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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00384837, IN00385579, IN00386509, IN00389455, IN00390581, IN00390853 and IN00391322. Complaint IN00384837 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F686, F695, F697, F804 and F921. Complaint IN00385579 - Substantiated. Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00386509 - Substantiated. Federal/State deficiencies related to the allegations are cited at F585, F677, F697 and F921. Complaint IN00389455 - Substantiated. Federal/State deficiencies related to the allegations are cited at F757, F804, F880 and F921. Complaint IN00390581 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00390853 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580, F677, F693 and F791. Complaint IN00391322 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F690 and F921. Survey dates: September 27, 28 and 29, 2022. Facility number: 000076 Provider number: 155156	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristina Herrera	Executive Director	11/09/2022

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.

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	AIM number: 100271060 Census Bed Type: SNF/NF: 23 SNF: 13 NF: 88 Total: 124 Census Payor Type: Medicare: 13 Medicaid: 77 Other: 34 Total: 124 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/6/22.			
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 (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(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 record review and interview, the facility failed to ensure a resident's representative was notified prior to a room change for 1 of 3 residents reviewed for notification of change. (Resident G) Finding includes: Resident G's record was reviewed on 9/27/22 at 10:02 a.m. The resident was admitted to the	F 0580	**Aperion- Arbors Michigan City** **POC** **Complaint** **Exit 09/29/22**	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility on 7/13/21. Diagnoses included, but were not limited to, hemiparesis and hemiplegia post CVA affecting the left side, dysphagia (difficulty swallowing) and congestive heart failure. The Copy of Intrafacility Transfer, dated 9/1/22, indicated the resident was being moved from the 400 unit, to a room on the 300 unit. The signature line on the document indicated, "res and dtr" (resident and daughter), and the facility staff signature line indicated, "unit nurse". There was no documentation related to the room change in the progress notes. Interview with the Social Service Director, on 9/28/22 at 1:57 p.m., indicated she was the person that would usually complete the room change forms and notify family members of room changes, unless the unit manager did it first. She indicated she had not spoken with the resident's family regarding the room change on 9/1/22. Interview with the Unit Manager, on 9/28/22, at 1:59 p.m., indicated she did not complete the room change form or speak to the resident's family. She did not know who completed the room change form. This Federal tag relates to Complaint IN00390853.		**Compliance** **10/26/2022** **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 G was notified of room change. **2) How the facility identified other residents:** Audit was completed of all current residents' room changes, new orders, significant changes, and assessments from 9/27/2022 to current to ensure timely notification to the family. **3) Measures put into place/ System changes:** Nursing department was educated on Notify of Changes,	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			including but not limited to, notification of change Policy and Interfacility transfer and notifications of resident representatives. **4) How the corrective actions will be monitored:** **DON/ED/Designee will review orders, significant changes, assessments, and room changes 5 days a week for 3 months and then 3 days a week for 3 months to ensure that the family/resident representative notification has been completed. Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/ED/Designee and 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:** **10/26/2022**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on record review and interview, the facility failed to ensure a resident's grievance was thoroughly investigated for 1 of 4 residents reviewed for grievances. (Resident B) Finding includes: A closed record review for Resident B was completed on 9/28/22 at 11:21 a.m. Diagnoses included, but were not limited to, hypertension and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 3/8/22, indicated the resident was cognitively intact. A Concern/Compliment Form, dated 3/21/22, indicated the resident had a concern that she asked the nurse for ice in her machine for her arm. The nurse stated that the ice machine was broken	F 0585	**Aperion- Arbors Michigan City** **POC** **Complaint** **Exit** **09/29/22** **Compliance** **10/26/2022** **F 585 Grievances** *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*	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and did not put ice on it. She also had a concern that she asked a CNA to take her to the bathroom and the CNA stated, "you have to fend for yourself and take yourself to the bathroom". The resident indicated she then had wet herself. The nurse took her to the bathroom and then put her back into the bed with wet clothes on. The former Director of Nursing (DON), who no longer worked at the facility, had taken the report from the resident. She interviewed the nurse who denied the resident's complaint. There was no documentation who the CNA was or if they were interviewed. The Corrective Actions Taken indicated: suggested to staff to take care of the resident in pairs. The section that indicated if the complainant was satisfied with the outcome and actions taken was not filled out. Interview with the Interim DON on 9/28/22 at 3:30 p.m., indicated she could not find any further documentation related to the investigation of the grievance the resident had filed. A facility policy titled, "Grievances", and received as current from the Interim DON on 9/29/22, indicated, "...All written grievances shall include:..." "...Steps taken to investigate the grievance...." This Federal tag relates to Complaint IN00386509. 3.1-7(a)(2)		*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 no longer resides in facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** Audit was completed of grievances of the last 90 days to ensure that each grievance was thoroughly investigated. **3) Measures put into place/ System changes:** All staff educated on grievance policy and notification of concerns. **4) How the corrective actions will be monitored:** **DON/ED/Designee will review grievances 5 days a week for 3 months and 3 days a week for 3 months to ensure that grievances have been thoroughly investigated per facility policy.** **The results of these audits will be provided to the QA**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Committee by the DON/ED/Designee and 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: 10/26/2022**	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to investigate and report an injury of unknown origin to the State Agency for 1 of 1 residents reviewed for injuries of unknown origin. (Resident D) Finding includes: The record for Resident D was reviewed on 9/28/22 at 9:21 a.m. The resident was admitted to the facility on 10/30/20. Diagnoses included, but were not limited to, unspecified dementia. The resident was on hospice services. The Quarterly Minimum Data Set assessment, dated 8/26/22, indicated the resident had severe cognitive impairment, and required extensive +1 assistance for bed mobility and transfers. A Progress Note, dated 6/21/22, indicated the resident had a skin tear of unknown origin on his left elbow. A Wound Assessment, dated 6/21/22, indicated there was a large skin tear measuring 11 centimeters (cm) x 2.9 cm on the back of the left arm. There was no documentation of discoloration around the right eye.	F 0609	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 10/26/2022 **F 609 Reporting alleged violations** **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.*	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Hospice Aide Visit Note, dated 6/21/22, indicated the resident's skin was intact during the visit on the previous day. Upon arrival, the aide noted bruising around the right eye, and the left arm was wrapped in a dressing. The hospice aide had contacted the hospice nurse. A Hospice Nurse Progress Note, dated 6/27/22, indicated the resident had an 11 cm x 1 cm skin tear and discoloration under the right eye from unknown cause. The current policy, "Abuse Prevention and Reporting", was received from the Nurse Consultant on 9/27/22 at 10:15 a.m., indicated, "...For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an "injury of unknown source". An injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person or the source could not be explained by the resident; and The injury is suspicious because of the extent of injury or location of the injury..." Interview with the Hospice Nurse, on 9/28/22 at 9:35 a.m., indicated she had visited the resident on June 21. The resident had "black eye" to the right eye that was very dark in color, and a large skin tear on his left elbow. She had spoken to the Director of Nursing (DON), who indicated they did not know what happened. She indicated the bruising remained for several weeks. Interview with LPN 2, on 9/28/22 at 9:41 a.m., indicated she remembered the resident had discoloration around his eye and a skin tear, but		**1) Immediate actions taken for those residents identified:** Resident D's discolored eye has resolved. Investigation into how the discoloration was obtained was initiated and completed. **2) How the facility identified other residents:** All residents could be affected by the cited practice. A full house skin sweep was conducted to identify any areas of concern. An investigation was completed on any newly identified areas to discern cause. **3) Measures put into place/ System changes:** Education has been provided to the IDT and nursing staff regarding reporting injuries of unknown origin for investigation and appropriate notifications. **4) How the corrective actions will be monitored:** DON/designee will review all new skin assessments 5 x a week for 3months and 3 x a week for 3 months to ensure that all injuries are investigated, and the Executive Director is informed of any injuries of unknown origin .	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	does not recall what happened. Interview with the Interim DON, on 9/28/22 at 10:45 a.m., indicated there was no documentation related to the discoloration around the right eye, or investigation as to what happened. She also indicated the incident had not been reported to the State Agency. This Federal tag relates to Complaint IN00385579. 3.1-28(c) 3.1-28(d)		The DON will be responsible for compliance. **Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/Designee and 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: 10/26/2022**	
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 observation, record review and interview, the facility failed to provide ADL (activities of daily living) assistance to a dependant resident related to completing scheduled showers for 1 of 3 residents reviewed for ADL care. (Resident J) Finding includes:	F 0677	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 11/08/2022	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The record for Resident J was reviewed on 9/29/22 at 1:57 p.m. The resident was admitted to the facility on 3/23/18. Diagnoses included, but were not limited to, hemiplegia effecting the left side and chronic pain. The Quarterly Minimum Data Set assessment, dated 8/22/22, indicated the resident was cognitively intact and required extensive +1 assistance for bed mobility and transfers. An ADL Care Plan, dated 1/5/22, indicated the resident needed assistance with ADL care related to left side hemiplegia, chronic pain, incontinence and osteoarthritis. Interventions included to assist with personal hygiene as needed and to honor resident preferences. The Preference Care Plan, dated 1/12/21, indicated the resident preferred showers two times a week on Tuesday and Friday. The August and September 2022 tasks record and shower sheets indicated the resident did not receive a shower or bed bath on the following dates: 8/5, 8/23, 8/30, 9/16 and 9/23. Interview with the resident on 9/27/22 at 1:57 p.m., indicated she was not being showered twice a week. She also indicated they always tried to give her a bed bath when she wanted a shower. Interview with the Assistant Director of Nursing on 9/29/22 at 2:40 p.m., indicated they had been having issues getting showers completed, but that had improved. She indicated a shower sheet should be completed and signed by the nurse for every shower and there were no additional shower sheets for the resident.		**F 677 ADL Dependent Residents** *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 J 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 independent residents needing assistance with grooming and personal hygiene. The facility staff provided showers, grooming, and personal care as needed. **3) Measures put into place/ System changes:** The facility staff was in-serviced on providing ADL care for residents unable to carry out activities of daily living and to ensure that residents	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This Federal tag relates to Complaints IN00384837, IN00386509, IN00390853 and IN00391322. 3.1-38(a)(3)		receive showers, grooming, and hygiene. **4) How the corrective actions will be monitored:** **The DON/Designee** will review shower sheets 5 days a week for 3 months and then 3 days a week for 3 months to ensure proper hygiene is maintained for facility residents. Facility will observe 5 residents 5 days a week for 6 weeks and then 3 residents five days for 6 weeks to ensure that showers and ADL care and showers are being given. **Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/Designee and 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** **11/8/22**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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- (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 record review and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident C) Finding includes: A closed record review for Resident C was completed on 9/27/22 at 11:23 a.m. Diagnoses included, but were not limited to, stroke, hypertension, and diabetes mellitus. The resident was admitted to the facility on 6/7/22 and discharged on 6/17/22. The Admission Minimum Data Set (MDS) assessment, dated 6/14/22, indicated the resident was cognitively intact. The resident required an	F 0686	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 10/26/2022 **F-686 Treatment /Svcs** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	extensive 2 + person assist with bed mobility and transfers. The resident required an extensive 1 person assist with dressing, toilet use, and personal hygiene. The resident had 1 unstageable pressure ulcer due to slough and/or eschar (dead tissue) and 7 unstageable DTI (deep tissue injury) pressure ulcers. The resident was admitted to the facility with all of the pressure ulcers. A Care Plan, revised on 6/8/22, indicated the resident had a potential for further impairment to skin integrity. An intervention included to complete treatments as ordered to the skin impairments. Wound Rounds indicated the resident had the following pressure ulcers on admission: 1. DTI to the coccyx measurement: 2.1 cm (centimeters) x 0.3 cm 2. DTI to left 2nd toe measurement: 0.3 cm x 0.9 cm 3. DTI to left 5th toe measurement: 0.5 cm x 0.3 cm 4. DTI to left distal lateral foot measurement: 1.3 cm x 0.5 cm 5. DTI to left heel measurement: 0.3 cm x 0.4 cm 6. DTI to right great lateral toe measurement: 0.2 cm x 0.2 cm 7. DTI to right great toe measurement: 0.3 cm x 0.2 cm 8. Unstageable to right knee		*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 c 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 in the facility with alteration in skin or high risk of skin alterations have the potential to be affected by the cited practice. **3) Measures put into place/ System changes:** A. Nursing staff have been in serviced on the importance of ensuring that an appropriate treatment is in place, proper identification of etiology of a wound, updating the plan of care and the importance of completing treatments according to the Physicians' Order. B. A QA tool has been implemented to ensure	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	measurement: 0.6 cm x 2.5 cm The June 2022 Physician's Order Summary (POS) indicated the following orders: - Betadine (antiseptic) Swabsticks Swab 10%. Apply to right lateral great toe topically one time a day for wound care. Cleanse with normal saline, pat dry, apply Betadine to wound bed daily. Start date - 6/10/22 - Betadine (antiseptic) Swabsticks Swab 10%. Apply to right great toe topically one time a day for wound care. Cleanse with normal saline, pat dry, apply Betadine to wound bed daily. Start date - 6/10/22 - Betadine (antiseptic) Swabsticks Swab 10%. Apply to left 2nd toe topically one time a day for wound care. Cleanse with normal saline, pat dry, apply Betadine to wound bed daily. Start date - 6/10/22 - Betadine (antiseptic) Swabsticks Swab 10%. Apply to left 5th toe topically one time a day for wound care. Cleanse with normal saline, pat dry, apply Betadine to wound bed daily. Start date - 6/10/22 - Betadine Swabsticks Swab 10%. Apply to left distal lateral foot one time a day for wound care. Cleanse with normal saline, pat dry, apply Betadine to wound bed daily. Start date - 6/10/22 - Betadine to foot ulcers every day shift for skin care. Start date - 6/8/22 - Cleanse left lateral lower extremity with normal saline. Apply Santyl (wound ointment), cover with moist gauze and Kerlix (band roll) every day		compliance to these measures. **4) How the corrective actions will be monitored:** The DON or designee will complete an audit of 2 residents with pressure injuries 5x's a week randomly to validate that the current treatment is in place and correctly dated x's 6 weeks then 3x's a week for 4 weeks then weekly thereafter. The DON is responsible for compliance. **Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be provided to the QA Committee by the DON/Designee and 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: 10/26/2022**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shift for wound care. Start date - 6/8/22. - Cleanse right anterior knee with normal saline, apply Santyl, cover with moist gauze and Kerlix every day shift for wound care. Start date - 6/8/22 - Cover coccyx with foam dressing every 3 days for skin care. Start date - 6/8/22 - Foam Dressing Pad to coccyx every day for wound care. Start date - 6/10/22 - No-Sting Skin-Prep. Apply to left heel topically every day for wound care. Cleanse with normal saline, pat dry, and apply skin prep to wound bed daily. Start date - 6/10/22 The June 2022 Treatment Administration Record (TAR) indicated the above treatments were not documented as completed on the following days: - Betadine to right lateral great toe topically: 6/10, 6/11, 6/15, and 6/17/22 - Betadine to right great toe topically: 6/10, 6/11, 6/15, and 6/17/22 - Betadine to left 2nd toe topically: 6/10, 6/11, 6/15, and 6/17/22 - Betadine to left 5th toe topically: 6/10, 6/11, 6/15, and 6/17/22 - Betadine to left distal lateral foot: 6/10, 6/11, 6/15, and 6/17/22 - Betadine to foot ulcers: 6/9, 6/10, 6/11, and 6/17/22 - Cleanse left lateral lower extremity with normal			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	saline. Apply Santyl (wound ointment), cover with moist gauze and Kerlix: 6/9, 6/10, 6/11, 6/12, and 6/17/22 - Cleanse right anterior knee with normal saline, apply Santyl, cover with moist gauze and Kerlix: 6/9, 6/10, 6/11, 6/12, 6/15, and 6/17/22 - Cover coccyx with foam dressing every 3 days: 6/11 and 6/17/22 - Foam Dressing Pad to coccyx every day: 6/10, 6/11, and 6/12/22 - No-Sting Skin-Prep. Apply to left heel topically: 6/10, and 6/11/22 Interview with the Wound Nurse on 9/28/22 at 10:50 a.m., indicated she completed all of the wound treatments in the facility during the week and the nursing staff was responsible to complete them on the weekends. She could not provide any further documentation the wound treatments had been completed as ordered. A facility policy titled, "Pressure Injury and Skin Condition Assessment" and received as current from the Nurse Consultant on 9/28/22, indicated, "...18. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration...." This Federal tag relates to Complaint IN00384837. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence.			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on record review and interview, the facility failed to ensure nursing staff provided foley catheter care every shift for 1 of 3 residents reviewed for catheters. (Resident T) Finding includes:	F 0690	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident T's record was reviewed on 9/19/22 at 12:05 p.m. Diagnoses included, but were not limited to, neurogenic bladder, pneumonia, renal insufficiency, and multiple sclerosis. The Quarterly Minimum Data Set assessment, dated 9/4/22, indicated the resident was cognitively intact. She required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident had an indwelling catheter. A Care Plan, dated 9/24/22, indicated the resident had an indwelling foley catheter related to neurogenic bladder. Interventions included, but were not limited to, position catheter bag and tubing below the level of the bladder, change catheter as needed, and check tubing for kinks. The Task list for the last 30 days was reviewed. The task, "Bowel and Bladder - Catheter Care," was to be completed on every shift. Catheter care was not completed on the following dates and shifts: - 8/31/22: Day shift - 9/11/22: Evening and night shift - 9/14/22: Evening shift - 9/16/22: Evening shift - 9/19/22: Night shift - 9/22/22: Evening shift - 9/25/22: Night shift		Compliance 10/26/2022 **F 690 Bowel/Bladder incontinence Cath/UTI** **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:** Resident T's orders were audited to assure that documentation of catheter care was present on the POC **2) How the facility identified other residents:** All residents that have a catheter have the potential to be affected	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 9/27/22: Evening and night shift Interview with the Nurse Consultant on 9/29/22 at 2:15 p.m., indicated she had no further information to provide. This Federal tag relates to Complaint IN00391322. 3.1-41(a)		by this cited practice **3) Measures put into place/ System changes:** Licensed Nurses/CNAs have been educated on the need to provide catheter each shift and to provide documentation in the electronic chart **4) How the corrective actions will be monitored:** DON/Designee will review documentation at least 5x/week for 3 months and 3x a week for 3 months to ensure that catheter care is being rendered per resident plan of care. DON/ Designee will complete observation on at least one resident weekly at various shifts to ensure catheter care is being completed as per plan of care. **Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/Designee and 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.	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			5) Date of compliance: 10/26/2022	
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 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 record review and interview, the facility failed to ensure gastrostomy tube (G-tube) care was completed as ordered related to cleaning, dressing changes and flushes for 1 of 3 residents reviewed for G-tubes. (Resident G) Finding includes: On 9/27/22 at 9:22 a.m., G-tube care was observed for Resident G with RN 2. There was no dressing in place around the G-tube. There was a moderate	F 0693	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 10/26/2022	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	amount of dried, bloody discharge surrounding the tube and surrounding skin. The RN indicated the evening nurse was supposed to change the dressing each day. She further indicated she would clean the area and put a dressing in place. The resident's record was reviewed on 9/27/22 at 10:02 a.m. The resident was admitted to the facility on 7/13/21. Diagnoses included, but was not limited to, hemiparesis and hemiplegia post CVA affecting the left side, dysphagia (difficulty swallowing) and congestive heart failure. The Annual Minimum Data Set assessment, dated 6/27/22, indicated the resident had moderate cognitive impairment, and required extensive assistance of +1 staff for bed mobility, transfers and toileting. A Physician's Order, dated 8/3/21, indicated to cleanse the G-tube insertion site with normal saline, pat dry and cover with a split gauze and tape daily and as needed if soiled or dislodged. Additionally, flush the G-tube with 60 milliliters of water every shift. The Treatment Administration Record (TAR) for September 2022 indicated flushes were not completed on the following shifts and dates: - Night shift: 9/2-9/13, 9/15, 9/17, 9/18 and 9/22-9/27. - Evening shift: 9/6, 9/8, 9/13, 9/14, 9/15, 9/17, 9/23 and 9/24. The TAR for September 2022 indicated G-tube care was not completed daily on the following shifts and dates: - 9/1, 9/2, 9/4, 9/6, 9/7, 9/8, 9/11 and 9/26. Interview with the Interim Director of Nursing on		**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 G had the g-tube dressing placed per Physician order. **2) How the facility identified other residents:** All residents who have g-tubes have the potential to be affected by the cited practice. A facility audit was conducted to identify any residents that have g-tubes and to ensure that all dressings were placed per physician's order and documented. **3) Measures put into place/ System changes:**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9/27/22 at 1:55 p.m., indicated she had already spoken to the evening nurse regarding treatments not being completed. She was not aware the flushes were not completed as ordered. This Federal tag relates to Complaint IN00390853. 3.1-44(a)(2)		The nursing staff has been re-educated on following physician orders for treatment related to g-tube site care and application of dressings. **4) How the corrective actions will be monitored:** Observation audits will be completed at least 3 times a week for 3 weeks at various times by DON/designee to ensure proper placement of dressings per physician's order. Thereafter, observation audits will be conducted randomly at least weekly for 8 weeks to ensure dressings are in place. The DON is responsible for oversight. **Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/Designee and 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: 10/26/2022**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration flow rate for 2 of 3 residents reviewed for respiratory care. (Residents P and R) Findings include: 1. On 9/28/22 at 11:10 a.m., Resident P was observed lying in bed with her oxygen nasal cannula in place. The oxygen concentrator flow rate was set at 1.5 liters per minute (lpm) On 9/28/22 at 2:18 p.m., the resident's oxygen concentrator setting was observed with the Director of Nursing (DON). She indicated it was set on 1.5 lpm. The resident's record was reviewed on 9/28/22 at 12:13 p.m. The resident was admitted on 12/8/21. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease.	F 0695	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 10/26/2022 **F695 Oxygen** **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*	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's Order, dated 3/155/22, indicated the resident was to have oxygen at 2 lpm continuously. 2. On 9/28/22 at 1:54 p.m., Resident R was observed seated in her wheelchair with her oxygen nasal cannula in place. The oxygen concentrator flow rate was set at 4 lpm. On 9/28/22 at 2:20 p.m., the resident's oxygen concentrator setting was observed with the DON. She indicated it was set on 4 lpm. The resident's record was reviewed on 9/28/22 at 2:11 p.m. The resident was admitted to 8/23/22. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. A Physician's Order, dated 8/23/22, indicated the reside was to have oxygen at 3 lpm continuously. Interview with the DON during observations indicated the oxygen concentrators were not at the correct settings. This Federal tag relates to Complaint IN00384837. 3.1-47(a)(6)		*federal and state law.* **1) Immediate actions taken for those residents identified:** Resident P's oxygen liter flow was set at the proper rate per MD order. Resident R's oxygen liter flow was set at the proper rate per MD order. **2) How the facility identified other residents:** All residents who receive oxygen have the potential to be affected by the cited practice. An audit was completed on all residents who receive oxygen therapy to ensure physician order is followed. **3) Measures put into place/ System changes:** The nursing staff has been re-educated on Oxygen use per physician order by the DON/designee. During Angel Rounds the oxygen devices of residents who receive oxygen will be observed to ensure the correct liter flow per physician order. Concerns will be immediately addressed with a nurse. Findings will be documented on the Angel Rounds Checklist and reviewed during daily (M-F) meetings. The DON is responsible for compliance.	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			4) How the corrective actions will be monitored: **The results of these audits will be provided to the QA Committee by the DON/Designee and 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** **10/26/2022**	
F 0697 SS=D 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 accurately assess and manage pain for a resident with a history of pain for 1 of 3 residents reviewed for pain. (Resident G) Finding includes: On 9/27/22 at 9:22 a.m., RN 2 was observed giving care to Resident G while he was in bed. When his left arm was moved, the resident indicated to be careful because it was painful to move. The resident indicated he had pain in his joints all the time. He rated the pain 8 out of 10.	F 0697	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 11/08/20 **F697- Pain Management** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	10/27/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 9/28/22 at 9:21 a.m., the resident was observed with the Unit Manager. He was seated in bed eating breakfast. He indicated he was having the usual pain in his joints. He rated the pain 8 out of 10. He indicated he had told the nurse and thought he had received a pain pill. The resident's record was reviewed on 9/27/22 at 10:02 a.m. The resident was admitted to the facility on 7/13/21. Diagnoses included, but was not limited to, hemiperisis and hemiplegia post CVA affecting the left side, dysphagia (difficulty swallowing) and congestive heart failure. The Annual Minimum Data Set assessment, dated 6/27/22, indicated the resident had moderate cognitive impairment, and required extensive assistance of +1 staff for bed mobility, transfers and toileting. He had pain frequently that he rated 6 out of 10. A Physician's Order, dated 5/4/22, indicated to assess pain every shift. A Pain Care Plan, dated 7/14/21, indicated the resident had potential for pain related to left hemiplegia, contractures to left wrist and hand. Interventions included to administer analgesia as ordered, and to give one half hour before treatments or care. Another intervention was to monitor and record pain characteristics. The September 2022 Medication and Treatment Administration Record indicated the resident's pain was 0 out of 10 on every shift of every day. The resident had not received any as needed Tylenol during September. During an interview with the Unit Manager on 9/28/22 after the resident observation, she		*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 G was assessed for pain and pain medication order reviewed with MD. **2) How the facility identified other residents:** All residents requiring pain medication have the potential to be affected by the cited practice. All residents that receive routine and PRN pain medications were assessed and orders reviewed to ensure that the cited practice does not re-occur. **3) Measures put into place/ System changes:** Nursing staff have been re-educated on pain assessment and the use of the pain scale, verbal and non-verbal cues for pain, documenting pain medication effectiveness and notification of the MD/NP of any unresolved pain. Licensed nurses and QMAs were also re-educated on reordering pain medication from	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the Nurse Practitioner was here today and she would ask her to see the resident and possibly get something else for pain. This Federal tag relates to Complaints IN00384837 and IN00386509. 3.1-37(a)		pharmacy, use of the back-up pharmacy, and use of the EDK for emergency medication. **4) How the corrective actions will be monitored:** DON or designee will review documentation relative to resident's pain daily (M-F) during clinical meeting to ensure compliance with provision of appropriate pain interventions for a period of 6 weeks and 3 times a week for the next 6 months. . Facility will observe 5 residents 5 days a week for 6 weeks and then 3 residents five days for 6 weeks to ask or observe for signs and symptoms of pain and that the pain is being addressed by the IDT. **Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/Designee and 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**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			indicated.	
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; 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 record review and interview, the facility failed to ensure a resident was free from unnecessary medications, related to not administering insulin as ordered for 1 of 3 residents reviewed for insulin. (Resident L) Finding includes: Record Review for Resident L was completed on 9/29/22 at 11:36 a.m. Diagnoses included, but were not limited to, diabetes mellitus,	F 0757	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Complia nce 10/26/2022 **F-757 Unnecessary Meds**	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hypertension, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 8/24/22, indicated the resident was cognitively intact. The resident had received insulin. A Care Plan, dated 5/13/22, indicated the resident had diabetes mellitus and was insulin dependent. An intervention included for diabetes medication as ordered by the doctor. The September 2022 Physician's Order Summary (POS) indicated an order for Lantus (insulin) Solution. Inject 17 units at bedtime. The September 2022 Medication Administrator Record (MAR) indicated the insulin was not documented as administered on the following time and dates: 8:00 p.m.: 9/17, 9/19, 9/21, 9/23, and 9/27/22 Interview with the Assistant Director of Nursing on 9/29/22 at 2:25 p.m., indicated they could not find any documentation the insulin was administered on the above time and dates. This Federal tag relates to Complaint IN00389455. 3.1-48(a)(6)		*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 L's medication orders were reviewed and Licensed Nursing staff in-serviced on the correct orders. **2) How the facility identified other residents:** **All residents that are prescribed medication are at risk for the cited practice; therefore, all residents of the facility have the potential to be affected.** **3) Measures put into place/ System changes:** **Licensed nurses and QMAs have been re-educated relative to medication administration, including but not limited to, ensuring that medications are**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			administered per physician orders, and documented according to facility policies and procedures. **4) How the corrective actions will be monitored:** **The DON/Designee will review the MARS daily 5 days a week for 4 weeks, then 2 days a week for 4 weeks, then weekly for 4 weeks to ensure proper documentation relating to medication administration. Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/Designee and 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:** **10/26/2022**	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review, and interview, the facility failed to ensure a resident received routine and/ or emergency dental services related to heavy debris build up and broken teeth for 1 of 1 residents reviewed for dental services. (Resident G) Finding includes: On 9/27/22 at 9:22 a.m., Resident G was observed in bed. He was noted to have some missing upper teeth, a broken partial tooth on the upper right side, and a heavy build up of debris on his lower teeth. On 9/29/22 at 8:52 a.m., the resident was observed with the Interim Director of Nursing (DON) and DON. There was a heavy build up of debris on his lower teeth and broken tooth observed. He indicated at that time that no one helped him brush his teeth and he did not have a toothbrush. The resident's record was reviewed on 9/27/22 at 10:02 a.m. The resident was admitted to the facility on 7/13/21. Diagnoses included, but were not limited to, hemiparesis and hemiplegia post CVA affecting the left side, dysphagia (difficulty swallowing) and congestive heart failure. The Annual Minimum Data Set assessment, dated 6/27/22, indicated the resident had moderate cognitive impairment, and required extensive assistance of +1 staff for bed mobility, transfers, toileting and personal hygiene. A Dental Care Plan, dated 7/14/21, indicated the resident had potential for oral/dental problems	F 0791	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 11/08/2022 F-791 Routine Dental services **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:** Resident G was provided with a new toothbrush and assistance with oral hygiene. Resident G has been scheduled to see the dentist.	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	related to dementia and self care deficit. Interventions included to consider a dental consult, discuss oral health concerns with family and provide the amount of assistance needed with oral care each shift. Interview with the Interim DON, on 9/29/22 at 8:52 a.m., indicated residents would be referred to the dentist if they complained of mouth pain or the family requested they see a dentist. She instructed a CNA to get the resident a toothbrush. She indicated they would contact the family to get consent for a dental appointment. This Federal tag relates to Complaint IN00390853. 3.1-24(a)(1)		**2) How the facility identified other residents:** All residents who reside in the facility have the potential to be affected. Dental consents were reviewed for all residents. If the resident/POA elected not to have services Social Services provided education on electing dental services at any time. **3) Measures put into place/ System changes:** Social Service and Nursing managers have been re-educated regarding follow up of ancillary Consents with care plans quarterly/annually and change of status. **4) How the corrective actions will be monitored:** **Upon Admission and quarterly a Dental assessment will be completed on all resident to ensure that all dental needs are being met. Resident/POA will be educated on any negative findings.** All care plans will be reviewed quarterly to ensure documentation on offering ancillary services including dental. **Any identified concerns will be promptly addressed with the responsible individual(s).** The Executive Director/Designee will be responsible for oversight of these audits.	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			The results of these audits will be provided to the QA Committee by the ED/Designee and 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.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food served to resident rooms was received hot for 1 of 2 units observed. This had the potential to affect 34 residents who resided on that unit. (400 unit) Finding includes: On 9/27/22 at 1:06 p.m., a test lunch tray was obtained from the serving cart on the 400 unit. The Dietary Manager use a food thermometer to obtain the following food temperatures: - diced potatoes: 125 degrees. - ham slice: 105.6 degrees	F 0804	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 10/26/2022 **F804 food temps** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- cooked greens: 122 degrees The ham slice was sampled and noted to be luke warm to cold. Interview with the Dietary Manager at that time, indicated ideally she would like food to be 140 degrees when served to residents, but 125 degrees was acceptable. She indicated 105.6 was too cold. They did not have heated serving carts or the bottom portion of the plate/ lid combination used to help keep food warm, only the lids. This Federal tag is related to Complaints IN00384837 and IN00389455. 3.1-21(a)(2)		*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:** Food was heated to acceptable temperature. **2) How the facility identified other residents:** All residents that consume food have potential to be affected by this cited practice. **3) Measures put into place/ System changes:** Acting Dietary Manager and Dietary staff have been re-educated on policy relative to safe and palatable food temperatures. **4) How the corrective actions will be monitored:** Dietary manager/designee will temp all 3 meals a day, daily, ongoing, on the unit before serving residents to ensure safe food	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			temperatures. **Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the Dietary Manager/Designee and 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: 10/26/2022**	
F 0880 SS=D 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. §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:			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§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 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.			

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§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 random observations, interviews, and record review, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19 related to the use of personal protective equipment (PPE) in an isolation room. (Room 416, LPN 1 and CNA 1) Findings include: 1. During a random observation on 9/28/22 at 9:53 a.m., LPN 1 entered Room 416 to speak with the resident. The LPN was only wearing a surgical mask. At that time, a sign on the resident's door indicated "Droplet/Contact Isolation. Proper Personal Protective Equipment (PPE): an isolation gown, protective eye wear, a N95 face mask and gloves to both hands before entering." There was also a PPE bin located right outside the door. Interview with LPN 1 on 9/28/22 at 9:55 a.m., indicated the resident was on isolation precautions. She should have donned the appropriate PPE before entering the room.	F 0880	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22 Compliance 10/26/2022 **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*	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. During a random observation on 9/28/22 at 10:01 a.m., CNA 1 entered the same room to speak with the resident. The CNA was only wearing a surgical mask. Interview with CNA 1 on 9/28/22 at 10:04 a.m., indicated she saw the sign on the door related to isolation and the PPE bin at the doorway but was unsure if the resident was on isolation. She further indicated if they were in a "Yellow Zone" room, she would just make sure she pulled her surgical mask up before entering the room. If the resident was in "Red Zone" or was positive for COVID-19, then should would put on all of the "extra PPE." An updated and current facility policy titled, "INFECTION CONTROL - Interim COVID-19 policy", and received from the Nurse Consultant on 9/28/22, indicated, "...If entering a Yellow zone or Red Zone room under transmission-based precautions, staff must wear FULL PPE, including N95, eye protection, gown and gloves...." This Federal tag relates to Complaint IN00389455. 3.1-18(b)		*required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** LPN #1 and CNA #1 were immediately re- educated on proper mask wearing and on infection Control Policies. They were both re-educated on isolation precautions. **2) How the facility identified other residents:** All residents have the potential to be affected by this cited practice. **3) Measures put into place/ System changes:** 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**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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: 10/26/2022**	
F 0921 SS=F 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 ensure the residents' environment was clean and in good repair related to dirty and discolored floors, discolored walls, dirty shower rooms with cracked and broken tiles, broken furniture, and a leaking toilet for 4 of 4 units. (100 Unit, 200 Unit, 300 Unit, and 400 Unit)	F 0921	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22	10/26/2022

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: During the Environmental Tour on 9/27/22, from 9:24 a.m., through 10:21 a.m., with the Maintenance Director, the following was observed: 1. 100 Unit a. Room 124: The room door panel was coming off. The floor was dirty with debris and black mars by the heating/cooling unit. The wall next to the heating/cooling unit had brown/orange discolorations. The toilet was making a running noise and had a puddle of water all around the base on the floor. Two residents resided in the room. b. Assisted Dining Room: There was a brown/orange discoloration all over the walls and on the heating/cooling units. A large portion of the baseboard was missing in the corner of the room. There was a large gouge on the wall below the windows. The floor had black gouges and multiple pieces of the flooring was missing. The door panel was coming off. Fourteen residents ate in the dining room. c. Shower Room: The ceiling in one of the shower stalls was bowing down and had dark marks on it. 2. 200 Unit a. Room 227: The floor was dirty with debris. Two resident resided in the room. b. Room 232: The floor was dirty with debris. The baseboard by the room entrance was pulled away from the wall. Two residents resided in the room.		Compliance 10/26/2022 **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:** **All the identified concerns below were corrected:** On the units **100 Hallway** a. Room 124: The room door panel was coming off. The floor was dirty with debris and black mars by the heating/cooling unit. The wall next to the heating/cooling unit had brown/orange discolorations. The toilet was making a running noise and had a puddle of water all around the base on the floor. Two residents resided in the room. b.	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	c. Shower Room: Tiles were chipped on the walls and floors. The floors were dirty with built up debris. The shower curtain rods were rusted and chipped. 3. 300 Unit a. Shower Room: Tiles were chipped on the walls and floors. There was a large hole of broken tile on the wall by the bathroom. The floors were dirty with built up debris. The shower curtain rods were rusted and chipped. b. Activity Room: A chair had duct tape on one of the arms, the other arm had a large piece gouged out and broken. A table with a rubber gasket that went around the base was on the floor hanging from the table and not in place. The walls had dark mars throughout the room. 4. 400 Unit: a. Room 412: The floor was dirty with debris. One resident resided in the room. b. Shower Room: Tiles were chipped on the walls and floors. The floors were dirty with built up debris. The shower curtain rods were rusted and chipped. A large amount of dust buildup on the sprinklers and vents on the ceiling. Interview with Housekeeping 1 on 9/27/22 at 10:09 a.m., indicated she was responsible for cleaning the 300 and 400 Units. She had to clean the resident rooms, shower rooms, and common areas. There was another housekeeper there that was responsible for the 100 and 200 Units. She indicated she would try to get all areas cleaned every day before her shift was over, but it was challenging at times to be able to finish		Assisted Dining Room: There was a brown/orange discoloration all over the walls and on the heating/cooling units. A large portion of the baseboard was missing in the corner of the room. There was a large gouge on the wall below the windows. The floor had black gouges and multiple pieces of the flooring was missing. The door panel was coming off. Fourteen residents ate in the dining room. c. Shower Room: The ceiling in one of the shower stalls was bowing down and had dark marks on it. **200 Hallway:** a. Room 227: The floor was dirty with debris. Two residents resided in the room. b. Room 232: The floor was dirty with debris. The baseboard by the room entrance was pulled away from the wall. Two residents resided in the room. c. Shower Room: Tiles were chipped on the walls and floors. The floors were dirty with built up debris. The shower curtain rods were rusted and chipped. **300-Hallway** 3. 300 Unit a. Shower Room: Tiles were chipped on the walls and floors. There was a large hole of broken tile on the wall by the bathroom. The floors were dirty with built up debris. The shower curtain rods were rusted and chipped. b. Activity Room: A chair	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	everything with just 2 housekeepers. Interview with the Maintenance Director on 9/27/22 at 10:21 a.m., indicated the facility did not have a Housekeeping Supervisor currently. He indicated all of the above was in need of cleaning or repair. This Federal tag relates to Complaints IN00384837, IN00386509, IN00389455, IN00390581, and IN00391322. 3.1-19(f)		had duct tape on one of the arms, the other arm had a large piece gouged out and broken. A table with a rubber gasket that went around the base was on the floor hanging from the table and not in place. The walls had dark mars throughout the room **400- Hallway** a. Room 412: The floor was dirty with debris. One resident resided in the room. b. Shower Room: Tiles were chipped on the walls and floors. The floors were dirty with built up debris. The shower curtain rods were rusted and chipped. A large amount of dust buildup on the sprinklers and vents on the ceiling. **) How the facility identified other residents:** **All residents are at risk for the same cited practice.** **3)Measures put into place/ System changes:** **All staff was re-inserviced on notifying Maintenance Director and Housekeeping staff when environment needs to be repaired and/or cleaned.** **4)How the corrective actions will be monitored:** **The Administrator/designee will monitor corrective actions & will ensure sustained compliance; Completing rounds 5 days a week to ensure**	

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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the facility is a safe, comfortable, and sanitary environment.Any identified concerns will be promptly addressed with the responsible individual(s). **The results of these audits will be provided to the QA Committee by the ED/Designee and 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: 10/26/2022**	