DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00377002, IN00374801, IN00373994, IN00371800, IN00371067, IN00370624, IN00370212 and IN00369956. Complaint IN00377002 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F684. Complaint IN00374801 - Substantiated. Federal/State deficiencies related to the allegations are cited at F745 and F921. Complaint IN00373994 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697 and F921. Complaint IN00371800 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686. Complaint IN00371067 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686 and F757. Complaint IN00370624 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697. Complaint IN00370212 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00369956 - Substantiated. No deficiencies related to the allegations are cited.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Survey dates: April 11, 12, 13, 14, 18, 19, 20 and 21, 2022. Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 108 SNF: 6 Total: 114 Census Payor Type: Medicare: 12 Medicaid: 73 Other: 29 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/26/22.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) 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, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly			

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	(that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to ensure a resident's representative was notified for 1 of 1 residents reviewed for a resident to resident altercation. (Resident P)	F 0580	**Aperion- Arbors Michigan City** **POC Annual/Recertification**	05/09/2022

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	Finding includes: Review of Abuse Allegations on 4/12/22 at 9:00 a.m., indicated Resident P was in an altercation with his then roommate. Interview with Resident P on 4/12/22 at 2:14 p.m., indicated he did not recall the incident with his roommate, except that his roommate stole his coat, returned it the next day, and then the roommate moved out. Resident P's record was reviewed on 4/18/22 at 9:01 a.m. Diagnoses included, but not limited to, stroke, high blood pressure, Parkinson's disease, and Alzheimer's dementia. The Quarterly Minimum Data Set (MDS), dated 3/23/22, indicated the resident was moderately cognitively impaired. The Incident Report, dated 3/29/22 at 10:01 a.m., indicated that Resident P had been in an altercation with his roommate. This resulted in the both residents yelling at each other and Resident P received a small scratched on his hand from his roommate. The residents were separated and a room change was completed. The record lacked an indication that Resident P's representative was notified of the resident to resident altercation, and that he had received a small scratch on his hand. Interview with the Assistant Director of Nursing on 4/18/22 at 12:54 p.m., indicated there was not any documentation that the resident's representative was notified regarding the altercation.		**Exit 04/21/2022** **Compliance 05/09/2022** **F 580 Notification** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** POA of resident P was notified of resident-to-resident altercation. **2) How the facility identified other residents:** Audit was completed of all current residents' new orders, significant changes, and assessments from 4-11-22 to current to ensure timely notification to the family.	

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	This Federal tag relates to Complaint IN00370212. 3.1-5(a)(1)		**3) Measures put into place/ System changes:** Nursing staff was educated relative to Notification of Changes (Injury/Decline/Room, etc.), including but not limited to notifying resident's representatives if there are any resident-to-resident altercations. **4) How the corrective actions will be monitored:** **Director of Nursing (DON), Executive Director (ED), or Designee will review new orders, significant changes, and assessments 5 days a week for 3 months and 3 days a week for 3 months in an effort to identify any areas that require resident representative notification, and to ensure notification has been made. Any identified concerns will promptly be addressed with the responsible individual(s).** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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			4) Date of compliance: 05/09/2022	
F 0583 SS=B Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.			

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	(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure the resident's privacy was respected related to a Nurses' Report Sheet with resident information left out in the open with personal resident information for 1 of 1 random observations. (300 Hall) Finding includes: During an observation on 4/18/22 at 11:05 a.m., Resident 40 was observed walking out of the living room in the 300 unit carrying a Nurses' Report Sheet. During an interview with Resident 40 on 4/18/22 at 11:05 a.m., the resident presented the 300 Unit Nurses' Report Sheet and indicated she had found the report sheet in the living room and had read the sheet. The resident indicated she had the paper in her possession since the night of 4/17/22. The 300 Unit Nurses' Report Sheet was reviewed on 4/18/22 at 11:10 a.m. The document contained information regarding 35 residents on the unit. Information included, but was not limited to, first and last names, shower days, medications, code status, physician names, diet, isolation, hospice care, and general notes. Interview with the Administrator on 4/18/22 at 5:15 p.m., indicated the Nurses' Report Sheet should have not been left out in the open and no further information was provided. 3.1-3(p)(2)	F 0583	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/222** **Compliance 05/09/2022** **F 583 Privacy** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Confidential records were removed from sitting area at the time of survey. **2) How the facility**	05/09/2022

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			identified other residents: All residents have the potential to be affected, therefore, this plan of correction applies to all residents currently residing in the facility. **3) Measures put into place/ System changes:** All Staff was immediately in-serviced relative to Personal Privacy/Confidentiality of Records, including but not limited to, ensuring residents' privacy related to Nurses' Report Sheets and other resident sensitive information. **4) How the corrective actions will be monitored: The DON/Designee will** complete Privacy Rounds **randomly** at least 5 times weekly for 4 weeks, at varied times, to ensure privacy is maintained. Thereafter, these privacy rounds will be conducted randomly at least 3 times weekly for 8 weeks, at varied times. Any identified concerns will be promptly addressed with responsible individual(s). ED will be notified immediately of any infraction. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is**	

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			achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 05/09/2022**	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized			

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	rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to develop and implement a care plan for pain for 1 of 36 resident care plans reviewed. (Resident J) Finding includes: Resident J's record was reviewed on 4/13/22 at 9:38 a.m. The resident was admitted on 1/7/22. Diagnoses included, but were not limited to, vascular dementia and dysphasia (difficulty swallowing) following a stroke and peripheral vascular disease. The Quarterly Minimum Data Set (MDS) assessment, dated 1/21/22, indicated the resident had severe cognitive impairment, and required extensive two person assistance for bed mobility. She had received scheduled pain medication in the past 5 days.	F 0656	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/2022** **Compliance 05/09/2022** F656 Care Plan Development The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	05/09/2022

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	A Physician's Order, dated 3/9/22, indicated to administer Tramadol, (pain medication) 50 milligrams (mg) every six hours for pain. A Physician's Order, dated 3/1/22, indicated to administer Tylenol, 650 mg every 6 hours as needed for pain. The record lacked a care plan related to pain. Interview with the MDS Nurse on 4/14/22 at 3:00 p.m., indicated the resident should have a care plan for pain in place, and it must have been overlooked. 3.1-35(a)		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident J's care plan was reviewed, and updated, relative to pain. **2) How the facility identified other residents:** An audit will be completed to identify all residents with pain in the last 30 days. The careplans of identified residents will be reviewed and updated, as necessary, to reflect the presence of pain. **3) Measures put into place/ System changes:** Nursing staff and the IDT will receive education relative to Develop/Implement Comprehensive Care Plan, including but not limited to, implementing and/or updating a resident's care plan to ensure pain is addressed. **4) How the corrective actions will be monitored:** DON/Designee will review the care	

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			plans of 10 random residents per week for 1 month to ensure pain is addressed, as necessary. Thereafter, DON/Designee will review the careplans of 10 random residents per month for 2 months to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/2022**	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for			

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	the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on observation, record review, and interview, the facility failed to ensure a care plan was reviewed and revised as needed related to enteral feedings for 1 of 30 residents whose care plans were reviewed. (Resident 35) Finding includes: On 4/13/22 at 8:59 a.m., Resident 35 was observed lying in bed. Her tube feeding of Jevity 1.5 (tube feeding formula) was on and infusing at 75 ml (milliliters) per hour per pump. The record for Resident 35 was reviewed on 4/13/22 at 10:17 a.m. Diagnoses included, but were not limited to, hypertension, Parkinson's disease, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/9/22, indicated the resident	F 0657	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/222** **Compliance 05/09/2022** **F657 Care Plan Revision** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	05/09/2022

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	was severely cognitively impaired and received most of her nutrition by tube feeding. A Physician's Order, dated 3/23/22, indicated enteral feed (tube feeding) Jevity 1.5 (tube feeding formula) 75 ml (milliliters) per hour for 16 hours. On at 10 p.m. and off at 6 p.m., for a total volume 1200 ml. A Care Plan, dated 11/15/21, indicated the resident required a tube feeding and received Jevity 237 ml via feeding tube five times daily. The care plan had not been updated to reflect the current tube feeding orders. Interview with the Interim Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/13/22 at 1:12 p.m., indicated they had no information as to why the care plan had not been updated. 3.1-35(b)(1)		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 35's care plan was reviewed and revised, as necessary, to reflect enteral feedings. **2) How the facility identified other residents:** Residents who receive enteral feedings/nutrition have the potential to be affected, therefore, this plan of correction applies to those residents. The careplans of identified residents will be reviewed and updated, as necessary, to reflect the presence enteral feedings/nutrition. **3) Measures put into place/ System changes:** Licensed Nursing staff will receive education relative to Care Plan Timing and Revision, including but not limited to, reviewing and revising a resident's care plan to ensure enteral feeding/nutrition is addressed. **4) How the corrective actions will be monitored:**	

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	155156	A. BUILDING 00 B. WING	04/21/2022

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			DON/Designee will review the care plans of at least 5 random residents with enteral feedings/nutrition per week for 1 month to ensure enteral feeding/ nutrition is addressed. Thereafter, DON/Designee will review the careplans of 5 random residents per month for 2 months to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/2022**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure dependent residents received	F 0677	**Aperion- Arbors Michigan City POC Annual/Recertification**	05/09/2022

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assistance with ADLs (activities of daily living) related to bathing for 2 of 5 residents reviewed for ADLs. (Residents C and Q)

Findings include:

1. Resident C's closed record was reviewed on 4/14/22 at 9:04 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and end stage renal disease.

The Quarterly MDS (Minimum Data Set) assessment, dated 3/31/22, indicated the resident was cognitively intact and required extensive assistance with personal hygiene and bathing.

The ADL task profile indicated the resident preferred bathing on Mondays and Fridays on the day shift.

The ADL task charting, dated 3/1/22 through 4/4/22, indicated the resident had only received bathing on 3/7/22, 3/14/22, 3/21/22, 3/25/22, and 4/1/22. She had refused bathing on 4/4/22. There was lack of documentation bathing had been offered or completed twice a week.

Interview with the Interim Director of Nursing (DON) on 4/14/22 at 3:50 p.m., indicated she was unable to find any further documentation of bathing.2. Interview with Resident Q on 4/12/22 at 11:39 a.m., indicated she had not received a full bed bath or a shower in 2 weeks. They "only wipe the important parts."

Interview with Resident Q on 4/18/22 at 1:30 p.m., indicated she had not received a full bed bath, and would prefer a shower when she can get up and moving better.

Exit 04/21/2022
Compliance 05/09/2022

F 677 ADL Care provided

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

1) Immediate actions taken for those residents identified:
1. Resident C no longer resides in the facility; therefore, no further corrective action could be taken for this resident.
2. Resident Q was offered and given a shower at the time of survey.

2) How the facility identified other residents:
The facility completed an audit to identify any dependent residents need assistance with showers, The facility staff provided showers and personal care, as needed.

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	Resident Q's record was reviewed on 4/14/22 at 10:09 a.m. Diagnoses were included, but not limited to, heart failure, diabetes mellitus, anxiety, and depression. The Admission Minimum Data Set assessment, completed on 3/24/22, indicated she was impaired on her one lower side, used a wheelchair and a walker for ambulation. An Activities-Preferences interview was completed on 3/21/22 at 3:16 p.m. with the resident. It was very important for her to choose between a shower or bed bath. Her preferred bathing type was a shower, alternating with a bed bath and twice a week was accepted. The ADL task charting indicated she preferred bathing on Tuesday and Friday evenings. The record lacked an indication that the resident received or refused a shower or a full bed bath for the month of April 2022. A Care Plan, revised on 3/20/22, indicated she had Activities of Daily Living self-care performance deficit. An intervention may include for bathing/showering, for the staff to set up her needed items for a shower or bath and assist her as needed. Interview with CNA 3 and CNA 4 on 4/18/22 at 2:16 p.m., indicated in the "Shower Book," her showers were on Tuesdays and Friday evening. If the resident refused, the nurse would have been notified. Staff chart the bathing in the computers. Interview with Administrator on 4/18/22 at 2:30 p.m., indicated the CNA should document the type of bathing that was completed and if the		**3) Measures put into place/ System changes:** Facility staff was in-serviced relative to ADL Care Provided for Dependent Residents, including but not limited to, ensuring dependent residents receive assistance with ADLs. **4) How the corrective actions will be monitored:** **The DON/Designee** will complete Dignity Rounds at least 3 times weekly, at varied times, to ensure proper hygiene is maintained for residents. The DON/Designee will review POC charting to ensure that residents are offered at least 2 showers a week. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:**	

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	resident had refused the bathing, there should been documentation. The CNA should have notified the nurse and the nurse should have documented in the Nurse Notes that the resident had refused, if that had occurred. This Federal tag relates to Complaint IN00377002. 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)		**05/09/2022**	
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on record review and interview, the facility failed to complete a laboratory test, failed to monitor a resident's blood sugars which resulted in hospitalization for hypoglycemia (low blood sugar) and failed to increase monitoring of a resident with low hemoglobin (carries oxygen from the respiratory organs to the rest of the body) laboratory results and on antibiotic therapy for 2 of 4 residents reviewed for discharge. (Residents C and L) Findings include: 1. Resident C's closed record was reviewed on 4/14/22 at 9:04 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus,	F 0684	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/2022** **Compliance 05/09/2022** **F684 Quality of Care** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	05/09/2022

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hypertension, and end stage renal disease.

The Quarterly MDS (Minimum Data Set) assessment, dated 3/31/22, indicated the resident was cognitively intact and required extensive assistance with activities of daily living.

A Care Plan indicated the resident had a diagnosis of diabetes and was insulin dependent. An intervention included to administer diabetes medication as ordered and to monitor for side effects and effectiveness.

A Nurse Practitioner Note, dated 2/9/22 at 8:48 p.m., indicated the resident had been experiencing low blood sugars in the morning. She reported experiencing nausea, dizziness, lightheadedness, and diaphoresis when her blood sugars were low. She also complained of diarrhea "all day, every day" for the past 3 days. The Nurse Practitioner's plan included a decrease in Lantus (insulin) to 28 units at bedtime, monitor blood sugars before meals and at bedtime, and to test the resident's stool for C. diff (clostridium difficile, a bacteria that causes severe diarrhea).

A Physician's Order, dated 2/8/22, indicated an order for Lantus 28 units at bedtime. The Medication Administration Record (MAR), dated 2/2022, indicated the resident received the insulin on 2/8/22, 2/9/22, and 2/10/22. There were no HS (bedtime) blood sugar monitoring results documented.

A Progress Note, dated 2/10/22 at 2:22 p.m., indicated the resident was to have a CMP (comprehensive metabolic panel, lab test to monitor electrolytes) drawn on 2/11/22 and needed a stool sample to be collected for testing of C.diff. There was lack of any further

constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

1) Immediate actions taken for those residents identified:

1. & 2. Residents C and L no longer reside in the facility; therefore, no further corrective action could be taken for these residents.

2) How the facility identified other residents:

An audit has been conducted to identify residents who require blood glucose monitoring, have abnormal labs requiring increased monitoring, and who are receiving antibiotic therapy; this plan of correction applies to the residents identified in this audit. Necessary monitoring related to the aforementioned conditions has been implemented for identified residents.

3) Measures put into place/ System changes:

Licensed nursing staff will be re-educated relative to Quality of

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	documentation the stool sample had been collected and the C. diff testing had been completed as ordered by the Nurse Practitioner. A Progress Note, dated 2/11/22 at 7:09 p.m., indicated the resident's glucose at 5:00 a.m. per the CMP lab results was 24. The Nurse Practitioner was notified, and the Lantus was decreased to 20 units at bedtime. A Physician's Order, dated 2/11/22, indicated an order for Lantus 28 units at bedtime, hold for HS blood sugar less than 150. The Medication Administration Record (MAR), dated 2/2022, indicated the resident received the insulin on 2/13/22, 2/14/22, 2/15/22, 2/16/22, 2/17/22, 2/18/22, 2/20/22, 2/21/22, and 2/22/22. There were no HS (bedtime) blood sugar monitoring results documented. A Progress Note, dated 2/23/22 at 7:00 a.m., indicated the resident was unresponsive and her blood sugar was 33. She was given orange juice with sugar and 40% glucose. The resident remained unresponsive, and her blood sugar remained low. The Nurse Practitioner was notified and 911 was called. The resident was transported to the hospital at 7:15 a.m. A Progress Note, dated 2/23/22 at 6:42 p.m., indicated the resident had been admitted to the hospital with a diagnosis of altered mental status and hypoglycemia. The resident was re-admitted to the facility on 2/25/22. A Nurse Practitioner Note, dated 2/28/22 at 3:12 p.m., indicated the resident had been admitted to the hospital for altered mental status and hypoglycemia. All her insulin had been discontinued while in the hospital and she also		Care, including but not limited to, ensuring completion of ordered labs, obtaining blood glucose readings in accordance with physician orders, monitoring of residents with abnormal lab results, and monitoring of residents receiving antibiotic therapy. **4) How the corrective actions will be monitored:** DON/designee will review the charts of at least 3 residents week for 4 weeks, including eMAR and eTAR, to validate that blood glucose levels are obtained and documented, labs are obtained and documented, and that necessary monitoring associated with blood glucose levels, lab results, and antibiotic therapy is documented. Thereafter, DON/designee will review the charts of at least 5 residents monthly for 2 months to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or**	

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	tested positive for clostridium difficile. Interview with the Interim Director of Nursing (DON) and the Administrator on 4/14/22 at 3:50 p.m., indicated the Nurse Practitioner would put her own orders in the computer. She had not decreased the Lantus to 20 units on 2/11/22 as the Progress Note indicated. She had just added the parameters to hold the Lantus if the resident's blood sugar was below 150. They were unable to provide any documentation of HS blood sugar monitoring for the resident. They indicated the lab test for C. diff had not been completed until the resident was in the hospital. 2. The record for Resident L was reviewed on 4/19/22 at 8:50 a.m. Diagnoses included, but were not limited to COVID-19, anemia (lack of healthy red blood cells), heart failure, respiratory failure, and pneumonia. The Admission Minimum Data Set (MDS), dated 3/3/22, indicated the resident was moderately cognitively impaired and had received anticoagulants and antibiotics over the last 7 days. A Physician's Order, dated 2/25/22, indicated metoprolol tartrate (to lower blood pressure) 50 mg (milligrams) tablet , 1 tablet by mouth two times a day. A Physician's Order, dated 2/25/22, indicated ceftriaxone sodium solution (an antibiotic) 2000 mg was to be administered one time a day intravenously (in the vein via a tubing) in the evening until 3/20/22. A Physician's Order, dated 3/9/22 at 7:00 a.m., indicated polysaccharide iron complex capsule (an		**patterns and make recommendations to revise the plan of correction as indicated.** **Date of compliance: 05/09/22**	

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iron supplement) 150 mg was ordered to administer two times a day.

The February Medication Administration Record (MAR) indicated the metoprolol tartrate and the ceftriaxone sodium solution were administered as ordered.

The March MAR indicated the metoprolol tartrate, the ceftriaxone sodium solution and the polysaccharide iron complex were administered as ordered.

A Nurse Note, dated 3/5/22 at 4:47 p.m., indicated the resident had a low hemoglobin level of 6.8 -low (normal range 14.0-18.0 grams/deciliter). The physician was notified and new orders were placed to repeat the CBC (complete blood count) again on 3/6/22 and 3/7/22 and call the physician with results.

A Nurse Note, dated 3/6/22 at 3:14 p.m., indicated the hemoglobin level was 6.6. Physician was notified and orders were given to repeat the CBC again the next morning. The resident and resident representative were aware.

A Nurse Note, dated 3/8/22 at 8:00 a.m., indicated the hemoglobin level was 7.2. The physician and representative were aware and new orders were given to test for occult blood (blood found in stool).

A Nurse Note, dated 3/12/22 at 9:05 p.m., indicated the resident was sent to the hospital due to low hemoglobin and blood in stool.

The Infection/Antibiotic Charting indicated the resident had daily monitoring due to having an infection and had received antibiotic therapy. On

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	each shift from 3/8/22-3/12/22, the resident's blood pressure document as "136/80 from 3/7/22 at 5:23 p.m." The record lacked an accurate documentation that the resident was being monitored via blood pressures for 3 consecutive laboratory test results for low hemoglobin levels as a Nursing measure. Interview with the Interim Director of Nursing (DON) on 4/19/22 at 1:38 p.m., indicated if a resident had abnormal labs such as a low hemoglobin, the nursing staff would be expected to do a full assessment more often, including taking a current blood pressure. Interview with the Assistant Director of Nursing (ADON) on 4/19/22 at 1:51 p.m., indicated if a resident had an infection or was on antibiotic therapy, the nursing staff were to chart using the Infection/Antibiotic Charting. The charting generated a template which should guide the staff to know what vital signs and assessments to do. The template included, but was not limited to, an updated blood pressure, temperature, respirations, and pulse. The staff should have assessed and monitored the resident's blood pressure with each of the assessments completed. This Federal Tag relates to Complaint IN00377002. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, record review and interview, the facility failed to implement interventions for a resident with pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. (Resident J) Finding includes: On 4/13/22 at 9:00 a.m., Resident J was observed in her bed. She was again observed in her bed at 10:50 a.m., and during continuous observation from 1:00 p.m. to 3:20 p.m. On 4/14/22 the resident was observed in bed at 8:40 a.m., 11:55 a.m., 1:10 p.m., 1:45 p.m. She was not observed out of bed during these two days. On 4/13/22, during continuous observation from 1:00 p.m. to 3:20 p.m., the resident was in her bed. At 2:02 p.m., two staff members entered the room and assisted her roommate, they did not reposition the resident. At 2:23 CNA 1 entered the room. She checked the resident's brief and adjusted her oxygen tubing, but did not reposition her. The resident's record was reviewed on 4/13/22 at 9:38 a.m. The resident was admitted on 1/7/22. Diagnoses included, but were not limited to, vascular dementia and dysphasia (difficulty	F 0686	**Aperion Care Arbors Michigan City** **Annual Recertification 2022** **Compliance 05/09/2022** **F 686 Treatment/Svcs to Prevention/Heal Pressure Ulcer** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	05/09/2022

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	swallowing) following a CVA. The Quarterly Minimum Data Set assessment, dated 1/21/22, indicated the resident had severe cognitive impairment, and required extensive two person assistance for bed mobility. She had one stage one pressure ulcer and was identified as at risk for developing pressure ulcers. A Physician's Order, dated 1/7/22, indicated the resident was to be out of bed as tolerated. A Pressure Ulcer Care Plan, dated 3/26/22, indicated to reposition the resident every 2 hours and as needed. Interview with CNA 1 on 4/13/22 at 3:18 p.m., indicated she did not reposition the resident when she checked on her at 2:23 p.m. Interview with CNA 2 on 4/14/22 at 2:10 p.m., indicated they used to get the resident up every other day, but was not sure if they were still doing that. Interview with the Wound Nurse on 1/14/22 at 2:15 p.m., indicated staff should be getting the resident out of bed every day. This Federal tag relates to Complaints IN00371067 and IN00371800. 3.1-40		Resident J is no longer resides in the facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** Residents with altered skin integrity, or those at high risk of altered skin integrity have the potential to be affected by this practice. The medical records of the identified residents have been reviewed to ensure appropriate interventions for prevention of alteration in skin integrity are documented. **3) Measures put into place/ System changes:** Nursing staff have been re-educated relative to Treatment/Svcs to Prevent/Heal Pressure Ulcer, including but not limited to ensuring identified interventions are implemented for each resident. DON/designee will conduct a random audit of at least 5 residents per week, for 6 weeks, with alterations in skin integrity to validate that the current interventions to prevent new or worsening alterations in skin integrity are in place. Thereafter, a random audit of at least 3 residents per week, for 6 weeks will be conducted to ensure continued compliance. Any	

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	155156	A. BUILDING 00 B. WING	04/21/2022

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APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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			identified concerns will be promptly addressed with the responsible individual(s). **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/2022**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and			

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	services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, record review, and interview, the facility failed to provide treatment for limited range of motion related to a palm protector not in place for 1 of 3 residents reviewed for range of motion. (Resident 35) Finding includes: On 4/11/22 at 10:38 a.m., Resident 35 was observed lying in bed. Both of her hands were contracted and in a closed in a fist. There were no palm protectors observed in place. On 4/13/22 at 8:59 a.m., Resident 35 was observed lying in bed. Both of her hands were contracted and in a closed in a fist. There were no palm protectors observed in place. On 4/13/22 at 11:01 a.m., Resident 35 was observed lying in bed. Both of her hands were contracted and in a closed in a fist. There were rolled up washcloths observed in both hands. The record for Resident 35 was reviewed on 4/13/22 at 10:17 a.m. Diagnoses included, but were not limited to, hypertension, Parkinson's disease, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/9/22, indicated the resident was severely cognitively impaired and had	F 0688	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/2022** **Compliance 05/09/2022** **F688 ROM** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for**	05/09/2022

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	impaired function range of motion on both sides to both upper and lower extremities. A Physician's Order, dated 9/4/19, indicated the resident was to wear bilateral palmar guard splints at all times as tolerated. A Care Plan indicated the resident had contractures. An intervention included to "...provide positioning devices/splints as ordered..." The Treatment Administration Record (TAR), dated 4/2022, indicated the bilateral palmar guard splints had been signed out every shift as being in place. Interview with the Interim Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/13/22 at 1:12 p.m., indicated they would check into why the resident had not had the palm protectors in place. Interview with LPN 3 on 4/13/22 at 1:18 p.m., indicated she had completed rounds right before lunch and noticed the resident had not had her palm protectors in place. She placed rolled up washcloths in the resident's hands at that time because she could not find the palm protectors. 3.1-42(a)(2)		**those residents identified:** Resident 35 was provided with ROM, and palm protectors were placed at the time of survey. **2) How the facility identified other residents:** All residents who have contractures or at risk for contractures have the potential to be affected by this practice. An audit was conducted to identify these residents, care plans were reviewed and updated, as necessary. **3) Measures put into place/ System changes:** Nursing staff will be re-educated relative to Increase/Prevent Decrease in ROM/Mobility, including but not limited to provision of treatment for limited range of motion and proper use of palm protectors/splints. DON/Unit Managers/Charge Nurses/Designee will conduct random visual observation audits of at least 5 residents per week, for 4 weeks, with ordered palm protectors/splints to ensure placement as per orders/recommendations. Thereafter, these audits will be conducted on at least 2 residents per week for 8 weeks to ensure continued compliance. Findings will be documented on the Angel Rounds sheet and	

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			reviewed at the daily meetings. DON is responsible for compliance. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 05/09/2022**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake			

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	to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure a resident with fluid restrictions was appropriately assessed for 1 of 1 resident reviewed for dialysis. (Resident 91) Finding includes: Resident 91's record was reviewed on 4/13/22 at 2:38 p.m. Diagnoses included, but were not limited to, chronic kidney disease, hypertension, renal failure, diabetes mellitus, and non-Alzheimer's dementia. The Quarterly Minimum Data Set (MDS), dated 3/14/22, indicated the resident was moderately cognitively impaired. The resident was receiving a therapeutic diet and received dialysis treatments. The Physician's Order dated 9/6/2021 at 3:00 p.m., indicated the resident had a 1500 milliliter (ml) fluid restriction for a 24 hour period. The record lacked an indication of a Care Plan related to a 1500 ml fluid restriction. The Nutrition-Fluid Task for March 2022 and April 2022 was reviewed 04/18/22 08:58 AM. The following days, the resident exceeded the 1500 ml fluid restriction per the Physician's Order. - 3/20/22 - 1600 cc - 3/21/22 - 2630 cc - 3/22/22 - 3080 cc - 3/24/22 - 2090 cc - 4/3/22 - 1600 cc - 4/12/22 - 1780 cc	F 0692	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/2022** **Compliance 05/09/2022** **F692 Nutrition/Hydration** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 91 was re-educated about fluid restriction order at the time of survey. **2) How the facility identified other residents:**	05/09/2022

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	The record lacked an indication of notification to the physician, dialysis center, or other responsible party. It also lacked an indication of education provided to the resident or staff regarding the fluid restriction on the days he exceed the 1500 ml limit. Interview with the Interim Director of Nursing on 4/14/22 at 3:30 p.m., indicated the physician, dialysis staff, or responsible party should have been notified and interventions should have been in place to follow the Physician's Order. 3.1-46(b)		An audit was conducted to identify residents with orders for a fluid restriction, this plan of correction applies to identified residents. Fluid intake records for the identified residents were reviewed for the previous 14-day period, any overages were reported to resident's physicians, as necessary. Additionally, care plans for identified residents have been reviewed and revised, as necessary, to reflect the fluid restriction. **3) Measures put into place/ System changes:** Nursing and Dietary staff will be re-educated relative to Nutrition/Hydration Status Maintenance, including but not limited to, appropriate assessment of residents with fluid restriction orders, and necessary notifications to be made if fluid restriction amounts are exceeded. DON/designee will conduct audits of fluid intake records for all residents with an ordered fluid restriction 3 times weekly for 4 weeks to ensure appropriate assessments are completed, and necessary notifications are made, when indicated. Thereafter, these audits will be conducted weekly for 8 weeks to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible	

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			individual(s). **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **05/09/2022**	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment			

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	and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, record review, and interview, the facility failed to ensure residents receiving enteral nutrition received appropriate treatment and services related to the incorrect tube feeding administration for 1 of 1 residents reviewed for tube feeding. (Resident 35) Finding includes: On 4/11/22 at 10:38 a.m. Resident 35 was observed lying in bed. Her tube feeding was not connected or infusing. The tubing was capped and hanging on the feeding pump pole. On 4/13/22 at 8:59 a.m., Resident 35 was observed lying in bed. Her tube feeding of Jevity 1.5 (tube feeding formula) was on and infusing at 75 ml (milliliters) per hour per pump. The record for Resident 35 was reviewed on 4/13/22 at 10:17 a.m. Diagnoses included, but were not limited to, hypertension, Parkinson's disease, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/9/22, indicated the resident was severely cognitively impaired and received most of her nutrition by tube feeding. A Comprehensive Clinical Review Meeting Note, dated 3/22/22, indicated a recommended change of the ordered tube feeding to Jevity 1.5 (tube feeding formula) 60 ml (milliliters) per hour for 20 hours.	F 0693	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/2022** **Compliance 05/09/2022** **F693 Feeding Tube Management** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 35's feeding was adjusted to run at the correct rate per physician order at the time of survey.	05/09/2022

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	A Physician's Order, dated 3/23/22, indicated enteral feed (tube feeding) Jevity 1.5, 75 ml per hour for 16 hours. On at 10 p.m. and off at 6 p.m., for a total volume 1200 ml. The time passed from 10 p.m. through 6 p.m. equals 20 hours, not 16 hours as ordered. The total volume infused during that time at a rate of 75 ml per hour would be 1500 ml, not 1200 ml as ordered. Interview with the Interim Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/13/22 at 1:12 p.m., indicated they would look into the tube feeding order and clarify it. 3.1-44(a)(2)		**2) How the facility identified other residents:** Residents who receive enteral feedings have the potential to be affected by this practice. Physician orders for enteral feedings were reviewed, enteral feeding pumps were visually inspected to ensure appropriate flow rate settings, and care plans of identified residents were reviewed and updated, as necessary. **3) Measures put into place/ System changes:** Licensed nursing staff will be re-educated relative to Tube Feeding Mgmt/Restore Eating Skills, including but not limited to, ensuring that enteral feeding orders are written correctly and that the feedings are administered according to the orders as written. DON/Designee will conduct random visual observation audits at least 5 times per week for 4 weeks to ensure enteral feeding pumps are set at the ordered rate and are infusing at the scheduled times. Thereafter, these audits will be conducted at least 2 times weekly, randomly, for 8 weeks to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s).	

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			4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 05/09/2022**	
F 0697 SS=E Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to ensure a resident's pain was effectively managed for 4 of 5 residents reviewed for pain. (Residents J, S, R and E) Findings include: 1. On 4/13/22 at 2:23, CNA 1 entered Resident J's room. She checked the resident's brief and adjusted her oxygen tubing, but did not reposition her. On 4/13/22 at 10:50 a.m., the resident was	F 0697	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/22/2022** **Compliance 05/09/2022** **F697- Pain Management** *This Plan of Correction is the center's credible allegation of*	05/09/2022

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	observed in bed. She was rubbing her right arm and grimacing. When asked if her arm hurt, she nodded her head. On 4/14/22 at 1:45 p.m., wound care was observed with the Wound Nurse and CNA 2. When the resident was rolled from side to side, she would grimace and moan. When the Wound Nurse cleansed the wounds on her buttocks, the resident grimaced and made a verbal sound of pain. When the Wound Nurse lifted her left leg to remove her protective boot, she again showed signs of pain. The resident was asked if she was having pain, she nodded her head and said on her back. The Wound Nurse indicate she had a pain pill an hour and a half ago. The resident's record was reviewed on 4/13/22 at 9:38 a.m. The resident was admitted on 1/7/22. Diagnoses included, but were not limited to, vascular dementia and dysphasia (difficulty swallowing) following a CVA. The Quarterly Minimum Data Set assessment, dated 1/21/22, indicated the resident had severe cognitive impairment, and required extensive two person assistance for bed mobility. She had received scheduled pain medication in the past 5 days. A Physician's Order, dated 3/9/22, indicated to administer Tramadol, (pain medication) 50 milligrams (mg) every six hours for pain. A Physician's Order, dated 3/1/22, indicated to administer Tylenol, 650 mg every 6 hours as needed for pain. Review of the Medication Administration Record indicated the resident received Tylenol one time in		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. & 4. Residents J and E no longer reside in the facility; therefore, no further corrective action could be taken for these residents. 2. & 3. Ordered pain medication for residents S and R have been obtained and administered according to physician orders. **2) How the facility identified other residents:** An audit will be completed to identify residents with routinely ordered pain medication, and frequently administered PRN pain medication, in the last 30 days. Identified residents have the potential to be affected by this practice. Residents will be assessed, pain medication orders	

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	March 2022, and two times in April 2022. There was not a care plan related to pain. Interview with CNA 1 on 4/13/22 at 3:18 p.m., indicated she had not repositioned the resident when she checked on her because she had a lot of pain when moved. Interview with the Wound Nurse on 4/14/22 at 2:15 p.m., indicated the resident was still having pain, but it was improved since adding the scheduled Tramadol. She indicated the resident could have Tylenol and would give her some at that time. She also indicated she would discuss the resident's pain with the Physician. 2. Interview with Resident S on 4/11/22 at 11:23 a.m., indicated he had not received received his pain medications when he was in pain last month. The staff had excuses of they did not have the medication yet, it was on order. Interview with Resident S on 4/18/22 at 10:43 a.m., indicated his pain level was a 10 on a scale of 1-10 with the worst pain on the back of his neck and upper shoulders. "The nurse told me the next scheduled pain medication was not until noon and that I had to wait until then." Resident S's record was reviewed on 4/18/22 at 11:00 a.m. Diagnoses included, but were not limited to, neurological conditions, cancer and chronic pain. The Quarterly Minimum Data Set assessment, dated 1/27/22, indicated he had a scheduled pain regimen and had frequent pain. The current Physician Order Summary indicated, on 3/26/22, to administer		will be reviewed, presence of the pain medication will be verified, and careplans will be reviewed and revised, as necessary. **3) Measures put into place/ System changes:** Licensed nursing staff will be re-educated relative to Pain Management, including but not limited to, ensuring residents' pain is effectively managed, pain is accurately assessed, effectiveness of administered pain medication is accurately assessed, pain medications are ordered, and received from the pharmacy; physicians are notified, when necessary, relative to pain management concerns, and pain is care planned. DON/designee will review the eMARs of at least 5 residents who receive routine pain medication, or frequent PRN pain medication, daily (M-F) during clinical meeting for 4 weeks to ensure accurate assessment, administration, documentation, and presence of medication in the facility. Thereafter, the eMARs of at least 5 residents per month for 8 weeks will be reviewed to ensure continued compliance. **4) How the corrective actions**	

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	155156	A. BUILDING 00 B. WING	04/21/2022

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	Hydrocodone-Acetaminophen (to treat pain) tablet 5-325 mg (milligram), 1 tablet by mouth every 6 hours for pain. The March Medication Administration Record (MAR) indicated the Hydrocodone-Acetaminophen 5-325 mg tablet was not administered as ordered and had the documentation of "pending delivery, waiting for delivery, not available, waiting on arrival, waiting on Pharmacy," for the following dates and times: - 3/9/2022 at 3:32 a.m. - 3/9/22 at 6:01 a.m. and 11:24 a.m. - 3/10/22 at 11:27 a.m. - 3/10/22 at 7:59 p.m. - 3/11/22 at 4:37 a.m. and 6:12 a.m. - 3/11/22 at 11:47 a.m. - 3/11/22 at 2:01 p.m. - 3/12/22 1:07 a.m. and 5:52 a.m. - 3/12/22 11:29 a.m. and 6:42 p.m. - 3/13/22 at 3:04 a.m. - 3/13/22 at 5:19 a.m., 11:56 a.m. and 6:12 p.m. - 3/14/22 12:39 a.m., 11:40 a.m. and 9:59 p.m. - 3/15/22 at 12:00 a.m. The record lacked an indication to why the medication was not delivered and that the Physician was notified the resident had not received his pain medications as ordered. A Nurse Practitioner (NP) Note on 3/14/22 at 2:00 p.m., indicated the resident was seen for an acute visit for chronic pain. The NP's assessment indicated the resident had frequent, throbbing pain with a pain of 7 out 10, with 10 being the worst pain. A refill prescription was written for Hydrocodone-Acetaminophen tablet 5-325 mg, 1 tablet by mouth every 6 hours for pain. The Pharmacy's (name of Pharmacy) delivery		**will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/22**	

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manifest,dated 3/1/22 at 2:52 a.m., indicated 30 tablets of Hydrocodone-Acetaminophen tablet 5-325 mg was delivered to the facility. The next 30 tablets of Hydrocodone-Acetaminophen tablet 5-325 mg was not delivered to the facility until 3/15/22 at 2:37 a.m.

A Care Plan, dated 6/15/20, indicated pain related to alcohol withdrawal and a history of prostate cancer. Interventions included, monitor/record/report to the nurse complaints of pain or requests for pain treatment.

Interview with the Interim Director of Nursing on 4/20/22 at 5:36 p.m., indicated the "n/a or x" on the March MAR. The record indicated the pain medication was pending or waiting on the pharmacy. The Nurse Notes lacked why the medication was not administered on time. The Pharmacy manifest indicated the pharmacy only sent 30 pills and he had them scheduled for 4 times a day, and that would only last him about 7 days. The Director of Nursing was unsure and unaware what had happened with the residents pain medications and it should had been addressed immediately.
3. Resident R's record was reviewed on 4/20/22 at 2:43 p.m. Diagnoses included, but not limited to, stroke, hemiplegia affecting left non-dominant side, and chronic pain syndrome.

The Quarterly Minimum Data Set (MDS) assessment, dated 3/21/22, indicated the resident was cognitively intact. The resident had received a scheduled pain medication regimen and had frequent pain in the last 5 days.

The Physician's Order, dated 2/20/2020 at 7:00 p.m., indicated Hysingla 40 milligram (mg) tablet (opioid pain medication) once in the evening.

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The Care Plan, revised on 3/27/18, indicated the resident had potential for acute and/or chronic pain and the intervention was to administer pain medications as ordered.

The Orders-Administration Notes were reviewed for November 2021, December 2021, January 2022, and February 2022. The record indicated the medication, Hysingla, was unavailable as the facility was waiting for pharmacy to deliver the medication on the following dates and times:
- 11/30/21 at 6:46 p.m.
- 12/1/2021 8:31 p.m.
- 12/29/2021 8:30 p.m.
- 12/30/21 at 9:25 p.m.
- 12/31/2021 at 6:42 p.m.
- 1/1/2022 at 9:07 p.m.
- 1/17/2022 at 7:52 p.m.
- 1/18/2022 at 6:37 p.m.
- 1/24/2022 at 10:22 p.m.
- 2/19/2022 at 9:10 p.m.
- 2/20/2022 at 10:02 p.m.
- 2/22/2022 at 12:02 a.m.

A Physician Progress Note, dated 2/21/22 at 7:00 p.m., indicated the resident had been out of the Hysingla for a few days and had increased generalized pain without it. The note indicated the physician refilled Hysingla 40 mg tablet.

Interview with Director of Nursing on 4/20/22 at 5:36 p.m., indicated there was no rational for why the medications were not given for multiple days.

4. Resident E's record was reviewed on 04/14/22 at 10:17 a.m. Diagnoses included, but were not limited to, rhabdomyolysis (breakdown of muscle tissue that releases a damaging protein into the

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blood), anxiety disorder, abnormal posture, sleep disorder, and anemia.

The Discharge Minimum Data Set (MDS) assessment, dated 2/18/22, indicated the resident was cognitively intact. The resident had frequent pain in last 5 days but it did not affect sleep or day to day activities.

The Care Plan, dated 3/12/20, indicated the resident had acute/chronic pain. Interventions included, but were not limited to, administration of pain medications per order.

The Physician's Order, dated 12/24/19 at 6:00 p.m., indicated Percocet 7.5-325 milligram (mg) tablet four times a day.

The Medication Administration Record (MAR) for December 2021 and January 2022 was reviewed on 4/14/22 at 10:17 a.m. The MAR indicated Percocet tablet 7.5-325 mg was not administered on the following dates and times:
- 12/8/21 at 6:00 p.m.
- 12/18/21 at 6:00 a.m.
- 12/21/21 at 12:00 p.m.
- 12/22/21 at 12:00 a.m., 6:00 a.m., and 12:00 p.m.
- 12/23/21 at 12:00 p.m.
- 1/3/22 at 12:00 p.m.
- 1/4/22 at 6:00 a.m. and 12:00 p.m.
- 1/8/22 at 12:00 p.m.
- 1/11/22 at 6:00 p.m.
- 1/14/22 at 12:00 p.m. and 6:00 p.m.
- 1/15/22 at 12:00 a.m. and 6:00 a.m.

Interview with Interim Director of Nursing on 4/14/22 at 3:28 p.m., indicated she was made aware of the concern and no further information was available.

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	This Federal tag relates to Complaints IN00370624 and IN00373994. 3.1-37(a)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident was provided with medically-related social services, related to referrals not sent to prepare a resident for discharge, for 1 of 1 residents reviewed for Social Services. (Resident L) Finding includes: Resident L's record was reviewed on 4/19/22 at 8:50 a.m. Diagnoses included, but not limited to, COVID-19, anemia, heart failure, respiratory failure, and pneumonia. The Admission Minimum Data Set (MDS), dated 3/3/22, indicated the resident was moderately cognitively impaired. A Care Plan Meeting Note, dated 3/3/22 at 1:19 p.m., indicated the resident's family had requested that referrals be sent to various other facilities to be closer to home. The record lacked an indication of referrals sent to other facilities. Interview with the Social Service Director (SSD) on 4/19/22 at 3:08 p.m., indicated the resident's	F 0745	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/22/2022** **Compliance 05/09/2022** **F 745 Social Services Discharge planning** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	05/09/2022

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	family wanted the resident to transfer to another facility closer to them. The SSD indicated once referrals were sent, it should be noted in the chart. Interview with the Administrator on 4/19/22 at 4:50 p.m., indicated Social Services should have documented when the referrals were sent. This Federal tag relates to Complaint IN00374801. 3.1-34(a)(6)		**1) Immediate actions taken for those residents identified:** Resident L no longer resides in the facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** All residents with the intention of having a short term stay that do not have a discharge care plan have the potential to be affected; therefore, this plan of correction applies to those residents. The care plans of the identified residents have been reviewed and revised, as necessary. **3) Measures put into place/ System changes:** SSD was re-educated on the discharge planning process, including but not limited to, sending appropriate referrals to prepare residents for discharge. ED, or designee, will audit the charts of new admissions to ensure appropriate referrals have been sent, with the same documented, for residents preparing to discharge 3 X a week	

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			for 4 weeks, then twice a week X 4 weeks. **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/2022**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring;			

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	or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on interview and record review, the facility failed to ensure medications were administered as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident B) Finding includes: An interview with the resident's representative on 4/11/22 at 3:04 p.m., indicated Resident B had not received medications and patches as ordered by the Physician in December of 2021. The reasons were they "ran out of the medications." Resident B was observed on 4/13/22 at 9:41 a.m. in his bed watching TV in his room. The resident had poor memory recall when interviewed. Resident B's record was reviewed on 4/13/22 at 10:30 a.m. Diagnoses included, but were not limited to, stroke, cancer, heart failure, high blood pressure, diabetes mellitus (blood sugars) and dementia. The December 2021 Physician Order Summary indicated the following medications: - atorvastatin calcium 40 mg (milligram) give 1 tablet by mouth in the evening for hyperlipidemia - hydralazine hydrochloride tablet 25 mg, give 1.5	F 0757	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/222** **Compliance 05/09/2022** **F 757 Unnec meds** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B’s medication orders were reviewed with orders clarified, as necessary. Licensed nurses	05/09/2022

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	tablets by mouth twice a day for heart failure - senna-docusate sodium tablet 8.6-50 mg give 1 tablet by mouth in the evening for constipation - sertraline hydrogen chloride 25 mg 1 tablet by mouth in the evening for depression related to major depressive disorder - isosorbide dinitrate 20 mg tablet give 20 mg by mouth twice a day for heart failure - alogliptin benzoate tablet 25 mg give 25 mg by mouth once a day related to diabetes mellitus - Probiotic capsule give 1 capsule by mouth one time a day for supplement - Vitamin D3 capsule 50 mcg (micrograms) give 1 capsule by mouth one time a day for supplement - Proheal sugar free twice a day for wound healing sugar free 30 cc (cubic centimeters). - Donepezil hydrochloride 10 mg tablet give 1 by mouth at bedtime for dementia - clonidine patch Weekly 0.3 MG/24 hours, Apply 1 patch transdermally (topically to the skin) one time a day, every Thursday. Remove old patch before applying new patch per scheduled time. The December 2021 Medication Administration Record indicated the following medications were not administered as ordered on the following days and times: - on 12/8/21 at 6:00 p.m.: atorvastatin calcium 40 mg, hydralazine hydrochloride tablet 25 mg, senna-docusate sodium tablet 8.6-50 mg, sertraline hydrogen chloride 25 mg, isosorbide dinitrate 20 mg tablet 20 mg, Proheal sugar free 30 cc. - on 12/8/21 at 8:00 p.m.: donepezil hydrochloride 10 mg tablet - on 12/9/21 at 9:00 a.m.: clonidine patch. The MAR indicated a "9" with a Nurse's Note at 10:00 a.m., indicated "awaiting delivery and the Physician was aware." The MAR indicated the clonidine patch placed on		were provided re-education relative to medication administration and documentation of the same. **2) How the facility identified other residents:** The facility completed an audit to identify that resident MARs are accurate, and medications are being signed out when administered. All residents have the potential to be affected, therefore, this plan of correction applies to all current residents. **3) Measures put into place/ System changes:** Licensed nursing staff have been re-educated relative to Drug Regimen is Free from Unnecessary Drugs, including but not limited to, ensuring medications are administered as ordered and adequate monitoring is documented, as necessary. DON/designee will audit MARs daily, on scheduled days of work, for 4 weeks, then weekly thereafter, to ensure that medications are administered in accordance with physician orders. Any identified concerns will be promptly addressed with the responsible individual(s). **4) How the corrective actions will be monitored:**	

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	12/2/22 9:00 a.m. and was not removed until 12/16/22 at 8:59 a.m. The record lacked an indication the Physician was notified the resident was not administered the clonidine patch for 14 days. The last blood pressure documented was from a Nurse Infection/Antibiotic charting note, dated 10/29/21 at 1:11 p.m., as "10/28/21 2:12 a.m. 147/88." The next documented blood pressure was on 1/31/22, "130/76." - on 12/20/21 at 8:00 a.m.: alogliptin benzoate tablet 25 mg - on 12/20/21 at 9:00 a.m.: hydralazine hydrochloride tablet 25 mg, 1.5 tablets; Probiotic capsule, Vitamin D3 capsule 50 mcg. Interview with the Interim Director of Nursing (DON) on 4/21/22 at 10:15 a.m., indicated per the pharmacy manifest, the clonidine patch was delivered on 12/10/21 at 11:22 a.m. She had no information to why the nurses did not administer the clonidine patch on the resident when it had arrived from the pharmacy. The Nurse Notes lacked documentation that his blood pressures were monitored and his vital signs appeared copied and pasted from previous notes. The DON was unaware and lacked any further information to why mediations were not administered in December of 2021. This Federal tag relates to Complaint IN00371067. 3.1-48(a)(6)		The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 05/09/2022**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to store food under sanitary conditions related to food not dated when opened for 110 of 114 residents who received their meals from the kitchen and failed to distribute room meal trays under sanitary conditions related to desserts uncovered during lunch room tray service for 1 of 4 hallways. (Main Kitchen and 300 Hallway) Findings include: 1. During an observation during the initial kitchen tour, on 4/11/22 at 8:50 a.m. with the Cook, there were three plastic bins with dry cereal in them, unlabeled and undated. One bin did not have a lid. Interview with the Cook during the kitchen tour, indicated the all food items should be labeled, dated and contained.	F 0812	**Aperion- Arbors Michigan City POC Annual/Recertification Exit 04/22/2022** **Compliance 05/09/2022** **F812 Food/Procurement** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of*	05/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	04/21/2022

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	The current policy, "Food Storage (Dry, Refrigerated and Frozen)", was received from the Administrator on 4/19/22 at 10:32 a.m., indicated, "...Food shall be stored on shelves in a clean, dry area free of contamination...." and, "...All food items will be labeled. The label must include the name of the food and the date it must be sold, consumed or discarded...."2. During the lunch room tray service on 4/13/22 at 11:54 a.m., the following was observed in the 300 Hallway: - CNA 5 carried a room tray from the food cart down the hallway with the dessert uncovered to Room 316. - Social Services carried a room tray from the food cart down the hallway with the dessert uncovered to Room 320. Interview with the Dietary Manager on 4/13//22 at 12:10 p.m., indicated he was unaware the food on the room meal tray had to be covered when transported down a hallway and served to a resident. Interview with CNA 5 on 4/13/22 at 1:12 p.m., indicated there were not any supplies on the food cart to cover the dessert, usually the kitchen prepared everything. A policy for "In-Room Dining for Infection Control," was provided by the Administrator on 4/14/22 at 4:35 p.m. This current policy indicated, "Guideline: In order to control the spread of infectious disease, it may be necessary to implement in-room dining operations. Procedure:...3. All foods should covered during transport...." 3.1-21(i)(3)		*deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. & 2. Dietary staff ensured that all foods in storage areas were labeled and dated. Dietary staff and staff delivering meal trays were re-in serviced on covering all food when preparing to leave the kitchen and ensuring that all meal tray items are covered. **2) How the facility identified other residents:** All residents have the potential to be affected; therefore, this plan of correction applies to all residents. **3) Measures put into place/ System changes:** Dietary staff was re-educated relative to Food Procurement, Store/Prepare/Serve-Sanitary, including but not limited to ensuring food is stored under sanitary conditions, writing the date opened on food containers, and distributing room meal trays under sanitary conditions with all items covered during tray service. Dietary manager/designee will conduct random kitchen sanitation	

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			audits 5 days a week for 4 weeks to ensure proper food storage, proper date labeling, and distribution of meal trays under sanitary conditions. Thereafter, these rounds will be conducted randomly at least 3 times per week for 8 weeks. Any identified concerns will be promptly addressed with responsible individual(s). **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/2022**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility			

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to improper cleaning of reusable equipment and gloves not worn while administering an injection for 2 of 7 residents observed during medication pass, failure to ensure staff were aware of a resident on contact precautions and improper mask use for random observations for infection control. (Room 438-A, Housekeeping Supervisor, Housekeeper 1, and CNA 6) Findings include: 1. On 4/13/22 at 9:10 a.m., LPN 1 was observed	F 0880	**F880 Infection control** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	05/09/2022

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	preparing a resident's medications. She placed a pulse oximeter on the resident's finger. She then removed the pulse oximeter and cleaned it using an alcohol prep pad and set it on top of the medication cart. She administered the resident's medications and went on to the next resident. She prepared the next resident's medications and placed the pulse oximeter on his finger. She also placed a wrist blood pressure cuff on the resident's wrist. She then removed the pulse oximeter, cleaned it using an alcohol prep pad, and set it on top of the medication cart. She removed the blood pressure cuff and set it on top of the medication cart. She did not clean the blood pressure cuff. She administered the resident's medications and went on to the next resident. Interview with the Assistant Director of Nursing/Infection Preventionist on 4/13/22 at 9:59 a.m., indicated the staff should be cleaning the reusable equipment with a disinfectant wipe. A facility policy, titled "Cleaning & Sanitizing-Wheelchairs and Other Medical Equipment," indicated, "...4. All surfaces shall be thoroughly cleaned with a sanitizing agent which prohibits the growth of bacteria and microorganisms. 5. Devices/equipment used for more than one resident shall be cleaned between each resident..." 2. On 4/13/22 at 11:25 a.m., LPN 2 was observed preparing Room 438's insulin. She placed the needle on the insulin pen, primed the pen and turned the dial to 10 units. She took the insulin pen to the resident's room. She approached the resident and indicated she was going to administer his insulin to his abdomen. The resident agreed. LPN 2 then cleaned the resident's left abdominal area with an alcohol prep pad and		*federal and state law.* **1) Immediate actions taken for those residents identified:** Housekeeping supervisor, Housekeeper, and CNA 6 were immediately re- educated on proper mask wearing and on infection Control Policies LPN 1 was re-educated on properly cleaning reusable medical equipment. LPN 2 was re-educated on hand washing and wearing gloves while administering an injection. IP was in-serviced on informing ancillary staff of preference related to infection control practices. CNA 6 was in-serviced on not pulling his mask down to talk or touching the outside of his mask. Resident 171 isolation set up was placed outside the door and preference is not to have signage outside the door. **2) How the facility identified other residents:** All residents have the potential to be affected; therefore, this plan of correction applies to all residents. **3) Measures put into place/ System changes:** All staff re- educated on proper cleaning of reusable equipment. Nursing staff re-educated on the use of gloves while administering injections, proper handwashing,	

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	administered the insulin injection. She did not wash her hands prior to administering the injection and did not wear gloves while administering the injection. Interview with LPN 2 on 4/13/22 at 11:29 a.m., indicated she would usually wear gloves while giving an injection, but she had not this time. She did not feel she was coming in to contact with any blood or body fluids so gloves would not be required. Interview the Assistant Director of Nursing/Infection Preventionist on 4/13/22 at 11:44 a.m., indicated LPN 2 should have worn gloves while giving the injection. A facility policy, titled "Injectable Medication Administration," indicated, "...I. General Procedure...Wash hands with soap and water...Put on gloves...Inject medication..."3. On 4/11/22 at 2:26 p.m., Resident 171 was observed seated in his doorway on the 400 unit. There was a sign on the door that indicated visitors should see nurse before entering and an isolation bin outside his door. On 4/12/22 and through 4/18/22, the sign was no longer on the door. The isolation bin remained outside his door. The residents record was reviewed on 4/13/22 at 11:30 a.m. A Physician's Order, dated 3/29/22, indicated the resident was to be on contact isolation for C. diff (clostridium difficile, an infectious intestinal condition). Interview with Housekeeper 1 on 4/18/22 at 1:25 p.m., indicated resident rooms with C. diff required full personal protective equipment to enter and		All staff were re-in serviced on donning and doffing PPE, Handwashing, proper mask wearing and all other infection control policies. Facility IDT team completed a root cause analysis and Infection Control Self-Assessment with the Corporate Infection Control Preventionist. Reviewed findings and developed action plan and education materials based on findings. Staff will be re-educated regarding spread of infections as is relates to infection control policies **4) How the corrective actions will be monitored:** The Director of Nursing or designee will (See Action Plan for the recommended monitoring) **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/22**	

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	needed to be cleaned with bleach. She indicated there were no C. diff rooms currently on the 400 unit. She indicated she was not aware Resident 171 was on any type of isolation precautions. Interview with the Housekeeping Supervisor on 4/18/22 at 1:35 p.m., indicated resident rooms with C. diff should have a sign on the door and a bedside commode in the room. She indicated there were no residents at this time, or in the past couple weeks, on the 400 unit with C. diff. Interview with the Assistant Director of Nursing on 4/18/22 at 1:42 p.m., indicated the resident had a C. diff infection, but did not want the sign on his door and had removed it. She indicated all staff had been educated regarding the resident's isolation status. She was not aware the housekeeping staff was unaware of his isolation status. 4. Interview with a resident's family member on 4/11/22 at 2:25 p.m., indicated that a certain CNA had been pulling his mask down to talk to people and when feeding her loved one. On 4/12/22 at 2:15 p.m., CNA 6 was observed to have on an N95 mask while at the 300 Nurse's Station. CNA 6 had pulled down the outside of his mask when he talked with the nurse that was sitting at the desk. and was within 6 feet. On 4/12/22 at 2:24 p.m., CNA 6 was observed speaking with a resident in their room, within 6 feet of the resident. CNA 6 had pulled down the outside of his N95 mask to speak to the resident. The resident had not been wearing a mask. On 4/13/22 at 11:42 a.m., CNA 6 had passed out lunch meal trays to staff in the 300 Dining Room. CNA 6 was observed to have pulled down the outside his N95 mask to speak with the staff,			

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	passed the meal tray to that staff person and then repeated that action for 4 meal trays. He failed to use proper hygiene after he touched the outside of his mask. Interview with the Infection Control Perfectionist on 4/14/22 at 9:25 a.m., indicated that she expected staff to not to touch the outside of their masks without proper hygiene and to not pull down their masks while speaking with staff or residents. 3.1-18(b)			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this			

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	paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing			

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	supplies or processing test results. Based on record review and interview, the facility failed to conduct COVID-19 testing for staff per guidelines for 3 of 5 staff records reviewed. (Employees 1, 3 and 5) Finding includes: The Vaccination Matrix was reviewed on 4/12/22 at 12:55 p.m. Employees 1 and 3 had received their first dose of COVID-19 vaccine on 12/8/21, they were past due to receive their second dose. Employee 5 had been granted a non-medical exemption from receiving the vaccine. Employee 5 was tested on 2/25, 3/8, 3/25, 4/1, 4/5 and 4/8/2022. There was no testing for the week of 2/27 or 3/13/22. There were no tests results provided for Employees 1 and 3. The current policy, "COVID-19 Vaccinations and Testing", indicated, "...prior to being vaccinated, all clinical and field staff are required to be tested weekly...." Interview with the ADON on 4/13/22 at 11:44 a.m., indicated there were no additional tests for review for the above employees.	F 0886	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/2022** **Compliance 05/09/2022** **F886 Testing** **1) Immediate corrective action(s) for those residents affected by the deficient practice:** Employee 1 and 3 updated with vaccine information and tested as required. **2) Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** All residents have the potential to be affected; therefore, this plan of correction applies to all residents. Vaccination Matrix forms were audited to ensure staff that are required to test have completed the testing per facility policy. **3) Facility measures and systemic changes to ensure the deficient practice does not recur:** All staff in-serviced relative to	05/09/2022

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			COVID-19 Testing-Residents & Staff, including but not limited to, definition of “up to date”, test date/times, and vaccination clinic dates. Staff was also educated on medical and religious exemption forms. IP/designee will audit the employee vaccination matrix bi-weekly, ongoing, to identify unvaccinated or partially vaccinated and to ensure these staff members have completed testing per guidelines and are provided with information on the vaccine. Results of these audits will be provided to the DON/designee weekly, ongoing, to validate staff are being tested according to guidelines. **4) Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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F 0888 SS=C Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or			

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APERION CARE ARBORS MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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	telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination			

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	status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical			

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	precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;			
	Based on record review and interview, the facility failed to ensure staff were fully vaccinated for COVID-19 and/or had an exemption in place for 4 of 190 employees who worked on 4 of 4 units in the facility. This resulted in a 97.8% staff vaccination rate. (Employees 1, 2, 3 and 4) Finding includes: The COVID-19 Staff Vaccination Matrix was reviewed on 4/12/22 at 12:55 p.m. The Matrix indicated Employees 1, 2, 3 and 4 were partially vaccinated and had no exemptions in place, and the second dose was past due. The assigned work area for Employees 1 and 3 was listed as 200 Unit, Employee 2 worked on all units, Employee 4 worked on 100 Unit. The current facility policy, "COVID-19 Vaccination and Testing", indicated, "...All GSE staff are required to receive an FDA authorized	F 0888	**Aperion- Arbors Michigan City** **POC Annual/Recertification** **Exit 04/21/2022** **Compliance 05/09/2022** **F888 Vaccination** **1) Immediate corrective action(s) for those residents affected by the deficient practice:** Employees 1, 2, & 3 received their second COVID-19 dose on 4/19/22. Employee 4 completed a non-medical exemption on 4/12/22.	05/09/2022

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	COVID-19 vaccination...." Interview with the Assistant Director of Nursing on 4/12/22 at 2:52 p.m., indicated Employees 1, 2 and 3 were scheduled to receive their second dose on 4/19/22. She indicated Employee 4 had requested and signed a non-medical exemption on 4/12/22. 3.1-18(b)		**2) Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** All residents have the potential to be affected; therefore, this plan of correction applies to all residents. Vaccination Matrix forms were audited to ensure all staff are up to date with vaccinations or have completed an exemption form. **3) Facility measures and systemic changes to ensure the deficient practice does not recur:** All staff have been in-serviced relative to COVID-19 Vaccination of Facility Staff, including but not limited to, the definition of “up to date” and completion of medical or religious exemption form, as necessary. IP/designee will audit the employee vaccination matrix bi-weekly, ongoing, to identify unvaccinated or partially vaccinated and to ensure these staff members have been provided with information on the vaccine and medical/religious exemptions. Results of these audits will be provided to the DON/designee	

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			weekly, ongoing, to validate staff are being vaccinated, or completing exemption forms, according to guidelines. **4) Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 05/09/2022**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a sanitary, safe, and homelike environment related to dirty kitchen floors and	F 0921	**Aperion- Arbors Michigan City POC Annual/Recertification 2021**	05/09/2022

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	utility carts, marred walls, peeling paint, broken furniture, and heating unit uncovered in the kitchen and on 2 of 4 units observed. (Main Kitchen, Hallways 100 and 200) Findings include: 1. During the initial kitchen tour, on 4/11/22 at 8:50 a.m. with the Cook, the following was observed: a. In the walk in freezer, there was debris and 3 pancakes on the floor, and the floors were visibly dirty and sticky. b. There was a metal shelf where food processing equipment was kept that had pink and yellow spilled substances and crumbs on it. c. There were 5 utility carts that had food debris, crumbs and spilled substances on them. Interview with the Cook during the kitchen tour, indicated the above items were in need of cleaning.2. During the Environmental Tour with the Maintenance Director on 04/21/22 at 11:57 a.m., the following was observed: 100 Hallway: a. In Room 107, the walls and the door were marred. There was one resident who resided in this room. b. In Room 109, the heating unit cover was on the floor. One resident resided in the room. c. In Room 124, the pain had peeled on bathroom wall. There were two residents who shared the bathroom.		**Compliance 05/09/2022** **F-921 Safe/Functional/Sanitary/Comfortable Environment** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. & 2. All items listed on the 2567 have been cleaned, painted, repaired, and covered as appropriate. . **2) How the facility identified other residents:** All residents have the potential to be affected; therefore, this plan of correction applies to all residents. **3)Measures put into place/**	

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	200 Hallway: a. Room 202 had a gouged corner wall by the bathroom, caps were missing off of the bottom of the right side enabler bar on the bed and the dresser drawers were broken. There were two residents who resided in this room. b. Room 204's dresser drawers were broken. There was one resident who resided in this room. c. In Room 214, there was a hole in the wall located near the glove container, and a dried brown substance splattered on the same wall. There were two residents who resided in this room. Interview with Maintenance Director on 04/21/22 at 12:12 p.m., indicated he was not previously aware of any of the repairs or cleaning that was presented during the tour. This Federal tag relates to Complaints IN00373994 and IN00374801. 3.1-19(f)(5)		**System changes:** Facility staff was in-serviced relative to Safe/Functional/Sanitary/Comfortable Environ, including but not limited to, procedure for notifying Maintenance Director when environment repairs are needed. The Administrator/designee will conduct environmental rounds 5 days a week for 4 weeks to ensure the facility environment is maintained as a safe, comfortable, and sanitary environment. Thereafter, these rounds will be conducted 3 times a week for 8 weeks to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). **4)How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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