PRINTED: 11/16/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	MEDICARE & MEDI T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number 155156	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 09/29/2022
	ROVIDER OR SUPPLIE	ER MICHIGAN CITY	1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE OPRIATE COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00	IN00384837, IN00 IN00390581, IN00 Complaint IN0038 Federal/State defin	the Investigation of Complaints 0385579, IN00386509, IN00389455, 0390853 and IN00391322. 84837 - Substantiated. ciencies related to the ed at F677, F686, F695, F697,	F 0000		
	F804 and F921.	cu at 1077, 1000, 1055, 1057,			
	-	85579 - Substantiated.			
	Federal/State defie	ciencies related to the			
	allegations are cite	ed at F609.			
	Federal/State defie	86509 - Substantiated. ciencies related to the ed at F585, F677, F697 and F921.			
	-				
	•	89455 - Substantiated.			
		ciencies related to the ed at F757, F804, F880 and F921.			
	Complaint IN0039	90581 - Substantiated.			
	Federal/State defice allegations are cite	ciencies related to the ed at F921.			
	Federal/State defie	90853 - Substantiated. ciencies related to the ed at F580, F677, F693 and F791.			
	Federal/State defie	91322 - Substantiated. ciencies related to the			
	allegations are cite	ed at F677, F690 and F921.			
	Survey dates: Sep	tember 27, 28 and 29, 2022.			
	Facility number: 0 Provider number:				
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIC	GNATURE	TITLE	(X6) DATE
Kristina He			Executive	Discotor	11/09/2022

Any defiency statement 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.

000076

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CC A. BUILDING B. WING	nstruction 00	(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE		
APERIO	N CARE ARBORS	MICHIGAN CITY	MICHIG	GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION	
	AIM number: 100	271060				
	Census Bed Type: SNF/NF: 23 SNF: 13 NF: 88 Total: 124					
	Census Payor Typ Medicare: 13 Medicaid: 77 Other: 34 Total: 124	e:				
	These deficiencies accordance with 4	reflect State Findings cited in 10 IAC 16.2-3.1.				
	Quality review con	mpleted on 10/6/22.				
⁼ 0580 SS=D Bldg. 00	§483.10(g)(14) N (i) A facility must resident; consult physician; and no her authority, the when there is- (A) An accident i results in injury a requiring physicia (B) A significant physical, mental, (that is, a deterio psychosocial sta conditions or clin (C) A need to alt (that is, a need to form of treatmen	s (Injury/Decline/Room, etc.) lotification of Changes. immediately inform the with the resident's otify, consistent with his or resident representative(s) nvolving the resident which nd has the potential for an intervention; change in the resident's or psychosocial status ration in health, mental, or tus in either life-threatening ical complications); er treatment significantly o discontinue an existing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	x1) provider/supplier/clia identification number 155156	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF PROVIDER OR SUPPLI		1101	T ADDRESS, CITY, STATE, ZIP CO E COOLSPRING AVE IGAN CITY, IN 46360	D	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
resident from th §483.15(c)(1)(ii) (ii) When makin (g)(14)(i) of this ensure that all p in §483.15(c)(2) upon request to (iii) The facility r resident and the any, when there (A) A change in assignment as s (B) A change in or State law or r paragraph (e)(1 (iv) The facility r update the addr phone number of representative(s §483.10(g)(15) Admission to a of facility that is a defined in §483. admission agree configuration, in that comprise th and must specif room changes b under §483.15(c) Based on record to failed to ensure a notified prior to a reviewed for noti	g notification under paragraph section, the facility must vertinent information specified is available and provided the physician. nust also promptly notify the resident representative, if is- room or roommate specified in §483.10(e)(6); or resident rights under Federal egulations as specified in 0) of this section. nust record and periodically ess (mailing and email) and of the resident s). composite distinct part. A composite distinct part (as 5) must disclose in its ement its physical cluding the various locations e composite distinct part, y the policies that apply to between its different locations c)(9). review and interview, the facility resident's representative was a room change for 1 of 3 residents fication of change. (Resident G)	F 0580	Aperion- Arbo Michigan City POC Complaint Exit 09		10/26/202

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/29/2022 155156 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE facility on 7/13/21. Diagnoses included, but were Compliance not limited to, hemiparesis and hemiplegia post 10/26/2022 CVA affecting the left side, dysphagia (difficulty swallowing) and congestive heart failure. F 580 Notification The Copy of Intrafacility Transfer, dated 9/1/22, This Plan of Correction is the indicated the resident was being moved from the center's credible allegation of 400 unit, to a room on the 300 unit. The signature compliance. line on the document indicated, "res and dtr" (resident and daughter), and the facility staff Preparation and/or execution of signature line indicated, "unit nurse". There was this plan of correction does not no documentation related to the room change in constitute admission or agreement the progress notes. by the provider of the truth of the facts alleged or conclusions set Interview with the Social Service Director, on forth in the statement of 9/28/22 at 1:57 p.m., indicated she was the person deficiencies. The plan of that would usually complete the room change correction is prepared and/or forms and notify family members of room changes, executed solely because it is unless the unit manager did it first. She indicated required by the provisions of she had not spoken with the resident's family federal and state law. regarding the room change on 9/1/22. 1) Immediate actions taken Interview with the Unit Manager, on 9/28/22, at for those residents identified: 1:59 p.m., indicated she did not complete the room POA of resident G was notified of change form or speak to the resident's family. She room change. did not know who completed the room change form. How the facility 2) This Federal tag relates to Complaint IN00390853. 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. Measures put into place/ 3) System changes: Nursing department was educated on Notify of Changes,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 39FZ11

Facility ID: 000076

If continuation sheet

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	ILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2022	
		155156	B. WI				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE ARBORS	MICHIGAN CITY		MICHIO	GAN CITY, IN 46360		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	Ε	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	 DEFICIENCY) including but not limited to, notification of change Policy Interfacility transfer and notifications of resident representatives. 4) How the corrective action will be monitored: DON/ED/Designee will review orders, significant changes, assessments, and room changes 5 days a wee for 3 months and then 3 day week for 3 months to ensure that the family/resident representative notification been completed. Any identic concerns will be promptly addressed with the responsindividual(s). The results of these audits be provided to the QA Committee by the DON/ED/Designee and will reviewed in Quality Assura Meeting monthly x6 month 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 plan of correction as indicated. 	and ons d eek ays a re has tified sible sible sible sible sor ee e the	DATE

39FZ11 Facility ID: 000076

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If continuation sheet Pa

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLI		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Griev §483.10(j)(1) Th voice grievances agency or entity without discrimin fear of discrimina grievances inclu and treatment w well as that whic the behavior of s and other conce facility stay. §483.10(j)(2) Th the facility must facility to resolve have, in accorda §483.10(j)(3) Th information on h complaint availa §483.10(j)(4) Th grievance policy resolution of all g residents' rights Upon request, th of the grievance grievance policy (i) Notifying resid postings in prom the facility of the (meaning spoke grievance can name, business	e resident has the right to a to the facility or other that hears grievances ation or reprisal and without ation or reprisal. Such de those with respect to care hich has been furnished as h has not been furnished, taff and of other residents, rns regarding their LTC e resident has the right to and make prompt efforts by the e grievances the resident may nce with this paragraph. e facility must make bow to file a grievance or ble to the resident. e facility must establish a to ensure the prompt grievances regarding the contained in this paragraph. e provider must give a copy policy to the resident. The				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360			
	1					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR(DEFICIENCY)	D BE	(X5) COMPLETIO DATE
		ame for completing the				
	written decision n grievance; and th independent entii may be filed, that agency, Quality I State Survey Age Care Ombudsma advocacy system (ii) Identifying a O responsible for o process, receivin through to their of necessary invest maintaining the o information asso example, the ide grievances subm written grievance and coordinating agencies as neo allegations; (iii) As necessary prevent further p resident right wh being investigate (iv) Consistent w immediately repo involving neglect unknown source resident property services on behat administrator of t by State law; (v) Ensuring that	Grievance Official who is verseeing the grievance g and tracking grievances conclusions; leading any igations by the facility; confidentiality of all ciated with grievances, for nity of the resident for those litted anonymously, issuing e decisions to the resident; with state and federal essary in light of specific <i>x</i> , taking immediate action to obtential violations of any ile the alleged violation is d; ith §483.12(c)(1), orting all alleged violations , abuse, including injuries of , and/or misappropriation of <i>x</i> , by anyone furnishing If of the provider, to the he provider; and as required all written grievance				
	received, a sumr resident's grieva	e the date the grievance was nary statement of the nce, the steps taken to rievance, a summary of the				

STATEMENT OF AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF PROVI		R R MICHIGAN CITY		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETIO DATE
per the why cor be grid waa (vi) acc vio by juri Agu or I vio witti (vii) res tha grid Baa fail tho rev Fin A c cor inc and acc vio by juri Agu or I vio witti tha grid acc vio by juri Agu or I vio witti tha fail tho rev Fin A c cor inc and acc vio by juri Agu or I vio witti tha fail tho rev Fin A c cor inc and acc vio by juri acc vio by juri Agu or I vio witti tha fail tho rev Fin A c cor inc and acc vio by juri acc vio by stritti tha fail tho rev Fin A cor inc and acc vio vio vitti tha fail tho rev Fin A cor inc and acc vio vio vio vitti tha fail tho rev fail tho rev fail tho tho fail tho fai tho fail tho fail tho fai tho fai tho fail tho fai tho fai tho fai tho fai tho fai tho fai tho fai tho fai tho fai tho fai tho fai tho fai t	tinent findings resident's cor ether the griev firmed, any co taken by the fa- evance, and the s issued; Taking appro- cordance with lation of the re- the facility or it sdiction, such ency, Quality I ocal law enfor lation for any co- nin its area of) Maintaining e- ult of all grieva n 3 years from evance decisic sed on record re- ed to ensure a r roughly investi- iewed for grieva ding includes: closed record re- npleted on 9/28 luded, but were diabetes mellit e Admission Mi essment, dated is concern/Compli- icated the reside ed the nurse for	or conclusions regarding cerns(s), a statement as to ance was confirmed or not prrective action taken or to acility as a result of the e date the written decision oriate corrective action in State law if the alleged sidents' rights is confirmed an outside entity having as the State Survey mprovement Organization, cement agency confirms a of these residents' rights responsibility; and evidence demonstrating the inces for a period of no less the issuance of the n. view and interview, the facility esident's grievance was gated for 1 of 4 residents inces. (Resident B) view for Resident B was (22 at 11:21 a.m. Diagnoses not limited to, hypertension us.	F 05		Aperion- Arbors Michigan POC Complaint Exit 09/29/22 Compliance 10/26/2022 F 585 Grievances This Plan of Correction is th center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agree by the provider of the truth	ne of on of not eement	10/26/202

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039
(X3) DATE SURVEY
COMPLETED

PRINTED: 11/16/2022

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 09/29/2022
	PROVIDER OR SUPPLIEF		1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	that she asked a CN and the CNA stated yourself and take yourself	on it. She also had a concern A to take her to the bathroom , "you have to fend for purself to the bathroom". The he then had wet herself. The e bathroom and then put her ith wet clothes on.		facts alleged or conclusions s 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	et
	longer worked at th from the resident. S denied the resident's documentation who interviewed. The Corrective Act	r of Nursing (DON), who no e facility, had taken the report he interviewed the nurse who s complaint. There was no the CNA was or if they were ions Taken indicated:		1) Immediate actions take for those residents identified Resident B no longer resides facility; therefore, no further corrective action could be take for this resident.	in
	pairs. The section that ind satisfied with the ou not filled out.	icated if the complainant was atcome and actions taken was		2) How the facility identified other residents: Audit was completed of grieva of the last 90 days to ensure t each grievance was thorough investigated.	hat
	p.m., indicated she documentation relat grievance the reside A facility policy titl	nterim DON on 9/28/22 at 3:30 could not find any further ted to the investigation of the ent had filed. ed, "Grievances", and received Interim DON on 9/29/22,		 3) Measures put into place System changes: All staff educated on grievand policy and notification of conce 4) How the corrective action 	ce erns.
	include:" "Steps grievance"	itten grievances shall taken to investigate the		will be monitored: DON/ED/Designee will review grievances 5 days a week for 3 months and 3 day	ys a
	This Federal tag rel 3.1-7(a)(2)	ates to Complaint IN00386509.		week for 3 months to ensure that grievances have been thoroughly investigated per facility policy. The results of these audits v be provided to the QA	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 39

39FZ11 Facility

Facility ID: 000076

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	R MEDICARE & MEDI					1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/29/2022		
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC DEFICIENCY)	BE	(X5) COMPLETION DATE
				Committee by the DON/ED/Designee and wi reviewed in Quality Assum Meeting monthly x6 mont until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Commit will identify any trends or patterns and make recommendations to revis plan of correction as indice 5) Date of compliance: 10/26/2022	rance hs or tee se the	
F 0609 SS=D Bldg. 00	abuse, neglect, et the facility must: §483.12(c)(1) En violations involvir exploitation or mi injuries of unknow misappropriation reported immedia hours after the al events that cause or result in serious than 24 hours if t allegation do not result in serious b administrator of t officials (including Agency and adul	ponse to allegations of exploitation, or mistreatment, sure that all alleged ng abuse, neglect, istreatment, including				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	A. BUILDING <u>00</u> B. WING		<u>00</u>	x3) date s comple 09/29/2	ETED
	PROVIDER OR SUPPLII			1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL				Ē	(X5) COMPLETION
TAG	REGULATORY OF care facilities) in through establish §483.12(c)(4) Re investigations to her designated re officials in accord including to the S 5 working days of alleged violation corrective action Based on record re failed to investiga unknown origin to residents reviewed (Resident D) Finding includes: The record for Re 9/28/22 at 9:21 a.1 the facility on 10/7 were not limited to resident was on ho The Quarterly Min dated 8/26/22, ind cognitive impairm assistance for bed A Progress Note, or resident had a skin left elbow. A Wound Assessm	AR LSC IDENTIFYING INFORMATION accordance with State law hed procedures. eport the results of all the administrator or his or epresentative and to other dance with State law, State Survey Agency, within of the incident, and if the is verified appropriate must be taken. eview and interview, the facility te and report an injury of the State Agency for 1 of 1 d for injuries of unknown origin. sident D was reviewed on m. The resident was admitted to 30/20. Diagnoses included, but b, unspecified dementia. The	F 06	TAG	Aperion- Arbors Michigan City POC Complain 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 agreem by the provider of the truth of th facts alleged or conclusions set forth in the statement of deficiencies. The plan of	t f ent e	DATE
	centimeters (cm)	x 2.9 cm on the back of the left o documentation of			correction is prepared and/or executed solely because it is required by the provisions of federal and state law.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	B) DATE SURVEY COMPLETED 09/29/2022
	PROVIDER OR SUPPLII		1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360	
X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	A Hospice Aide V	visit Note, dated 6/21/22,			
		lent's skin was intact during the		1) Immediate actions taken for	
	-	ous day. Upon arrival, the aide		those residents identified:	
		ound the right eye, and the left			
		in a dressing. The hospice aide		Resident D's discolored	
	had contacted the	hospice nurse.		eye has resolved. Investigation	
				into how the discoloration was	
	· ·	Progress Note, dated 6/27/22,		obtained was initiated and	
		lent had an 11 cm x 1 cm skin		completed.	
		tion under the right eye from			
	unknown cause.			2) How the facility identified	
				other residents:	
		, "Abuse Prevention and			
		eceived from the Nurse		All residents could be affected	
		7/22 at 10:15 a.m., indicated,		by the cited practice. A full house)
	-	uries not involving an allegation		skin sweep was conducted to	
	-	et, the administrator will appoint		identify any areas of concern. An	
		further facts to make a o whether the injury should be		investigation was completed on	
		njury of unknown source". An		any newly identified areas to discern cause.	
		lassified as an "injury of		discerti cause.	
		when both of the following		3) Measures put into place/	
		t: The source of the injury was		System changes:	
		ny person or the source could		bystem enanges.	
	-	by the resident; and The injury is		Education has been provided to	
	-	e of the extent of injury or		the IDT and nursing staff regarding	na
	location of the inj			reporting injuries of unknown orig	-
	5	-		for investigation and appropriate	
	Interview with the	e Hospice Nurse, on 9/28/22 at		notifications.	
		ed she had visited the resident on			
		lent had "black eye" to the right		4) How the corrective actions	
	eye that was very	dark in color, and a large skin		will be monitored:	
	tear on his left elb	ow. She had spoken to the			
		ng (DON), who indicated they		DON/designee will review all nev	v
		t happened. She indicated the		skin assessments 5 x a week for	
	bruising remained	for several weeks.		3months and 3 x a week for 3	
				months to ensure that all injuries	
		N 2, on 9/28/22 at 9:41 a.m.,		are investigated, and the	
		embered the resident had		Executive Director is informed of	
	discoloration arou	nd his eye and a skin tear, but		any injuries of unknown origin .	

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Event ID: **39FZ11** Facility ID: **000076**

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		(-)	PLETED
	or conduction	155156	B. WING	- 1	09/29/2022	
			STRE	EET ADDRESS, CITY, STATE, ZIP CO	- I	
NAME OF 1	PROVIDER OR SUPPLIE	R		1 E COOLSPRING AVE		
APERIO	N CARE ARBORS	MICHIGAN CITY	MIC	HIGAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE AF	OULD BE PROPRIATE	COMPLETION DATE
	does not recall wh	at happened.		The DON will be respor		
	T	L		compliance. Any ident		
		Interim DON, on 9/28/22 at		concerns will be prom		
		ed there was no documentation ploration around the right eye,		addressed with the res	sponsible	
		to what happened. She also		individual(s).		
	•	ent had not been reported to		The results of these au	udits will	
	the State Agency.	1		be provided to the QA Committee by the		
	This Federal tag re	elates to Complaint IN00385579.		DON/Designee and wil reviewed in Quality As		
	3.1-28(c)			Meeting monthly x6 m		
	3.1-28(d)			until an average of 90%		
				compliance or greater		
				achieved x3 consecuti	ve	
				months. The QA Com	mittee	
				will identify any trends	or	
				patterns and make		
				recommendations to replan of correction as in		
				5) Date of compliance	:	
				10/26/2022		
0677	483.24(a)(2)					
SS=D		ed for Dependent Residents				
Bldg. 00		resident who is unable to				
	-	s of daily living receives the				
	-	es to maintain good ng, and personal and oral				
	hygiene;	iy, anu personai anu olai				
		ion, record review and	F 0677	Aperion- Arbors Michig	an Citv	10/26/202
		lity failed to provide ADL	1 00//			
	(activities of daily	living) assistance to a		POC C	omplaint	
	-	t related to completing				
		for 1 of 3 residents reviewed		Exit 09)/29/22	
	for ADL care. (Re	sident J)				
	T:			Compliance		
	Finding includes:			11/08/2022		
	1					1

DEPARTMENT OF HE

FORM CMS-2567(02-99) Previous Versions Obsolete

	Г OF HEALTH AND HU R MEDICARE & MEDIC					FO	TED: 11/16/2022 RM APPROVED 1B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156			A. BU B. W		00	COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIEI			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	at 1:57 p.m. The refacility on 3/23/18. not limited to, hem and chronic pain. The Quarterly Min dated 8/22/22, indic cognitively intact a assistance for bed r An ADL Care Plan resident needed ass to left side hemiple and osteoarthritis. I assist with personal honor resident pref	ident J was reviewed on 9/29/22 esident was admitted to the Diagnoses included, but were iplegia effecting the left side imum Data Set assessment, cated the resident was nd required extensive +1 nobility and transfers. A, dated 1/5/22, indicated the esistance with ADL care related egia, chronic pain, incontinence Interventions included to I hygiene as needed and to erences.			F 677 ADL Dependent Residents This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does no constitute admission or agreed by the provider of the truth of a facts alleged or conclusions sa 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.	ot ment the	
		ed showers two times a week			1) Immediate actions taken for the test of	or	

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.

2) How the facility identified other residents: The facility completed an audit to

shower at the time of survey.

Resident J was offered and given a

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

If continuation sheet

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39FZ11 Event ID:

Facility ID: 000076

STATEMENT OF DEFI AND PLAN OF CORRE		x1) provider/supplier/clia identification number 155156	(X2) MULTIPL A. BUILDING B. WING	A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF PROVIDER			110	EET ADDRESS, CITY, STATE, ZIP CO 1 E COOLSPRING AVE CHIGAN CITY, IN 46360	DD		
TAG REG This Fe	CH DEFICIEN ULATORY OI deral tag re	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION lates to Complaints IN00384837, 390853 and IN00391322.	ID PREFIX TAG	CROSS-REFERENCED TO THE AF	OULD BE PPROPRIATE	(X5) COMPLETIO DATE	
3.1-38(4	a)(3)			 4) How the corrective a will be monitored: The DON/Designee will shower sheets 5 days a 3 months and then 3 da for 3 months to ensure hygiene is maintained for residents. Facility will of residents 5 days a weel weeks and then 3 resid days for 6 weeks to er showers are being give identified concerns will promptly addressed w responsible individual. The results of these au be provided to the QA Committee by the DON/Designee and will reviewed in Quality As Meeting monthly x6 m until an average of 90% compliance or greater achieved x3 consecuti months. The QA Com will identify any trends patterns and make recommendations to replan of correction as in 5) Date of compliance 11/8/22 	I review a week for ays a week proper or facility bserve 5 k for 6 ents five asure that and n. Any II be ith the (s). udits will I be ssurance onths or % is ve mittee s or evise the ndicated.		

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIE		1101	i address, city, state, zip cod E COOLSPRING AVE IGAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION	
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin I §483.25(b)(1) Pro Based on the cor a resident, the fa (i) A resident reco professional stam pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a condition demons unavoidable; and (ii) A resident with necessary treatm with professional promote healing, new ulcers from a Based on record re failed to ensure a r received the necess promote healing, r completed as order for pressure ulcers Finding includes: A closed record re completed on 9/27 included, but were hypertension, and was admitted to th discharged on 6/17 The Admission Mi assessment, dated	o Prevent/Heal Pressure ntegrity essure ulcers. nprehensive assessment of cility must ensure that- eives care, consistent with dards of practice, to prevent nd does not develop nless the individual's clinical strates that they were n pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent developing. view and interview, the facility esident with pressure ulcers sary treatment and services to elated to treatments not red for 1 of 3 residents reviewed . (Resident C) view for Resident C was /22 at 11:23 a.m. Diagnoses not limited to, stroke, diabetes mellitus. The resident e facility on 6/7/22 and	F 0686	Aperion- Arbors Mich City POC Con Exit 09/2 Compliance 10/26/2022 F-686 Treatment /Svcs The facility requests pap compliance for this citati This Plan of Correction is center's credible allegation compliance.	er the	

	R MEDICARE & MEDI					*	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	î î	LDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2022	
VAME OF 1	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP COD		
	N CARE ARBORS				COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG			DATE
		on assist with bed mobility and			Preparation and/or execution		
		ident required an extensive 1			this plan of correction does no		
	-	dressing, toilet use, and			constitute admission or agree		
		The resident had 1 unstageable			by the provider of the truth of		
	-	to slough and/or eschar (dead			facts alleged or conclusions s	et	
		geable DTI (deep tissue injury)			forth in the statement of		
	-	he resident was admitted to the			deficiencies. The plan of		
	tacility with all of	the pressure ulcers.			correction is prepared and/or		
					executed solely because it is		
		ed on 6/8/22, indicated the			required by the provisions of		
	-	ential for further impairment to			federal and state law.		
	•••	intervention included to					
		ts as ordered to the skin			1) Immediate actions taken f	or	
	impairments.				those residents identified:		
					Resident c no longer reside		
		dicated the resident had the			the facility; therefore, no furthe		
	following pressure	e ulcers on admission:			corrective action could be take	en	
					for this resident.		
	1. DTI to the cocc	-					
	measurement: 2.1	cm (centimeters) x 0.3 cm			2) How the facility identified		
					other residents:		
	2. DTI to left 2nd				All residents in the facility with		
	measurement: 0.3	cm x 0.9 cm			alteration in skin or high risk o		
					skin alterations have the poter	ntial	
	3. DTI to left 5th t				to be affected by the cited		
	measurement: 0.5	cm x 0.3 cm			practice.		
	4. DTI to left dista	l lateral foot			3) Measures put into place/		
	measurement: 1.3				System changes:		
					A. Nursing staff have been in		
	5. DTI to left heel				serviced on the importance of		
	measurement: 0.3	cm x 0.4 cm			ensuring that an appropriate		
					treatment is in place, proper		
	6. DTI to right gre	at lateral toe			identification of etiology of a		
	measurement: 0.2				wound, updating the plan of ca	are	
					and the importance of comple		
	7. DTI to right gre	at toe			treatments according to the	.5	
	measurement: 0.3				Physicians' Order.		
					B. A QA tool has been		

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Event ID: 39FZ11

Facility ID: 000076

If continuation sheet Page 17 of 48

PRINTED: 11/16/2022 FORM APPROVED

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING			COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIE			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360	1	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	measurement: 0.6	cm x 2.5 cm			compliance to these measure	es.	
	 indicated the follo Betadine (antisep Apply to right late day for wound car pat dry, apply Beta date - 6/10/22 Betadine (antisep Apply to right gree for wound care. C dry, apply Betadin date - 6/10/22 Betadine (antisep Apply to left 2nd twound care. Clea apply Betadine to 6/10/22 Betadine (antisep Apply to left 2nd twound care. Clea apply Betadine to 6/10/22 Betadine (antisep Apply to left 5th twound care. Clea apply Betadine to 6/10/22 Betadine Swabst distal lateral foot of Cleanse with norm Betadine to wound Betadine to foot care. Start date - 6 Cleanse left later saline. Apply San 	 ptic) Swabsticks Swab 10%. pral great toe topically one time a re. Cleanse with normal saline, adine to wound bed daily. Start ptic) Swabsticks Swab 10%. at toe topically one time a day Cleanse with normal saline, pat at toe topically one time a day for nse with normal saline, pat dry, wound bed daily. Start date - ptic) Swabsticks Swab 10%. toe topically one time a day for nse with normal saline, pat dry, wound bed daily. Start date - ptic) Swabsticks Swab 10%. toe topically one time a day for nse with normal saline, pat dry, wound bed daily. Start date - ptic) Swabsticks Swab 10%. toe topically one time a day for nse with normal saline, pat dry, wound bed daily. Start date - ticks Swab 10%. Apply to left one time a day for wound care. nal saline, pat dry, apply d bed daily. Start date - 6/10/22 ulcers every day shift for skin 			4) How the corrective action will be monitored: The DON or designee will complete an audit of 2 reside with pressure injuries 5x's a v randomly to validate that the current treatment is in place a correctly dated x's 6 weeks the 3x's a week for 4 weeks then weekly thereafter. The DON responsible for compliance. A identified concerns will be promptly addressed with the responsible individual(s). The results of these audits be provided to the QA Committee by the DON/Designee and will be reviewed in Quality Assuran Meeting monthly x6 months 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 plan of correction as indicat 5) Date of compliance: 10/26/2022	nts veek and hen s Any e will hce or	

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Event ID: **39FZ11** Facility ID: **000076**

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CC A. BUILDING B. WING	DINSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2022		
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	REGULATORY C	re. Start date - 6/8/22.	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE	
	apply Santyl, cove every day shift for	erior knee with normal saline, or with moist gauze and Kerlix or wound care. Start date - 6/8/22 th foam dressing every 3 days					
	for skin care. Star						
	wound care. Start	date - 6/10/22					
	every day for wou	rep. Apply to left heel topically nd care. Cleanse with normal d apply skin prep to wound bed 6/10/22					
	(TAR) indicated the	eatment Administration Record ne above treatments were not mpleted on the following days:					
	- Betadine to right 6/11, 6/15, and 6/1	lateral great toe topically: 6/10, 7/22					
	- Betadine to right 6/15, and 6/17/22	great toe topically: 6/10, 6/11,					
	- Betadine to left 2 and 6/17/22	2nd toe topically: 6/10, 6/11, 6/15,					
	- Betadine to left 5 and 6/17/22	ith toe topically: 6/10, 6/11, 6/15,					
	- Betadine to left of and 6/17/22	listal lateral foot: 6/10, 6/11, 6/15,					
	- Betadine to foot 6/17/22	ulcers: 6/9, 6/10, 6/11, and					
	- Cleanse left later	al lower extremity with normal					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 09/29/2022		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	saline. Apply San	tyl (wound ointment), cover and Kerlix: 6/9, 6/10, 6/11, 6/12,					
	apply Santyl, cove	terior knee with normal saline, er with moist gauze and Kerlix: 12, 6/15, and 6/17/22					
	- Cover coccyx wi 6/11 and 6/17/22	th foam dressing every 3 days:					
	- Foam Dressing F 6/11, and 6/12/22	Pad to coccyx every day: 6/10,					
	- No-Sting Skin-P 6/10, and 6/11/22	rep. Apply to left heel topically:					
	10:50 a.m., indica wound treatments and the nursing sta them on the week	Wound Nurse on 9/28/22 at ted she completed all of the in the facility during the week aff was responsible to complete ends. She could not provide tentation the wound treatments ed as ordered.					
	Condition Assessr from the Nurse Co "18. Physician o	itled, "Pressure Injury and Skin nent" and received as current onsultant on 9/28/22, indicated, rdered treatments shall be iff on the electronic Treatment ecord after each					
	This Federal tag re	elates to Complaint IN00384837.					
	3.1-40(a)(2)						
0690 SS=D 3ldg. 00	483.25(e)(1)-(3) Bowel/Bladder Ir §483.25(e) Incor	ncontinence, Catheter, UTI					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 39FZ11

Facility ID: 000076

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155156	ì í	LDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE ARBORS	MICHIGAN CITY			GAN CITY, IN 46360		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	Е	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident who is c bowel on admiss assistance to ma or her clinical cor that continence is §483.25(e)(2)For incontinence, bas comprehensive a ensure that- (i) A resident who an indwelling cat unless the reside demonstrates that necessary; (ii) A resident wh indwelling cathet one is assessed as soon as possi clinical condition catheterization is (iii) A resident wh receives appropri to prevent urinary	e facility must ensure that ontinent of bladder and ion receives services and intain continence unless his nation is or becomes such as not possible to maintain. The a resident with urinary sed on the resident's assessment, the facility must be enters the facility without heter is not catheterized nt's clinical condition at catheterization was to enters the facility with an er or subsequently receives for removal of the catheter ble unless the resident's demonstrates that necessary; and to is incontinent of bladder iate treatment and services y tract infections and to be to the extent possible.					
	incontinence, bas comprehensive a ensure that a res bowel receives a	r a resident with fecal sed on the resident's assessment, the facility must ident who is incontinent of ppropriate treatment and re as much normal bowel ble.					
	failed to ensure nu	view and interview, the facility rsing staff provided foley	F 06	90	Aperion- Arbors Michigan C	-	10/26/202
	reviewed for cathe	r shift for 1 of 3 residents ters. (Resident T)			POC Comp Exit 09/29/		
	Finding includes:						

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/29/2022 155156 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Compliance Resident T's record was reviewed on 9/19/22 at 10/26/2022 12:05 p.m. Diagnoses included, but were not limited to, neurogenic bladder, pneumonia, renal insufficiency, and multiple sclerosis. F 690 Bowel/Bladder incontinence The Quarterly Minimum Data Set assessment, Cath/UTI dated 9/4/22, indicated the resident was cognitively intact. She required extensive The facility requests paper assistance with bed mobility, transfers, dressing, compliance for this citation. toilet use, and personal hygiene. The resident had an indwelling catheter. This Plan of Correction is the center's credible allegation of A Care Plan, dated 9/24/22, indicated the resident compliance. had an indwelling foley catheter related to neurogenic bladder. Interventions included, but Preparation and/or execution of were not limited to, position catheter bag and this plan of correction does not tubing below the level of the bladder, change constitute admission or agreement catheter as needed, and check tubing for kinks. by the provider of the truth of the facts alleged or conclusions set The Task list for the last 30 days was reviewed. forth in the statement of The task, "Bowel and Bladder - Catheter Care," deficiencies. The plan of was to be completed on every shift. Catheter care correction is prepared and/or was not completed on the following dates and executed solely because it is shifts: required by the provisions of federal and state law. - 8/31/22: Day shift 1) Immediate actions taken for - 9/11/22: Evening and night shift those residents identified: - 9/14/22: Evening shift Resident T's orders were audited to assure that documentation of - 9/16/22: Evening shift catheter care was present on the POC - 9/19/22: Night shift 2) How the facility identified - 9/22/22: Evening shift other residents: - 9/25/22: Night shift All residents that have a catheter have the potential to be affected

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Event ID: 39FZ11

Facility ID: 000076

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OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360		
APERIO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C - 9/27/22: Evening Interview with the 2:15 p.m., indicate to provide.	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	MICHI ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) by this cited practice 3) Measures put into place/ System changes: Licensed Nurses/CNAs have to educated on the need to provid catheter each shift and to prov documentation in the electroni chart 4) How the corrective actions will be monitored: DON/Designee will review documentation at least 5x/wee for 3 months and 3x a week fo months to ensure that catheter care is being rendered per ress plan of care. DON/ Designee w complete observation on at leas one resident weekly at various shifts to ensure catheter care i being completed as per plan o care. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits w be provided to the QA Committee by the DON/Designee and will be reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee	DATE	
					and ise	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155156	A. BUILDING B. WING	00	COMPLETED 09/29/2022
NAME OF 1	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD	
APERIO	N CARE ARBORS	MICHIGAN CITY		E COOLSPRING AVE IGAN CITY, IN 46360	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PBE PRIATE DATE
	RECOLUTION			5) Date of compliance: 10/26/2022	DITE
- 0693	483.25(g)(4)(5)				
SS=D	Tube Feeding Mg	gmt/Restore Eating Skills			
Bldg. 00	· ·	astric and gastrostomy			
		itaneous endoscopic percutaneous endoscopic			
	jejunostomy, and	enteral fluids). Based on a			
		ehensive assessment, the ire that a resident-			
	facility must ensu				
		esident who has been able			
	•	one or with assistance is not thods unless the resident's			
	clinical condition	demonstrates that enteral			
	feeding was clinic consented to by t	cally indicated and			
		esident who is fed by enteral he appropriate treatment			
		estore, if possible, oral			
	-	to prevent complications of			
	-	cluding but not limited to onia, diarrhea, vomiting,			
	dehydration, met	abolic abnormalities, and			
	nasal-pharyngea Based on record re	l ulcers. view and interview, the facility	F 0693		10/26/2022
	failed to ensure ga	strostomy tube (G-tube) care	1 0095	Aperion- Arbors Mic	
	•	ordered related to cleaning, nd flushes for 1 of 3 residents		City	
	reviewed for G-tub			POC Com	plaint
	Finding includes:			Exit 09/29	0/22
		a.m., G-tube care was observed		Compliance	
		h RN 2. There was no dressing c G-tube. There was a moderate		10/26/2022	

	R MEDICARE & MEDI			001/000 100	OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED 09/29/2022	
		155156	B. WING		09/29/2022	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE ARBORS	MICHIGAN CITY		E COOLSPRING AVE IIGAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	amount of dried, b	loody discharge surrounding		F693 Feeding Tube		
	the tube and surrou	unding skin. The RN indicated		Management		
	the evening nurse	was supposed to change the				
	dressing each day.	She further indicated she		This Plan of Correction is the		
	would clean the ar	ea and put a dressing in place.		center's credible allegation of	f	
				compliance.		
	The resident's reco	ord was reviewed on 9/27/22 at				
	10:02 a.m. The re	sident was admitted to the		Preparation and/or execution	of	
	facility on 7/13/21	. Diagnoses included, but was		this plan of correction does n		
	not limited to, her	niparesis and hemiplegia post		constitute admission or agree	ement	
	CVA affecting the	left side, dysphagia (difficulty		by the provider of the truth of	^t the	
	swallowing) and c	ongestive heart failure.		facts alleged or conclusions s		
		-		forth in the statement of		
	The Annual Minin	num Data Set assessment, dated		deficiencies. The plan of		
	6/27/22, indicated	the resident had moderate		correction is prepared and/or		
	cognitive impairm	ent, and required extensive		executed solely because it is		
	assistance of +1 st	aff for bed mobility, transfers		required by the provisions of		
	and toileting.			federal and state law.		
	A Physician's Orde	er, dated 8/3/21, indicated to		1) Immediate actions tak	en	
	cleanse the G-tube	insertion site with normal		for those residents identifie	d:	
	saline, pat dry and	cover with a split gauze and				
	tape daily and as n	eeded if soiled or dislodged.		Resident G had the g-tube		
	Additionally, flush	the G-tube with 60 milliliters of		dressing placed per Physicia	n	
	water every shift.			order.		
	The Treatment Ad	ministration Record (TAR) for		2) How the facility identif	fied	
	September 2022 in	ndicated flushes were not		other residents:		
	-	following shifts and dates:		All residents who have g-tube	es	
	- Night shift: 9/2-9	0/13, 9/15, 9/17, 9/18 and		have the potential to be affect		
	9/22-9/27.			by the cited practice. A facility		
	- Evening shift: 9/	6, 9/8, 9/13, 9/14, 9/15, 9/17, 9/23		audit was conducted to identi		
	and 9/24.			any residents that have g-tub	•	
				and to ensure that all dressin		
	The TAR for Sept	ember 2022 indicated G-tube		were placed per physician's of	•	
	-	leted daily on the following		and documented.		
	shifts and dates:					
		, 9/7, 9/8, 9/11 and 9/26.		3) Measures put into place	ce/	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,- ,,,,,,-,-,-,-,-,-,		System shangaar		

System changes:

FORM CMS-2567(02-99) Previous Versions Obsolete

Interview with the Interim Director of Nursing on

Event ID: 39FZ11

Facility ID: 000076

If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF PROVIDER			1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360		
TAG REGU 9/27/22 spoken not bein flushes	CH DEFICIEN ULATORY OF at 1:55 p.m to the eveni ng complete were not co	STATEMENT OF DEFICIENCIE (CY MUST BE PRECEDED BY FULL <u>& LSC IDENTIFYING INFORMATION</u> , indicated she had already ng nurse regarding treatments d. She was not aware the mpleted as ordered. ates to Complaint IN00390853.	ID PREFIX TAG	 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The nursing staff has been re-educated on following physic orders for treatment related to g-tube site care and application dressings. 4) How the corrective actions will be monitored: Observation audits will be completed at least 3 times a we for 3 weeks at various times by DON/designee to ensure prope placement of dressings per physician's order. Thereafter, observation audits will be conducted randomly at least weekly for 8 weeks to ensure 	of eek	
				dressings are in place. The DO is responsible for oversight. An 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 of until 100% compliance is achieved. The QA Committee v identify any trends or patterns a make recommendations to revis the plan of correction as indicat 5) Date of compliance: 10/26/2022	y II or will and se	

ENTERS FOI	NT OF DEFICIENCIES	Y1) DDOWIDED (SUDDI IED (CLIA	(X2) MULTIPLE C	ONSTRUCTION	(3) DATE SURVEY
		X1) PROVIDER/SUPPLIER/CLIA	· · ·	i de la companya de l	- /
		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
	155156		B. WING		09/29/2022
NAME OF 1	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP COD	
				COOLSPRING AVE	
APERIO	N CARE ARBORS	MICHIGAN CITY	MICHI	GAN CITY, IN 46360	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
⁻ 0695 SS=D		heostomy Care and			
Bldg. 00	tracheostomy ca The facility must needs respiratory tracheostomy ca is provided such professional star comprehensive p the residents' go 483.65 of this su Based on observat interview, the faci	re and tracheal suctioning, care, consistent with dards of practice, the person-centered care plan, als and preferences, and	F 0695	Aperion- Arbors Michigan City POC Complaint Exit 09/29/22	10/26/2022
		tion flow rate for 2 of 3 for respiratory care.		Compliance 10/26/2022 F695 Oxygen The facility requests paper compliance for this citation.	
	1. On 9/28/22 at 11:10 a.m., Resident P was				
		bed with her oxygen nasal		This Plan of Correction is the	
		The oxygen concentrator flow		center's credible allegation of	
	rate was set at 1.5	liters per minute (lpm)		compliance.	
	concentrator settin	g p.m., the resident's oxygen g was observed with the g (DON). She indicated it was		Preparation and/or execution of this plan of correction does not constitute admission or agreeme by the provider of the truth of the facts alleged or conclusions set	ent e
	The resident's reco	ord was reviewed on 9/28/22 at		forth in the statement of	
	12:13 p.m. The re	sident was admitted on 12/8/21.		deficiencies. The plan of	
	Diagnoses include	d, but were not limited to,		correction is prepared and/or	
	chronic obstructiv	e pulmonary disease.		executed solely because it is	
	1		1	required by the provisions of	1

CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> 155156 B. WING			(X3) DATE SURVEY COMPLETED 09/29/2022
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	A Physician's Orderesident was to have continuously. 2. On 9/28/22 at 1 observed seated in oxygen nasal cannuc concentrator flow no on 9/28/22 at 2:20 concentrator setting. She indicated it was the resident's records included chronic obstructive A Physician's Ordereside was to have Interview with the indicated the oxyget the correct settings	r, dated 3/155/22, indicated the re oxygen at 2 lpm 2:54 p.m., Resident R was her wheelchair with her ala in place. The oxygen rate was set at 4 lpm. p.m., the resident's oxygen g was observed with the DON. is set on 4 lpm. rd was reviewed on 9/28/22 at dent was admitted to 8/23/22. d, but were not limited to, pulmonary disease. r, dated 8/23/22, indicated the oxygen at 3 lpm continuously. DON during observations en concentrators were not at		 federal and state law. 1) Immediate actions taken for those residents identified: Resident P's oxygen liter flow was set at the proper per MD order. Resident R's oxyger liter flow was set at the proper 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 or 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 therapy to ensure by the proper of the proper o	or rate n rate en ed der er
				oxygen will be observed to ens the correct liter flow per physic order. Concerns will be immediately addressed with a nurse. Findings will be documented on the Angel Rou Checklist and reviewed during daily (M-F) meetings. The DOI responsible for compliance.	sure cian inds

	NT OF DEFICIENCIES	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUC	TION		1B NO. 0938-039 SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156			A. BUILDING <u>00</u> B. WING			COMPI	LETED 0/2022
	PROVIDER OR SUPPLIE			STREET ADDRESS 1101 E COOL MICHIGAN CI		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PREFIX CROS TAG	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
				will b The r be pr Com DON/ revie Meeti until achie identi make the pl 5) Da	w the corrective action e monitored: esults of these audits of ovided to the QA mittee by the 'Designee and will be wed in Quality Assurance ing monthly for 6 months 100% compliance is ved. The QA Committe fy any trends or patterns recommendations to re an of correction as indice ate of compliance	will ce s or e will s and vise	
⁼ 0697 SS=D Bldg. 00	require such serv professional stan comprehensive p and the residents Based on observati interview, the facil and manage pain for pain for 1 of 3 resid (Resident G) Finding includes: On 9/27/22 at 9:22 care to Resident G left arm was move careful because it was	Management. ensure that pain rovided to residents who ices, consistent with dards of practice, the erson-centered care plan, d goals and preferences. on, record review and ity failed to accurately assess or a resident with a history of dents reviewed for pain. a.m., RN 2 was observed giving while he was in bed. When his d, the resident indicated to be was painful to move. The use had pain in his joints all the	F 069	F697 This I cente comp Prepa	Aperion- Arbors gan City POC Compla Exit 09/29/2 Compliance 11/08 - Pain Management Plan of Correction is the rr's credible allegation of liance. aration and/or execution lan of correction does n	aint 2 8/20 of	10/27/202

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE (A. BUILDING B. WING	construction	(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIE		1101 8	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E COMPLETION DATE
IAU		a.m., the resident was observed	IAU	constitute admission or agreem	
		ager. He was seated in bed		by the provider of the truth of th	
		Ie indicated he was having the		facts alleged or conclusions set	
	-	bints. He rated the pain 8 out of		forth in the statement of	
		e had told the nurse and		deficiencies. The plan of	
	thought he had rec			correction is prepared and/or	
		1 1		executed solely because it is	
	The resident's reco	ord was reviewed on 9/27/22 at		required by the provisions of	
		sident was admitted to the		federal and state law.	
		. Diagnoses included, but was			
		niperisis and hemiplegia post		1) Immediate actions taken fo	r
		e left side, dysphagia (difficulty		those residents identified:	
	-	ongestive heart failure.		Resident G was assessed for p	ain
	6)	8		and pain medication order	
	The Annual Minin	num Data Set assessment, dated		reviewed with MD.	
		the resident had moderate		2) How the facility identified	
		ent, and required extensive		other residents:	
		aff for bed mobility, transfers			
		ad pain frequently that he rated		All residents requiring pain	
	6 out of 10.			medication have the potential to	n
				be affected by the cited practice	
	A Physician's Ord	er, dated 5/4/22, indicated to		All residents that receive routin	
	assess pain every s			and PRN pain medications wer	
	1 5			assessed and orders reviewed	
	A Pain Care Plan,	dated 7/14/21, indicated the		ensure that the cited practice	
		tial for pain related to left		does not re-occur.	
	-	ictures to left wrist and hand.			
		ided to administer analgesia as		3) Measures put into place/	
		ve one half hour before		System changes:	
	-	Another intervention was to			
	monitor and record	d pain characteristics.		Nursing staff have been	
				re-educated on pain assessme	nt
	The September 20	22 Medication and Treatment		and the use of the pain scale,	
	-	cord indicated the resident's		verbal and non-verbal cues for	
	pain was 0 out of	10 on every shift of every day.		pain, documenting pain	
	The resident had n	ot received any as needed		medication effectiveness and	
	Tylenol during Se	ptember.		notification of the MD/NP of any	y
				unresolved pain. Licensed nurs	
	During an intervie	w with the Unit Manager on		and QMAs were also re-educat	
		esident observation, she		on reordering pain medication f	rom

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Event ID:

39FZ11

Facility ID: 000076

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING				· · · · · · · · · · · · · · · · · · ·	3) DATE SURVEY COMPLETED 09/29/2022
	PROVIDER OR SUPPLIEI N CARE ARBORS		1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC
TAG	indicated the Nurse and she would ask possibly get someth	Practitioner was here today her to see the resident and hing else for pain.	TAG	pharmacy, use of the back-up pharmacy, and use of the EDK f emergency medication.	or DATE
	This Federal tag rel and IN00386509.	ates to Complaints IN00384837		4) How the corrective actions will be monitored:	
	3.1-37(a)			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 period of 6 weeks and 3 times a week for the next 6 months Facility will observe 5 residents days a week for 6 weeks and the 3 residents five days for 6 weeks to ask or observe for sig and symptoms of pain and that the pain is being addressed by t IDT. Any identified concerns will be promptly addressed with the responsible individual(s).	r a 5 en ns
				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	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,	CONSTRUCTION	· · ·	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155156	A. BUILDING <u>00</u> B. WING		COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIE N CARE ARBORS		1101	T ADDRESS, CITY, STATE, ZIP CO E COOLSPRING AVE IIGAN CITY, IN 46360		(X5)
PREFIX TAG	(EACH DEFICIE	R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDERS PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) indicated.	IOULD BE	COMPLETION DATE
= 0757 SS=D Bldg. 00	Drugs §483.45(d) Unne Each resident's of from unnecessar drug is any drug §483.45(d)(1) In duplicate drug th §483.45(d)(2) Fo §483.45(d)(2) Fo §483.45(d)(3) Wi or §483.45(d)(3) Wi or §483.45(d)(4) Wi for its use; or §483.45(d)(5) In consequences w should be reduce §483.45(d)(6) An reasons stated in (5) of this section Based on record re failed to ensure a r unnecessary media administering insu residents reviewed Finding includes: Record Review fo 9/29/22 at 11:36 a	excessive dose (including erapy); or r excessive duration; or thout adequate monitoring; thout adequate indications the presence of adverse hich indicate the dose ed or discontinued; or y combinations of the paragraphs (d)(1) through	F 0757	Exit 0	Complaint 9/29/22 Complia	10/26/2022

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL OF CORRECTION IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING	(X3) DATE SURVEY COMPLETED
	155156		- 09/29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CO 1101 E COOLSPRING AVE	OD
APERIO	N CARE ARBORS MICHIGAN CITY	MICHIGAN CITY, IN 46360	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORI	RECTION (X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY F	L PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DN TAG DEFICIENCY)	OULD BE COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMA		DITLE
	hypertension, and end stage renal disease.	This Plan of Correction	
		center's credible allega	tion of
	The Quarterly Minimum Data Set (MDS)	compliance.	
	assessment, dated 8/24/22, indicated the reside		
	was cognitively intact. The resident had receiv	,	
	insulin.	this plan of correction of	
		constitute admission or	-
	A Care Plan, dated 5/13/22, indicated the resid		
	had diabetes mellitus and was insulin depender An intervention included for diabetes medication	facts alleged or conclus forth in the statement o	
	as ordered by the doctor.		
	as ordered by the doctor.	deficiencies. The plan correction is prepared a	
	The September 2022 Physician's Order Summa		
	(POS) indicated an order for Lantus (insulin)	required by the provision	
	Solution. Inject 17 units at bedtime.	federal and state law.	
	The September 2022 Medication Administrator	1) Immediate actions t	aken for
	Record (MAR) indicated the insulin was not	those residents identi	fied:
	documented as administered on the following t		
	and dates:	were reviewed and Lice	
	8:00 p.m.: 9/17, 9/19, 9/21, 9/23, and 9/27/22	Nursing staff in-service	d on the
		correct orders.	
	Interview with the Assistant Director of Nursin 0/20/22 at 2:25 mm in director of the second during		
	on 9/29/22 at 2:25 p.m., indicated they could n find any documentation the insulin was	0) Have the featility later	atified
	administered on the above time and dates.	2) How the facility ide other residents:	
	administered on the above time and dates.	All residents that are	
	This Federal tag relates to Complaint IN00389		are at
	This reactar agreeaces to complaint involses	risk for the cited pract	
	3.1-48(a)(6)	therefore, all residents	-
		facility have the poten	
		affected.	
		3) Measures put into p	blace/
		System changes:	
		Licensed nurses and	
		have been re-educated	
		to medication adminis	
		including but not limit	
		ensuring that medicat	ions are

39FZ11 Facility ID: 000076

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	A. BUILDING <u>00</u> COMPI		(X3) DATE SURVEY COMPLETED 09/29/2022
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP CO COOLSPRING AVE GAN CITY, IN 46360	D
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5) ULD BE COMPLETIC PROPRIATE DATE
				administered per physi orders, and documente according to facility po and procedures.	ed
				4) How the corrective a will be monitored: The DON/Designee will the MARS daily 5 days for 4 weeks, then 2 day week for 4 weeks, then for 4 weeks to ensure p documentation relating medication administrat identified concerns will promptly addressed will responsible individual The results of these au be provided to the QA Committee by the DON/Designee and will reviewed in Quality As Meeting monthly x6 mo until an average of 90% compliance or greater achieved x3 consecutive months. The QA Commit will identify any trends	I review a week ys a weekly proper g to tion. Any I be ith the (s). I be surance onths or 6 is ve mittee
				patterns and make recommendations to re plan of correction as ir 5) Date of compliance: 10/26/2022	ndicated.
0791 SS=D 3ldg. 00	483.55(b)(1)-(5) Routine/Emerger §483.55 Dental S	ncy Dental Srvcs in NFs Services			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/29/2022 155156 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 39FZ11 Facility ID: 000076 Page 35 of 48 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

11/16/2022

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING			(X3) DATE SURVEY COMPLETED 09/29/2022	
JAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD					
	PERION CARE ARBORS MICHIGAN CITY				COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	reimbursement o	f dental services as an					
	incurred medical	expense under the State					
	plan.						
		ion, record review, and	F 07	791	Aperion- Arbors Michigan City	10/26/2022	
		lity failed to ensure a resident					
	received routine and/ or emergency dental				POC Complain	it	
	services related to heavy debris build up and						
	broken teeth for 1			Exit 09/29/22			
	dental services. (Resident G) Finding includes:						
					Compliance		
					11/08/2022		
	On 9/27/22 at 9:22	a.m., Resident G was observed			F-791 Routine Dental services		
	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				The facility requests paper		
	teeth.				compliance for this citation.		
	On 9/29/22 at 8:52	a.m., the resident was observed			This Plan of Correction is the		
	with the Interim D	irector of Nursing (DON) and			center's credible allegation of		
		heavy build up of debris on his			compliance.		
		oken tooth observed. He					
		me that no one helped him			Preparation and/or execution of		
	brush his teeth and	he did not have a toothbrush.			this plan of correction does not		
				constitute admission or agreem			
	The resident's record was reviewed on $9/27/22$ at				by the provider of the truth of th		
		sident was admitted to the			facts alleged or conclusions set	r	
		. Diagnoses included, but were			forth in the statement of		
		niparesis and hemiplegia post left side, dysphagia (difficulty			deficiencies. The plan of		
	-	ongestive heart failure.			correction is prepared and/or		
	swanowing) and c	ongestive heart failure.			executed solely because it is required by the provisions of		
	The Annual Minin	num Data Set assessment, dated			federal and state law.		
		the resident had moderate					
		ent, and required extensive			1) Immediate actions take	n	
		aff for bed mobility, transfers,			for those residents identified:		
	toileting and perso	-			Resident G was provided with a	a	
	A Dental Care Pla	n, dated 7/14/21, indicated the			new toothbrush and assistance with oral hygiene. Resident G		
		tial for oral/dental problems			been scheduled to see the den		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/29/2022
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C related to dementia Interventions inclu consult, discuss or and provide the an oral care each shift Interview with the a.m., indicated res dentist if they com family requested th a CNA to get the r indicated they woo consent for a denta	Interim DON, on 9/29/22 at 8:52 idents would be referred to the plained of mouth pain or the hey see a dentist. She instructed esident a toothbrush. She ild contact the family to get	ID PREFIX TAG	 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) 2) How the facility identified other residents: All residents who reside in th facility have the potential to affected. Dental consents w reviewed for all residents. If resident/POA elected not to services Social Services pro- education on electing denta services at any time. 3) Measures put into pl System changes: Social Service and Nursing managers have been re-edu regarding follow up of ancilla Consents with care plans 	he DATE DATE
				 quarterly/annually and chan status. 4) How the corrective actions will be monitored: Upon Admission and quarterly a Dental assessm will be completed on all resident to ensure that all dental needs are being me Resident/POA will be educt on any negative findings. All care plans will be review quarterly to ensure documer on offering ancillary services including dental. Any identi concerns will be promptly addressed with the responsible for overs these audits. 	nent t. ated ed ntation s fied sible

PRINTED: 11/16/2022

	R MEDICARE & MEDI					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 09/29/2022	
	PROVIDER OR SUPPLIE		110 ⁻	ET ADDRESS, CITY, STATE, ZIP CO 1 E COOLSPRING AVE HIGAN CITY, IN 46360	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE	
				The results of these au be provided to the QA Committee by the ED/I and will be reviewed in Assurance Meeting mon months or until 100% cd is achieved. The QA C will identify any trends of and make recommenda revise the plan of correct indicated.	Designee a Quality nthly for 6 ompliance ommittee or patterns ations to		
- 0804 SS=E Bldg. 00	Temp §483.60(d) Food Each resident rec provides- §483.60(d)(1) Fo conserve nutritive appearance; §483.60(d)(2) Fo palatable, attracti appetizing tempe Based on observat failed to ensure foo was received hot for had the potential to resided on that uni Finding includes: On 9/27/22 at 1:06 obtained from the The Dietary Mana; obtain the followir	perives and the facility bod prepared by methods that a value, flavor, and bod and drink that is we, and at a safe and rature. on and interview, the facility bod served to resident rooms for 1 of 2 units observed. This to affect 34 residents who t. (400 unit) p.m., a test lunch tray was serving cart on the 400 unit. ger use a food thermometer to g food temperatures:	F 0804		omplaint 0/29/22 <i>is the</i>	10/26/2022	
	- diced potatoes: 1 - ham slice: 105.6	-		Preparation and/or exec	cution of		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/29/2022 155156 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE - cooked greens: 122 degrees this plan of correction does not constitute admission or agreement The ham slice was sampled and noted to be luke by the provider of the truth of the warm to cold. facts alleged or conclusions set forth in the statement of Interview with the Dietary Manager at that time, deficiencies. The plan of indicated ideally she would like food to be 140 correction is prepared and/or degrees when served to residents, but 125 executed solely because it is degrees was acceptable. She indicated 105.6 was required by the provisions of too cold. They did not have heated serving carts federal and state law. or the bottom portion of the plate/ lid combination used to help keep food warm, only the lids. 1) Immediate actions taken for those residents identified: This Federal tag is related to Complaints IN00384837 and IN00389455. Food was heated to acceptable temperature. 3.1-21(a)(2) 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 39FZ11 Facility ID: 000076 If continuation sheet Page 39 of 48

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	СОМ	e survey pleted 9/2022
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP CO COOLSPRING AVE GAN CITY, IN 46360	DD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE PPROPRIATE	(X5) COMPLETION DATE
				temperatures. Any ider concerns will be prom addressed with the res individual(s).	ptly	
				The results of these au be provided to the QA Committee by the Diet Manager/Designee and reviewed in Quality As Meeting monthly x6 m until an average of 90 compliance or greater achieved x3 consecuti months. The QA Com will identify any trends patterns and make recommendations to r plan of correction as in	ary d will be sourance onths or % is ve mittee s or evise the ndicated.	
⁼ 0880 SS=D Bldg. 00	infection preventi designed to provi comfortable envir the development communicable di §483.80(a) Infect program. The facility must prevention and co	ion & Control		10/26/2022		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/29/2022	
NAME OF P	ROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD		
APERION	I CARE ARBORS	MICHIGAN CITY		COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETIO
TAG		DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	identifying, report controlling infection diseases for all mini- visitors, and other services under an based upon the for conducted accord following accepted §483.80(a)(2) Wi and procedures for include, but are mini- (i) A system of su- identify possible infections before persons in the far (ii) When and to communicable dible reported; (iii) Standard and precautions to be of infections; (iv)When and ho for a resident; ind (A) The type and depending upon organism involved (B) A requirement the least restriction (v) The circumstar must prohibit emi- communicable di lesions from direct their food, if direct disease; and	urveillance designed to communicable diseases or they can spread to other cility; whom possible incidents of isease or infections should d transmission-based e followed to prevent spread w isolation should be used cluding but not limited to: duration of the isolation, the infectious agent or ed, and at that the isolation should be we possible for the resident stances. ances under which the facility				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155156	A. BUILI B. WING	DING	<u>00</u>	3) DATE SU COMPLET 09/29/20	ſED
	PROVIDER OR SUPPLI		1	1101 E	DDRESS, CITY, STATE, ZIP COD COOLSPRING AVE AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE SNCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
	incidents identifia and the corrective facility. §483.80(e) Liner Personnel must transport linens of infection. §483.80(f) Annue The facility will c its IPCP and upon necessary. Based on random record review, the infection control g implemented, incl contain COVID-1 protective equipm (Room 416, LPN Findings include: 1. During a rando a.m., LPN 1 enter resident. The LPI mask. At that time indicated "Drople Personal Protective gloves to both har also a PPE bin loc Interview with LF indicated the resid precautions. She	handle, store, process, and so as to prevent the spread al review. onduct an annual review of date their program, as observations, interviews, and facility failed to ensure guidelines were in place and uding those to prevent and/or 9 related to the use of personal ent (PPE) in an isolation room.	F 0880	0	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	ent	10/26/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	X3) DATE SURVEY COMPLETED 09/29/2022
NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY			1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C 2. During a rando 10:01 a.m., CNA with the resident. surgical mask. Interview with CN indicated she saw isolation and the F unsure if the resid further indicated if room, she would j surgical mask up b resident was in "R COVID-19, then s "extra PPE." An updated and cu "INFECTION CO policy", and receiv on 9/28/22, indica or Red Zone room precautions, staff N95, eye protection	⁷ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION m observation on 9/28/22 at l entered the same room to speak The CNA was only wearing a IA 1 on 9/28/22 at 10:04 a.m., the sign on the door related to PE bin at the doorway but was ent was on isolation. She f they were in a "Yellow Zone" ust make sure she pulled her before entering the room. If the ed Zone" or was positive for hould would put on all of the urrent facility policy titled, NTROL - Interim COVID-19 ved from the Nurse Consultant ted, "If entering a Yellow zone under transmission-based must wear FULL PPE, including n, gown and gloves" elates to Complaint IN00389455.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) 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 isola precautions. 2) How the facility identified other residents: All residents have the potentia 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 r cause analysis and Infection Control Self-Assessment with the Corporate Infection Control Preventionist. Reviewed finding and developed action plan and education materials based on findings. Staff will be re-educated regard spread of infections as is relate to infection control policies.	r tion l to e. root he js

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155156	(X2) MULTIPI A. BUILDIN B. WING	le construction ig <u>00</u>	СОМ	'E SURVEY PLETED 19/2022
	PROVIDER OR SUPPLIE		110	EET ADDRESS, CITY, STATE, ZIP CO D1 E COOLSPRING AVE CHIGAN CITY, IN 46360	DD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETION DATE
				 will be monitored: The Director of Nursing designee will (See Action the recommended monitor of the results of these and be reviewed in Quality Assurance Meeting models for a compliance or grant achieved x3 consecution months. The QA Commulation will identify any trends patterns and make recommendations to right of correction as in 5) Date of compliance 10/26/2022 	on Plan for itoring) udits will onthly for verage of eater is ive mittee s or evise the ndicated.	
F 0921 SS=F Bldg. 00	§483.90(i) Other The facility must sanitary, and con residents, staff ar Based on observati failed to ensure the clean and in good a discolored floors, or rooms with cracked furniture, and a lea	Sanitary/Comfortable Environ Environmental Conditions provide a safe, functional, afortable environment for ad the public. on and interview, the facility residents' environment was epair related to dirty and liscolored walls, dirty shower d and broken tiles, broken king toilet for 4 of 4 units. (100 0 Unit, and 400 Unit)	F 0921		/lichigan complaint 0/29/22	10/26/2022

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	COMPLETED 09/29/2022
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD E COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO
TAG	× ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	Findings include:			Compliance	
	During the Environ 9:24 a.m., through	nmental Tour on 9/27/22, from 10:21 a.m., with the etor, the following was		10/26/2022 F-921 Safe/Functional/Sanitary/Comf ortable Environment	
	1. 100 Unit			This Plan of Correction is the center's credible allegation of	
	The floor was dirty the heating/cooling heating/cooling un discolorations. The noise and had a pub base on the floor. room. b. Assisted Dining brown/orange disc on the heating/cool the baseboard was room. There was a the windows. The multiple pieces of	room door panel was coming off. with debris and black mars by g unit. The wall next to the it had brown/orange e toilet was making a running ddle of water all around the Two residents resided in the Room: There was a oloration all over the walls and ling units. A large portion of missing in the corner of the a large gouge on the wall below floor had black gouges and the flooring was missing. The ming off. Fourteen residents		 compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreemed 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: 	ent e
	ate in the dining ro	-		All the identified concerns below were corrected:	
		The ceiling in one of the shower down and had dark marks on it.		On the units 100 Hallway	
	2. 200 Unit			a. Room 124: The room door pa was coming off. The floor was d with debris and black mars by th	irty
	a. Room 227: The	floor was dirty with debris.		heating/cooling unit. The wall ne	
	Two resident resid			to the heating/cooling unit had brown/orange discolorations. Th	
	b. Room 232: The	floor was dirty with debris. The		toilet was making a running nois	
		oom entrance was pulled away		and had a puddle of water all	
	from the wall. Tw	o residents resided in the room.		around the base on the floor. Tw residents resided in the room. b	

	R MEDICARE & MEDI	-	VO MUT	TIDLE CONSTRUCTION		IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155156	(X2) MUL A. BUIL B. WINC	<u></u>	(X3) DATE COMPI 09/29	LETED
NAME OF I	PROVIDER OR SUPPLI	FD		STREET ADDRESS, CITY, STATE, 2	ZIP COD	
		MICHIGAN CITY		1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360		
	1					(375)
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF REFIX (EACH CORRECTIVE ACTIVE	F CORRECTION	(X5) COMPLETION
PREFIX TAG	-	ENCY MUST BE PRECEDED BY FULL		REFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO TAG DEFICIENCE		
IAG		OR LSC IDENTIFYING INFORMATION Tiles were chipped on the walls		into		DATE
		loors were dirty with built up		Assisted Dining Ro		
		er curtain rods were rusted and		a brown/orange dis		
		er curtain rods were rusted and				
	chipped.			heating/cooling uni		
	2 200 Linit			portion of the base		
	3. 300 Unit			missing in the corn		
	a Shower Dear	Tilos wars abinned on the wells		There was a large		
		Tiles were chipped on the walls		wall below the wind		
		was a large hole of broken tile bathroom. The floors were		had black gouges a		
				pieces of the floorin		
		debris. The shower curtain		The door panel was	-	
	rods were rusted a	and empped.		Fourteen residents		
	1. A stimite Deserve	A shell had beet to be an and aff		dining room. c. Sho		
	-	: A chair had duct tape on one of		ceiling in one of the		
		r arm had a large piece gouged		was bowing down a	and had dark	
		A table with a rubber gasket that		marks on it.		
		base was on the floor hanging				
		l not in place. The walls had		200 Hallway:	9	
	dark mars through	iout the room.		a. Room 227: The t	-	
	4 400 11			with debris. Two re		
	4. 400 Unit:			in the room. b. Roo		
	- D 412. Th	fleen and the with debaie. One		floor was dirty with		
	a. Room 412: 11 resident resided in	e floor was dirty with debris. One		baseboard by the r		
	resident resided in	i the room.		was pulled away fro		
	h Charry D.	Tilog war aking a such such		Two residents resid		
		Tiles were chipped on the walls		c. Shower Room: T		
		loors were dirty with built up		chipped on the wal		
		er curtain rods were rusted and		The floors were dir		
		amount of dust buildup on the		debris. The shower		
	sprinklers and ver	its on the centing.		were rusted and ch	ippea.	
	Interview with Ho	ousekeeping 1 on 9/27/22 at 10:09		300-Hallway		
		e was responsible for cleaning		3. 300 Unit a. Shov	ver Room: Tiles	
		Jnits. She had to clean the		were chipped on th		
		nower rooms, and common areas.		floors. There was a		
		r housekeeper there that was		broken tile on the w	-	
		e 100 and 200 Units. She		bathroom. The floo	-	
	-	lld try to get all areas cleaned		with built up debris	•	
	1					
	every day before	her shift was over, but it was		curtain rods were r	usted and	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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If continuation sheet

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Facility ID: 000076

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	X3) DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360	09/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C everything with ju Interview with the 9/27/22 at 10:21 a have a Housekeep indicated all of the or repair. This Federal tag re	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION st 2 housekeepers. Maintenance Director on .m., indicated the facility did not ing Supervisor currently. He e above was in need of cleaning elates to Complaints IN00384837, 0389455, IN00390581, and	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) had duct tape on one of the arr 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 flo hanging from the table and not place. The walls had dark mars throughout the room 400- Hallway a. Room 412: The floor was dir with debris. One resident reside in the room. b. Shower Room: Tiles were chipped on the walls and floors. The floors were dirty with built up debris. The showe curtain rods were rusted and chipped. A large amount of dus buildup on the sprinklers and ve 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 Directo and Housekeeping staff when environment needs to be repaired and/or cleaned. 4)How the corrective actions will be monitored: The Administrator/designe will monitor corrective actions & will ensure sustained compliance; Completing rounds 5 days a week to ensure	e s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

39FZ11 Facility ID: 000076

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2022
	ROVIDER OR SUPPLIE		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				the facility is a safe, comfortable, and sanitary environment.Any identified concerns will be promptly addressed with the respons individual(s). The results of these audits be provided to the QA Committee by the ED/Desig and will be reviewed in Qua Assurance Meeting monthly months or until an average 90% compliance or greater achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indica 5) Date of compliance: 10/26/2022	sible will nee hity y x6 of is e the

11 Facility ID: 000076

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