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	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00396040, IN00396435, IN00396689, IN00398992, IN00400678, IN00401271, and IN00401730. Complaint IN00396040 - Substantiated. Federal/state deficiencies related to the allegations are cited at F679, F684, F686, and F693. Complaint IN00396435 - Unsubstantiated due to lack of evidence. Complaint IN00396689 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00398992 - Substantiated. Federal/state deficiencies related to the allegations are cited at F600, F677, F690, and F692. Complaint IN00400678 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677 and F880. Complaint IN00401271 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F600, F684, and F698. Complaint IN00401730 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684. Unrelated deficiency is cited. Survey dates: February 13, 14, and 15, 2023 Facility number: 000076 Provider number: 155156	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristina Herrera	Executive Director	03/13/2023

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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	AIM number: 100271060 Census Bed Type: SNF/NF: 133 Total: 133 Census Payor Type: Medicare: 23 Medicaid: 72 Other: 38 Total: 133 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/17/23.			
F 0580 SS=G Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in			

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	§483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to promptly notify the Physician of abnormal laboratory findings, resulting in a delay in treatment for which the resident was hospitalized for septic shock and required intubation and ultimately death for 1 of 4 residents reviewed for a change in condition. (Resident E) Finding includes: The closed record for Resident E was reviewed on	F 0580	**Aperion- Arbors Michigan City** **Complaint Survey** **Exit 02/15/2023** **Compliance 03/9/2023** **F 580 Notification**	03/09/2023

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	2/13/23 at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was Minimum Data Set (MDS) assessment available for review. The Admission Nursing Assessment, dated 2/2/23, indicated the resident was observed with pursed lip breathing and his lung sounds on both sides were clear, diminished with rales. No equipment for respiratory status was checked on the form. A Physician's Order, dated 2/3/23, indicated to obtain labs: a CBC (Complete Blood Count) with differential and platelets, a CMP (Comprehensive Metabolic Panel), a Glycohemoglobin A1C, a Lipid panel, a renal function panel, a thyroid profile with a T4 and TSH, and a PSA. The lab results were obtained on 2/3/22 and reported to the facility on 2/3/23 at 10:24 p.m., however, there was no documentation the Physician was ever notified of the abnormal results. The lab results were as follows: - CBC Hemoglobin was 10.3 grams (gm) (normal 14.0 - 18.0) Hematocrit was 33.7% (normal 42.0 - 52.0) - CMP Blood Urea Nitrogen (BUN) was 132 (normal 7-28) Creatinine was 4.02 (normal 0.44-1.32) Sodium was 164 (normal 138-147) Glucose was 230 (normal 70-110) The lab had suggested the BUN and Sodium be repeated if necessary.		*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 no longer resides in the facility. **2) How the facility identified other residents:** Audits completed of all current residents' labs orders to ensure that physician notification was completed. **3) Measures put into place/ System changes:** Nursing department educated on notification Policy **4) How the corrective actions**	

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	The resident's vital signs on 2/5/23 were documented at 10:37 a.m. The resident's blood pressure was 164/86 and the oxygen saturation was 97% on room air. A Nurses' Note, dated 2/5/23 at 12:20 p.m., indicated "resident is not responding, BP is 95/50,o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family." [sic] A Nurses' Note, dated 2/5/23 at 1:20 p.m., indicated report was given to the Emergency Room (ER) at the hospital. A signed document by the Paramedic, dated 2/5/23, indicated EMS (Emergency Medical Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen. The patient's dialysis port was uncovered and not secured to the patient. The patient had multiple sores to his body." A History and Physical by the ER Physician, dated 2/5/23 at 12:33 p.m., indicated "...Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per EMS without any oxygen which improved on nonbreather. Patient has a dialysis catheter in his right subclavian that is no longer sutured down. EMS reportedly place a tegaderm over the dialysis catheter to help stabilize it in place. It is unclear how long symptoms have been going on for." A physical exam indicated the patient was ill-appearing and did not respond or follow any commands. The patient had decreased breath		**will be monitored:** **DON/ED will review 24 hours report daily for orders (including Lab) , significant changes, and assessments 5 days a week for 3 months and 3 days a week for 3 months. This will ensure that the family notification is completed.** **The results of 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.** **5) Date of compliance: 03/09/2023**	

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	sounds bilaterally. At 1:30 p.m., the resident was intubated due to hypoxemia and respiratory failure. Labs were obtained which indicated the resident tested positive for COVID-19. The BUN was 199, Creatinine was 6.2, Sodium was 156, Potassium was 5.8 (normal 3.6-5.0) Glucose was 382, and White Blood Cells were 15.50 (normal 4.8-10.8). A Lactic Acid lab test was obtained which was 3.4 (normal 0.5-1.0. A high lactic acid meant that body tissues were not getting enough oxygen). The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired in the hospital on 2/7/23. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the Physician was not notified of the critical lab results drawn and received on 2/3/23. This Federal tag relates to Complaint IN00401271. 3.1-5(a)(3)			
F 0600 SS=G 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			

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	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 record review and interview the facility failed to protect a resident's right to be free from neglect related to the failure of monitoring/assessing a dialysis perma catheter, lack of Physician notification of abnormal lab results and failure to administer oxygen for a resident in respiratory distress which resulted in a hospitalization for septic shock and required intubation and ultimately death for 1 of 3 residents reviewed for neglect (Resident E) Finding includes: The closed record for Resident E was reviewed on 2/13/23 at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was Minimum Data Set (MDS) assessment available for review. The resident was admitted directly to the facility on 2/2/23 from another Long Term Care facility. Ancillary Physician's Orders on the transfer information, dated 1/30/23, indicated the resident was receiving oxygen continuously at 2 liters via nasal cannula and had a dialysis perma catheter to the right chest that was to be checked/assessed every shift. The resident had discontinued dialysis treatment on 1/18/23. A Nurses' Note, dated 2/2/23 at 2:01 p.m.,	F 0600	**Aperion- Arbors** **Complaint Survey 02/15/23** **Compliance 03/9/23** **F-600 Free from Abuse** *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 no longer resides in the facility **2) How the facility identified**	03/09/2023

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	indicated the resident arrived via ambulance transport accompanied by two ambulance transporters. Nursing tried to acclimate the resident to the room, call light, surrounding areas and the television, however, the resident did not respond. Vital signs were checked and within normal limits. A rapid COVID-19 test was administered with negative results. The remainder of the new admission process was passed to the oncoming shift. A Nurses' Note, dated 2/2/23 at 7:34 p.m., indicated all medication was verified with the Physician and entered into the electronic Medication Administration Record (MAR). The Admission Nursing Assessment, dated 2/2/23, indicated the resident was observed with pursed lip breathing and his lung sounds on both sides were clear, diminished with rales. No equipment for respiratory status was checked on the form. Under the section of Intravenous (IV) therapy, nothing was checked as well for the dialysis perma catheter. Physician's Orders, dated 2/2-2/5/23, indicated there were no orders for oxygen or to check/assess the dialysis perma catheter to the right chest. Physician's Orders, dated 2/2/23, indicated the resident was NPO and was to receive an enteral tube feeding of Glucerna 1.5 at 65 cubic centimeters (cc) from 10:00 a.m., until 6:00 a.m. The peg tube was to be flushed with 180 milliliters (ml) of water every 4 hours. A Physician's Order, dated 2/3/23, indicated to obtain labs: a CBC (Complete Blood Count) with differential and platelets, a CMP (Comprehensive		**other residents:** All residents have the potential to be affected by this deficient practice. All residents have the potential to be affected by the finding. Skin checks were completed to identify areas that need to be assessed and monitored. (including permi-cath). Lab audit completed to ensure notification to the Physician. Facility staff completed house wide Oxygen saturation audit to identify resident that have a need for oxygen. **3) Measures put into place/ System changes:** Staff will be re-educated on Facility abuse Policy. (Including Neglect) Staff were re-educated on Abuse on 2/1/23 and ongoing. · Nursing staff educated on admissions, notification and Identifying assessing and monitoring. · Nursing staff re-educated on change in condition (including respiratory distress) and when to apply oxygen. · Skin checks upon admission and weekly **4) How the corrective actions will be monitored:** The Administrator /designee will	

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	Metabolic Panel), a Glycohemoglobin A1C, a Lipid panel, a renal function panel, a thyroid profile with a T4 and TSH, and a PSA. The lab results were obtained on 2/3/22 and reported to the facility on 2/3/23 at 10:24 p.m., however, there was no documentation the Physician was ever notified of the abnormal results. The lab results were as follows: - CBC Hemoglobin was 10.3 grams (gm) (normal 14.0 - 18.0) Hematocrit was 33.7% (normal 42.0 - 52.0) - CMP Blood Urea Nitrogen (BUN) was 132 (normal 7-28) Creatinine was 4.02 (normal 0.44-1.32) Sodium was 164 (normal 138-147) Glucose was 230 (normal 70-110) The lab had suggested the BUN and Sodium be repeated if necessary. The resident's vital signs on 2/5/23 were documented at 10:37 a.m. The resident's blood pressure was 164/86 and the oxygen saturation was 97% on room air. A Nurses' Note, dated 2/5/23 at 12:20 p.m., indicated "resident is not responding, BP is 95/50,o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family." [sic] A Nurses' Note, dated 2/5/23 at 1:20 p.m., indicated report was given to the Emergency Room (ER) at the hospital. A signed document by the Paramedic, dated 2/5/23, indicated EMS (Emergency Medical		conduct audits in care area related to neglect including Change in condition, labs, MD notifications, abnormal vital and dressings. Administrator DON/designee will conduct these audits with 5 residents per week for 6 weeks. 3 resident for 6 weeks and 2 residents 12 weeks to ensure staff compliance with Abuse Policy. Any reported issues will be handled per the Abuse Policy. Audits will continue until 6 months of compliance is achieved. **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/09/23**	

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	Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen. The patient's dialysis port was uncovered and not secured to the patient. The patient had multiple sores to his body." A History and Physical by the ER Physician, dated 2/5/23 at 12:33 p.m., indicated "...Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per EMS without any oxygen which improved on nonbreather. Patient has a dialysis catheter in his right subclavian that is no longer sutured down. EMS reportedly place a tegaderm over the dialysis catheter to help stabilize it in place. It is unclear how long symptoms have been going on for." A physical exam indicated the patient was ill-appearing and did not respond or follow any commands. The patient had decreased breath sounds bilaterally. At 1:30 p.m., the resident was intubated due to hypoxemia and respiratory failure. Labs were obtained which indicated the resident tested positive for COVID-19. The BUN was 199, Creatinine was 6.2, Sodium was 156, Potassium was 5.8 (normal 3.6-5.0) Glucose was 382, and White Blood Cells were 15.50 (normal 4.8-10.8). A Lactic Acid lab test was obtained which was 3.4 (normal 0.5-1.0. A high lactic acid meant that body tissues were not getting enough oxygen). The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired			

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	in the hospital on 2/7/23. Interview with the Administrator on 2/14/23 at 3:30 p.m., indicated the LPN who admitted the resident was asked about the dialysis perma catheter at the time of admission. The LPN indicated she had seen the catheter and it was covered. The Administrator indicated the LPN was fired from the facility. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the Physician was not notified of the labs drawn on 2/3/23. There was no documentation/assessment of the dialysis perma catheter and there was no documentation of any oxygen administered when the resident started to have a change in condition before he was sent to the hospital. They had no further information for review. This Federal tag relates to Complaints IN00398992 and IN00401271. 3.1-27(a)(3)			
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 record review and interview, the facility failed to ensure ADL (activities of daily living) care was provided to a dependent resident related to showering as scheduled for 1 of 3 residents reviewed for ADL care. (Resident F) Finding includes:	F 0677	**Aperion- Arbors** **POC Complaint Survey** **Exit 02/15/23** **Compliance 03/09/23**	03/09/2023

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	The closed record for Resident F was reviewed on 2/14/23 at 8:48 a.m. She was admitted on 11/23/22. Diagnoses included, but were not limited to, orthopedic aftercare, heart failure, and chronic obstructive pulmonary disease. She was discharged to the hospital on 1/12/23. The Admission Minimum Data Set assessment, dated 11/28/22, indicated she required extensive staff assistance for bed mobility and toileting, and only transferred once or twice with extensive assistance. The Point of Care tasks indicated she was scheduled to receive a shower or bath on Mondays and Thursdays. Shower sheets were missing for 11/24/22, 11/28/22, 12/5/22, 12/15/22 and 12/26/22. There were no refusals documented on these dates. Interview with the Administrator on 2/15/23 at 11:30 a.m., indicated there was no additional information for this resident. This Federal tag relates to Complaints IN00396689, IN00398992 and IN00400678. 3.1-38(a)(2)(A)		**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 F no longer resides in the facility. **2) How the facility identified other residents:** The facility completed an audit to identify any dependent residents who need assistance with grooming and personal hygiene. The facility staff provided grooming and personal care including showers as needed. **3) Measures put into place/ System changes:** The facility	

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			staff was in-serviced on providing ADL care for residents unable to carry out activities of daily living and to ensure that residents receive good nutrition, grooming and hygiene. **4) How the corrective actions will be monitored:** **The DON/Designee** will complete Dignity Rounds at least 5 times weekly at varied times to ensure proper hygiene is maintained for facility residents. The Administrator will run POC audit 5 times weekly to ensure that residents are offered a shower and responses are documented in the electronic record. **The results of 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.** **5) Date of compliance:** **03/09/23**	

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F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure cognitively impaired residents in isolation for COVID-19 had ongoing activities in the room and a resident was assisted to a favorite activity of church for 3 of 3 residents reviewed for activities. (Residents D, B, and K) Findings include: 1. On 2/14/23 at 9:00 a.m., Resident D was observed curled up in a ball lying on the bed in the room. At that time, the resident was in isolation for COVID-19. The lights were turned off and there was no television or radio in the room. At 12:57 p.m., the resident was laying in bed, again with the lights turned off. There was no television or radio in the room. On 2/14/23 at 10:15 a.m., the resident was observed curled up lying in the bed, wearing a hospital gown. There were several stuffed toys at the foot of the bed. There was no television or radio in the room. The Record for the resident was reviewed on	F 0679	**Aperion- Arbors** **POC Complaint** **Exit 02/15/2023** **Compliance 03/09/23** **F679 Activities** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	03/09/2023

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	2/13/23 at 6:15 p.m. Diagnoses included, but were not limited to, epilepsy, schizophrenia, high blood pressure, intellectual disabilities, speech disturbance, and peg tube status. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident was severely impaired for decision making. The resident was able to answer the questions for the activity section. She indicated it was very important for her to choose what clothes to wear, somewhat important to read books or the newspaper, very important to listen to music, and very important to do her favorite activities. The resident received all of her nutrition by the way of a peg tube. An Activity Assessment, dated 1/27/23, indicated current interests included television and music. There was no Care Plan for activities. Physician's Orders, dated 2/11/23, indicated strict isolation for COVID-19. An Activity Participation Sheet for the month of 2/2023, indicated on 2/12/23, current events, music, and sensory were offered to the resident. On 2/14/23, music, sensory and a stop by visit was offered to the resident. Interview with the Activity Director on 2/15/23 at 11:14 a.m., indicated she was unaware there was no television or radio in the resident's room. 2. An interview with Resident B on 2/14/23 at 12:49 p.m., indicated the resident only liked to go to the church services the facility provided on Saturdays. The staff kept telling him that they did not have enough people working to get him up and ready to go so that he could attend weekly.		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident D was provided with TV. Resident B was escorted to the next available church service. Resident K was provided with a radio. **2) How the facility identified other residents:** All residents who reside in the facility have the risk to be affected by the alleged deficient practice. The resident preferences were review by the Activity Director to ensure that the facility is providing preferred activities for residents in isolation and cognitively intact and impaired residents. **3) Measures put into place/ System changes:** Activity staff educated on the facility activity programs and preferences. **4) How the corrective actions will be monitored:** The Activities Review tool will be completed at least 3 times a week for 4 weeks and weekly thereafter to ensure compliance. The **Administrator/Designee** is responsible for compliance.	

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	He did not enjoy any of the other activities the facility provided. Resident B's record was reviewed on 2/13/23 at 4:26 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) affecting the left side following a stroke and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was moderately cognitively impaired. He required extensive assistance with two persons physical assist for bed mobility, transfer, dressing, and personal hygiene. He had a functional limitation in range of motion with impairment on one side for both upper and lower extremities. A Care Plan, dated 7/26/21, indicated the resident had an interest in watching TV/movies, listening to music, pet interaction, spending time with family, sports, and current events. Interventions included, but were not limited to, one to one activities provided three times weekly and encourage the resident to participate in activities of his choosing. An interview with the Activity Director on 2/15/23 at 2:32 p.m., indicated the resident had been to one church service since the beginning of the year. It was an ongoing issue with the staff not getting the resident up and ready to go to the services every Saturday morning. 3. On 2/13/23 at 4:12 p.m., Resident K was observed in bed with no television on or other activity occurring at the time. On 2/14/23 at 11:06 a.m., the resident was observed in bed with no television on or other		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 03/09/23**	

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	activity occurring at the time. On 2/14/23 at 12:48 p.m., the resident was observed in bed with no television on or other activity occurring at the time. On 2/14/23 at 1:55 p.m., the resident was observed in bed with no television on or other activity occurring at the time. On 2/15/23 at 10:23 a.m., the resident was observed in bed with no television on or other activity occurring at the time. Resident K's record was reviewed on 2/14/23 at 10:16 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia, schizophrenia, major depressive disorder, and Asperger's syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 1/3/23, indicated the resident was severely impaired for daily decision making. She required extensive assistance for all activities of daily living including bed mobility, transfer, eating, dressing, toileting, and personal hygiene. A Care Plan, revised on 11/15/21, indicated the resident had an interest in music, religion, books, and hand massages. Interventions included, but were not limited to, one to one visits three times a week, reading books to the resident, and keep sensory items available to the resident. Interview with the Director of Nursing on 2/15/23 at 1:55 p.m., indicated she would reach out to the Activity Director regarding activities for the resident such as music therapy for during the day. This Federal tag relates to Complaint IN00396040.			

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	3.1-33(a)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident received appropriate care and services including new admission follow up nursing assessments and lack of oxygen after a change in condition which resulted in a hospitalization for septic shock and intubation for 1 of 4 residents reviewed for a change in condition (Resident E). The facility also failed to ensure follow up assessments were completed after falls and bruises were monitored until healed for 2 of 3 residents reviewed for falls and 1 of 3 residents reviewed for abuse. (Residents L, J and N) Findings include: 1. The closed record for Resident E was reviewed on 2/13/23 at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was no Minimum Data Set (MDS) assessment available for review.	F 0684	**Aperion- Arbors** **POC Complaint 02/2023** **Exit 02/15/2023** **Compliance 03/09/2023** **F684 Quality of Care** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	03/09/2023

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	The resident was admitted directly to the facility on 2/2/23 from another Long Term Care facility. Ancillary Physician's Orders on the transfer information, dated 1/30/23, indicated the resident was receiving oxygen continuously at 2 liters via nasal cannula. A Nurses' Note, dated 2/2/23 at 2:01 p.m., indicated the resident arrived via ambulance transport accompanied by two ambulance transporters. Nursing tried to acclimate the resident to the room, call light, surrounding areas and the television, however, the resident did not respond. Vital signs were checked and within normal limits. A rapid COVID-19 test was administered with negative results. The remainder of the new admission process was passed to the oncoming shift. A Nurses' Note, dated 2/2/23 at 7:34 p.m., indicated all medication was verified with the Physician and entered into the electronic Medication Administration Record (MAR). The Admission Nursing Assessment, dated 2/2/23, indicated the resident was observed with pursed lip breathing (helps assist with shortness of breath) and his lung sounds on both sides were clear, diminished with rales (abnormal rattling sound in the lungs). No equipment for respiratory status was checked on the form. There were no further nursing assessments documented either as a new admission or as a follow up to the abnormal admission respiratory assessment. Physician's Orders, dated 2/2-2/5/23, indicated there were no orders for oxygen.		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident E no longer resides in the facility Vitals were taken and updated for resident L Skin check was completed for resident N and documented in the resident electronic chart indicating the condition of the bruises. **2) How the facility identified other residents:** All residents have the potential to be affected. Facility skin sweep completed on all current resident to ensure that other residents are not affected by the same deficient practice. Vitals completed for all residents in the facility to ensure the policy is being followed. Nurse managers reviewed all discharges and admission in the last 15 day to ensure that · Nursing assessments were completed · Change of condition was identified · Respiratory Assessments were completed (including Covid screener)	

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	A Nurses' Note, dated 2/5/23 at 12:20 p.m., indicated "resident is not responding, BP is 95/50,o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family." [sic] A Nurses' Note, dated 2/5/23 at 1:20 p.m., indicated report was given to the Emergency Room (ER) at the hospital. A signed document by the Paramedic, dated 2/5/23, indicated EMS (Emergency Medical Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen..." A History and Physical by the ER Physician, dated 2/5/23 at 12:33 p.m., indicated "...Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per EMS without any oxygen which improved on nonbreather... It is unclear how long symptoms have been going on for." A physical exam indicated the patient was ill-appearing and did not respond or follow any commands. The patient had decreased breath sounds bilaterally. At 1:30 p.m., the resident was intubated due to hypoxemia and respiratory failure. Labs were obtained which indicated the resident tested positive for COVID-19. A Lactic Acid lab test was obtained which was 3.4 (normal 0.5-1.0. A high lactic acid meant that body tissues were not getting enough oxygen). The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic		· Vitals, and Monitoring policy **3) Measures put into place/ System changes:** Staff was re-educated regarding nursing assessment, change in condition, respiratory assessment. Nursing staff also reviewed the policies for monitoring and vitals **4) How the corrective actions will be monitored:** The Director of Nursing or designee will observe at least 3 residents per week to ensure all skin conditions are identified, documented, and monitored weekly as indicated. Nursing assessments, change of condition and respiratory assessment are completed timely and correctly. The Director of Nursing or designee will review vitals 5 days a week to ensure vitals are being taken in accordance with the facility policy **The results of 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**	

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	shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired in the hospital on 2/7/23. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated there was no documentation of any follow up assessments or oxygen administered when the resident started to have a change in condition before he was sent to the hospital. They had no further information for review. 2. The record for Resident L was reviewed on 2/14/23 at 10:00 a.m. Diagnoses included, but were not limited to, COVID-19, heart disease, atrial fibrillation, high blood pressure, and angina. The 1/24/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident had a history of 2 or more falls since the last assessment and 1 with a minor injury. A Care Plan, revised on 11/3/22, indicated the resident was at risk for falls. A Fall Initial Occurrence Note, dated 1/20/23 at 10:43 a.m., indicated the resident had an unwitnessed fall on 1/20/23 at 9:05 a.m. in her bathroom. The resident was observed on the floor outside of the bathroom. The resident indicated she did not lift her walker up far enough and fell. The resident was assessed for injuries and none were noted at the time. The resident had no pain and was picked up from the floor with 2 staff members. 72 hour Charting following the fall was completed		**will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/09/2023**	

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	on 1/20/23 at 4:35 p.m., 1/21/23 at 7:20 p.m., 1/22/23 at 5:00 a.m. and 9:51 a.m., and the last documented fall follow up was on 1/23/23 at 5:02 a.m. The 72 hour Charting on 1/20/23 at 4:35 p.m., indicated the resident's temperature, pulse, respirations, and blood pressure were all taken from 1/20/23 at 11:50 a.m. The 72 hour Charting on 1/21/23 at 7:20 p.m., and 1/22/23 at 5:00 a.m., indicated the resident's temperature, pulse, respirations, and blood pressure were all taken from 1/21/23 at 11:50 a.m. Interview with the Nurse Consultant on 2/14/23 at 3:30 p.m., indicated residents were to be assessed for 72 hours every shift post fall. Interview with the Director of Nursing on 2/15/23 at 2:00 p.m., indicated staff were to initiate 72 hour charting for every shift after a fall. There was no further information to review. 3. Resident J's record was reviewed on 2/14/23 at 1:45 p.m. Diagnoses included, but were not limited to, dementia, dysphagia and Diabetes Mellitus. The Annual Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident had significant cognitive impairment and required extensive staff assistance for bed mobility and transfers. A Nurses' Note, dated 2/10/23 at 10:29 p.m., indicated the resident had been found next to his bed on the floor. The resident was assessed and no injury was noted. On 2/11/23 at 7:58 a.m. and 4:00 p.m., a 72 hour Charting progress note had been completed related to the fall. There were no additional 72			

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	hour assessments related to the fall. Interview with the Nurse Consultant on 2/14/23 at 3:30 p.m., indicated residents were to be assessed for 72 hours every shift post fall. 4. Resident N's record was reviewed on 2/14/23 at 2:06 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, Alzheimer's disease, generalized anxiety disorder, and psychosis. The Annual Minimum Data Set (MDS) assessment, dated 1/16/23, indicated the resident was severely cognitively impaired. The resident displayed behavioral symptoms not directed towards others such as physical symptoms like hitting or scratching self, pacing, or verbal/vocal symptoms like screaming or disruptive sounds. A Nurses' Note, dated 2/6/23 at 4:24 p.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. A Nurses' Note, dated 2/6/23 at 7:52 p.m., indicated the resident had reddish-purple bruising noted to both arms. A Nurses' Note, dated 2/7/23 at 10:51 a.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. A Nurses' Note, dated 2/7/23 at 4:10 p.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. A Nurses' Note, dated 2/8/23 at 1:25 p.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. A Nurses' Note, dated 2/9/23 at 12:15 p.m.,			

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	indicated the resident had reddish-purple, green, and yellow bruising noted to both arms. A Nurses' Note, dated 2/9/23 at 8:32 p.m., indicated the resident had reddish-purple, green, and yellow bruising noted to both arms. A Nurses' Note, dated 2/10/23 at 3:46 p.m., indicated the resident had deep purple, and reddish-purple, and green bruising noted to both arms. There were no further notes documented. Interview with the Director of Nursing on 2/15/23 at 1:55 p.m., indicated the bruising should have been monitored until healed. A Policy titled "Skin Condition Assessment & Monitoring - Pressure and Non-Pressure" and noted as current indicated " ...Guidelines ... Non-pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc.) will be assessed for healing progress and signs of complications or infection weekly ... When bruises are healing without complications as indicated on the above table, the nurse will monitor the site weekly. At the point of signs of healing, approximately 7-14 days, or when the bruise has turned color to green, yellow, brown, the nurse will document a last entry indicating that the normal healing process has taken place without complications, and no further follow-up will be needed." This Federal tag relates to Complaint IN00396040, IN00401271, and IN00401730. 3.1-37(a)			

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	155156	A. BUILDING 00 B. WING	02/15/2023

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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 new pressure ulcers were assessed and monitored for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: The closed record for Resident F was reviewed on 2/14/23 at 8:48 a.m. She was admitted on 11/23/22. Diagnoses included, but were not limited to, orthopedic aftercare, heart failure, and chronic obstructive pulmonary disease. She was discharged to the hospital on 1/12/23. The Admission Minimum Data Set assessment, dated 11/28/22, indicated she required extensive staff assistance for bed mobility and toileting, and only transferred once or twice with extensive assistance. A Nurses' Note, dated 1/8/23, indicated the resident had new open areas on her coccyx and	F 0686	Aperion- Arbors Michigan City POC Complaint Exit 02/15/2023 Compliance 03/09/2023 **F-686 Treatment /Svcs** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	03/09/2023

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	left posterior thigh. Bandages were placed and the Physician was contacted for orders. An IDT (interdisciplinary team) Note, dated 1/11/23, indicated the resident had new wounds to coccyx and posterior thigh and the wound nurse would assess and provide treatment. There were no measurements, staging, or descriptions of the wounds. Interview with the Wound Nurse on 2/15/23 at 1:10 p.m., indicated she had not been aware of the resident's wounds and had not assessed them. This Federal tag is related to Complaint IN00396040. 3.1-40(a)(2)		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident F no longer resides in the facility; therefore, no further corrective action could be taken for this resident. **2) How the facility identified other residents:** All residents in the facility with alteration in skin or high risk of skin alterations have the potential to be affected by the cited practice. A skin sweep was completed in the facility to identify skin concern. All areas identified were identified, treatment placed and monitored per facility policy. **3) Measures put into place/ System changes:** A. Wound care nurse was re-educated on the wound policy including the importance of ensuring that an appropriate treatment is in place, proper identification of etiology of a wound, measuring, updating the plan of care and the importance of completing treatments according to the Physicians' Order. Nursing staff were also educated on completion of documentation.	

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			B. A QA tool has been updated and implemented to ensure compliance to these measures. **4) How the corrective actions will be monitored:** The DON or designee will complete an audit of the treatment record for residents with pressure injuries 5x's a week randomly to validate that the current treatment is in place and correctly dated x's 6 weeks then 3x's a week for 4 weeks then weekly thereafter. The DON is responsible for compliance. **Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be provided to the QA Committee by the DON/Designee and will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **03/09/22**	
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI			

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Bldg. 00	§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on record review and interview, the facility failed to ensure vitals signs were monitored every shift for a resident with a urinary tract infection (UTI) for 1 of 4 residents reviewed for a change in condition. (Resident F)	F 0690	**Aperion Arbors** **F690 UTI** **Exit 2/15/2023**	03/09/2023

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	Finding includes: The closed record for Resident F was reviewed on 2/14/23 at 8:48 a.m. She was admitted on 11/23/22. Diagnoses included, but were not limited to, orthopedic aftercare, heart failure, and chronic obstructive pulmonary disease. She was discharged to the hospital on 1/12/23. The Admission Minimum Data Set assessment, dated 11/28/22, indicated she required extensive staff assistance for bed mobility and toileting, and only transferred once or twice with extensive assistance. A Nurses' Note, dated 1/7/23, indicated the resident was sent to the ER and was diagnosed with a UTI. A Physician's Order, dated 1/7/23, indicated Macrobid (antibiotic) 100 milligrams, twice daily for 7 days for the UTI. Temperatures were recorded on the following dates and times: 1/7/23 8:19 a.m. 1/8/23 8:23 a.m. 1/9/23 9:46 a.m. Pulse rates were recorded on the following dates and times: 1/10/23 8:33 a.m. 1/11/23 3:33 p.m. Interview with the Director of Nursing, on 2/14/23 at 3:30 p.m., indicated vitals should be taken every shift for 72 hours when started on an antibiotic. This Federal tag relates to Complaint IN00398992.		**Compliance 03/09/23** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident F no longer resides in the facility **2) How the facility identified other residents:** All residents that have an order for an antibiotic are at risk for this deficient practice. All residents receiving an antibiotic were reviewed to ensure that they were monitored for 72 hours after starting the antibiotic. **3) Measures put into place/**	

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	3.1-41(a)(2)		**System changes** Nurses were educated on the policies for antibiotics and monitoring. **4) How the corrective actions will be monitored:** DON/Designee will review documentation at least 3x/week to ensure residents with an antibiotic is being monitored per facility policy. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 3/09/2023**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable			

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	parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure a resident with weight loss received nutritional supplements as ordered for 1 of 3 residents reviewed for nutrition. (Resident J) Finding includes: On 2/15/23 at 8:05 a.m., Resident J was observed seated in his room eating breakfast. He had pureed eggs and cereal, and thickened juice and water. There were no supplements on his tray. QMA 1 was passing medications on his hall. There were no supplements observed on her cart. Resident J's record was reviewed on 2/14/23 at 1:45 p.m. Diagnoses included, but were not limited to, dementia, dysphagia and Diabetes Mellitus. The Annual Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident had significant cognitive impairment and required extensive staff assistance for bed mobility and transfers. A Nutritional Assessment, dated 2/2/23, indicated	F 0692	**Aperion- Arbors** **POC Complaint** **Exit 02/15/2023** **Compliance 03/09/2023** **F692- Nutrition/Hydration** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	03/09/2023

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	the resident had an unplanned weight loss of 8.6% in 1 month. Recommendation was to increase supplementation to prevent further weight loss. Physician's Order, dated 2/2/23, indicated house supplement, 60 milliliters three times a day. Physician's Order, dated 11/9/21, indicated Magic cup 4 ounces once a day. The resident was on a regular diet, pureed texture and honey thickened liquids. The resident's breakfast tray ticket did not indicate the resident received the Magic cup at breakfast. The lunch ticket indicated he received it then. The February 2023 Medication Administration Record (MAR) indicated the Magic cup was to be given at 8:00 a.m., and the house supplement at 9:00 a.m. At 10:55 a.m., neither had been signed out as given yet that day. At 10:55 a.m., QMA 1 completed passing medications and returned the cart to the station. Interview with the QMA at that time, indicated she did not have any house supplements on her cart because nobody needed it. When asked about Resident J, she then indicated she had given him the house supplement. She entered the medication room and came out with a carton of Nepro (a supplement used for renal patients) and indicated this was what she had given him today during medication pass . She had given the drink to him in a cup, however, the supplement was not honey thickened. LPN 2 was standing nearby and indicated Nepro was not the house supplement. The QMA indicated he also had his Magic cup, she then signed both out on her computer.		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident J was provided with supplement ordered by the physician. **2) How the facility identified other residents:** All residents who receive supplements have the potential to be affected by the alleged deficient practice. A facility audit was conducted to identify any residents that have an order for supplements to ensure they are receiving as ordered. **3) Measures put into place/ System changes:** The nursing staff was educated on supplements by the DON/designee QMA 1 was educated on all the types of supplements provided in the facility. Random audits 3 times a week a various time will be completed by DON/designee to ensure resident are receiving ordered supplements. The DON is responsible for compliance.	

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	Interview with the Administrator, on 2/15/23 at 11:40 a.m., indicated the resident received his Magic cup with his lunch, the MAR should have been updated, and the QMA wasn't truthful. This Federal tag relates to Complaint IN00398992. 3.1-46(a)(2)		**4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **03/09/23**	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and			

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	nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube (peg tube) care was completed as ordered related to cleaning, bandage changes, and water flushes, enteral feedings were documented and administered, and treatments were obtained for a possible infection at the site for 2 of 3 residents reviewed for peg tubes. (Residents D and B) Findings include: 1. On 2/14/23 at 9:00 a.m., Resident D was observed curled up in a ball lying on the bed in the room. At that time, there was a piston syringe set and bottle with the date of 2/10/23 on the outside in black marker. At 9:15 a.m., LPN 1 was asked to go into the room to assess the resident's peg tube site. The resident's gown was not tied so it fell off of her shoulders. The peg tube was secured in the abdomen, and there was no bandage covering or around the stoma. The Record for the resident was reviewed on 2/13/23 at 6:15 p.m. Diagnoses included, but were not limited to, epilepsy, schizophrenia, high blood pressure, intellectual disabilities, speech disturbance, and peg tube status. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident was severely impaired for decision making. The resident received all of her nutrition by the way of a peg tube. Physician's Orders, dated 1/25/23, indicated change syringe every 24 hours and prn every night shift. Physician's Orders dated 2/7/23, indicated cleanse	F 0693	**Aperion- Arbors** **POC Complaint** **Exit 02/15/2023** **Compliance 03/09/2023** **F693 Feeding Tube Management/Restore eating skills** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident D orders were reviewed and an order for enteral feeding was placed in the resident's electronic chart. Area around the	03/09/2023

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	the peg tube site with normal saline, pat dry, and apply split gauze dressing every night shift. The resident was NPO. May bolus enteral feedings of Jevity 1.5, 5 cans daily. Physician's Orders, dated 2/9/23, indicated flush peg tube with 50 cubic centimeters of water every 4 hours for hydration. The Medication Administration Record (MAR) for the month of 2/2023, indicated the syringe change was signed out as being completed on 2/10 through 2/13/23. The cleaning of the peg tube site and applying the bandage was not signed out as being completed on 2/12/23. There was no documentation on the MAR or the Treatment Administration Record (TAR) to indicate if the resident was getting her enteral feeding of Jevity 1.5 - 5 cans a day. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the peg tube should have had a bandage around the stoma. There was no documentation the enteral feeding bolus was being administered to the resident at least 5 times a day. 2. Resident B's record was reviewed on 2/13/23 at 4:26 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following a stroke, dysphagia (swallowing difficulties), and gastrostomy (g-tube). The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was moderately cognitively impaired and he had a feeding tube. A Physician's Order, dated 8/3/21, indicated flush enteral tube every shift with 60 milliliters (ml) of water.		resident stoma was cleaned and dressing placed per physician's order. Resident B was g-tube was assessed for foul odor **2) How the facility identified other residents:** All residents who receive enteral feedings have the potential to be affected by the alleged deficient practice. A facility audit was conducted to identify any residents that have a G tube site to ensure that orders are indicated in the resident's electronic chart. All resident with a stoma were assessed and all negative findings were notified to the Physician. **3) Measures put into place/ System changes:** The nursing staff was educated enteral feeding policy and notification to the physician by the DON/designee Random audits 3 times a week a various time will be completed by DON/designee to ensure resident are receiving ordered enteral feedings and ensuring that stoma sites are being monitored per physician's order. The DON is responsible for compliance. **4) How the corrective actions**	

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	The December 2022 Medication Administration Record (MAR) indicated the water flush was not administered as ordered on 12/16/22 at 8:00 a.m., 12/24/22 at 4:00 p.m., and 12/27/22 at 12:00 a.m. The January 2023 MAR indicated the water flush was not administered as ordered on 1/13/23 at 4:00 p.m. and 1/19/23 at 4:00 p.m. The February 2023 MAR indicated the water flush was not administered as ordered on 2/7/23 at 4:00 p.m. and 2/12/23 at 8:00 a.m. A Nurses' Note, dated 1/23/23 at 7:10 a.m., indicated the resident's g-tube site was observed during a dressing change with a foul odor and drainage noted. The writer indicated they would inform the oncoming nurse to alert the Nurse Practitioner and the wound care nurse. There was no further documentation regarding the foul odor and drainage noted to the g-tube site. Interview with the Director of Nursing on 2/15/23 at 1:47 p.m., indicated there was no follow-up regarding the foul odor and drainage noted on 1/23/23 and the flushes should have been administered as ordered. This Federal tag relates to Complaint IN00396040. 3.1-44(a)(2)		**will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **03/09/23**	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of			

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	155156	A. BUILDING 00 B. WING	02/15/2023

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	practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to monitor/assess dialysis perma catheter and fistula sites, obtain orders for hemodialysis, and monitor fluid restriction for 2 of 3 residents reviewed for dialysis. (Residents E and H) Findings include: 1. The closed record for Resident E was reviewed on 2/13/23 at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was Minimum Data Set (MDS) assessment available for review. The resident was admitted directly to the facility on 2/2/23 from another Long Term Care facility. Ancillary Physician's Orders on the transfer information, dated 1/30/23, indicated the resident was receiving oxygen continuously at 2 liters via nasal cannula and had a dialysis perma catheter to the right chest that was to be checked/assessed every shift. The resident had discontinued dialysis treatment on 1/18/23. A Nurses' Note, dated 2/2/23 at 2:01 p.m., indicated the resident arrived via ambulance transport accompanied by two ambulance transporters. Nursing tried to acclimate the resident to the room, call light, surrounding areas and the television, however, the resident did not respond. Vital signs were checked and within normal limits. A rapid COVID-19 test was administered with negative results. The remainder of the new admission process was passed to the	F 0698	**Aperion- Arbors** **POC Complaint** **Exit 02/15/2023** **Compliance 3/09/2023** **F698 Dialysis** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident E no longer resides in the facility Resident H fluid restriction orders reviewed, and MD notified of the	03/09/2023

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	oncoming shift. A Nurses' Note, dated 2/2/23 at 7:34 p.m., indicated all medication was verified with the Physician and entered into the electronic Medication Administration Record (MAR). The Admission Nursing Assessment, dated 2/2/23, indicated under the section of Intravenous (IV) therapy, nothing was checked for the dialysis perma catheter. Physician's Orders, dated 2/2-2/5/23, indicated there was no orders check/assess the dialysis perma catheter to the right chest. A Nurses' Note, dated 2/5/23 at 12:20 p.m., indicated "resident is not responding, BP is 95/50,o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family." [sic] A Nurses' Note, dated 2/5/23 at 1:20 p.m., indicated report was given to the Emergency Room (ER) at the hospital. A signed document by the Paramedic, dated 2/5/23, indicated EMS (Emergency Medical Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen. The patient's dialysis port was uncovered and not secured to the patient. The patient had multiple sores to his body." A History and Physical by the ER Physician, dated 2/5/23 at 12:33 p.m., indicated "...Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per		increase of fluid that resident was receiving. Orders place for fistula care and monitoring for resident H. Orders placed for dialysis for resident H. **2) How the facility identified other residents:** All residents who receive Dialysis have the potential to be affected by the alleged deficient practice. An audit was completed on all residents who receive dialysis therapy to ensure physician orders are in place and followed. An audit was completed to ensure that permi-caths were identified on admission and order placed to monitor. **3) Measures put into place/ System changes:** The nursing staff will be re-educated on dialysis use per physician order by the DON/designee by 2/27/19 and as needed. The DON/designee will complete random audits on random shifts a minimum of 3 times weekly. The DON/Designee is responsible for compliance. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will	

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	EMS without any oxygen which improved on nonbreather. Patient has a dialysis catheter in his right subclavian that is no longer sutured down. EMS reportedly place a tegaderm over the dialysis catheter to help stabilize it in place. It is unclear how long symptoms have been going on for." The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired in the hospital on 2/7/23. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the there were no Physician's orders or documentation/assessment of the dialysis perma catheter. 2. Resident H's record was reviewed on 2/15/23 at 9:20 a.m. The resident was readmitted to the facility after a hospitalization on 2/3/23. Diagnoses included, but were not limited to, end stage renal disease and dependence on dialysis. The Admission Minimum Data Set assessment, dated 2/7/23, indicated he was cognitively intact and required extensive staff assistance for bed mobility and transfers. There were no Physician Orders in place related to dialysis, monitoring of the fistula (access site) or assessing vital signs before and after dialysis. A Physician's Order, dated 2/4/23, indicated the resident was on a fluid restriction of 1500 milliliters (ml) per 24 hours. Fluid intake logs indicated the following amounts consumed:		identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 03/09/2023**	

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	2/6/23 1,960 mls 2/7/23 2,470 mls 2/9/23 2,240 mls 2/11/23 2,350 mls The Medication Administration Record (MAR) for the month of 2/2023 indicated there was no documentation or monitoring of the fluid restriction or the fistula. Interview with the Director of Nursing, on 2/15/23, indicated the orders had not been updated when the resident returned from the hospital. This Federal tag relates to Complaint IN00401271. 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or			

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	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to ensure an antibiotic ointment was not used for an excessive duration on a gastrostomy (g-tube) site for 1 of 3 residents reviewed for g-tubes. (Resident B) Finding includes: On 2/13/23 at 4:16 p.m., Resident B's g-tube site was observed to have a split gauze dressing surrounding the site. There was no redness, drainage, or odor noted to the site. Resident B's record was reviewed on 2/13/23 at 4:26 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following a stroke, dysphagia (swallowing difficulties), and gastrostomy (g-tube). The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was moderately cognitively impaired and he had a feeding tube. A Physician's Order, dated 9/28/22, indicated cleanse g-tube insertion site with normal saline and pat dry, apply Bacitracin (topical antibiotic ointment) and cover with split gauze and tape. Change daily and as needed for soiled or dislodged dressing. Interview with the Director of Nursing on 2/15/23 at 1:47 p.m., indicated she followed up with the Nurse Practitioner regarding the Bacitracin ointment and it would be discontinued immediately.	F 0757	**POC Complaint Survey** **Exit 02/15/2023** **Compliance 03/09/2023** **F 757 Unnec 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.* **1) Immediate actions taken for those residents identified:** Resident b medication order was reviewed, and medication discontinued. **2) How the facility identified other residents:** **All resident that are prescribed medication are at risk for the**	03/09/2023

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	3.1-48(a)(2)		**same deficient practice. A review of all residents with orders for excessive dosing and stop date for medication.** **3) Measures put into place/ System changes:** **All nursing staff and admission staff have been re-educated on medications for excessive dosing and inadequate monitoring.** **4) How the corrective actions will be monitored:** **The DON/Designee will review all order changes/new admission medication orders for proper diagnosis and errors. The DON/Designee will audit 3 resident's charts?/EMAR a week to ensure that there is no excessive dosing.** **The results of 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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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should		**5) Date of compliance: 03/09/23**	

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	be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain	F 0880	**Aperion- Arbors** **POC Infection Control Survey**	03/09/2023

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	COVID-19, related to personal protective equipment (PPE) not worn before entering COVID-19 positive resident rooms, hand hygiene not completed before donning PPE, and the lack of increased monitoring for residents diagnosed with COVID-19 for random observations for infection control for 4 of 4 residents reviewed for COVID-19 and 1 of 4 units observed. (Residents D, L, C and K and Unit 200) Findings include: 1. During a random observation 2/14/23 at 9:10 a.m., Housekeeper 1 was observed pushing a cleaning cart towards Resident D's room. At that time she was wearing gloves to both hands and asked if there was anyone in the room. There was a sign on the resident's door which indicated "Red Zone" and proper PPE was to be utilized before entering the room. At the time, the housekeeper was wearing an N95 face mask. She donned a clean isolation gown with the same gloved hands and walked into the room without any protective eyewear. The housekeeper mopped the floor and cleaned the room. The resident was observed in the room lying in the bed. During a random observation on 2/14/23 at 9:15 a.m., LPN 1 was observed preparing to enter the resident's room. The LPN was wearing 2 surgical face masks. She removed an N95 face mask from the drawer and placed it over the surgical masks. She donned a clean isolation gown and donned clean gloves to both hands and entered the resident's room. The LPN did not perform hand hygiene before donning the gloves. She did not wear any protective eye wear. While inside the room, she was asked to lift the resident's gown to observe her peg tube.		**Exit 02/15/2023** **Compliance 03/09/2023** **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 required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Staff identified practicing this deficient practice were immediately in serviced on the policy for infection control. CNA1 Housekeeper 1 and LPN1. Resident D,K,L and C respiratory screeners were updated **2) How the facility identified other residents:** All residents in	

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	The record for Resident D was reviewed on 2/13/23 at 6:15 p.m. Diagnoses included, but were not limited to, epilepsy, schizophrenia, high blood pressure, intellectual disabilities, speech disturbance, and peg tube status. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident was severely impaired for decision making. The resident received all of her nutrition by the way of peg tube. Physician's Orders, dated 2/11/23, indicated strict isolation for COVID-19. A Nurses' Note, dated 2/12/23 at 5:57 a.m., indicated the resident changed rooms due to being COVID-19 positive. The Respiratory Infection Screener Assessment indicated the following assessments were completed after the resident had tested positive for COVID-19: - 2/12/23 at 1:58 p.m. and 8:29 p.m. - 2/13/23 at 2:15 a.m. the pulse respirations, and oxygen saturation were from 2/12/23 at 8:29 p.m. - 2/13/23 at 6:47 p.m., the pulse and respirations were from 2/12/23 at 8:29 p.m., and the oxygen saturation was from 2/13 at 9:17 a.m. - 2/14/23 at 4:19 a.m., the pulse and respirations were from 2/12/23 at 8:29 p.m., and the oxygen saturation was from 2/13 at 9:17 a.m. Interview with the Nurse Consultant on 2/14/23 at 3:30 p.m., indicated residents who were positive for COVID-19 were to be assessed every shift. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the Respiratory Screening Assessments were not completed every shift as		transmission-based precautions have the potential to be affected by this deficient practice. All residents with respiratory screeners were audited for accuracy. **3) Measures put into place/ System changes:** Facility IDT team completed a root cause analysis and Infection Control Self-Assessment with the Corporate Infection Control Preventionist. Reviewed findings and developed action plan and education materials based on findings. Staff re-educated regarding PPE use and spread of infections as it relates to transmission-based precautions. Nursing staff reeducated on respiratory screener for Covid 19 monitoring. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will monitor for appropriate PPE use by completing visual rounds throughout the facility at least once daily to ensure that staff and visitors are practicing appropriate Infection Control guidelines. Daily monitoring and visual rounds will	

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	per their policy when a resident had COVID-19. At the time of the respiratory assessment, current vital signs were to be obtained. They had no further information for review. 2. During a random observation on 2/13/23 at 6:30 p.m., CNA 1 was observed passing meal trays to the residents in their rooms. Resident L's room had a sign on the door that indicated "Red Zone" and proper PPE was to utilized before entering the room. CNA 1 indicated at that time, the resident was positive for COVID-19. The CNA had the resident's meal tray and before entering the room, he donned a clean isolation gown, removed his old N95 face mask and donned a clean N95 face mask, donned clean gloves to both hands and placed a face shield over his eyes. He did not perform hand hygiene before donning any of the PPE. The record for Resident L was reviewed on 2/14/23 at 10:00 a.m. Diagnoses included, but were not limited to, COVID-19, heart disease, atrial fibrillation, high blood pressure, and angina. The 1/24/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident had a history of 2 or more falls since last assessment and 1 with a minor injury. Physician's Orders, dated 2/8/23, indicated droplet and contact isolation for COVID-19 positive. Nurses' Notes, dated 2/8/23 at 4:00 p.m., indicated the resident tested positive for COVID-19. The Respiratory Infection Screener Assessment indicated the following assessments were completed after the resident had tested positive		continue for at least 6 weeks and until compliance in maintained then rounds and monitoring 5x/week for 5 weeks x2 weeks, then at least 3x/week thereafter on varied shifts. The Director of Nursing/ Designee will review respiratory screeners 5 days a week for 6 months to ensure completion and accuracy. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/09/23**	

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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
	for COVID-19: - 2/9/23 at 9:52 p.m., the temperature was from 2/8/23 - 2/10/23 at 12:57 a.m., the temperature was from 2/8/22 and the oxygen saturation was from 2/9/23 at 9:53 p.m. - 2/10/23 at 11:53 a.m., the temperature was from 2/8/22 and the oxygen saturation was from 2/9/23 at 9:53 p.m. - 2/11/23 at 10:15 a.m. the temperature and oxygen saturation was from 2/11/23 at 12:01 a.m. - 2/11/23 at 9:04 p.m., 2/12/23 at 1:05 a.m., 12:37 p.m., and 8:47 p.m., and 2/13/23 at 1:00 a.m. all vital signs were from 2/11/23 at 12:01 a.m. - 2/14/22 at 1:52 p.m., and 8:42 p.m., all vital signs were from 2/14/23 at 1:52 p.m. - 2/15/23 at 1:17 a.m., all vital signs were from 2/14/23 at 1:52 p.m. Interview with LPN 1 on 2/14/23 at 9:50 a.m., indicated she was unaware if she could wear 2 surgical face masks at time and the N95 face mask needed to be directly against her face and not over the surgical face masks. She indicated she thought her glasses were fine to wear as protective eye wear. Interview with the Nurse Consultant on 2/14/23 at 3:30 p.m., indicated residents who were positive for COVID-19 were to be assessed every shift. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., the Respiratory Screening Assessments were not completed every shift as per their policy when a resident had COVID-19. At the time of the respiratory assessment, current vital signs were to be obtained. They had no further information for review. The updated and current 10/31/22 "Infection			

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	155156	A. BUILDING 00 B. WING	02/15/2023

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	Control interim COVID-19" policy, provided by the Director of Nursing on 2/13/23 at 6:30 p.m., indicated the health care professional should perform hand hygiene before and after all resident contact, contact with potentially infectious material and before putting on and after removing PPE. 3. Resident C's record was reviewed on 2/13/23 at 6:18 p.m. Diagnoses included, but were not limited to, COVID-19, heart disease, and chronic obstructive pulmonary disease. The Quarterly Minimum Data Set (MDS) assessment, dated 1/3/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 2/9/23 at 7:00 a.m., indicated the resident was COVID-19 positive and required strict isolation with droplet and contact precautions. A Physician's Order, dated 2/9/23 at 7:00 a.m., indicated COVID-19 monitoring temperature, oxygen saturation, and symptoms every shift. A Respiratory Infection Screener, dated 2/9/23 at 9:27 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. A Respiratory Infection Screener, dated 2/10/23 at 10:23 a.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. A Respiratory Infection Screener, dated 2/10/23 at 7:53 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment.			

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	There was no further documentation related to COVID-19 assessments. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the resident should have a full assessment completed at least every shift including a respiratory assessment while COVID-19 positive. 4. Resident K's record was reviewed on 2/14/23 at 10:16 a.m. Diagnoses included, but were not limited to, COVID-19, Parkinson's disease, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 1/3/23, indicated the resident was severely impaired for daily decision making. A Physician's Order, dated 2/9/23 at 7:00 a.m., indicated the resident was COVID-19 positive and required strict isolation with droplet and contact precautions. A Physician's Order, dated 2/9/23 at 3:00 p.m., indicated COVID-19 monitoring temperature, oxygen saturation, and symptoms every shift. A Respiratory Infection Screener, dated 2/9/23 at 9:17 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. A Respiratory Infection Screener, dated 2/10/23 at 12:55 a.m., included vital signs noted from previous assessment at 9:18 p.m. A Respiratory Infection Screener, dated 2/10/23 at 10:26 a.m., included vital signs noted from previous assessment on 2/9/23 at 9:18 p.m.			

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	A Respiratory Infection Screener, dated 2/10/23 at 7:56 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. There was no further documentation related to COVID-19 assessments. Interview with the Director of Nursing on 2/15/23 at 1:55 p.m., indicated the Respiratory Infection Screener assessments were to be completed with updated vital signs every shift while COVID-19 positive. 5. During random observations on 2/13/23 on the 200 Unit the following was observed: a. At 6:05 p.m., CNA 2 was observed delivering meal trays to Room 201. The door was marked for transmission based precautions as both residents were positive for COVID-19. CNA 2 entered the room without performing hand hygiene. She was wearing a surgical mask. She did not don an N95 mask, eye protection, a gown, or gloves. She did not perform hand hygiene upon exiting the room. b. At 6:09 p.m., CNA 1 was observed delivering a meal tray to Resident C. The door was marked for transmission based precautions as the resident was COVID-19 positive as well as her roommate Resident K. CNA 1 did not perform hand hygiene prior to entering the room. He was wearing an N95 mask. He did not don eye protection, a gown, or gloves. Upon exiting the room, he did not dispose of his N95 mask and he did not perform hand hygiene. c. At 6:13 p.m., CNA 2 was observed answering a call light for Resident C. The door was marked for transmission based precautions as the resident			

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	was COVID-19 positive as well as her roommate Resident K. CNA 2 did not perform hand hygiene prior to entering the room. She was wearing a surgical mask. She did not don an N95 mask, eye protection, a gown, or gloves. Upon exiting the room, she did not perform hand hygiene. d. At 6:17 p.m., CNA 2 was observed entering Resident C and Resident K's room carrying a meal tray. She did not perform hand hygiene prior to entering the room. She was wearing a surgical mask. She did not don an N95 mask, eye protection, a gown, or gloves. She performed hand hygiene upon exiting the room. Interview with CNA 2 on 2/13/23 at 6:40 p.m., indicated she did not don PPE prior to going into any of the COVID-19 positive rooms on the 200 unit. The updated and current 10/31/22 "Infection Control interim COVID-19" policy, provided by the Director of Nursing on 2/13/23 at 6:30 p.m., indicated if entering a Red Zone room under COVID-19 transmission based precautions, staff must wear full PPE including N95 respirator, eye protection, gown and gloves. If the resident test positive for COVID-19, frequency of monitoring will be increased to at least every shift, including vital signs (temperature, pulse, respirations, oxygen saturation) This Federal tag relates to Complaint IN00400678. 3.1-18(b)			