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	01/24/2024

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

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F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00421652, IN00421988, IN00425514, IN00426277, and IN00426305. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00421652 - Federal/State deficiencies related to the allegations are cited at F693. Complaint IN00421988 - No deficiencies related to the allegations are cited. Complaint IN00425514 - Federal/State deficiencies related to the allegations are cited at F600 and F689. Complaint IN00426277 - No deficiencies related to the allegations are cited. Complaint IN00426305 - No deficiencies related to the allegations are cited. Survey dates: January 22, 23, and 24, 2024 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 138 Total: 138 Census Payor Type: Medicare: 15 Medicaid: 105 Other: 18 Total: 138	F 0000	**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.** **The facility respectfully requests a desk review for these alleged deficient practices.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Todd Smith	Executive Director	02/06/2024

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/29/24.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, record review, and interview, the facility failed to ensure residents were free from physical abuse, related to a physical altercation by a resident with a history of aggression towards others, which resulted in physical contact with two residents, and was witnessed by another resident. (Residents D, E, and S) Findings include: Resident C was observed on 1/22/24 at 9:30 a.m., walking independently in the hallway to the front lobby area. At 10:02 a.m., he was in his room and was sitting on the bed. He was unable to verbalize the situation that had occurred with other residents in the facility, and indicated everything	F 0600	**Tag number: F600 – Free From Abuse, Neglect, and Exploitation** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident C had an inpatient psychiatric hospital stay after altercation with Residents D and E. Resident returned to facility after psychiatric hospital stay and was put on 1:1 observation for 72 hours and then 15-minute checks for the next several**	02/14/2024

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	was okay now. He indicated he now went out the front door to smoke his cigarettes. Resident D was observed on 1/22/24 at 10:42 a.m. in his room, and independently transferred himself from the bed to the wheelchair. He indicated he was, "viciously" attacked by Resident C. He did not "feel real safe," though the facility was doing everything possible to keep them safe. He indicated Resident C no longer smoked in the Courtyard with him. The day of the incident, he went out to the Courtyard, and saw Resident E in the grass. Resident E had informed him that Resident C had just, "beat the s*** out of him". Resident D had informed Resident E that he needed to call the Police, and at that time, Resident C came up behind him and, "sucker punched" him in the face. The staff came running out to the Courtyard and they called the Police. Resident E was observed on 1/23/24 at 8:45 a.m., sitting in a wheelchair in the Dining Room. He stated he was hit by Resident C. He felt safe at the facility. The staff responded well and have kept Resident C away from him. He was able to propel himself from the Dining Room. An undated facility reported incident to IDOH, indicated Residents C, D, and E were in the designated smoking area on 1/5/24 at 9:01 a.m. Resident C made contact with Resident E's and D's faces. The residents were separated. Residents E and D had first aid administered and denied request for x-rays and Emergency Room evaluations. Resident C was placed on one-on-one with a staff member until Law Enforcement arrived at 9:15 a.m., and he was then transferred to the Hospital. 1. Resident C's record was reviewed on 1/23/24 at		**days. There were no further negative interactions between the residents.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with mental illness have the potential to be affected by the alleged deficient practice. The Social Service Director has appropriately care planned all facility residents that have mental illness to include those residents who have had physical altercations with other residents. A 100% audit was conducted by the Social Service department to ensure all residents with mental illness are care planned accordingly and also are being seen by our Psychiatric Service, Guidestar, as needed.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/Social Service Director/Designee to re-educate facility staff on observing, monitoring and recognizing mental illness including triggers and**	

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	8:49 a.m. The diagnoses included, but were not limited to, Parkinson's disease and psychosis. A Quarterly Minimum Data Set (MDS) assessment, dated 11/1/23, indicated an intact cognitive status, no behaviors, no physical impairments of the extremities, and supervision was required for bed mobility and transfers. A Care Plan, dated 11/16/22, and revised on 1/16/24, indicated a history of being physically abusive. On 9/10/23 and 1/5/24 he had made physical contact with other residents. The interventions included, medications would be administered as ordered, redirection was to be attempted, he would be removed from the agitation, one-on-one care would be provided as needed, behavior would be discussed with the resident and informed that it was inappropriate, staff would intervene as needed and the rights and safety of others would be protected, activity programs were to be encouraged, behavioral episodes were to be observed, documented, and underlying causes would be attempted to be determined, a non-confrontational environment would be provided, and psychological care as ordered. A Physician's Order, dated 9/11/23, indicated Zyprexa (anti-psychotic) 20 milligrams (mg) was to be given at bedtime and 10 mg was to given one time during the day. The Nurses' Progress Notes indicated the following: - On 9/10/23 at 6:14 a.m., the resident exited his room and slapped the resident in the room across the hall, for no apparent reason. He then went back to his room, and closed the door. He was educated on his unacceptable behavior. The		**interventions to prevent escalation and abuse. Re-education to be completed by 2/14/2024. All triggers and interventions to be reviewed quarterly and as needed by Social Services.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. **Social Services/Designee will conduct an audit of all new admissions the next business day post admission and 5 residents per week for 12 weeks who are currently on Psychiatric Service Case Load with Guidestar to ensure proper care planning and treatment of residents with mental illness. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 2/14/2024	

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	Director of Nursing (DON), Power of Attorney (POA), and Physician were notified. - On 9/10/23 at 7:45 a.m., Resident C remained on 15-minute monitoring. He was agitated, not easily redirected, and had a change in his mental status. - On 9/10/23 at 9:40 a.m., an order was received to transfer the resident to the Emergency Room for an evaluation and treatment. - The resident returned to the facility on 9/10/23 at 8:03 p.m. and was transferred to another room at 8:40 p.m. A Psychiatric Progress Note, dated 9/11/23, indicated the resident had struck another resident in the face. The Social Service Director indicated the staff had observed Resident C going to the other doorway, and would look into the other resident's room. The altercation was unprovoked and unexpected. He had been pacing about the facility with very little social or verbal interaction prior to the incident. He denied hearing voices or having hallucinations. An order was placed to increase the Zyprexa to 10 mg every morning and 20 mg at bedtime, and to start Klonopin (anti-anxiety) 0.5 mg daily. He displayed increased restlessness, pacing, anxiety, and irritable moods. No physical aggression. A Psychiatric Progress Note, dated 9/12/23, indicated Resident C did not remember hitting the other resident. He continued to display increased restlessness, pacing, anxiety, irritable moods. No physical aggression. A Nurse's Progress Note, dated 1/5/24 at 10:04 a.m., indicated the nurse was notified by a CNA that the resident had a physical altercation with two other residents in the smoking area. Resident C was sent to the Emergency Room.			

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	A Nurse's Progress Note, dated 1/15/24 at 1:39 p.m., indicated the resident returned from the hospital. He was oriented to person, place, time, and events. A Communication Progress Note, dated 1/15/24 at 2:01 p.m., indicated the Administrator and Social Service Director spoke with him about the incident and facility expectations of his behaviors. He was informed he was not to touch anyone else, regardless of what had been said to him. He stated he understood. One-on-one care was started for 72 hours and would be followed by 15-minute checks afterward, until reviewed again by the team. 2. Resident D's record was reviewed on 1/23/24 at 10:10 a.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly MDS assessment, dated 11/15/23, indicated an intact cognitive status, no behaviors, no physical impairments of the extremities, required moderate assistance with transfers, and supervised with wheelchair mobility. A Nurse's Progress Note, dated 1/5/24 at 12 p.m., entered late on 1/9/24 at 1:36 p.m., indicated the resident was observed coming into the facility with a bloody nose, and indicated he had been hit by Resident C. First aid was rendered. He refused further treatment and x-rays. The abuse investigation interview on 1/5/24, indicated Resident D stated Resident E had just been hit by Resident C, and he was talking to Resident E and told him to call the cops. Resident C then "hauled off and hit me in the face, twice" with his fist. Resident C also attempted to kick him in the face. Resident D had his hands over his			

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	face to protect himself. Resident C then entered back into the building. Another resident went inside to inform the staff. The incident occurred after breakfast in the smoking area. The nurse came out and intervened. Resident D indicated he did not feel safe with Resident C in the facility. He had not had any past encounters with Resident C, though he feels Resident C is very angry and easily triggered. 3. Resident E's record was reviewed on 1/23/24 at 10:36 a.m. The diagnoses included, but were not limited to, hypertension. A Quarterly MDS assessment, dated 11/14/23, indicated an intact cognitive status, no behaviors, required supervision with transfers, and was independent with wheelchair mobility. A Nurse's Progress Note, dated 1/5/24 at 12:30 p.m., indicated Resident E was observed coming into the facility, and was bleeding from a scrape under the left eye. Resident E indicated another resident had made contact with his face. First aid was rendered and he refused further treatment. The investigation of the incident, dated 1/5/24, indicated a Law Enforcement officer came to the facility and a Police Report was completed. Resident S was interviewed and indicated he was not harmed. He entered the smoking area and Resident E was sitting by the wall. They were talking, when Resident C, who was walking past them, turned and hit Resident E with his fist. The first hit was to the back of the head and then he kicked Resident E in the face/mouth area. He indicated Resident C said they could call the cops on him. At that time, Resident S left the area to get towel for Resident E due to the bleeding, and to			

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	inform the staff. Resident C admitted he "smacked" the other residents "because of the thing they had said to him." He remained calm and cooperative during the interview and complied with placing himself on the gurney. Employee 1 indicated she had looked outside, and observed Resident D's nose bleeding. Resident D informed her Resident C had attacked him, and requested the Police be notified. Resident D was assessed and first aid rendered. He refused further treatment. Employee 2 indicated she had heard residents discussing the physical altercation outside in the Courtyard, and observed Resident D with blood coming from his nose, and Resident E with an abrasion under his left eye that was bleeding. Both residents came back inside the facility and first aid was rendered. They both refused further treatment. During an interview on 1/23/24 at 9:24 a.m., the Administrator indicated Resident C was only allowed to smoke in the front of the building now, and he agreed to this. He was admitted into a Behavioral Hospital, and when he returned to the facility, he was placed on-one-on one care for 72 hours, then on every 15-minute checks. He has had no further behaviors, and now the staff were to monitor him when he was out of his room. There had been no further incidents. All information regarding the altercations was now at the Prosecutor's office. The facility abuse policy, dated 10/28/22, and received from the Social Service Director as current, indicated the residents had a right to be			

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	free from abuse and the facility has attempted to establish a secure environment. Physical Abuse was the infliction of injury on a resident that occurred other than by accidental means. Resident to resident altercations that include any willful action that results in physical injury, mental anguish, or pain was to be reported in accordance with the regulations. This citation relates to Complaint IN 00425514. 3.1-27(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure adequate supervision was provided to residents in the designated smoking area, which resulted in resident to resident physical altercations involving 3 residents. (Residents C, D, and E) Finding includes: An undated facility reported incident to IDOH, indicated Residents C, D, and E were in the designated smoking area on 1/5/24 at 9:01 a.m. Resident C made contact with Resident E's and D's faces. The residents were separated. Residents E and D had first aid administered and	F 0689	**Tag number: F689 – Free of Accident Hazards/Supervision/Devices** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident C had an inpatient psychiatric hospital stay after altercation with Residents D and E. Resident returned to facility after psychiatric hospital stay and was put on 1:1 observation for**	02/14/2024

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	denied request for x-rays and Emergency Room evaluations. Resident C was placed on one-on-one observation with a staff member until Law Enforcement arrived at 9:15 a.m., and he was then transferred to the hospital. Cross reference F600. 1. Resident C's record was reviewed on 1/23/24 at 8:49 a.m. The diagnoses included, but were not limited to, Parkinson's disease and psychosis. A Quarterly Minimum Data Set (MDS) assessment, dated 11/1/23, indicated an intact cognitive status, no behaviors, no physical impairments of the extremities, and supervision was required for bed mobility and transfers. A Smoking Safety Risk assessment, dated 10/30/23, indicated supervision was required while smoking. A Care Plan, dated 6/8/23, indicated supervision while smoking was required. The goal indicated he would smoke safely in the designated area at scheduled times. The interventions included the resident would be supervised while smoking. 2. Resident D's record was reviewed on 1/23/24 at 10:10 a.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly MDS assessment, dated 11/15/23, indicated an intact cognitive status, no behaviors, no physical impairments of the extremities, required moderate assistance with transfers, and supervised with wheelchair mobility. A Smoking Safety Risk assessment, dated 11/15/23, indicated supervision was required while		**72 hours and then 15-minute checks for the next several days. There were no further negative interactions between the residents. All residents who smoke are currently monitored by staff in a common smoking area.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with mental illness have the potential to be affected by the alleged deficient practice. The Social Service Director has appropriately care planned all facility residents that have mental illness to include those residents who have had physical altercations with other residents. A 100% audit was conducted by the Social Service department to ensure all residents with mental illness are care planned accordingly and also are being seen by our Psychiatric Service, Guidestar, as needed. All residents who smoke are currently monitored by staff in a common smoking area.** III What measures will be put into place and what systemic	

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	smoking. A Care Plan, dated 11/1/23, indicated supervision while smoking was required. The interventions included supervision would be provided when smoking. 3. Resident E's record was reviewed on 1/23/24 at 10:36 a.m. The diagnoses included, but were not limited to, hypertension. A Quarterly MDS assessment, dated 11/14/23, indicated an intact cognitive status, no behaviors, required supervision with transfers, and was independent with wheelchair mobility. A Care Plan, dated 6/8/23, indicated supervision while smoking was required. The interventions included supervision would be provided when smoking. During an interview on 1/23/24 at 9:24 a.m., the Administrator indicated some of the residents were non-complaint with the smoking policy. Family and friends would bring them smoking material and not report it to the facility. During an interview on 1/23/24 at 10:25 a.m., Employee 1 indicated she had worked the morning of the incident. She was unsure if any staff member had been supervising the smoking area when the incident occurred. During an interview on 1/23/24 at 10:26 a.m., Employee 2 indicated she had worked the morning of the incident and the residents were outside in the the smoking area unsupervised. The incident occurred prior to the first scheduled smoking break time, and Activities staff usually supervised the residents during scheduled smoking times.		changes will be made to ensure that the deficient practice does not recur; **DON/Social Service Director/Designee to re-educate facility staff on observing, monitoring and recognizing mental illness including triggers and interventions/de-escalation practices to prevent abuse. Re-education to be completed by 2/14/2024. In addition, those residents who smoke were provided education on the facility's smoking policy and signed a smoking agreement by Social Services.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. **Social Services/Designee will conduct an audit of the common smoking area that is to be supervised by staff as follows: 6 X week for 12 weeks to ensure smoking compliance by residents who smoke in the common smoking area. The results of these audits will be reviewed in Quality Assurance Meeting quarterly for 3 months or until an average of 90% compliance or greater is achieved on the second quarter audited. The QA**	

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	During an interview on 1/23/24 at 10:33 a.m., the Activity Director indicated the residents were unsupervised in the smoking area. The incident occurred prior to the scheduled smoking break. The residents involved were non-compliant with the smoking policy. The facility's Safe Smoking Policy, dated 10/24/22 and provided as current, indicated the designated smoking area was the back Courtyard area. The level of assistance would be determined, and if supervision was required while residents were smoking. The Care Plan would reflect the results of the assessment. This citation relates to Complaint IN00425514. 3.1-45(a)(2)		**Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** Date of compliance: 2/14/2024	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral			

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	01/24/2024

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

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	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 tubes (g-tubes/ feeding tubes) were cleaned at the insertion site as ordered by the Physician, for 2 of 3 residents reviewed for g-tubes. (Residents B and M) Findings include: 1. During an observation on 1/22/24 at 10:58 a.m. with Employee 1 and Employee 3, Resident B was lying in bed. The g-tube insertion site had no dressing, had a light drainage and dark crusting was observed around the insertion area. Employee 1 indicated there was drainage, and the area was to be cleansed every shift. She indicated there was no order for a dressing, and the g-tube was not used except for flushes. G-tube insertion site care was completed by Employee 1 after other care was rendered. Resident B's record was reviewed on 1/22/24 at 2:17 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly Minimum Data Set (MDS) assessment, dated 12/3/23, indicated an intact cognitive status, required set up for meals, received a mechanically altered diet, and there was no feeding or fluid intake by way of the g-tube. A Care Plan, dated 12/15/22, indicated a g-tube was present and received water flushes. The interventions include, local care would be provided to the g-tube site as ordered, and the	F 0693	**Tag number: F693 – Tube Feeding Mgmt/Restore Eating Skills** I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident B and M have had their insertion sites cleaned.** II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents with treatment orders have the potential to be affected by the alleged deficient practice. All residents with G-Tubes were audited to ensure each insertion site was cleaned. Treatment orders were audited for the last 30 days for completion.** III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/Designee to re-educate nursing staff on**	02/14/2024

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	site would be monitored for signs and symptoms of infection. A Physician's Order, dated 10/18/23 and discontinued on 12/18/23, indicated the g-tube insertion site was to cleansed daily with soap and water and then covered with a split gauze dressing every night. The Treatment Administration Records (TAR) for November and December 2023, indicated the g-tube care had not been completed on November 3, 4, 10, and 26, 2023 and December 2, 8, and 15, 2023. A Physician's Order, dated 12/19/23, indicated the g-tube insertion site was to be cleansed daily with soap and water on night shift. The TARs, dated December 2023 and January 2024, indicated the care had not been completed on December 19 and 22, 2023 and January 1, 7, and 19, 2024. 2. During an observation on 1/23/24 at 3:05 p.m. with the Corporate Nurse Consultant and Employee 4, Resident M was lying in bed. Employee 4 was removing the dressing around the g-tube insertion site. The dressing removed from the site had a scant amount of brownish/red drainage. Employee 4 indicated the site did drain a little. There was crusting around the insertion site. Resident M's record was reviewed on 1/23/24 at 1:16 p.m. The diagnoses included, but were not limited to, stroke. An Annual MDS assessment, dated 12/28/23, indicated a severely impaired cognitive status, was dependent for nutrition, and had a feeding		**following physician orders for treatments and monitoring of residents with G-Tube sites to be sure feedings to ensure insertion sites are clean.** IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct a G-Tube audit to ensure insertion sites are clean. DON/designee will also audit treatment orders to ensure completion. Audits will be completed 5x/week for 12 weeks. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 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.** Date of compliance: 2/14/2024	

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	tube for all nutrition and fluids. A Care Plan, dated 1/7/22, indicated a feeding tube was present. The goal indicated the insertion site would be free of infection. A Physician's Order, dated 12/12/23, indicated the g-tube insertion site was to be cleansed with soap and water every day with care. The TARs, dated December 2023 and January 2024, indicated the insertion site was not cleansed on December 12 and 25, 2023 and January 9, 2024. This citation related to Complaint IN00421652. 3.1-44(a)(2)			