STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APERION CARE UNIVERSITY PARK	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure catheter care was provided and care planned for 1 of 3 residents reviewed (Resident U). Findings include: The clinical record for Resident U was reviewed on 7/17/20 at 9:30 A.M. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. There was no documentation in the CNA task area to indicate Resident U was provided daily catheter care from 7/1/20 to 7/23/20. There was no documentation in the Medication Administration Record [REDACTED]. There was documentation in the progress notes indicating Resident U was provided catheter care on the following days: 7/7/20, 7/11/20, 7/15/20. There was no documentation to indicate Resident U had a care plan addressing his catheter. The Director of Nursing Services (DNS) was interviewed on 7/22/20 at 2:20 P.M. During the interview the DON indicated residents with catheters should be receiving daily catheter care and it should be documented in their chart. Catheter care would be documented in either the CNA task area or the resident's MAR by the nurse's providing the care. The DNS indicated there was no documentation to indicate Resident U was receiving daily catheter care. The DNS was interviewed 7/23/20 at 9:53 A.M. During the interview the DNS indicated Resident U should have had a care plan to address his catheter and the care that was to have been provided. She indicated he did not have a care plan to address his catheter. A policy, dated 2/14/2019, was provided by the DNS on 7/22/20 at 2:40 P.M., titled Urinary Catheter Care. The policy indicated .16. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate. (Source: CDC Guidelines for Prevention of Catheter Associated Urinary Tract Infections 2009) Encrustations on the foley catheter should be removed from the meatus outward with clean wash cloth, rinsed with clean water on an as needed basis. This Federal citation is related to Complaints IN 298 and IN 846. 3.1-41(a)(2)
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure increased pain was addressed for 1 of 3 residents reviewed for accidents with injuries (Resident K). Findings include: The clinical record for Resident K was reviewed on 7/17/20 at 9:30 A.M. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A change in condition form dated 3/3/20 at 11:37 A.M., indicated Resident K had a swollen, painful left foot/ankle and was having difficulty walking on the area. The physician was notified and an x-ray was ordered of the left foot/ankle. An x-ray Radiology Result Report dated 3/3/20 at 11:40 P.M., indicated Resident K's left foot/ankle was not fractured. A progress note from 3/4/20 at 10:30 P.M., indicated Resident K's symptoms had remained the same. The left foot/ankle had swelling and the resident was unable to apply pressure to the foot. The left foot was elevated. A progress note from 3/5/20 at 11:59 P.M., indicated Resident K's symptoms had worsened. The foot/ankle was swollen, the resident cried out in pain when the foot was touched and she was unable to walk on the foot. There was no note the physician or family had been notified of the increased pain. A progress note from 3/6/20 at 10:00 P.M., indicated Resident K's symptoms had worsened. The left foot/ankle was very tender and continued to be swollen. There was no note the physician or family had been notified of the increased pain. There were no documented assessments of Resident K's left foot/ankle on 3/7/20, 3/8/20, 3/9/20, 3/11/20, 3/12/20, 3/13/20, 3/14/20, 3/15/20 or 3/16/20. A nurse practitioner's note dated 3/10/20 at 3:23 P.M., indicated Resident K had increased left foot pain overnight. The NP indicated the pain was due to a left ankle sprain and Physical Therapy was to be consulted for further evaluation. A physician's orders [REDACTED]. There was no documentation to indicate Physical Therapy evaluated Resident K's left ankle pain after the 3/10/20 order was placed. Physical Therapist 15 was interviewed on 7/21/20 at 10:47 A.M. During the interview PT 15 indicated residents are usually seen the next day or within 48 hours of a PT evaluation order. If a resident is having pain, PT tries to see them pretty quickly. PT 15 indicated there was no documentation to indicate Resident K's left ankle pain was evaluated by PT after the order was placed on 3/10/20. Licensed Practical Nurse 23 was interviewed on 7/22/20 at 12:47 P.M. During the interview LPN 23 indicated she would document an assessment of a swollen painful ankle daily until the issue was resolved. LPN 23 also indicated she would contact the doctor if a resident had increased pain or tenderness. The Director of Nursing Services (DNS) was interviewed on 7/21/20 at 9:47 A.M. During the interview the DNS indicated Resident K should have had daily documented assessments of her left foot/ankle until the issue resolved. She indicated the assessments had not happened. The DNS also indicated the physician should have been notified of Resident K's increased pain in her left foot/ankle on 3/5/20 and 3/6/20. A Physical Therapy policy was requested on 7/23/20 at 9:23 A.M. The DNS indicated the facility did not have a Physical Therapy policy. A policy, dated 11/28/2012, was provided by the DNS on 7/21/20 at 9:47 A.M., titled Pain Assessment. The policy indicated Purpose: .To respect and support the resident's optimal pain management .8. The resident's physician will be notified when an assessment reveals inadequate pain control implementation of an appropriate plan of care. A policy, dated 1/29/2018, was provided by the DNS on 7/21/20 at 9:47 A.M., titled Assessment of Resident. The policy indicated .Other assessment monitoring shall be initiated and recorded on facility approved forms or in conjunction with resident's clinical condition, assessed need and planned interventions. These assessments are to be performed at the time of admission when the resident's past or current history indicated the need/problem is present and is observed or deemed necessary. This Federal citation is related to Complaints IN 846, and IN 286. 3.1-37(a)
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review, and interview, the facility failed to ensure 3 of 3 residents recieved medications as ordered. (Resident G, Resident B and Resident L) Findings include The facility's undated policy titled Mediation Errors and Drug Reactions, indicated General Guidelines: . 3. A detailed account of the incident must be recorded in the resident's medical record. . Documentation should include: . b. The name, strength, and dosage of medication administered. The facility's policy titled Physician Orders- Entering and Processing, revised 1/31/18, indicated 4. If the medication is needed immediately, it will be removed from the Emergency Drug Kit (EDK). The facility's undated policy titled Medications Administration Oral, indicated 1. Always adhere to the five rights of medication administration, right drug, right resident, right dose, right time, right route, plus right documentation. 1. The record of Resident G was reviewed on 7/17/2020. Resident G was admitted for IV antibiotic therapy. The IV antibiotic [MEDICATION NAME] Sodium solution 2 grams was ordered to be given one time a day from 5/24/2020 through 6/27/2020. The record indicated on 6/1/2020 the resident approached the licensed practical nurse (LPN) and complained of itching after she initiated the antibiotic. The progress note dated 6/1/2020 at 05:36 indicated the nurse gave a wrong IV medication. The resident came to the nurses station and stated he was feeling itchy. The nurse immediately assessed the resident, took vitals, found them to be within normal limits, assessed and flushed the resident's IV port with normal saline. The nurse also monitored the resident for 15

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 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) minutes, notified the NP and DON (Director of Nursing). The record did not indicate the IV medication, strength, nor the dose given in error. During an interview on 7/17/2020 at 1:01 P.M., the DON indicated that the error had been reported to her and the nurse practitioner (NP). The antibiotic given was another resident's IV antibiotic. Resident G was given one dose of [MEDICATION NAME] (an [MEDICATION NAME]). The Benedryl stopped the itching. The facility had not reported this because it was not more than the itching and had no [MEDICATION NAME] effects. The DON indicated the notes should have included the name of the medication that was given in error. 2. The record for Resident B was reviewed on 7/17/2020. Resident B was admitted from the hospital. The hospital discharge orders included the following medications to be administered: [MEDICATION NAME] 2 grams IV every 8 hours, and Phentytoin extended 300 milligrams (mg) by mouth 2 times daily. The hospital records indicated the last dose of [MEDICATION NAME] had been given on 4/8 at 0853 (8:53 A.M.), and the last dose of [MEDICATION NAME] given on 4/8 at 08:54 A.M. The facility Medication Administration Record [REDACTED].M. and the [MEDICATION NAME] start date was 4/10 in the A.M. (morning). The MAR indicated [REDACTED].M., nor the [MEDICATION NAME] ordered until 4/10/2020 with the first dose given until 9:00 P.M. Resident B missed 3 doses of [MEDICATION NAME], 4/8 afternoon, evening dose and 4/9 morning dose; and 4 doses of [MEDICATION NAME] 4/8 evening dose, 4/9 morning and evening doses, and 4/10 morning dose. During an interview on 7/17/2020 at 11:32 A.M., the DON indicated when residents are admitted ,the nurse submits the orders into the computer and faxes them to pharmacy. The run times will get medications sent out by 11. The DNS indicated the pharmacies are in Indianapolis and Chicago. The DON indicated staff should have notified the NP or physician that the [MEDICATION NAME] and [MEDICATION NAME] had not been givenas ordered. The DON indicated she was not working in the facility at that time so was not sure of why these got missed. She indicated she did not know if the EDK had the [MEDICATION NAME] in it at that time since the pharmacy stopped coming into the building to fill the EDK because Covid-19 hit and that she fills the EDK now with what the Pharmacy gives her to fill. She indicated she has not seen any reconstitutable IV medications such as [MEDICATION NAME] in the EDK. 3. On 7/17/20 at 12:15 P.M., the clinical record of Resident L was reviewed and indicated the following [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The March 2020 Medication Administration Record [REDACTED].M., in an intervew, the DON indicated there was no documentation why Resident L's IV antibiotic medication was not given on 3/14/20 at 9:00 p.m. This Federal tag relates to Complaints IN 800, IN 203, and IN 703. 3.1-48(c)2
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure infection control guidelines were implemented regarding transmission based precautions and equipment cleaning and for 5 of 5 residents reviewed. (Resident W, Resident O, Resident Z, Resident V, Resident Y and Resident X) Findings include The facility's policy titled Infection Control, revised 7/21/20, indicated the following: New Admission/Readmission Guidelines Per CDC Responding to Coronavirus in Nursing Homes: . Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19 for 14 days. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator . eye protection . gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms . Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). . Infection Control Precautions & Recommended PPE: Facility HCP will utilize the following PPE and infection control precautions: . Personal Protective Equipment Employees should select appropriate PPE and demonstrate knowledge of: . what PPE is necessary . For a resident on Droplet Precautions: In addition to gloves and gown, staff don a mask (N95 if available or surgical mask) within six feet of a resident: 1. During facility observations of each hall on 7/17, 7/20, and 7/21/2020 the facility failed to evidence any rooms had been marked for isolation. During review of Resident W's record on 7/17/2020, an order for [REDACTED]. [DIAGNOSES REDACTED]. There was no personal protective equipment (PPE) cart outside the room. During an observation on 7/21/2020 at 9:27 A.M., Employee 23 was observed to administer intravenous (IV) antibiotics to Resident W. Employee 23 failed to wear a gown into the room. The room was not identified as needing contact precautions, nor did it have an isolation PPE cart outside of it. During an interview on 7/21/2020 at 9:27 A.M., Employee 23 indicated she needed to put a sign regarding contact precautions becasue [MEDICAL CONDITION] in the urine of Resident W. During an interview on 7/21/2020 at 9:49 A.M., the Director of Nursing (DON) indicated contact isolation includes gloves, sign on door, hand hygiene and educating the resident. On 7/22/2020 at 10:36 A.M. Resident Ws room was observed without a cart for PPE. 2. During observation on 7/22/2020, the only room identified to be on isolation precautions was that of Resident W. On 7/23/2020, the shared room of Residents O and Z was observed to have a sign on the door with see nurse prior to entering. The door was open, and there was a PPE cart outside of this room. On 7/22/2020 at 10:50 A.M. Employee 6 indicated that Resident O just came from the hospital and had a COVID-19 test pending. During an interview on 7/22/2020 at 10:52 A.M., Employee 5 indicated Residents O and Z's room was on precautions to rule out COVID-19, but she did not know the results of the test yet because Resident O was admitted recently. She indicated Resident Z had a fever of 103.0 degrees today and was not feeling well so a chest X-ray had been ordered. During an interview on 7/22/2020 at 11:30 A.M., the DON indicated the facility did not have a COVID-19 result yet on Resident O. Resident O was on droplet isolation until they ruled out COVID-19. She indicated Resident Z had not been in the hospital so did not have a test pending. 3. On 7/22/20 at 9:15 a.m., the clinical record of Resident V was reviewed. The record indicated [DIAGNOSES REDACTED]. was medically ready for discharge from the hospital Social services had asked the nurse if the resident was medically ready. The nurse indicated the patient was medically ready and was not tested for COVID because she had no symptoms. On 7/23/20 at 10:50 a.m., in an interview, the Assistant Director of Nursing indicated if the resident had a negative COVID19 test result before admission to the facility from the hospital, then the resident would not be placed in isolation. If the resident was admitted without a negative COVID19 test results then the resident should have been placed in isolation for 14 days. On 7/23/20 at 11:30 a.m., in an interview, the Director of Nursing (DON) indicated prior to admission, Resident V's COVID19 test results were received. The test was negative so the resident was not placed in isolation. On 7/23/20 at 12:24 p.m., the DON indicated before a resident was admitted to the facility a preadmission assessment is done by the facility. The DON indicated she could not find the resident's COVID19 test result even though the result should have been in the resident's admission information packet. Resident V was observed on the following dates: On 7/21/20 at 1:50 p.m., the resident's door was open 6, there was no signage on the outside of the door to indicate the resident was in isolation. The privacy curtain was opened between Resident V and the roommate. Neither resident wore a mask. On 7/22/20 at 12:00 p.m., the resident's door was open 6. There was no signage on the outside of the door to indicate the residents were in isolation. The privacy curtain between the residents was open and neither resident wore a mask. On 7/23/20 at 9:55 a.m., the resident's door was open 6. There was no signage on the outside of the door to indicate the resident was in isolation, there was no isolation cart outside the residents room. The resident's call light was on. QMA 6 entered the resident room with a surgical mask on her face and no other personal protective equipment. 4. During a continuous observation on 7/22/20 from 11:45 a.m. to 11:52 a.m., the following was observed: LPN 20 took a glucometer into Resident Y's room, used a lancet to draw blood from the resident's finger, placed a drop of blood onto the strip in the glucometer machine, removed gloves, sanitized hands and left the room. LPN 20 placed the glucometer on top of the med cart, donned gloves, wiped the glucometer with an alcohol prep for 7 seconds, removed gloves and sanitized hands. LPN 20 took the glucometer into Resident X's room, used a lancet to draw blood from the resident's finger, placed a drop of blood on the strip in the glucometer, removed gloves sanitized hands and left the room. LPN 20 placed the glucometer on top of the med cart, donned gloves, cleaned the glucometer with an alcohol wipe for 15 seconds removed gloves, sanitized hands and placed the glucometer in the top drawer of the med cart. On 7/22/20 at 12:53 a.m, in an interview, LPN 20 indicated she should have cleaned the glucometer for 2 minutes with a sanitizer wipe but the facility didn't have any, so she cleaned the glucometer with alcohol prep instead. On 7/22/20 at 12:31 p.m., interviewed Director of Nursing (DON) indicated the facility had germicidal wipes available and the glucometer should have been cleaned with a germicidal wipe after each use. A policy dated 8/1/16 and revised on 11/17/17, was provided by the DON on 7/22/20 at 1:00 p.m., titled Glucometer Cleaning indicated it was the policy currently used by

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) the facility. The policy indicated .4. Wipe meter with 1:10 solution bleach wipe towel until all surfaces of the glucometer are wet This Federal citation is related to Complaint IN 203. 3.1-18(a)