters with pink and red tissue marked with a scab. A progress note, dated 6/5/20, indicated the following, .WEEKLY SKIN OBSERVATIONS .Open lesion observed to foot. purulent drainage (a thick and milky discharge from a wound that is often a sign of infection) from left heel. Left heel open area, dorsum of left foot blister, right heel blister A physician order, dated 6/5/20, indicated the following, .[MEDICATION NAME] (antibiotic) .300 MG (milligrams) .Give 1 capsule by mouth every 6 hours for Wound infection for 10 days A physician order, dated 6/8/20, indicated the following, .Santyl Ointment (used to remove damaged tissue from skin ulcers) .Apply to Left heel topically one time a day for DTI (deep tissue injury) to left heel The order was discontinued on 6/25/20. A physician order, dated 6/8/20, indicated the following, .Venelex Ointment .Apply to top L (left) foot, r (right) heel topically one time a day for WOUND CARE There was no indication of a treatment order for Resident B's wound to left foot and heel from 5/22/20 to 6/8/20. A Wound Care Report, dated 6/11/20, indicated the following, .We have been asked to see (Resident B) for bilateral heel ulcers. Today is initial wound evaluation at our clinic .On initial take down of his dressings it was noted he had quite a bit of [MEDICAL CONDITION] and odor is drainage (sic) from his left heel ulcer .Wound Exam .Wound 1. To left calcaneus (heel bone) - area measures 5.6 x 13.0 x 0.1 cm (centimeters). Areas odor is (sic). Area has a moderate level of purulence/sanguineous (bloody) drainage area is primarily eschar with some devitalized tissue .Area was debrided times 50% to remove the devitalized tissue at wound edges and attempt to remove some of the unstable eschar to wound base using scissors and pickups .[DIAGNOSES REDACTED].Unstageable pressure ulcer of left heel A Wound Care Report, dated 6/18/20, indicated the following, .still odor to that left heel .left calcaneus quite a bit smaller .The remaining open areas is thick, adherent and wet and odorous eschar .Wound will be stages (sic) of 4. Wound measures 5.4 x 6.5 x 0.7 cm (centimeters) .Debridement was performed using a blade, scissors, and forceps A Wound Care Report, dated 6/25/20, indicated the following, .still odor to left heel .reports recommendation is for left AKA (above the knee amputation) .Left calcaneal wound remains odor (sic) .Area was debrided of most superficial eschar and slough The records indicated Resident B was sent to the hospital from a wound care appointment, on 7/9/20, related to altered mental status and a low blood sugar level. Hospital records, dated 7/9/20 for admission, indicated the following, .imaging was completed on his left heel which was concerning for soft tissue gas and bony changes in his heel concerning for osteo[DIAGNOSES REDACTED] .Impressions/Status/Plan .Left heel osteo[DIAGNOSES REDACTED] and nonhealing (sic) ulcer .patient left heel wound is not salvageable and would benefit from a left AKA (above the knee amputation), which he went to have this afternoon, 7/13 An interview conducted with the Director of Nursing (DON), on 7/29/20 at 2:05 p.m., indicated the order for Venelex, dated 5/21/20, was supposed to say the back of the left thigh and bilateral heels. The order was only put in for application to the posterior thigh. The heel treatment was not added until later. The DON further indicated, on 7/29/20 at 4:40 p.m., that she believes the left heel wound was present upon admission and she changed the documentation on the admission assessment to reflect that. She doesn't believe the wound was open upon admission but wasn't sure. A policy titled Skin Condition Assessment & Monitoring - Pressure and Non-Pressure, revised 6/8/18, was provided by the DON on 7/29/20 at 4:09 p.m. The policy indicated the following, .Purpose .To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented .Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least weekly by licensed nurse and documented in the resident's clinical record .A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse .Wound Assessment/Measurement: .6. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care .7. Physician ordered treatments shall be initiated by the staff on the electronic Treatment Administration Record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses note 3.1-40(a)(1) 3.1-40(a)(2)

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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