STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING _____ B. WING _____	R-C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	INITIAL COMMENTS Paper compliance to the Investigation of Complaints IN00335691, IN00335951, IN00336210, IN00337918, IN00339042, IN00339545, IN00343422, and IN00346180 and a COVID-19 Focused Infection Control Survey completed on March 5, 2021. Review date: April 8, 2021 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Aperion Care Arbors Michigan City was found to be in compliance with 41 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the paper compliance review to the complaint investigation and COVID-19 Focused Infection Control Survey.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.