STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	12/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00384837, IN00385579, IN00386509, IN00389455, IN00390581, IN00390853, and IN00391322 completed on 9/29/22. This visit was done in conjunction with the Investigation of Complaints IN00391437, IN00393256, IN00393399, IN00393607, IN00394878 and IN00395083. This visit resulted in a Partially Extended Survey - Immediate Jeopardy. Complaint IN00384837 - Not Corrected. Complaint IN00385579 - Corrected. Complaint IN00386509 - Not Corrected. Complaint IN00389455 - Not Corrected. Complaint IN00390581 - Corrected. Complaint IN00390853 - Not Corrected. Complaint IN00391322 - Not Corrected. Complaint IN00391437 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F757. Complaint IN00393256 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F677, F686 and F757. Complaint IN00393399 - Unsubstantiated due to lack of evidence.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristina Herrera	Executive Director	12/17/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Complaint IN00393607 - Unsubstantiated due to lack of evidence. Complaint IN00394878 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00395083 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600. Survey dates: November 29, 30, and December 1, 2022. Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 125 Total: 125 Census Payor Type: Medicare: 6 Medicaid: 82 Other: 37 Total: 125 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/5/22.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and	F 0677	Aperion- Arbors Michigan City	12/23/2022

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	interview, the facility failed to provide ADL (activities of daily living) assistance to a dependent resident related to completing scheduled showers for 1 of 3 residents reviewed for ADL care. (Resident E) Finding includes: Resident E's record was reviewed on 11/29/22 at 1:37 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus, anxiety disorder, psychotic disorder, kidney failure, high blood pressure, chronic obstructive pulmonary disease, and heart disease. The Discharge Minimum Data Set assessment, dated 11/18/22, indicated her cognitive patterns had not been assessed. She required supervision for activities of daily living (ADLs) including bed mobility, transfer, walk in room, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene, and bathing. An ADL Care Plan, dated 8/24/22, indicated the resident needed assistance due to impaired mobility related to heart failure. Interventions included, but were not limited to, the resident required limited to total assist with 1-2 staff for bathing/showering. The CNA Task List indicated the resident preferred bathing on Tuesday and Friday during the day. The November 2022 Tasks record and shower sheets indicated the resident did not receive a shower or bed bath on the following dates: 11/8/22, 11/11/22, 11/15/22, and 11/22/22. Interview with the Director of Nursing and		PSR to 9/29/22 Complaint Exit 12/1/2022 Compliance 12/23/2022 F 677 ADL Dependent Residents *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident E was offered and given a shower at the time of survey. **2) How the facility identified other residents:** The facility completed an audit to identify any dependent residents needing grooming and personal hygiene. The facility staff provided showers, grooming, and personal care as needed. **3) Measures put into place/ System changes:** Facility staff was in-serviced on ADL Care Provided for Dependent	

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	Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. This deficiency was cited on 9/29/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-38(a)(2)(A)		Residents, including but not limited to, providing ADL care for residents unable to carry out activities of daily living and to ensure that residents receive showers, grooming, and hygiene. Education also provided on the POC system and how to document ADL care. **4) How the corrective actions will be monitored:** DON/designee will review the shower audit report for all residents at least twice weekly x30 days, then at least once weekly x60 days, then at least monthly thereafter to ensure showers are documented as scheduled. Any identified concerns will be promptly addressed with responsible individual(s). Additionally, DON/Designee will randomly interview at least 5 residents per week for 90 days, to validate showers are being received, any resident who verbalizes not receiving showers, per schedule, will be offered a shower or bed bath, with DON/Designee validation of provision of the same. Thereafter, 5 resident interviews per month will be conducted for 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be	

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			provided to the QA Committee by the DON/Designee and will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 2 of 3 residents reviewed for pressure ulcers. (Residents L and D) Findings include: 1. During an interview on 11/30/22 at 8:50 a.m.,	F 0686	Aperion- Arbors Michigan City PSR to 9/29/22 Complaint Exit 12/1/2022 Compliance 12/23/2022 F-686 Treatment /Svcs *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	12/23/2022

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	Resident L indicated his pressure ulcer treatments were not always done on the weekends. The record for Resident L was reviewed on 11/30/22 at 9:00 a.m. The resident was admitted on 4/22/22. Diagnoses included, but were not limited to, acute kidney failure, morbid obesity, paraplegia, pressure ulcer, right leg amputation, heart failure, major depressive disorder, G- tube, and colostomy. The 10/12/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident had pressure ulcers. A Care Plan, updated 10/12/22, indicated the resident had a pressure ulcer present to the sacrum, left ischium, left lateral foot, and right ischium due to at history of ulcers, immobility, and paraplegic. The approaches were to administer treatments as ordered and assess for effectiveness. Physician's Orders, dated 10/23/22, indicated Calcium Alginate-Silver Pad 4.25, apply to sacrum, right ischial, left posterior leg, left lateral foot, and left ischial topically one time a day for wound care. Cleanse with normal saline, pat dry, apply calcium alginate with silver to wound bed, super absorbent pad and cover with dry dressing. The Treatment Administration Record for 11/2022, indicated the treatments were not signed out as being completed on 11/10, 11/12, 11/13, 11/16, 11/17, 11/18, 11/23 and 11/27/22. Interview with the Wound Nurse on 11/30/22 at 2:30 p.m., indicated she was in the facility on 11/16 and 11/17/22 and completed his treatments. She		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. Resident L's dressings were observed at the time of facility notification to identify if ordered treatments had been applied according to physician orders. Dressings were applied, as necessary. 2. Resident D no longer resides in the facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** Residents with pressure ulcers, and ordered treatments, have the potential to be affected by the cited practice. **3) Measures put into place/ System changes:** A. Licensed nurses have been in serviced relative to Treatment/Svcs to Prevent/Heal Pressure Ulcer, including but not limited to, the importance of ensuring physician ordered treatments are applied, and application of treatments is	

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	had forgotten to sign the treatments out as being completed. Interview with the Executive Director on 12/1/22 at 9:52 a.m., indicated she had spoken with the staff who worked on the above days and they told her they had completed the pressure ulcer treatments, but did not document. The ED had staff sign the treatment record on 11/23 and 11/27/22 for all the treatments being completed. Interview with the Director of Nursing on 12/1/22 at 2:00 p.m., indicated the pressure ulcer treatments were to be completed as ordered by the Physician.2. Resident D's closed record was reviewed on 11/30/22 at 2:05 p.m. Diagnoses included, but were not limited to, cutaneous abscess of abdominal wall, sepsis, chronic obstructive pulmonary disease, major depressive disorder, anxiety, heart failure, and heart disease. The Admission Minimum Data Set (MDS) assessment, dated 10/25/22, indicated the resident was cognitively intact for daily decision making. The resident had 1 stage 2 pressure ulcer that was present upon admission, and 2 stage 3 pressure ulcers that were present upon admission. A Physician's Order, dated 10/24/22 at 8:00 a.m., indicated apply kerlix to right lower leg as preventative one time a day every Monday, Wednesday, and Friday for wound care. The November 2022 Treatment Administration Record (TAR), indicated the kerlix to the right lower leg was not signed out as being completed and was blank on 11/11/22 and 11/16/22. A Physician's Order, dated 11/22/22 at 12:06 p.m., indicated calcium alginate silver pad 4, apply to		signed out on the eTAR upon completion. B. A QA tool has been updated and implemented to validate compliance. **4) How the corrective actions will be monitored:** DON/designee will review the TAR audit report at least 3 times per week x 30 days, then at least twice weekly x 30 days and at least once weekly thereafter to ensure treatments were completed as ordered. Any identified concerns will be promptly addressed with the responsible individual(s). Visual observations of wound dressings will be completed on at least 10 residents per week receiving wound treatments x 30 days, then at least 5 residents per week x 30 days, then at least 5 residents monthly thereafter to ensure dressing changes are completed as ordered. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be provided to the QA Committee by the DON/Designee and will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA	

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	right lateral lower leg topically one time a day. The November 2022 TAR indicated the calcium alginate treatment to the right lateral lower leg was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. A Physician's Order, dated 10/22/22 at 8:00 a.m., indicated calcium alginate silver pad 4 apply to sacrum topically one time a day. The November 2022 TAR indicated the calcium alginate treatment to the sacrum was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. A Physician's Order, dated 10/22/22 at 8:00 a.m., indicated Curity Iodoform Packing Strip miscellaneous (gauze pads and dressings) apply to left ischial topically one time a day for wound care, cleanse with normal saline, pat dry, apply iodoform packing strip to wound bed and cover with dry dressing. The November 2022 TAR indicated the iodoform packing treatment to the left ischial was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. A Physician's Order, dated 10/22/22 at 8:00 a.m., indicated Curity Iodoform Packing Strip Miscellaneous (gauze pads and dressings), apply to right ischial topically one time a day for wound care Cleanse with normal saline, pat dry, and apply iodoform packing strips to wound bed and cover with dry dressing.		Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	The November 2022 TAR indicated the Iodoform packing treatment to the right ischial was not signed out as being completed and was blank was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. A Physician's Order, dated 10/27/22 at 8:00 a.m., indicated Santyl ointment 250 unit/gram apply to right lower posterior leg topically one time a day for wound care, cleanse with normal saline, pat dry, apply Santyl to wound bed and cover with dry dressing. The November 2022 TAR indicated the Santyl ointment to the right lower posterior leg was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. Interview with the Wound Nurse on 12/1/22 at 11:27 a.m., indicated the resident went out to the wound clinic on Tuesday and Friday each week, but it was not noted in the chart. She indicated on 11/9/22, she must have been rushing and did not sign out the treatment on the TAR. This deficiency was cited on 9/29/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-40(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review and interview, the facility failed to ensure gastrostomy tube (G-tube) water flushes were completed as ordered by the Physician for 1 of 3 residents reviewed for G-tubes. (Resident L) Finding includes: On 11/30/22 AT 9:30 a.m., Resident L was observed lying in bed. At that time, LPN 1 pulled up his gown so his G-tube site could be assessed. There was a split gauze bandage around the stoma with a date of 11/30/22. The record for Resident L was reviewed on 11/30/22 at 9:00 a.m. The resident was admitted on 4/22/22. Diagnoses included, but were not limited to, acute kidney failure, morbid obesity, paraplegia, pressure ulcer, right leg amputation,	F 0693	Aperion- Arbors Michigan City PSR to 9/29/22 Complaint Exit 12/1/2022 Compliance 12/23/2022 F693 – Tube Feeding Management/Restore Eating Skills *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*	12/23/2022

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	heart failure, major depressive disorder, G- tube, and colostomy. The 10/12/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and had a G-tube. A Care Plan, updated 10/12/22, indicated the resident had a G-tube used for water flushes only. Physician's Orders, on the current 11/2022 Physician Order Summary, indicated there were no orders for the G-tube water flushes. Interview with the Director of Nursing (DON) on 12/1/22 at 2:00 p.m., indicated there was no order for the G-tube water flushes. The G-tube should be flushed daily for patency. This deficiency was cited on 9/29/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-44(a)(2)		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Please note that although a specific water flush order was not present, per facility policy, Resident L was receiving enteral tube water flushes prior to medication administration, between medications, and after medication administration. An order was obtained for routine enteral tube water flushes. **2) How the facility identified other residents:** Residents with enteral tubes have the potential to be affected by the cited practice; thus, this plan of correction applies to residents with enteral tubes. **3) Measures put into place/ System changes:** Licensed nurses have been re-educated relative to Tube Feeding Mgmt/Restore Eating Skills, including but not limited to, ensuring that all residents with enteral tubes have routine water flush orders and that flushes are administered according to physician order. **4) How the corrective actions will be monitored:**	

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			DON/Designee will review the eMARs/eTARs and enteral orders of 5 residents with enteral tubes per week for 30 days to validate documentation of water flushes. Thereafter, the eMARs/eTARs and enteral orders will be reviewed twice weekly for 30 days to validate documentation of water flushes, and then weekly for 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). Additionally, all new admissions with G-tube will be reviewed to ensure enteral feeding and flush orders are in place within 24 hours of admission, ongoing. Any identified concerns will be promptly addressed with responsible individual(s). The results of these audits will be provided to the QA Committee by the DON/Designee and will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate, the humidification bottle was dated, and orders for oxygen were obtained for 2 of 3 residents reviewed for oxygen. (Residents K and G) Findings include: 1. On 11/29/22 at 1:14 p.m., Resident K was observed in her room in bed. The resident was wearing oxygen by the way of a nasal cannula. The oxygen concentrator was set at 4.5 liters. On 11/30/22 at 10:21 a.m., 11:24 a.m., and 2:10 p.m., the resident remained in her room in bed. The resident continued to have the oxygen via the nasal cannula in use. The concentrator was set at 4 liters and the humidification bottle was not dated. On 12/1/22 at 9:04 a.m., the resident was in her room in bed. The resident's oxygen per nasal cannula was in use and the oxygen concentrator was set at 3.5 liters. The humidification bottle was not dated.	F 0695	Aperion- Arbors Michigan City PSR to 9/29/22 Complaint Exit 12/1/2022 Compliance 12/23/2022 F695 – Respiratory *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	12/23/2022

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	155156	A. BUILDING 00 B. WING	12/01/2022

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	The record for Resident K was reviewed on 11/30/22 at 10:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), anxiety, and dependence on supplemental oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 10/19/22, indicated the resident was cognitively intact and utilized oxygen while a resident of the facility. A Care Plan, dated 6/1/22 and reviewed on 10/19/22, indicated the resident had a history of adjusting the supplemental oxygen settings. Interventions included, but were not limited to, document episodes of noncompliance with current oxygen orders, educate the resident regarding the importance of adhering to physician orders, and oxygen via nasal cannula as ordered. A Physician's Order, dated 9/28/22, indicated the resident was to have oxygen at 5 liters continuously per nasal cannula. There were no orders for changing the tubing and humidification bottle. The November 2022 Medication Administration Record (MAR) indicated the 5 liters of oxygen was signed out as ordered 11/8 through 11/30/22. There was no documentation in the nurses' notes dated 11/8 through 11/30/22 indicating the resident had adjusted the flow rate and education had been provided. Interview with the 200 Unit Manager on 12/1/22 at 12:45 p.m., indicated the resident did adjust her oxygen flow rate and documentation should have been completed as indicated in the care plan.		1. Resident K's oxygen order was clarified to reflect the correct liter flow, and an order was obtained for routine oxygen tubing and humidification bottle changes. 2. Resident G was a new admission at the time of survey. Oxygen orders were obtained to reflect the correct liter flow and for routine tubing changes. **2) How the facility identified other residents:** All residents who utilize oxygen have the potential to be affected; therefore, this plan of correction applies to those residents. **3) Measures put into place/ System changes:** Nursing staff was re-educated on respiratory/tracheostomy care and suctioning, including but not limited to, ensuring oxygen orders reflecting the correct liter flow and routine tubing/humidification bottle change orders are in place for residents who utilize oxygen, and the importance of periodic visual observations to ensure oxygen flow rates correspond to the ordered flow rates. A new system was implemented with stickers on portable oxygen tanks and/or concentrators with # of liters/min to easily verify oxygen	

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	Observation of the humidification bottle on 12/1/22 at 2:05 p.m. with the 200 Unit Manager, indicated the bottle was not dated. The unit manager indicated she changed the bottle herself on Monday and dated it, she also indicated that was not the bottle she had changed out on Monday. 2. During an initial facility tour on 11/29/22 at 1:00 p.m., Resident G was observed lying in bed with her oxygen nasal cannula in place. The oxygen concentrator flow rate was set at 3 liters per minute (lpm). On 11/30/22 at 8:50 a.m., the resident's oxygen concentrator setting was observed at 3 lpm. Resident G's record was reviewed on 11/29/22 at 1:45 p.m. The resident was admitted on 11/22/22. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, and heart failure. The November 2022 Physician's Order Summary lacked an order for oxygen use. A Physician's Order, dated 11/29/22 at 3:00 p.m., indicated the resident was to have oxygen at 3 lpm continuously. Interview with the Administrator on 12/1/22 at 1:59 p.m., indicated the resident arrived at the facility using oxygen and it was assessed yesterday. New orders were put in for oxygen at 3 liters yesterday afternoon. This deficiency was cited on 9/29/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		is set at the correct flow rate. DON, or designee, will review oxygen orders and verify accuracy of flow rate on stickers at least weekly x 30 days and then monthly for 5 months thereafter. Any identified concerns will be promptly addressed with responsible individual(s). DON, or designee, will be responsible for auditing new admissions charts, and any new oxygen orders will be reviewed, at least 3 times per week X 30 days to ensure oxygen orders are transcribed accurately; thereafter, these reviews will be conducted weekly for 5 months. Any identified concerns will be promptly addressed with responsible individual(s). **4) How the corrective actions will be monitored:** Additionally, DON/Designee, will conduct visual observations during rounds at least 5 times per week on varied shifts x 30 days, then 3 times per week on varied shifts x 30 days, then at least weekly thereafter to ensure oxygen is administered as ordered. Any identified concerns will be promptly addressed with the responsible individual(s).	

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	3.1-47(a)(6)		DON/Designee will be responsible for providing the audit results to the QA committee. These audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Aperion- Arbors Michigan City	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to accurately assess and manage pain for residents with a history of pain for 3 of 4 residents reviewed for pain. (Residents L, G and J) Findings include: 1. During an interview with Resident L on 11/30/22 8:50 a.m., he indicated he had not had his pain medication in days. He had chronic pain and the medication was scheduled.	F 0697	Aperion- Arbors Michigan City PSR to 9/29/22 Complaint Exit 12/1/2022 Compliance 12/23/2022 F697 – Pain Management *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	12/23/2022

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	The record for Resident L was reviewed on 11/30/22 at 9:00 a.m. The resident was admitted on 4/22/22. Diagnoses included, but were not limited to, acute kidney failure, morbid obesity, paraplegia, pressure ulcer, right leg amputation, heart failure, major depressive disorder, G- tube, and colostomy. The 10/12/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact and received a scheduled pain medication. A Care Plan, updated 10/12/22, indicated the resident had the potential for pain related to mobility and wounds. The approaches were to administer medications as ordered. A Care Plan, updated 10/12/22, indicated the resident had pain related to chronic physical disability (paraplegia). The approaches were to administer analgesia (Oxycodone) as per orders and evaluate the effectiveness of pain interventions. Physician's Orders, dated 10/4/22, indicated Oxycodone HCl (a narcotic pain medication) tablet 10 milligrams (mg). Give 1 tablet every 6 hours for pain. Tylenol 8 Hour tablet extended release 650 mg every 4 hours for pain. Pain assessment every shift. The 11/2022 Medication Administration Record (MAR), indicated the following: - The pain assessment was not completed at 12 a.m. on 11/13, 11/22, 11/28, 11/29 and 11/30/22, at 8 a.m., on 11/27 and at 4 p.m., on 11/25 and 11/27/22.		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** 1. Resident L was assessed for pain at the time of survey. A new script was obtained for the Oxycodone. 2. Resident G no longer resides at the facility; therefor, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** All residents receiving pain medications have the potential to be affected by this cited practice. An audit was completed on all residents with pain medication to ensure assessments and plan of care were up to date, and that pain medications have been refilled, as necessary. **3) Measures put into place/ System changes:** Staff education was provided on Pain Management, including but not limited to, medication administration and the importance	

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	- The Oxycodone HCI tablet was to be administered at 12 a.m., 6 a.m.,12 p.m., and 6 p.m. The pain medication was not signed out as being administered on 11/12 and 11/13 at 6 a.m., 11/12 at 12 p.m., 11/25 at 6 p.m., and 11/27 at 12 p.m. and 6 p.m. A "9" (meaning not available) was coded on 11/28 at 12 a.m., 6 a.m., and 12 p.m., on 11/29 at 12 a.m., 6 a.m., at 12 p.m., and 11/30 at 12 a.m. and 6 a.m. - The Tylenol 8 Hour tablet extended release was to be administered at 12 a.m., 4 a.m., 8 a.m., 12 p.m., 4 p.m., and 8 p.m. The pain medication was not signed out as being administered on 11/12 and 11/26 at 4 a.m., 11/12 at 8 a.m., 11/12 and 11/27 at 12 p.m., 11/25 and 11/27 at 4 p.m., 11/25-11/28 at 8 p.m. A Nurses' Note, dated 11/30/22 at 11:21 a.m., indicated the Nurse Practitioner was here and a script for Oxycodone was written. Interview with the Director of Nursing 12/1/22 at 2:00 p.m., indicated the pain medications were not given nor was the pain assessment completed as ordered. The Oxycodone was not available in the emergency drug kit. The pharmacy only sends a very limited amount of medication, and a new script was needed often for renewal. 2. Resident G's record was reviewed on 11/29/22 at 1:45 p.m. The resident was admitted on 11/22/22. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, and heart failure. The Admission Minimum Data Set (MDS) assessment, dated 11/25/22, indicated it was still in progress. A Physician's Order, dated 11/23/22 at 12:00 a.m.,		of monitoring, assessing, documenting, and providing pain medication according to physician's order and resident plan of care. DON/designee will review MAR of at least 5 residents per week receiving scheduled and/or PRN pain meds x 30 days, then at least 3 residents per week x 30 days, then 5 residents per month thereafter to ensure medications are administered as ordered. Those same residents will also be interviewed after review of the MAR to verify pain medications are being administered as ordered, effectiveness of pain medication and accuracy of pain assessments. Any identified concerns will be promptly addressed with responsible individual(s). DON/designee will review PRN Pain medication administration report at least 3 times per week x 30 days, then at least twice weekly x 30 days, and at least once weekly thereafter, to validate appropriate assessment and documentation relative to PRN pain medications. Any identified concerns will be promptly addressed with responsible individual(s). **4) How the corrective actions will be monitored:** DON/Designee will be responsible for providing the audit results to	

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	indicated pain assessment every shift. A Physician's Order, dated 11/23/22 at 10:00 a.m., indicated Lidocaine pain relief 4% patch apply to shoulder left topically one time a day. A Physician's Order, dated 11/22/22 at 11:30 p.m., indicated Percocet tablet 7.5-325 milligrams 1 tablet by mouth every 12 hours as needed for pain. The November 2022 Medication Administration Record (MAR) indicated the pain assessment was not completed at 6:00 p.m. on 11/25/22, 11/26/22, and 11/29/22 and at 12:00 a.m. on 11/28/22. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. 3. Resident J's record was reviewed on 11/30/22 at 10:06 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, coronary artery disease, diabetes mellitus, and respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 11/13/22, indicated the resident was cognitively intact for daily decision making. He received a scheduled pain medication regimen and also as needed pain medications in the last five days. A Physician's Order, dated 11/7/22 at 4:00 p.m., indicated pain assessment every shift. A Physician's Order, dated 11/17/22 at 3:07 p.m., indicated Norco 5-325 milligram (mg) tablet, 1 tablet by mouth every 6 hours as needed for moderate pain (4-6 on pain scale) and give 2		the QA committee. These audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	tablets by mouth every 6 hours as needed for pain (5-10 on pain scale). Norco 5-325 mg 1 tablet was administered on 11/18/22 at 2:32 p.m., 11/19/22 at 5:02 p.m., 11/20/22 at 2:05 a.m., 11/24/22 at 9:57 p.m., and 11/27/22 at 11:03 a.m. Norco 5-325 mg 2 tablets were administered on 11/20/22 at 10:22 p.m. There was no documentation of a pain assessment completed at the times of the medication administration. Interview with the Administrator on 12/1/22 at 1:59 p.m., indicated the pain assessments were not completed at the time of the pain medication administration. The order was put in and did not include the prompt to assess using the pain scale. This deficiency was cited on 9/29/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or			

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	§483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure a resident was free from unnecessary medications, related to not administering antibiotics, insulin, and blood pressure medications as ordered for 4 of 4 residents reviewed for unnecessary medications. (Residents L, E, G, and D) Findings include: 1. The record for Resident L was reviewed on 11/30/22 at 9:00 a.m. The resident was admitted on 4/22/22. Diagnoses included, but were not limited to, acute kidney failure, morbid obesity, paraplegia, pressure ulcer, right leg amputation, heart failure, major depressive disorder, G- tube, and colostomy. The 10/12/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Physician's Orders, dated 11/16/22, indicated Clindamycin (an antibiotic medication) HCl 300 milligrams (mg), 1 capsule every 8 hours for 7 days for a wound infection.	F 0757	Aperion- Arbors Michigan City POC Complaint Exit 12/1/2022 Compliance 12/23/2022 F-757 Unnecessary Meds *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	12/23/2022

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	The Medication Administration Record (MAR), dated 11/2022, indicated the medication was first administered on 11/16/22 at 4:00 p.m., and signed out through 11/23/22 at 8:00 a.m. Physician's Orders, dated 11/24/22, indicated Clindamycin HCl 300 mg, 1 capsule two times a day for a wound infection. The 11/2022 MAR indicated the antibiotic was not signed as being administered at 8 a.m. on 11/27/22, and at 4 p.m. on 11/25 and 11/27/22. On 11/30/22 at 9:30 a.m., LPN 1 removed all of the antibiotic punch cards that were in the medication cart for the resident. There was 1 Clindamycin punch card with a pharmacy delivery date of 11/16/22 that had 1 pill remaining in the package. A total of 20 capsules were sent. Another Clindamycin punch card with a pharmacy delivery date of 11/24/22 had 6 pills remaining out of the 10 pills that were sent. Interview with the Director of Nursing on 12/1/22 at 2:00 p.m., indicated the antibiotic was to be administered as ordered by the Physician.2. Resident E's record was reviewed on 11/29/22 at 1:37 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus, anxiety disorder, psychotic disorder, kidney failure, high blood pressure, chronic obstructive pulmonary disease, and heart disease. A Physician's Order, dated 11/21/22 at 10:00 p.m., indicated Amoxicillin (an antibiotic) tablet 500-125 milligram (mg) 1 tablet by mouth three times a day. The November 2022 Medication Administration Record (MAR) indicated the resident did not receive the Amoxicillin on 11/22/22 at 6:00 a.m.,		**1) Immediate actions taken for those residents identified:** 1. Resident L, E, and G's medication orders were reviewed and Licensed Nursing staff in-serviced on the correct orders, physicians were notified of the discrepancies. 2. Resident D no longer resides in the facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** All residents that are prescribed medication are at risk for the cited practice; therefore, all residents of the facility have the potential to be affected. **3) Measures put into place/ System changes:** Licensed nurses and QMAs have been re-educated relative to Drug Regimen is Free from Unnecessary Drugs, including but not limited to, ensuring that medications are administered per physician orders, and documented according to facility policies and procedures. DON/designee will review the MAR/TAR missing documentation audit report at least 5 times per week x 30 days, then at least 3 times per week x 30 days, then at least weekly thereafter to ensure	

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	11/25/22 at 8:00 p.m., and 11/29/22 at 6 a.m. A Physician's Order, dated 11/12/22 at 9:00 p.m., indicated Insulin Glargine 300 unit/milliliter 25 units at bedtime. The November 2022 MAR indicated the resident did not receive the Insulin Glargine at 9:00 p.m. on 11/12/22, 11/13/22, 11/14/22, 11/15/22, 11/25/22, 11/26/22, and 11/27/22. The MAR was left blank. Interview with the Administrator on 12/1/22 at 1:58 p.m., indicated she had spoken with the resident today and she indicated the medications were not administered. 3. Resident G's record was reviewed on 11/29/22 at 1:45 p.m. The resident was admitted on 11/22/22. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, and heart failure. A Physician's Order, dated 11/23/22 at 9:00 p.m., indicated Lantus SoloStar (an antidiabetic medication) 40 units at bedtime. The November 2022 Medication Administration Record (MAR) indicated the resident did not receive the Lantus SoloStar medication at 9:00 p.m. on 11/25/22, 11/26/22, 11/27/22, and 11/29/22. A Physician's Order, dated 11/23/22 at 9:00 p.m., indicated Humalog Insulin (an antidiabetic medication) inject per sliding scale before meals and at bedtime as followed: - 0 - 150 = 0 - 151 - 200 = 2 - 201 - 250 = 4 - 251 - 300 = 6 - 301 - 350 = 8		medications are administered as ordered. Any identified concerns will be promptly addressed with responsible individual(s). DON/Designee, daily, on scheduled days of work, for 4 weeks, will review the eMARs of residents receiving Insulin and antibiotics to ensure documentation of administration is present. Schedule of reviews will follow the above schedule. Any identified concerns will be promptly addressed with responsible individual(s). DON/designee will audit medication punch cards of at least 2 residents per week receiving antibiotic therapy, as available, and at the end of antibiotic regimen x 30 days, then at least 4 residents per month, as available, thereafter, to ensure all doses have been administered as ordered. Any identified concerns will be promptly addressed with responsible individual(s). **4) How the corrective actions will be monitored:** The results of these audits will be 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	- 351 - 400 = 10 - 401+ = 12 Call Physician The November 2022 MAR indicated the Humalog Insulin was blank and not signed out at all on 11/25/22 at 9:00 p.m., 11/26/22 at 4:00 p.m., 11/26/22 at 9:00 p.m., 11/27/22 at 9:00 p.m., 11/29/22 at 4:00 p.m. and 9:00 p.m. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. 4. The closed record for Resident D was reviewed on 11/30/22 at 2:05 p.m. Diagnoses included, but were not limited to, cutaneous abscess of abdominal wall, sepsis, chronic obstructive pulmonary disease, major depressive disorder, anxiety, heart failure, and heart disease. The Admission Minimum Data Set (MDS) assessment, dated 10/25/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 10/20/22, indicated Midodrine (blood pressure medication) 10 milligram tablet by mouth every 8 hours. The November 2022 Medication Administration Record (MAR) indicated the resident did not receive the Midodrine on the following dates and times: - 11/15/22 5:00 p.m. coded 9 - See Progress Notes - 11/16/22 1:00 a.m. coded 9 - See Progress Notes - 11/17/22 9:00 a.m. coded 2 - Drug Refused - 11/17/22 5:00 p.m. coded 5 - Hold/See Progress Notes - 11/18/22 1:00 a.m. coded 5 - Hold/See Progress Notes		or patterns and make recommendations to revise the plan of correction as indicated.	

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	155156	A. BUILDING 00 B. WING	12/01/2022

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	- 11/21/22 1:00 a.m. coded 5 - Hold/See Progress Notes - 11/21/22 5:00 p.m. coded 5 - Hold/See Progress Notes There were no corresponding progress notes. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. This deficiency was cited on 9/29/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(6)			