PRINTED: 03/27/2023

			TREATED.				
PARTMENT OF HEALTH AND HUMAN SERVICES							
ENTERS FOR MEDICARE & MEDIC.	AID SERVICES		OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COMPLETED				

	D PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		A. BUILDING 00 B. WING			CO	COMPLETED 02/15/2023	
	PROVIDER OR SUPPLIEF			1101 E	ADDRESS, CITY, STATE, ZIP CO COOLSPRING AVE SAN CITY, IN 46360	D		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION JULD BE PROPRIATE	(X5) COMPLETION DATE	
0000								
Bldg. 00	IN00396040, IN003	ne Investigation of Complaints 396435, IN00396689, IN00398992, 401271, and IN00401730.	F 00	000				
	Federal/state defici	6040 - Substantiated. encies related to the d at F679, F684, F686, and F693.						
	Complaint IN00396 lack of evidence.	6435 - Unsubstantiated due to						
	-	6689 - Substantiated. encies related to the 1 at F677.						
	Federal/state deficie	8992 - Substantiated. encies related to the 1 at F600, F677, F690, and F692.						
	^	0678 - Substantiated. encies related to the d at F677 and F880.						
	Federal/state deficie	1271 - Substantiated. encies related to the 1 at F580, F600, F684, and F698.						
	•	1730 - Substantiated. encies related to the 1 at F684.						
	Unrelated deficienc	ey is cited.						
	Survey dates: Febr	uary 13, 14, and 15, 2023						
	Facility number: 00 Provider number: 1							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155156 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156		l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 02/15	LETED	
	ROVIDER OR SUPPLIER		•	1101 E	DDRESS, CITY, STATE, ZIP COD COOLSPRING AVE AN CITY, IN 46360		
7 1 21 1 0 1				1	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	AIM number: 1002	271060					
	Census Bed Type: SNF/NF: 133 Total: 133						
	C D T						
	Census Payor Type	:					
	Medicare: 23 Medicaid: 72						
	Other: 38						
	Total: 133						
	10tal. 155						
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review com	upleted on 2/17/23.					
F 0580	483.10(g)(14)(i)-(i	v)(15)					
SS=G		s (Injury/Decline/Room, etc.)					
Bldg. 00		otification of Changes.					
g		mmediately inform the					
	resident; consult v	-					
	· ·	tify, consistent with his or					
		resident representative(s)					
	when there is-						
		volving the resident which					
	, ,	nd has the potential for					
	requiring physicia	· · · · · · · · · · · · · · · · · · ·					
		hange in the resident's					
	` '	or psychosocial status					
		ation in health, mental, or					
	,	us in either life-threatening					
		cal complications);					
		r treatment significantly					
	• •	discontinue an existing					
	form of treatment	_					
		to commence a new form					
	of treatment); or	to commonde a new room					
	· ·	transfer or discharge the					
	• •	facility as specified in					

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Event ID:

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W	ING		02/15/	/2023
	PROVIDER OR SUPPLIER			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(g)(14)(i) of this so ensure that all per in §483.15(c)(2) is upon request to the (iii) The facility muresident and the rany, when there is (A) A change in reassignment as specific (B) A change in reassignment as specific (B) A change in reassignment (B) (10) (iv) The facility muresident (B) (10)	ust also promptly notify the esident representative, if secom or roommate ecified in §483.10(e)(6); or esident rights under Federal gulations as specified in of this section. ust record and periodically ses (mailing and email) and					
	facility that is a codefined in §483.5 admission agreen configuration, included that comprise the and must specify room changes be under §483.15(c)(Based on record refailed to promptly abnormal laborator in treatment for whospitalized for sepintubation and ultimes admission and ultimes admission.	uding the various locations composite distinct part, the policies that apply to tween its different locations	F 0:	580	Aperion- Arbors Michigan C Complaint Survey Exit 02/15/2023 Compliance 03/9/2023	ity	03/09/2023

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The closed record for Resident E was reviewed on

Event ID:

GFQM11 Facility ID: 000076

F 580 Notification

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155156	B. WI	ING	_	02/15/	/2023
NAME OF I	PROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					COOLSPRING AVE		
APERIO	N CARE ARBORS I	MICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION Diagnoses included but were		TAG	DEFICIENCT)		DATE
	_	D, respiratory failure, acute					
		tube, epilepsy, anxiety, and			This Plan of Correction is the		
	heart failure.				center's credible allegation of		
					compliance.		
	There was Minimum Data Set (MDS) assessment				,		
	available for review	7.			Preparation and/or execution	of	
					this plan of correction does no	t	
		rsing Assessment, dated			constitute admission or agreei	nent	
	2/2/23, indicated the resident was observed with				by the provider of the truth of t		
	pursed lip breathing and his lung sounds on both				facts alleged or conclusions se	et .	
	sides were clear, diminished with rales. No				forth in the statement of		
	equipment for respiratory status was checked on				deficiencies. The plan of		
	the form.				correction is prepared and/or		
	A D1	1 4 12/2/22 : 1: 4 14			executed solely because it is		
	-	r, dated 2/3/23, indicated to			required by the provisions of		
		(Complete Blood Count) with			federal and state law.		
	_	telets, a CMP (Comprehensive Glycohemoglobin A1C, a			4) Immediate actions take	_	
	1	function panel, a thyroid			1) Immediate actions take for those residents identified		
	profile with a T4 ar				Resident E no longer resides i		
	prome with a 14 an	1311, and a 1371.			the facility.	"	
	The lab results were	e obtained on 2/3/22 and					
	reported to the facil	ity on 2/3/23 at 10:24 p.m.,					
	however, there was	no documentation the			2) How the facility identified	ed	
		notified of the abnormal			other residents:		
		ults were as follows:			Audits completed of all curren	t	
	- CBC				residents' labs orders to ensur		
	_	0.3 grams (gm) (normal 14.0 -			that physician notification was		
	18.0)	70// 142.0 52.0			completed.		
	Hematocrit was 33.	7% (normal 42.0 - 52.0)					
	- CMP						
	_	en (BUN) was 132 (normal 7-28)			3) Measures put into place	e/	
	Creatinine was 4.02 (normal 0.44-1.32)				System changes:		
	Sodium was 164 (normal 138-147)				Nursing department educated	l on	
	Glucose was 230 (n	ormal 70-110)			notification Policy		
	The lab had sugges	ted the BUN and Sodium be					
	repeated if necessar				4) How the corrective actions		

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	00	COMPLETED	
		155156	B. WI	ING		02/15/2023	
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE		
APERIO	N CARE ARBORS I	MICHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	7F1 '1 4 '4 1	. 2/5/22			will be monitored:		
		signs on 2/5/23 were			DON/ED will review 24		
	documented at 10:37 a.m. The resident's blood pressure was 164/86 and the oxygen saturation				hours report daily for orders	•	
	was 97% on room a				(including Lab) , significant	_	
	was 9/70 oii 100iii a	ш.			changes, and assessments		
	A Nurses! Note dot	red 2/5/23 at 12:20 p.m.,			days a week for 3 months ar		
		is not responding, BP is			days a week for 3 months. T will ensure that the family	1113	
		respi is 16/min, blood sugar is			notification is completed.		
		in ER. notified to DON and			nouncation is completed.		
	family." [sic]	I III Day notified to Dorvand			The results of these audits v	vill	
	idinity. [Sie]				be reviewed in Quality	VIII	
	A Nurses' Note, dated 2/5/23 at 1:20 p.m.,				Assurance Meeting monthly	×6	
	indicated report was given to the Emergency				months or until an average of		
	Room (ER) at the h				90% compliance or greater is		
	1100111 (211) 411 1110 11				achieved x3 consecutive	"	
	A signed document	by the Paramedic, dated			months. The QA Committee	,	
	-	MS (Emergency Medical			will identify any trends or		
		ched to the extended care			patterns and make		
		erson. The patient had been			recommendations to revise	the	
		er an hour. The patient was			plan of correction as indicat	ed.	
		The patient's dialysis port was					
		secured to the patient. The					
	patient had multiple	-			5) Date of compliance:		
					03/09/2023		
		ical by the ER Physician,					
		3 p.m., indicated "Patient					
	presents to ED via l	EMS from (nursing home					
	· ·	ental status and shortness of					
		hypoxic down to the 80's per					
		xygen which improved on					
		t has a dialysis catheter in his					
	-	t is no longer sutured down.					
		ce a tegaderm over the dialysis					
	_	pilize it in place. It is unclear					
	how long symptoms	s have been going on for."					
		dicated the patient was					
		d not respond or follow any					
	commands. The nat	ient had decreased breath					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY ETED	
		155156	B. W	ING		02/15/	2023
	PROVIDER OR SUPPLIEI		•	1101 E	DDRESS, CITY, STATE, ZIP COD COOLSPRING AVE AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	intubated due to hy failure. Labs were resident tested posi was 199, Creatining Potassium was 5.8 382, and White Blod 4.8-10.8). A Lactic Acid lab to (normal 0.5-1.0. A body tissues were refered the transfer of the failure of the control of the control of the critic received on 2/3/23. This Federal tag refered was were at 11:30 a.m., indicate the control of the critic received on 2/3/23.	Director of Nursing on 2/15/23 cated the Physician was not call lab results drawn and					
F 0600 SS=G Bldg. 00	Exploitation The resident has abuse, neglect, m property, and exp subpart. This inclined freedom from corrinvoluntary seclus	the right to be free from nisappropriation of resident oloitation as defined in this ludes but is not limited to					

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Event ID:

GFQM11 Facility ID: 000076

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039		
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155156	B. WING		02/15/2023		
					1 1 1 1 1 1 1		
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD			
			1101 E COOLSPRING AVE				
APERION	N CARE ARBORS I	MICHIGAN CITY	MICHIO	GAN CITY, IN 46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	•			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE .		
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE		
	resident's medical	i symptoms.					
	0400 40/ \ \						
	§483.12(a) The fa	icility must-					
	0400 407 7747 81 7						
	- , , , ,	use verbal, mental, sexual,					
		, corporal punishment, or					
	involuntary seclus						
		view and interview the facility	F 0600		03/09/2023		
	•	esident's right to be free from					
	neglect related to th	ne failure of		Aperion- Arbors			
	monitoring/assessin	ng a dialysis perma catheter,					
	lack of Physician no	otification of abnormal lab		Complaint Survey 02/15/23			
	results and failure to	o administer oxygen for a					
		ory distress which resulted in a		Compliance 03/9/23			
	-	septic shock and required					
	-	nately death for 1 of 3 residents					
	reviewed for neglec	-		F-600 Free from Abuse			
	Teviewed for neglec	it (itesident E)		1 -000 i ree iroin Abuse			
	Finding includes:			This Plan of Correction is the			
	i maing merades.			center's credible allegation of			
	The closed record f	or Resident E was reviewed on		compliance.			
		. Diagnoses included but were		Compliance.			
	_	D, respiratory failure, acute		Proporation and/or avas: 4:5-5	of		
				Preparation and/or execution			
		tube, epilepsy, anxiety, and		this plan of correction does no			
	heart failure.			constitute admission or agree			
	man seri	D (G (A D)G)		by the provider of the truth of			
		m Data Set (MDS) assessment		facts alleged or conclusions s	et		
	available for review	V.		forth in the statement of			
				deficiencies. The plan of			
		lmitted directly to the facility		correction is prepared and/or			
		ther Long Term Care facility.		executed solely because it is			
		s's Orders on the transfer		required by the provisions of			
	information, dated	1/30/23, indicated the resident		federal and state law.			
	was receiving oxyg	en continuously at 2 liters via					
		and a dialysis perma catheter to		1) Immediate actions taken f	or		
		was to be checked/assessed		those residents identified:			
	_	ident had discontinued		Resident E no longer resides	in		
	dialysis treatment o			the facility			
		<i>x</i>					

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A Nurses' Note, dated 2/2/23 at 2:01 p.m.,

Event ID:

 $GFQM11 \quad \text{Facility ID:} \quad 000076$

2) How the facility identified

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W	ING		02/15/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			COOLSPRING AVE		
APERIO	N CARE ARBORS I	MICHIGAN CITY			GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		nt arrived via ambulance ied by two ambulance			other residents: All residents	=	
		_			have the potential to be affect by this deficient practice. All	lea	
	transporters. Nursing tried to acclimate the resident to the room, call light, surrounding areas				residents have the potential to	o he	
	and the television, however, the resident did not				affected by the finding. Skin	o be	
	respond. Vital signs were checked and within				checks were completed to ide	entify	
		oid COVID-19 test was			areas that need to be assess	-	
	administered with negative results. The remainder				and monitored. (including	=	
	of the new admission process was passed to the				permi-cath). Lab audit comple	eted	
	oncoming shift.				to ensure notification to the		
					Physician. Facility staff comp	leted	
	A Nurses' Note, dat	ted 2/2/23 at 7:34 p.m.,			house wide Oxygen saturatio	n	
	indicated all medication was verified with the				audit to identify resident that	have	
	Physician and entered into the electronic				a need for oxygen.		
	Medication Administration Record (MAR).						
	The Admission Nu	rsing Assessment, dated			3) Measures put into place/		
		e resident was observed with			System changes:		
	· ·	g and his lung sounds on both					
	sides were clear, di	minished with rales. No					
	equipment for respi	ratory status was checked on			Staff will be re-educated on		
	the form. Under the	section of Intravenous (IV)			Facility abuse Policy. (Includi	ng	
		as checked as well for the			Neglect) Staff were re-educa	ited	
	dialysis perma cath	eter.			on Abuse on 2/1/23 and ong	-	
					 Nursing staff educated 	on	
		dated 2/2-2/5/23, indicated			admissions, notification and		
	there were no order	• •			Identifying assessing and		
		alysis perma catheter to the			monitoring.		
	right chest.				Nursing staff re-educat paneling in condition (included)		
	Physician's Orders	dated 2/2/23, indicated the			on change in condition (include respiratory distress) and whe	•	
	_	and was to receive an enteral			apply oxygen.	וו נט	
		cerna 1.5 at 65 cubic			Skin checks upon		
		m 10:00 a.m., until 6:00 a.m.			admission and weekly		
	The peg tube was to be flushed with 180 milliliters						
	(ml) of water every						
	A Physician's Order	r, dated 2/3/23, indicated to			4) How the corrective setime		
		(Complete Blood Count) with			4) How the corrective action will be monitored: The	io	
					Administrator /designee will		
	differential and platelets, a CMP (Comprehensive				Administrator /designee will		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155156	B. W	ING		02/15/	2023
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	N CADE ADDODO	MICHICANICITY			COOLSPRING AVE		
APERIO	N CARE ARBORS	MICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Metabolic Panel), a	Glycohemoglobin A1C, a			conduct audits in care area re	lated	
	Lipid panel, a renal function panel, a thyroid				to neglect including Change ir	ı	
	profile with a T4 and TSH, and a PSA.				condition, labs, MD notification	ns,	
					abnormal vital and dressings.		
	The lab results were obtained on 2/3/22 and				Administrator DON/designee	will	
	reported to the faci	lity on 2/3/23 at 10:24 p.m.,			conduct these audits with 5		
	however, there was	s no documentation the			residents per week for 6 week	(s. 3	
	Physician was ever	notified of the abnormal			resident for 6 weeks and 2		
	results. The lab res	sults were as follows:			residents 12 weeks to ensure	staff	
	- CBC				compliance with Abuse Policy		
	Hemoglobin was 10	0.3 grams (gm) (normal 14.0 -			Any reported issues will be		
	18.0)				handled per the Abuse Policy		
	Hematocrit was 33.7% (normal 42.0 - 52.0)				Audits will continue until 6 mo	nths	
				of compliance is achieved.			
	- CMP						
	Blood Urea Nitroge	en (BUN) was 132 (normal 7-28)			The results of these audits w	/ill	
	Creatinine was 4.02	2 (normal 0.44-1.32)			be reviewed in Quality		
	Sodium was 164 (n	normal 138-147)			Assurance Meeting monthly	for	
	Glucose was 230 (r	normal 70-110)			6 months or until an average	of	
					90% compliance or greater is	8	
		ted the BUN and Sodium be			achieved x3 consecutive		
	repeated if necessar	ry.			months. The QA Committee		
					will identify any trends or		
		signs on 2/5/23 were			patterns and make		
		37 a.m. The resident's blood			recommendations to revise		
	_	6 and the oxygen saturation			plan of correction as indicate	ed.	
	was 97% on room a	air.					
		10/5/00 10.00			5) Date of compliance:		
		ted 2/5/23 at 12:20 p.m.,			03/09/23		
		is not responding, BP is					
		, respi is 16/min, blood sugar is					
		n in ER. notified to DON and					
	family." [sic]						
		. 10/5/02 100					
		ted 2/5/23 at 1:20 p.m.,					
	_	s given to the Emergency					
	Room (ER) at the h	nospital.					
	A =:==== 1 1	the the Demonstration 1 to 1					
	1 -	t by the Paramedic, dated					
	2/3/23, indicated E.	MS (Emergency Medical					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W	ING		02/15/	/2023
				CTREET	DDDEGG CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
ADEDIO	A CADE ADDODO	MICHICANI CITY			COOLSPRING AVE		
APERIO	N CARE ARBORS I	MICHIGAN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Service) was dispat	ched to the extended care					
	facility for a sick pe	erson. The patient had been					
	unconscious for ove	er 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 Phys	sical by the ER Physician,					
	dated 2/5/23 at 12:3	33 p.m., indicated "Patient					
	*	EMS from (nursing home					
	name) for altered m	nental status and shortness of					
	breath. Patient was	hypoxic down to the 80's per					
	· ·	xygen which improved on					
	nonbreather. Patien	t has a dialysis catheter in his					
	1 -	t is no longer sutured down.					
	EMS reportedly pla	ace a tegaderm over the dialysis					
	catheter to help stat	pilize it in place. It is unclear					
	how long symptom	s have been going on for."					
		dicated the patient was					
		d not respond or follow any					
	_	tient had decreased breath					
		At 1:30 p.m., the resident was					
		poxemia and respiratory					
		obtained which indicated the					
		tive for COVID-19. The BUN					
		e was 6.2, Sodium was 156,					
		(normal 3.6-5.0) Glucose was					
		ood Cells were 15.50 (normal					
	4.8-10.8).						
		est was obtained which was 3.4					
	`	high lactic acid meant that					
		not getting enough oxygen).					
		agnosed with Severe					
		k (Severe sepsis develops					
		caused organ damage. Septic					
		severe form in which the					
		w blood pressure, resulting in					
	damage to multiple	organs). The resident expired					

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AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION IG <u>00</u>	COMP	(X3) DATE SURVEY COMPLETED 02/15/2023	
	PROVIDER OR SUPPLIEIN CARE ARBORS		110	EET ADDRESS, CITY, STAT 01 E COOLSPRING A CHIGAN CITY, IN 463	VE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TAG	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE 1 TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
	in the hospital on 2 Interview with the p.m., indicated the was asked about the time of admission. seen the catheter ar Administrator indicate facility. Interview with the at 11:30 a.m., indicate of the labs documentation/associatheter and there woxygen administered have a change in course the hospital. They be review.						
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service nutrition, groomin hygiene; Based on record refailed to ensure AD care was provided to	ed for Dependent Residents esident who is unable to sof daily living receives the es to maintain good g, and personal and oral view and interview, the facility of (activities of daily living) to a dependent resident related reduled for 1 of 3 residents care. (Resident F)	F 0677	Aperion- Arbors POC Complaint Exit 02/15/23 Compliance 03/	: Survey	03/09/2023	

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED	
		155156	B. WI	ING		02/15/2	2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			COOLSPRING AVE			
ΔPERIO	N CARE ARBORS	MICHIGAN CITY			GAN CITY, IN 46360			
AI LINIO		WIIOTHGAN OTT		WIIOTIIC				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		for Resident F was reviewed on						
		a. She was admitted on 11/23/22.			F 677 ADL Dependent			
	Diagnoses included, but were not limited to,				Residents			
	_	e, heart failure, and chronic						
	_	ary disease. She was			This Plan of Correction is the			
	discharged to the hospital on 1/12/23.				center's credible allegation of			
					compliance.			
		nimum Data Set assessment,				_		
	dated 11/28/22, indicated she required extensive				Preparation and/or execution			
staff assistance for bed mobility and toileting, and only transferred once or twice with extensive				this plan of correction does no				
	_ ·	ce or twice with extensive			constitute admission or agree			
	assistance. The Point of Care tasks indicated she was				by the provider of the truth of			
					facts alleged or conclusions s	et		
		e a shower or bath on			forth in the statement of			
		sdays. Shower sheets were			deficiencies. The plan of			
		22, 11/28/22, 12/5/22, 12/15/22			correction is prepared and/or executed solely because it is			
		e were no refusals documented			required by the provisions of			
	on these dates.	e were no rerusais documented			federal and state law.			
	on these dates.				l lederar and State law.			
	Interview with the	Administrator on 2/15/23 at			1) Immediate actions taken f	or		
		ed there was no additional			those residents identified:	°'		
	information for this				Resident F no longer resides	in		
	Information for this	, residenti			the facility.	"'		
	This Federal tag re	lates to Complaints IN00396689,			and radinty.			
	IN00398992 and II	-						
					2) How the facility identified			
	3.1-38(a)(2)(A)				other residents:			
					The facility completed an audi	it to		
					identify any dependent reside			
					who need assistance with			
					grooming and personal hygier	ne.		
					The facility staff provided			
					grooming and personal care			
					including showers as needed.			
					3) Measures put into place/			
					System changes: The facility			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/15/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112			
				staff was in-serviced on provi ADL care for residents unable carry out activities of daily livi and to ensure that residents receive good nutrition, groom and hygiene.	e to ng			
				4) How the corrective action will be monitored: The DON/Designee will comp Dignity Rounds at least 5 time weekly at varied times to ensure proper hygiene is maintained facility residents. The Administrator will run POC autimes weekly to ensure that residents are offered a shower responses are documented in electronic record.	olete es ure for udit 5			
				The results of these audits to be reviewed in Quality Assurance Meeting monthly months or until an average of 90% compliance or greater if achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated 5) Date of compliance: 03/09/23	xx6 of s			

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/15/2023					
	NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE				
F 0679 SS=D Bldg. 00	§483.24(c) Activit §483.24(c)(1) The on the compreher plan and the prefe ongoing program choice of activities group and individing independent activinterests of and si and psychosocial encouraging both interaction in the Based on observation interview, the facility impaired residents ongoing activities in assisted to a favoring residents reviewed and K) Findings include: 1. On 2/14/23 at 9:00 observed curled up the room. At that the isolation for COVII and there was no tended to the television or radio in the constant of the constant in the constant of the constant	e facility must provide, based asive assessment and care brences of each resident, and to support residents in their is, both facility-sponsored ual activities and lities, designed to meet the support the physical, mental, well-being of each resident, independence and community. In record review, and the failed to ensure cognitively in isolation for COVID-19 had in the room and a resident was the activity of church for 3 of 3 for activities. (Residents D, B, Of a.m., Resident D was in a ball lying on the bed in me, the resident was in D-19. The lights were turned off levision or radio in the room. The resident was laying in bed, is turned off. There was no	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 agreed by the provider of the truth of the facts alleged or conclusions see forth in the statement of deficiencies. The plan of	t ment he				

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The Record for the resident was reviewed on

Event ID:

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correction is prepared and/or

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CENTERS FO	ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155156	A. BUILDING 00 COMPLETE B. WING 02/15/202				
		155156	B. W1	_		02/15/	72023
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE ARBORS	MICHIGAN CITY			COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
-		n. Diagnoses included, but were			executed solely because it is		
	_	epsy, schizophrenia, high blood			required by the provisions of		
	pressure, intellectual disabilities, speech disturbance, and peg tube status. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident				federal and state law.		
					4) Immediate estima talvan fo		
					1) Immediate actions taken for those residents identified:	or	
					those residents identified.		
	1	red for decision making. The			Resident D was provid	ed	
		o answer the questions for the			with TV. Resident B was esco		
		e indicated it was very			to the next available church		
		choose what clothes to wear,			service. Resident K was provid	ded	
	somewhat importar	nt to read books or the			with a radio.		
	newspaper, very in	nportant to listen to music, and					
		o her favorite activities. The			2) How the facility identified		
		ll of her nutrition by the way of			other residents:		
	a peg tube.				All residents who reside in the		
		1.1.10-700			facility have the risk to be affect		
		sment, dated 1/27/23, indicated			by the alleged deficient practic		
	current interests inc	cluded television and music.			The resident preferences were		
	There was no Care	Plan for activities			review by the Activity Director ensure that the facility is provide		
	There was no care	Tian for activities.			preferred activities for resident	-	
	Physician's Orders.	dated 2/11/23, indicated strict			isolation and cognitively intact		
	isolation for COVI				impaired residents.	and	
					'		
	An Activity Partici	pation 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				3) Measures put into place/		
					System changes:		
					Activity staff educated on the		
	was offered to the	resident.			facility activity programs and		
	T	A 11 11 D1 1 2/15/22			preferences.		
		Activity Director on 2/15/23 at			A Hamaka a a a a		
		ed she was unaware there was			4) How the corrective actions	6	
		lio in the resident's room. th Resident B on 2/14/23 at			will be monitored:	ho	
		ed the resident only liked to go			The Activities Review tool will		
		ces the facility provided on			completed at least 3 times a w for 4 weeks and weekly therea		
	I so the church service	ses are ruerity provided on	1		I ioi - wooks and weekly lileted	iii.Oi	I

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.

to ensure compliance. The

Administrator/Designee is

responsible for compliance.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET B. WING 02/15/20			ETED		
		100100	B. WI	_		02/15/	12023
	PROVIDER OR SUPPLIE			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE		
	N CARE ARBURS	IVIIONIGAN OH I		MICHIG	GAN CITY, IN 46360		_
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	He did not enjoy ar facility provided. Resident B's record 4:26 p.m. Diagnose to, hemiplegia (one left side following disorder. The Quarterly Min assessment, dated has moderately coextensive assistance assist for bed mobi personal hygiene. It range of motion with both upper and low has an interest in we to music, pet interest family, sports, and included, but were activities provided encourage the reside of his choosing. An interview with at 2:32 p.m., indication one church service year. It was an ong getting the resident services every Saturation on 2/13/23 at 4:0 observed in bed with activity occurring a con 2/14/23 at 11:0	7/26/21, indicated the resident vatching TV/movies, listening action, spending time with current events. Interventions not limited to, one to one three times weekly and dent to participate in activities the Activity Director on 2/15/23 ated the resident had been to since the beginning of the oing issue with the staff not tup and ready to go to the arday morning. 12 p.m., Resident K was th no television on or other		TAG	The results of these audits wi reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to rethe plan of correction as indices. 5) Date of compliance: 03/09/23	II be e s or e will s and vise	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETED			
		155156	B. W	ING		02/15	/2023
NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					COOLSPRING AVE		
APERION CARE ARBORS MICHIGAN CITY			MICHIG	GAN CITY, IN 46360			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	activity occurring at the time.						
	On 2/14/23 at 12:48 p.m., the resident was						
		th no television on or other					
	activity occurring a	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 tim						
	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						
		ses included, but were not					
	_	on's disease, dementia,					
	schizophrenia, maj	or depressive disorder, and					
	Asperger's syndron	ne.					
	The Quarterly Mini	imum Data Set (MDS)					
		/3/23, indicated the resident					
		red for daily decision making.					
		sive assistance for all activities					
	of daily living inclu	iding bed mobility, transfer,					
	eating, dressing, to	ileting, and personal hygiene.					
	A Care Plan revise	ed on 11/15/21, indicated the					
		erest in music, religion, books,					
		. Interventions included, but					
	_	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					
		ted she would reach out to the					
		egarding activities for the					
	-	isic therapy for during the day.					
		1 ' A DIO0207040					
	I his Federal tag re	ates to Complaint IN00396040.					

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	R MEDICARE & MEDIC			OMB NO. 0938-039				
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 02/15/2023			
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE			
F 0684 SS=G Bldg. 00	applies to all treat facility residents. comprehensive as facility must ensu treatment and car professional stand comprehensive per and the residents. Based on observati interview, the facility received appropriate new admission followed and lack of oxygen which resulted in a shock and intubation for a change in concalso failed to ensur completed after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings include: 1. The closed recompleted after fall until healed for 2 of and 1 of 3 residents (Residents L, J and Findings includes).	a fundamental principle that the ment and care provided to Based on the sessment of a resident, the re that residents receive the in accordance with dards of practice, the person-centered care plan, or choices. In the content of the person	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 o this plan of correction does not constitute admission or agreem by the provider of the truth of the facts alleged or conclusions set forth in the statement of	nent ne			

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

assessment available for review.

Event ID:

 $GFQM11 \quad \ \ {\rm Facility\ ID:} \quad \ 000076$

deficiencies. The plan of correction is prepared and/or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/15/2023 155156 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The resident was admitted directly to the facility executed solely because it is on 2/2/23 from another Long Term Care facility. required by the provisions of Ancillary Physician's Orders on the transfer federal and state law. information, dated 1/30/23, indicated the resident was receiving oxygen continuously at 2 liters via 1) Immediate actions taken for nasal cannula. those residents identified: A Nurses' Note, dated 2/2/23 at 2:01 p.m., Resident E no longer resides in indicated the resident arrived via ambulance the facility transport accompanied by two ambulance Vitals were taken and updated for transporters. Nursing tried to acclimate the resident L resident to the room, call light, surrounding areas Skin check was completed for and the television, however, the resident did not resident N and documented in the respond. Vital signs were checked and within resident electronic chart indicating normal limits. A rapid COVID-19 test was the condition of the bruises. administered with negative results. The remainder of the new admission process was passed to the oncoming shift. 2) How the facility identified other residents: A Nurses' Note, dated 2/2/23 at 7:34 p.m., indicated all medication was verified with the All residents have the Physician and entered into the electronic potential to be affected. Facility Medication Administration Record (MAR). skin sweep completed on all current resident to ensure that The Admission Nursing Assessment, dated other residents are not affected by 2/2/23, indicated the resident was observed with the same deficient practice. Vitals pursed lip breathing (helps assist with shortness completed for all residents in the of breath) and his lung sounds on both sides were facility to ensure the policy is clear, diminished with rales (abnormal rattling being followed. Nurse managers sound in the lungs). No equipment for respiratory reviewed all discharges and status was checked on the form. admission in the last 15 day to ensure that There were no further nursing assessments documented either as a new admission or as a Nursing assessments were follow up to the abnormal admission respiratory completed assessment. Change of condition was identified Physician's Orders, dated 2/2-2/5/23, indicated Respiratory Assessments there were no orders for oxygen. were completed (including Covid

screener)

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	00	COMPL	
		155156	B. WI	NG		02/15/	/2023
NAME OF 1	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					COOLSPRING AVE		
APERIO	N CARE ARBORS I	MICHIGAN CITY		MICHIGAN CITY, IN 46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ted 2/5/23 at 12:20 p.m.,			· Vitals, and Monitoring		
		is not responding, BP is			policy		
		respi is 16/min, blood sugar is in ER. notified to DON and					
	family." [sic]	I III ER. Hottiled to DON and			3) Measures put into place/		
	lamily. [sic]				System changes:		
A Nurses' Note.		ted 2/5/23 at 1:20 p.m.,			dystem changes.		
	indicated report was given to the Emergency				Staff was re-educated regardi	na	
	Room (ER) at the h				nursing assessment, change i	•	
		•			condition, respiratory assessn		
A signed document by the Paramedic, dated 2/5/23, indicated EMS (Emergency Medical Service) was dispatched to the extended care				Nursing staff also reviewed th			
				policies for monitoring and vita			
				1			
	facility for a sick pe	erson. The patient had been					
	unconscious for over	er an hour. The patient was			4) How the corrective actions	S	
	not on any oxygen	"			will be monitored:		
	A History and Phys	ical by the ER Physician,			The Director of Nursing or		
		33 p.m., indicated "Patient			designee will observe at least	3	
		EMS from (nursing home			residents per week to ensure		
	_	ental status and shortness of			skin conditions are identified,		
	breath. Patient was	hypoxic down to the 80's per			documented, and monitored		
	EMS without any o	xygen which improved on			weekly as indicated. Nursing		
	nonbreather It is t	anclear how long symptoms			assessments, change of cond	ition	
	have been going on	for."			and respiratory assessment a	re	
					completed timely and correctly	y .	
	1	dicated the patient was					
		d not respond or follow any			The Director of Nursing or		
	1	tient had decreased breath			designee will review vitals 5 d	•	
	· ·	At 1:30 p.m., the resident was			week to ensure vitals are bein	g	
	1	poxemia and respiratory			taken in accordance with the		
		bbtained which indicated the			facility policy		
	resident tested posit	uve for COVID-19.			The regulte of these sudits :-	.:II	
	A Lactic Acid leb to	est was obtained which was 3.4			The results of these audits w	/111	
		high lactic acid meant that			be reviewed in Quality	v6	
	·	ot getting enough oxygen).			Assurance Meeting monthly months or until an average of		
		agnosed with Severe			90% compliance or greater is		
		k (Severe sepsis develops			achieved x3 consecutive	•	
	1 r	(F210 ac10 po			- Sinorda Ad donidoculito		1

when the infection caused organ damage. Septic

months. The QA Committee

NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360 PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER	
MAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION 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 a risk for falls. A Fall Initial Occurrence Note, dated 1/20/23 at 10:43 a.m., indicated the resident had an 10:43 a.m., indicated the resident had an	THIS I DAIN	COMPLETED 02/15/2023
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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		
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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		
10:43 a.m., indicated the resident had an		
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		

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Event ID:

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If continuation sheet Page 21 of 52

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/15/2023	
	PROVIDER OR SUPPLIER		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE BAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
IAU	on 1/20/23 at 4:35 p at 5:00 a.m. and 9:5	p.m., 1/21/23 at 7:20 p.m., 1/22/23 if a.m., and the last documented on 1/23/23 at 5:02 a.m.	TAU	53.83.01	DATE
	indicated the reside	ng on 1/20/23 at 4:35 p.m., nt's temperature, pulse, pod pressure were all taken 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.				
	at 2:00 p.m., indicate charting for every suffurther information record was reviewed Diagnoses included	Director of Nursing on 2/15/23 ted staff were to initiate 72 hour hift after a fall. There was no to review. 3. Resident J's d on 2/14/23 at 1:45 p.m. , but were not limited to, a and Diabetes Mellitus.			
	The Annual Minimassessment, dated 1 had significant cogn	um Data Set (MDS) 1/21/22, indicated the resident nitive impairment and required stance for bed mobility and			
	indicated the reside	ed 2/10/23 at 10:29 p.m., nt had been found next to his ne resident was assessed and			
	Charting progress n	a.m. and 4:00 p.m., a 72 hour ote had been completed here were no additional 72			

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Event ID:

GFQM11 Facility ID: 000076

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155156	B. W	ING		02/15	/2023	
				CED FEET A	DDDDGG OVEW OTH THE GIR COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD			
ADEDIO		MICHICANI CITY			COOLSPRING AVE			
APERIO	N CARE ARBORS I	MICHIGAN CITY		MICHIG	GAN CITY, IN 46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	hour assessments re	elated to the fall.						
	Interview with the	Nurse Consultant on 2/14/23 at						
	3:30 p.m., indicated	d 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 behaviora	al symptoms not directed						
	towards others such	n as physical symptoms like						
	hitting or scratching	g self, pacing, or verbal/vocal						
	symptoms like scre	aming or disruptive sounds.						
	A Nurses' Note, dat	ted 2/6/23 at 4:24 p.m.,						
	indicated the reside	ent had deep purple and						
	reddish-purple brui	sing noted to both arms.						
	A Nurses' Note, dat	ted 2/6/23 at 7:52 p.m.,						
	indicated the reside	ent had reddish-purple bruising						
	noted to both arms.							
		ted 2/7/23 at 10:51 a.m.,						
	indicated the reside	ent had deep purple and						
	reddish-purple brui	sing 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 brui	sing noted to both arms.						
		ted 2/8/23 at 1:25 p.m.,						
		ent had deep purple and						
	reddish-purple brui	sing noted to both arms.						
	A Nurses' Note, dat	ted 2/9/23 at 12:15 p.m.,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		A. BU	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 00 B. WING			x3) date survey COMPLETED 02/15/2023	
	PROVIDER OR SUPPLIER			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE SAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
		nt had reddish-purple, green, 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.						
	indicated the reside	ed 2/10/23 at 3:46 p.m., nt had deep purple, and green bruising noted to both					
	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.						
	Monitoring - Pressure noted as current ind Non-pressure skin of (bruises/contusions, rashes, skin tears, states assessed for healing complications or interest and the above table, the weekly. At the poin approximately 7-14 turned color to gree will document a last normal healing processing the process of the process of the pressure	abrasions, lacerations, argical wounds, etc.) will be a progress and signs of fection weekly When bruises complications as indicated on nurse will monitor the site t of signs of healing, days, or when the bruise has n, yellow, brown, the nurse t entry indicating that the tess has taken place without no further follow-up will be					
	IN00401271, and II	ates to Complaint IN00396040, N00401730.					
	3.1-37(a)						

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Event ID:

GFQM11 Facility ID: 000076

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DEPARTMENT OF HEALTH AND HUMAN SERVIC	ES
CENTERS FOR MEDICARE & MEDICAID SERVICE	S

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ЛLDING	00	COMPL	
		155156	B. W	ING		02/15/	2023
	ROVIDER OR SUPPLIER			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin In §483.25(b)(1) Pres Based on the coma resident, the face (i) A resident receiprofessional stand pressure ulcers are pressure ulcers are pressure ulcers are pressure ulcers unavoidable; and (ii) A resident with necessary treatmed with professional supromote healing, promote healing, promo	prehensive assessment of allity must ensure that- lives care, consistent with lards of practice, to prevent and does not develop alless the individual's clinical trates that they were pressure ulcers receives and and services, consistent estandards of practice, to prevent infection and prevent eveloping. The pressure ulcers were pred for 1 of 3 residents are ulcers. (Resident F) The pressure ulcers were pred for 1 of 3 residents are ulcers. (Resident F) The pressure ulcers were pred for 1 of 3 residents are ulcers. (Resident F) The pressure ulcers were pred for 1 of 3 residents are ulcers. (Resident F)	F 00	586	Aperion- Arbors Michigan City POC Complai Exit 02/15/20 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 no constitute admission or agree by the provider of the truth of the	23 of t ment	03/09/2023

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W	ING		02/15/	/2023
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			COOLSPRING AVE		
APERIO!	N CARE ARBORS	MICHIGAN CITY			SAN CITY, IN 46360		
AI LINIOI	· · · · · · · · · · · · · · · · · · ·	WIIOTHOAN OTT	_	WIIOTHC			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΛΤΕ.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	left posterior thigh. Bandages were placed and the				facts alleged or conclusions s	et	
	Physician was cont	acted for orders.			forth in the statement of		
					deficiencies. The plan of		
		plinary team) Note, dated			correction is prepared and/or		
	1/11/23, indicated t	the resident had new wounds to			executed solely because it is		
	coccyx and posterio	or thigh and the wound nurse			required by the provisions of		
	would assess and p	rovide treatment.			federal and state law.		
	There were no mea	surements, staging, or			1) Immediate actions taken f	or	
	descriptions of the	wounds.			those residents identified:		
					Resident F no longer reside	es in	
		Wound Nurse on 2/15/23 at			the facility; therefore, no furthe	er	
	1:10 p.m., indicated	d she had not been aware of the			corrective action could be take	en	
	resident's wounds a	and had not assessed them.			for this resident.		
	This Federal tag is	related to Complaint			2) How the facility identified		
	IN00396040.				other residents:		
					All residents in the facility with	í	
	3.1-40(a)(2)				alteration in skin or high risk o	ıf	
					skin alterations have the poter	ntial	
					to be affected by the cited		
					practice. A skin sweep was		
					completed in the facility to ide	ntify	
					skin concern. All areas identifi	ed	
					were identified, treatment plac	ed	
					and monitored per facility poli	cy.	
					3) Measures put into place/		
					System changes:		
					A. Wound care nurse was		
					re-educated on the wound pol	icy	
					including the importance of		
					ensuring that an appropriate		
					treatment is in place, proper		
					identification of etiology of a		
					wound, measuring, updating t	he	
					plan of care and the important	ce of	
					completing treatments accord	ing	
					to the Physicians' Order. Nurs	ing	
					staff were also educated on		
					completion of documentation		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	l í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 02/15/	LETED
NAME OF P	PROVIDER OR SUPPLIEI		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE	1	
APERION	N CARE ARBORS	MICHIGAN CITY	MICHIGAN CITY, IN 46360				
APERION (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) B. A QA tool has been updated and implemented to ensure compliance to these measures. 4) How the corrective action will be monitored: The DON or designee will complete an audit of the treat record for residents with press injuries 5x's a week randomly validate that the current treat is in place and correctly dated 6 weeks then 3x's a week for weeks then weekly thereafter DON is responsible for compliance. Any identified concerns will be promptly addressed with the responsi individual(s). The results of these audits w be provided to the QA	ment sure to ment 1 x's 4 . The	(X5) COMPLETION DATE
F 0690	483.25(e)(1)-(3)				Committee by the DON/Designee and will be reviewed in Quality Assuran Meeting monthly x6 months until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated to 103/09/22	or	
SS=D	Bowel/Bladder Ind	continence, Catheter, UTI					

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 $GFQM11 \quad \text{Facility ID:} \quad 000076$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/15/2023			
	PROVIDER OR SUPPLIER		1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
Bldg. 00	§483.25(e) Inconti §483.25(e)(1) The resident who is co bowel on admissic assistance to mair or her clinical cond that continence is §483.25(e)(2)For a incontinence, base comprehensive as ensure that- (i) A resident who an indwelling cath unless the residen demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possib clinical condition of catheterization is in (iii) A resident who receives appropriate to prevent urinary restore continence §483.25(e)(3) For incontinence, base comprehensive as ensure that a resid bowel receives ap services to restore function as possib	renence. If acility must ensure that nitinent of bladder and on receives services and nitain continence unless his dition is or becomes such not possible to maintain. If a resident with urinary end on the resident's esessment, the facility must enters the facility without eter is not catheterized nit's clinical condition catheterization was If a removal of the catheter le unless the resident's elemonstrates that the ecessary; and one is incontinent of bladder and the treatment and services tract infections and to the extent possible. If a resident with fecal end on the resident's elemonstrate that the extent possible. If a resident with fecal end on the resident's elemonstrate that he extent possible. If a resident with fecal end on the resident's elemonstrate that he extent possible. If a resident with fecal end on the resident's elemonstrate that he extent possible. If a resident with fecal end on the resident's elemonstrate that he extent possible elemonstrate treatment and example the facility must be dent who is incontinent of propriate treatment and example example elemonstrates that he extent possible			
	failed to ensure vita	riew and interview, the facility ls signs were monitored every vith a urinary tract infection	F 0690	Aperion Arbors F690 UTI	03/09/2023
		idents reviewed for a change in		Exit 2/15/2023	
1	L condition, (Icesidell	· · /	1	LAIL 4/ 13/4U43	ı

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Event ID:

GFQM11 Facility ID: 000076

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W	ING _	·	02/15/	2023
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			COOLSPRING AVE		
APFRI∩I	N CARE ARBORS I	MICHIGAN CITY			SAN CITY, IN 46360		
				IVII OI III	7		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Finding includes:				Compliance 03/09/23		
				The facility requests paper			
	The closed record for Resident F was reviewed on				compliance for this citation.		
	2/14/23 at 8:48 a.m. She was admitted on 11/23/22.						
	-	l, but were not limited to,			This Plan of Correction is the		
	-	e, heart failure, and chronic			center's credible allegation of		
	-	ary disease. She was			compliance.		
	discharged to the ho	ospitai on 1/12/23.			Down and the second	- £	
	The Administra Minimum Date Cet account				Preparation and/or execution		
	The Admission Minimum Data Set assessment,				this plan of correction does no		
	dated 11/28/22, indicated she required extensive				constitute admission or agree		
	staff assistance for bed mobility and toileting, and only transferred once or twice with extensive				by the provider of the truth of		
	assistance.	ce of twice with extensive			facts alleged or conclusions s	et	
	assistance.				forth in the statement of		
	A Nursas! Note det	ted 1/7/23, indicated the			deficiencies. The plan of		
		the ER and was diagnosed			correction is prepared and/or		
	with a UTI.	the ER and was diagnosed			executed solely because it is		
	willia OII.				required by the provisions of federal and state law.		
	A Physician's Order	r, dated 1/7/23, indicated			leuciai ailu siale law.		
	-	ic) 100 milligrams, twice daily			1) Immediate actions taken f	or	
	for 7 days for the U	· ·			those residents identified:	OI .	
	101 / days for the O	· 11.			uiose residents identined.		
	Temperatures were	recorded on the following			Resident F no longer resides	in	
	dates and times:				the facility		
	1/7/23 8:19 a.m.						
	1/8/23 8:23 a.m.				2) How the facility identified		
	1/9/23 9:46 a.m.				other residents:		
	Pulse rates were red	corded on the following dates			All residents that have an orde	er for	
	and times:	Č			an antibiotic are at risk for this		
	1/10/23 8:33 a.m.				deficient practice. All residents		
	1/11/23 3:33 p.m.				receiving an antibiotic were		
	·				reviewed to ensure that they	vere	
	Interview with the l	Director of Nursing, on 2/14/23			monitored for 72 hours after		
	at 3:30 p.m., indica	ted vitals should be taken every			starting the antibiotic.		
	shift for 72 hours w	hen started on an antibiotic.					
	This Federal tag relates to Complaint IN00398992.				3) Measures put into place/		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2023 FORM APPROVED OMB NO. 0938-039

CELLIE TOI	THE PROPERTY OF THE CONTRACT OF THE PARTY OF	THE SELLCTORS				0.01	21.0.0,00	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155156	B. W	ING		02/15/	/2023	
				CTREET	DDDEGG CITY CTATE 7ID COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
ADEDION	N CARE ARBORS I	MICHIGANI CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360					
AFERIO	V CARE ARBORS I	WICHIGAN CHT		WIICHIIC	SAN CITT, IN 40300			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					System changes			
	3.1-41(a)(2)				Nurses were educated on the			
					policies for antibiotics and			
					monitoring.			
					4) How the corrective action	s		
					will be monitored:			
					DON/Designee will review			
					documentation at least 3x/we	ek to		
					ensure residents with an antib			
					is being monitored per facility			
					policy.			
					The results of these audits wi	ll be		
					reviewed in Quality Assurance			
					Meeting monthly for 6 months			
					until 100% compliance is			
					achieved. The QA Committee	e will		
					identify any trends or patterns			
					make recommendations to re			
					the plan of correction as indic	ated.		
					5) Date of compliance:			
					3/09/2023			
F 0692	183 25(a)(1) (2)							
SS=D	483.25(g)(1)-(3)	n Status Maintenance						
Bldg. 00	-	ed nutrition and hydration.						
Diag. 00	- '-'	ed number and hydration. Istric and gastrostomy						
	,	taneous endoscopic						
		percutaneous endoscopic						
		enteral fluids). Based on a						
		hensive assessment, the						
	facility must ensur							
	i aciiity must c nsui	C triat a residerit-						
	§483.25(g)(1) Mai	intains acceptable						

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

Event ID:

 $GFQM11 \quad \text{Facility ID:} \quad 000076$

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155156	B. W	NG _		02/15	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			COOLSPRING AVE		
ΔPERI∩N	N CARE ARBORS I	MICHIGAN CITY			GAN CITY, IN 46360		
AI LINIOI	TOAIL AILDOIGI	WILCH IN CHAIR		WIIGHIIG	7, 114 011 1 , 114 70000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	l ·	ritional status, such as					
		t or desirable body weight					
		lyte balance, unless the					
		condition demonstrates					
	that this is not pos						
	preferences indica	ate otnerwise;					
	\$402.05/~\/0\\	offered sufficient fluid intake					1
	(0)()	r hydration and health;					
	io maintain prope	i nyuralion anu nealin,					
	8483 25(a)(3) le o	offered a therapeutic diet					
		utritional problem and the					
		ler orders a therapeutic diet.					
		on, record review, and	F 00	592			03/09/2023
		ity failed to ensure a resident		-	Aperion- Arbors		35.03.2025
		ceived nutritional supplements			,		
	I -	3 residents reviewed for			POC Complaint		1
	nutrition. (Resident	J)					
					Exit 02/15/2023		
	Finding includes:						
					Compliance 03/09/2023		
		a.m., Resident J was observed					
		eating breakfast. He had					1
		real, and thickened juice and			F692- Nutrition/Hydration		
		no supplements on his tray.					
		g medications on his hall.			The facility requests paper		
	There were no supp	plements observed on her cart.			compliance for this citation.		
	Dagidant Ila mana	was reviewed on 2/14/23 at			This Plan of Correction is the		
		es included, but were not					
		a, dysphagia and Diabetes			center's credible allegation of compliance.		
	Mellitus.	a, a spinagia and Diabetts			Compilance.		
	1,10111145.				Preparation and/or execution	of	
	The Annual Minim	um Data Set (MDS)			this plan of correction does no		
		1/21/22, indicated the resident			constitute admission or agree		
		nitive impairment and required			by the provider of the truth of		
		stance for bed mobility and			facts alleged or conclusions s		
	transfers.				forth in the statement of		
					deficiencies. The plan of		
	A Nutritional Asses	ssment, dated 2/2/23, indicated			correction is prepared and/or		

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

Event ID:

GFQM11 Facility ID: 000076

If continuation sheet Page 31 of 52

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPLETED
		155156	B. WI	NG		02/15/2023
NAME OF F	PROVIDER OR SUPPLIEF	- L			ADDRESS, CITY, STATE, ZIP COD	
APERION	N CARE ARBORS I	MICHIGAN CITY			COOLSPRING AVE GAN CITY, IN 46360	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		unplanned weight loss of			executed solely because it is	
	8.6% in 1 month. Recommendation was to increase supplementation to prevent further weight loss.				required by the provisions of	
					federal and state law.	
	Physician's Order, dated 2/2/23, indicated house supplement, 60 milliliters three times a day.				1) Immediate actions take	en
					for those residents identified	d:
	Physician's Order, o	lated 11/9/21, indicated Magic			Resident J was provided with	
	cup 4 ounces once a	ı day.			supplement ordered by the	
					physician.	
		a regular diet, pureed texture				
	and honey thickened liquids.				2) How the facility identifi	ied
					other residents:	
		rfast tray ticket did not			All residents who receive	
		t received the Magic cup at			supplements have the potent	
		h ticket indicated he received it			be affected by the alleged def	icient
	then.				practice. A facility audit was	
	TI E 1 2022	Marin at Administration			conducted to identify any	
	1	Medication Administration			residents that have an order f	
		cated the Magic cup was to be			supplements to ensure they a	ıre
	_	and the house supplement at a.m., neither had been signed			receiving as ordered.	
	out as given yet tha	_			3) Measures put into plac	ام
	great great for the	<i>y</i> -			System changes:	-
		A 1 completed passing				
		urned the cart to the station.				
		QMA at that time, indicated				
	I .	y house supplements on her			The nursing staff was educate	ed on
		y needed it. When asked			supplements by the	
	1	ne then indicated she had			DON/designee	
		e supplement. She entered the			QMA 1 was educated on all th	
		nd came out with a carton of			types of supplements provide	d in
		nt used for renal patients) and			the facility.	
		what she had given him today			Random audits 3 times a wee	
		bass . She had given the drink			various time will be completed	•
	_	vever, the supplement was not			DON/designee to ensure resid	dent
	1	PN 2 was standing nearby and			are receiving ordered	
		s not the house supplement.			supplements. The DON is	
		d he also had his Magic cup,			responsible for compliance.	
I	I she then signed both	h out on her computer.			I	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156		r í	JILDING	onstruction 00	(X3) DATE COMPL 02/15 /	ETED	
	PROVIDER OR SUPPLIEF			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	11:40 a.m., indicate Magic cup with his been updated, and t	Administrator, on 2/15/23 at and the resident received his lunch, the MAR should have the QMA wasn't truthful. ates to Complaint IN00398992.			4) How the corrective actions will be monitored: The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved. The QA Committee identify any trends or patterns make recommendations to revithe plan of correction as indicated. 5) Date of compliance: 03/09/23	be or will and	
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-ga tubes, both percut gastrostomy and percut gastrostomy, and resident's compre facility must ensur §483.25(g)(4) A reto eat enough alor fed by enteral met	stric and gastrostomy taneous endoscopic percutaneous endoscopic enteral fluids). Based on a thensive assessment, the tree that a resident- esident who has been able the or with assistance is not thods unless the resident's demonstrates that enteral ally indicated and					
	means receives the and services to re eating skills and to enteral feeding incomplete aspiration pneumons.	esident who is fed by enteral ne appropriate treatment store, if possible, oral prevent complications of cluding but not limited to ponia, diarrhea, vomiting, abolic abnormalities, and					

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

Event ID:

GFQM11 Facility ID: 000076

If continuation sheet Page 33 of 52

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. WI	NG		02/15/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	₹			COOLSPRING AVE		
APFRION	N CARE ARBORS I	MICHIGAN CITY		MICHIGAN CITY, IN 46360			
					1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	nasal-pharyngeal ulcers.		F 0.				02/00/2022
	Based on observation, record review, and interview, the facility failed to ensure gastrostomy		F 06	193	Aperion- Arbors		03/09/2023
		e was completed as ordered			BOC Commission		
		bandage changes, and water			POC Complaint		
	_	lings were documented and			Exit 02/15/2023		
		reatments were obtained for a			EXIL 02/19/2023		
	i i	t the site for 2 of 3 residents			Compliance 03/09/2023		
	reviewed for peg tubes. (Residents D and B)				Compilation 03/03/2023		
	leviewed for peg ta	ses. (Residents B and B)					
	Findings include:				F693 Feeding Tube		
	S				Management/Restore eating	l	
	1. On 2/14/23 at 9:00 a.m., Resident D was				skills		
	observed curled up in a ball lying on the bed in						
	the room. At that ti	me, there was a piston syringe			The facility requests paper		
	set and bottle with t	the date of $2/10/23$ on the			compliance for this citation.		
	outside in black ma	rker. At 9:15 a.m., LPN 1 was					
	asked to go into the	room to assess the resident's			This Plan of Correction is the		
	peg tube site. The re	esident's gown was not tied so			center's credible allegation of	;	
	it fell off of her sho	ulders. The peg tube was			compliance.		
		men, and there was no					
	bandage covering o	r around the stoma.			Preparation and/or execution	of	
					this plan of correction does no	ot	
		resident was reviewed on			constitute admission or agree		
		. Diagnoses included, but were			by the provider of the truth of		
	_	psy, schizophrenia, high blood			facts alleged or conclusions s	set	
	-	al disabilities, speech			forth in the statement of		
	disturbance, and pe	g tube status.			deficiencies. The plan of		
					correction is prepared and/or		
		nimum Data Set (MDS)			executed solely because it is		
		/28/23, indicated the resident			required by the provisions of		
		red for decision making. The			federal and state law.		
		l of her nutrition by the way of			4) Immediate actions tole		
	a peg tube.				1) Immediate actions take		
	Physician's Orders	dated 1/25/23, indicated			for those residents identified	u.	
					Resident D orders were revie	wed	
	change syringe every 24 hours and prn every night shift.				and an order for enteral feedi		
	mgiit siiit.				was placed in the resident's	'' ' 9	
	Physician's Orders	dated 2/7/23, indicated cleanse			electronic chart. Area around	the	
		, ,	1		I Sissification of the Live and under the		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED
		155156	B. W	ING		02/15/2023
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	•
					COOLSPRING AVE	
APERION	N CARE ARBORS I	MICHIGAN CITY		MICHIGAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
	the peg tube site with normal saline, pat dry, and				resident stoma was cleaned a	
apply split gauze dressing every night shift. The				dressing placed per physician	ı's	
		May bolus enteral feedings of			order.	
	Jevity 1.5, 5 cans da	aily.			Decident Days falls	
	Dhygioianta Ond	dated 2/0/22 indicated fluck			Resident B was g-tube was	
	-	dated 2/9/23, indicated flush bic centimeters of water every			assessed for foul odor	
	4 hours for hydratic	-			2) How the facility identifi	ind
	i nouis foi nyurane	,11.			other residents:	IGU
	The Medication Ad	ministration Record (MAR) for			All residents who receive ente	eral
		3, indicated the syringe change			feedings have the potential to	
		eing completed on 2/10			affected by the alleged deficie	
	-	ne cleaning of the peg tube site			practice. A facility audit was	
	-	ndage was not signed out as			conducted to identify any	
	being completed on	-			residents that have a G tube s	site
					to ensure that orders are indic	cated
		nentation on the MAR or the			in the resident's electronic cha	art.
		tration Record (TAR) to			All resident with a stoma were	
		ent was getting her enteral			assessed and all negative find	-
	feeding of Jevity 1.	5 - 5 cans a day.			were notified to the Physician	
	Interview with the I	Director of Nursing on 2/15/23			3) Measures put into plac	e/
		ated the peg tube should have			System changes:	
		nd the stoma. There was no]	
	_	enteral feeding bolus was				
	being administered	to the resident at least 5 times				
	a day. 2. Resident l	B's record was reviewed on			The nursing staff was educate	ed
	2/13/23 at 4:26 p.m	. Diagnoses included, but were			enteral feeding policy and	
		plegia (one sided weakness)			notification to the physician b	у
	-	dysphagia (swallowing			the DON/designee	
	difficulties), and ga	strostomy (g-tube).			Random audits 3 times a wee	
		D			various time will be completed	- I
		mum Data Set (MDS)			DON/designee to ensure resid	dent
	· ·	2/26/22, indicated the resident			are receiving ordered enteral	
		gnitively impaired and he had a			feedings and ensuring that sto	
	feeding tube.				sites are being monitored per	
	A Dhysisian's Out	r, dated 8/3/21, indicated flush			physician's order. The DON is	5
		hift with 60 milliliters (ml) of			responsible for compliance.	
	-	mit with 60 miniters (mi) of			4) How the accuractive setime	
	water.				4) How the corrective action	>

Z I ZRO I OI	THE CHIEF	THE CERTIFICES			312 1.0. 0,00 00,	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155156	B. WING			
			_			
NAME OF F	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD		
				1101 E COOLSPRING AVE		
APERIO	N CARE ARBORS I	MICHIGAN CITY	MICHI	GAN CITY, IN 46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	BROWDERIC N. I.V. OF CORRESPOND	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI	DATE	
				will be monitored:		
	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.			The results of these audits w	ill be	
				reviewed in Quality Assurance		
				Meeting monthly for 6 months		
				until 100% compliance is		
				achieved. The QA Committee will		
				identify any trends or patterns		
				make recommendations to revise the plan of correction as indicated.		
				5) Date of compliance:		
				03/09/23		
				03/09/23		
	p.m. and 2/12/23 at	0.00 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	her documentation regarding the				
	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.					
	administered as ord	cicu.				
	This Federal tag relates to Complaint IN00396040.					
	3.1-44(2)(2)					
	3.1-44(a)(2)					
F 0698	483.25(I)					
SS=D	Dialysis					
Bldg. 00	<u> </u>					
ычу. 00	§483.25(I) Dialysis. The facility must ensure that residents who					
	require dialysis receive such services,					
	consistent with professional standards of					
	L consistent with big	บเธออเบเเลเ อเลเเนสเนร ปโ				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155156	B. Wl	ING		02/15	/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					COOLSPRING AVE		
APERIO	N CARE ARBORS I	MICHIGAN CITY		MICHIC	GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		prehensive person-centered					
	preferences.	residents' goals and					
	1 '	view and interview, the facility	F O	F 0698			03/09/2023
	failed to monitor/assess dialysis perma catheter		1 00))O	Aperion- Arbors		03/07/2023
	and fistula sites, obtain orders for hemodialysis,				, riperion 7 abore		
	and monitor fluid restriction for 2 of 3 residents				POC Complaint		
	reviewed for dialysis. (Residents E and H)						
	reviewed for diarysis. (Residents E and II)				Exit 02/15/2023		
	Findings include:						
					Compliance 3/09/2023		
	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,				F698 Dialysis		
		e, peg tube, epilepsy, anxiety,					
	and heart failure.				The facility requests paper		
	There was Minimus	m Data Set (MDS) assessment			compliance for this citation.		
	available for review				This Plan of Correction is the		
	available for review	··			center's credible allegation of		
	The resident was ad	lmitted directly to the facility			compliance.		
		ther Long Term Care facility.			Compilarice.		
		s's Orders on the transfer			Preparation and/or execution	of	
		1/30/23, indicated the resident		this plan of correction does in			
		en continuously at 2 liters via		constitute admission or agree			
		ad a dialysis perma catheter to			by the provider of the truth of t		
		was to be checked/assessed			facts alleged or conclusions se		
		ident had discontinued			forth in the statement of		
	dialysis treatment o	n 1/18/23.			deficiencies. The plan of		
					correction is prepared and/or		
	A Nurses' Note, dat	ted 2/2/23 at 2:01 p.m.,			executed solely because it is		
		nt arrived via ambulance			required by the provisions of		
	transport accompanied by two ambulance				federal and state law.		
	transporters. Nursing tried to acclimate the						
	resident to the room, call light, surrounding areas				1) Immediate actions taken for	or	
	and the television, however, the resident did not				those residents identified:		
	respond. Vital signs were checked and within				Resident E no longer		
	normal limits. A rapid COVID-19 test was				resides in the facility		
		negative results. The remainder			Resident H fluid restriction ord	lers	
	of the new admission	on process was passed to the	1		reviewed, and MD notified of t	he	

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	TOF HEALTH AND HU R MEDICARE & MEDIC						B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MUI A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/15/2023	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
APERIO	N CARE ARBORS	MICHIGAN CITY			COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
mo	oncoming shift.	RESCRIPENTITY THING INTORMATION		1710	increase of fluid that resident	was	DATE
	A Nurses' Note, da indicated all medic Physician and enter	ted 2/2/23 at 7:34 p.m., ation was verified with the red into the electronic istration Record (MAR).			receiving. Orders place for fis care and monitoring for reside Orders placed for dialysis for resident H.	tula	
	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.				2) How the facility identified other residents: All residents who receive Dial have the potential to be affect by the alleged deficient practi An audit was completed on all residents who receive dialysis therapy to ensure physician of	lysis ted ce. Il	
	indicated "resident 95/50,o2 is 80/min	ted 2/5/23 at 12:20 p.m., is not responding, BP is respi is 16/min, blood sugar is n in ER. notified to DON and			are in place and followed. An audit was completed to enthat permi-caths were identificadmission and order placed to monitor.	ed on	
	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				3) Measures put into place/ System changes: The nursing staff will be re-educated on dialysis use p physician order by the	er	
					DON/designee by 2/27/19 an needed. The DON/designee was complete random audits on random shifts a minimum of 3 times weekly. The DON/Designis responsible for compliance	will 3 gnee	
	A History and Physical dated 2/5/23 at 12:3	e sores to his body." sical by the ER Physician, 33 p.m., indicated "Patient EMS from (nursing home			4) How the corrective action will be monitored: The results of these audits wi reviewed in Quality Assuranc Meeting monthly for 6 months	II be e	

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name) for altered mental status and shortness of

breath. Patient was hypoxic down to the 80's per

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until 100% compliance is

achieved. The QA Committee will

If continuation sheet

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL		
		155156	B. W	_		02/15/	ZUZ3	
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD			
ΔDEDI∩!	N CARE ARBORS I	MICHIGAN CITY		1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360				
	Г				J. 114 OIT 1, 114 70000	1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
1710		xygen which improved on		1710	identify any trends or patterns	and	DATE	
	· ·	t has a dialysis catheter in his			make recommendations to re			
		at is no longer sutured down.			the plan of correction as indic			
	EMS reportedly pla	ice a tegaderm over the dialysis						
	catheter to help stabilize it in place. It is unclear				5) Date of compliance:			
	how long symptoms have been going on for."				03/09/2023			
	The resident was diagnosed with Severe							
	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.						
		0.1.						
		Director of Nursing on 2/15/23						
		ated the there were no or documentation/assessment						
	of the dialysis perm							
		ord was reviewed on 2/15/23 at						
		lent was readmitted to the						
		italization on 2/3/23.						
	Diagnoses included	, but were not limited to, end						
	stage renal disease	and dependence on dialysis.						
	Tile Admin 1 351							
		nimum Data Set assessment, ated he was cognitively intact						
		ive staff assistance for bed						
	mobility and transfe							
	and trailist							
	There were no Phys	sician Orders in place related to						
	dialysis, monitoring	g of the fistula (access site) or						
	assessing vital signs	s before and after dialysis.						
	A Dissert L O. 1	4-4-4 2/4/22 :1: 4 141						
	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 in	dicated the following amounts						
	consumed:	S						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155156		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/15/	ETED	
	PROVIDER OR SUPPLIER			1101 E	DDRESS, CITY, STATE, ZIP COD COOLSPRING AVE AN CITY, IN 46360	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0757 SS=D Bldg. 00	the month of 2/2023 documentation or more triction or the fiss. Interview with the I indicated the orders the resident returned. This Federal tag relations are supported by the second of the resident returned. This Federal tag relations are supported by the second of the resident resident is for Interview and the second of	Director of Nursing, on 2/15/23, had not been updated when it from the hospital. The ates to Complaint IN00401271. The ates to Complaint IN00401271. The ates to Complaint IN00401271. The ates to Complaint IN00401271.					

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

Event ID:

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· · · · · · · · · · · · · · · · · · ·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY ETED /2023
		133130	D. WI		ADDRESS STEW STATE TIP SOD	02/13/	2023
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE		
APERION	N CARE ARBORS I	MICHIGAN CITY			GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAU	§483.45(d)(6) Any reasons stated in (5) of this section. Based on observation review, the facility ointment was not us on a gastrostomy (greviewed for g-tube). Finding includes: On 2/13/23 at 4:16 was observed to have surrounding the site drainage, or odor not receive to the surrounding the site drainage, or odor not stroke, dysphagia (segastrostomy (g-tube). The Quarterly Mini assessment, dated 1 was moderately cogfeeding tube. A Physician's Order cleanse g-tube insert and pat dry, apply Fointment) and cover Change daily and as dislodged dressing. Interview with the I at 1:47 p.m., indicated.	on, interview, and record failed to ensure an antibiotic sed for an excessive duration getube) site for 1 of 3 residents is. (Resident B) p.m., Resident B's getube site we a split gauze dressing included, but were not limited sided weakness) following a swallowing difficulties), and is included, but were not limited sided weakness) following a swallowing difficulties), and is included, but were not limited sided weakness) following a swallowing difficulties), and is included, but were not limited sided weakness) following a swallowing difficulties), and is included, but were not limited sided weakness) following a swallowing difficulties), and is included, but were not limited sided weakness of the side	F 07	757	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 this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions of 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.	t ment the et vas	03/09/2023
	immediately.	ara de discontinued			All resident that are prescrib		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W			02/15/	
		132.00		_	ADDRESS, CITY, STATE, ZIP COD	52, 10,	
NAME OF P	ROVIDER OR SUPPLIER	R					
				1101 E	COOLSPRING AVE		
APERION	N CARE ARBORS I	MICHIGAN CITY	_				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					same deficient practice. A		
	3.1-48(a)(2)				review of all residents with		
					orders for excessive dosing		
					and stop date for medication	١.	
					•		
					3) Measures put into place/		
			1		System changes:		
					All nursing staff and admiss	ion	
					staff have been re-educated		
					medications for excessive	•	
					dosing and inadequate		
					monitoring.		
					monitoring.		
					4) How the corrective actions	•	
					will be monitored:	3	
					The DON/Designee will revie	w	
					all order changes/new admission medication orders	_	
						S	
					for proper diagnosis and	:11	
					errors. The DON/Designee w		
					audit 3 resident's charts?/EM		
					a week to ensure that there i	S	
					no excessive dosing.		
					The secults of these second	.:11	
					The results of these audits w	/111	
					be reviewed in Quality	0	
					Assurance Meeting monthly		
					months or until an average of		
					90% compliance or greater is	5	
			1		achieved x3 consecutive		
					months. The QA Committee		
					will identify any trends or		
					patterns and make		
					recommendations to revise t	the	

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Event ID:

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plan of correction as indicated.

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		1					
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155156	B. W	ING		02/15	/2023
					_		
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					COOLSPRING AVE		
APERION	N CARE ARBORS	MICHIGAN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRESPONDED		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
					5) Date of compliance: 03/0	10/22	
					5) Date of compliance, 03/0	13/23	
F 0880	0880 483.80(a)(1)(2)(4)(e)(f)						
SS=E							
Bldg. 00							
Diay. 00	§483.80 Infection						
	-	establish and maintain an					
	•	on and control program					
		de a safe, sanitary and					
	comfortable environment and to help prevent						
	the development and transmission of						
	communicable dis	seases and infections.					
	§483.80(a) Infecti	ion prevention and control					
	program.						
	The facility must e	establish an infection					
	prevention and co	ontrol program (IPCP) that					
	must include, at a	minimum, the following					
	elements:						
	§483.80(a)(1) A s	system for preventing,					
	- ' ' ' '	ing, investigating, and					
		ons and communicable					
		esidents, staff, volunteers,					
		r individuals providing					
	· ·	contractual arrangement					
		acility assessment					
	•	ling to §483.70(e) and					
		, ,					
	Tollowing accepted	d national standards;					
	8402 00/5\/2\ \\/-	itton atandarda, nalisiaa					
	- ,,,,	itten standards, policies,					
	and procedures for the program, which must						
	include, but are not limited to:						
	* * * * * * * * * * * * * * * * * * * *	rveillance designed to					
	identify possible communicable diseases or						
	infections before they can spread to other						
	persons in the facility;						
	(ii) When and to v	vhom possible incidents of					
	communicable dis	sease or infections should					

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If continuation sheet

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PRINTED: 03/27/2023

	T OF HEALTH AND HU R MEDICARE & MEDIO						ORM APPROVED MB NO. 0938-039	
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MUL A. BUIL B. WING	DING	nstruction 00	(X3) DATE SURVEY COMPLETED 02/15/2023		
	PROVIDER OR SUPPLIE			1101 E	DDRESS, CITY, STATE, ZIP COD			
APERIO	N CARE ARBORS	MICHIGAN CITY		MICHIG	AN CITY, IN 46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	be reported; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; independing upon organism involve (B) A requirement the least restrictive under the circum; (v) The circumstamust prohibit empromement food, if direct disease; and (vi) The hand hyg followed by staff contact. §483.80(a)(4) A sincidents identified and the corrective facility. §483.80(e) Linear Personnel must he transport linears of infection.	I transmission-based I followed to prevent spread I transmission-based I followed to prevent spread I w isolation should be used I studing but not limited to: I duration of the isolation, I the infectious agent or I d, and I that the isolation should be I the possible for the resident I stances. I ances under which the facility I ployees with a I sease or infected skin I contact with residents or I contact will transmit the I iene procedures to be I involved in direct resident I system for recording I d under the facility's IPCP I e actions taken by the I s. I handle, store, process, and I o as to prevent the spread						

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Based on observation, record review, and interview, the facility failed to ensure infection

including those to prevent and/or contain

control guidelines were in place and implemented,

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F 0880

Facility ID: 000076

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POC Infection Control Survey

Aperion- Arbors

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03/09/2023

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W	ING		02/15/	2023
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			COOLSPRING AVE		
∧DEDI∩!	N CARE ARBORS I	MICHIGANI CITY			GAN CITY, IN 46360		
AI LINOI		WICHIGAN CITT		WIICHIIC			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		to personal protective					
		ot worn before entering		Exit 02/15/2023			
	_	e resident rooms, hand hygiene					
		re donning PPE, and the lack		Compliance 03/09/2023			
		oring for residents diagnosed					
		r random observations for			F880 Infection control		
		r 4 of 4 residents reviewed for					
	COVID-19 and 1 of 4 units observed. (Residents						
	D, L, C and K and Unit 200)				This Plan of Correction is the		
					center's credible allegation of		
	Findings include:				compliance.		
	1. During a random observation 2/14/23 at 9:10				Preparation and/or execution	of	
	a.m., Housekeeper 1 was observed pushing a				this plan of correction does no		
	_	ds Resident D's room. At that			constitute admission or agreei		
	time she was weari	ng gloves to both hands and			by the provider of the truth of t		
	asked if there was a	nyone in the room. There was		facts alleged or conclusions set			
	a sign on the reside	nt's door which indicated "Red		forth in the statement of			
	Zone" and proper P	PE was to be utilized before			deficiencies. The plan of		
	entering the room.	At the time, the housekeeper			correction is prepared and/or		
	was wearing an N9	5 face mask. She donned a			executed solely because it is		
	clean isolation gow	n with the same gloved hands			required by the provisions of		
		room without any protective			federal and state law.		
	l -	ekeeper mopped the floor and					
		The resident was observed in			1) Immediate actions taken for	or	
	the room lying in the	ne bed.			those residents identified:		
					Staff identified practicing this		
	_	bservation on 2/14/23 at 9:15			deficient practice were		
	1	oserved preparing to enter the			immediately in serviced on the		
		e LPN was wearing 2 surgical			policy for infection control. CN	IA1	
		noved an N95 face mask from			Housekeeper 1 and LPN1.		
	_	eed it over the surgical masks.					
	She donned a clean isolation gown and donned				Resident D,K,L and C respirat	ory	
	clean gloves to both hands and entered the				screeners were updated		
	resident's room. The LPN did not perform hand						
	hygiene before donning the gloves. She did not				O) Ham the facility is a set of		
	wear any protective eye wear. While inside the		2) How the facility identified				
	room, she was asked to lift the resident's gown to observe her peg tube.				other residents:		
	ooserve her peg tud				All residents in		
	I				TILLESINGHIS III		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/15/2023 155156 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1101 E COOLSPRING AVE APERION CARE ARBORS MICHIGAN CITY MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The record for Resident D was reviewed on transmission-based precautions 2/13/23 at 6:15 p.m. Diagnoses included, but were have the potential to be affected not limited to, epilepsy, schizophrenia, high blood by this deficient practice. All pressure, intellectual disabilities, speech residents with respiratory disturbance, and peg tube status. screeners were audited for accuracy. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident 3) Measures put into place/ was severely impaired for decision making. The System changes: resident received all of her nutrition by the way of peg tube. Facility IDT team completed a root cause analysis and Infection Physician's Orders, dated 2/11/23, indicated strict Control Self-Assessment with the isolation for COVID-19. Corporate Infection Control Preventionist. Reviewed findings A Nurses' Note, dated 2/12/23 at 5:57 a.m., and developed action plan and indicated the resident changed rooms due to education materials based on being COVID-19 positive. findings. The Respiratory Infection Screener Assessment Staff re-educated regarding PPE indicated the following assessments were use and spread of infections as it completed after the resident had tested positive relates to transmission-based for COVID-19: precautions. - 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 Nursing staff reeducated on oxygen saturation were from 2/12/23 at 8:29 p.m. respiratory screener for Covid 19 - 2/13/23 at 6:47 p.m., the pulse and respirations monitoring. were from 2/12/23 at 8:29 p.m., and the oxygen saturation was from 2/13 at 9:17 a.m. 4) How the corrective actions - 2/14/23 at 4:19 a.m., the pulse and respirations will be monitored: were from 2/12/23 at 8:29 p.m., and the oxygen saturation was from 2/13 at 9:17 a.m. The Director of Nursing or designee will monitor for Interview with the Nurse Consultant on 2/14/23 at appropriate PPE use by 3:30 p.m., indicated residents who were positive completing visual rounds for COVID-19 were to be assessed every shift. throughout the facility at least once daily to ensure that staff and Interview with the Director of Nursing on 2/15/23 visitors are practicing appropriate at 11:30 a.m., indicated the Respiratory Screening Infection Control guidelines. Daily Assessments were not completed every shift as monitoring and visual rounds will

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155156	B. W	ING		02/15/	/2023
				OTP PET	DDDEGG CITY OT TO COP	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
4050101		MICHICANI CITY			COOLSPRING AVE		
APERION	N CARE ARBORS I	WIICHIGAN CITY		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	per their policy who	en a resident had COVID-19. At			continue for at least 6 weeks a	and	
	the time of the resp	iratory assessment, current			until compliance in maintained		
	_	be obtained. They had no			then rounds and monitoring		
	further information for review.				5x/week for 5 weeks x2 weeks	S.	
					then at least 3x/week thereafte		
	2. During a random observation on 2/13/23 at 6:30				varied shifts. The Director of		
		bserved passing meal trays to			Nursing/ Designee will review		
	the residents in their rooms. Resident L's room				respiratory screeners 5 days a	1	
	had a sign on the door that indicated "Red Zone"				week for 6 months to ensure		
	and proper PPE was to utilized before entering the				completion and accuracy.		
	room. CNA 1 indicated at that time, the resident				The results of these audits w	rill	
	was positive for COVID-19. The CNA had the				be reviewed in Quality		
	resident's meal tray and before entering the room,				Assurance Meeting monthly	x 6	
		solation gown, removed his			months The QA Committee v		
		and donned a clean N95 face			identify any trends or pattern		
		n gloves to both hands and			and make recommendations		
		l over his eyes. He did not			revise the plan of correction		
	_	ene before donning any of the			indicated.	as	
	PPE.	one before domning any of the			maicatea.		
	IIL.				5) Date of compliance:		
	The record for Resi	dent L was reviewed on			03/09/23		
		m. Diagnoses included, but were			03/03/23		
		/ID-19, heart disease, atrial					
	· ·	ood pressure, and angina.					
	1101111ation, ingil bio	ood pressure, and angina.					
	The 1/24/22 Ougests	erly Minimum Data Set (MDS)					
		ed the resident was moderately					
		on making. The resident had a					
	_	e falls since last assessment					
	and 1 with a minor						
	and i with a minor	шјш y.	1				
	Physician's Ordans	dated 2/8/23, indicated droplet					
		on for COVID-19 positive.					
	and comact isolatio	in for CO v ID-13 positive.					
	Numara! Notas datad 2/9/22 at 4:00 m ma indicated						
	Nurses' Notes, dated 2/8/23 at 4:00 p.m., indicated						
	the resident tested positive for COVID-19.						
	The Descriptory Infection Sergener Assessment						
	The Respiratory Infection Screener Assessment indicated the following assessments were						
	completed after the	resident had tested positive	1				1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		ì í	JILDING	instruction 00	(X3) DATE COMPL 02/15 /	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	for COVID-19: - 2/9/23 at 9:52 p.m 2/8/23 - 2/10/23 at 12:57 a 2/8/22 and the oxyg at 9:53 p.m 2/10/23 at 11:53 a 2/8/22 and the oxyg at 9:53 p.m 2/11/23 at 10:15 a saturation was from - 2/11/23 at 9:04 p.m. signs were from 2/1 - 2/14/22 at 1:52 p.m were from 2/14/23 a - 2/15/23 at 1:17 a.m 2/14/23 at 1:52 p.m Interview with LPN indicated she was u surgical face masks needed to be directl over the surgical fact thought her glasses protective eye wear Interview with the M 3:30 p.m., indicated for COVID-19 were Interview with the M 3:30 p.m., indicated for COVID-19 were Interview with the M 3:30 p.m., indicated for COVID-19 were Interview with the M 3:30 p.m., indicated for COVID-19 were Interview with the M at 11:30 a.m., the R Assessments were reper their policy whe the time of the resp vital signs were to be further information	a, the temperature was from ten saturation was from 2/9/23 a.m., the temperature was from 2/9/23 a.m., the temperature was from 2/9/23 a.m. the temperature and oxygen a 2/11/23 at 12:01 a.m. m., 2/12/23 at 1:05 a.m., 12:37 and 2/13/23 at 1:00 a.m. all vital 1/23 at 12:01 a.m. m., and 8:42 p.m., all vital signs at 1:52 p.m. m., all vital signs were from a 1 on 2/14/23 at 9:50 a.m., naware if she could wear 2 at time and the N95 face mask by against her face and not ce masks. She indicated she were fine to wear as a complete to be assessed every shift. Director of Nursing on 2/15/23 despiratory Screening not completed every shift as an a resident had COVID-19. At iratory assessment, current be obtained. They had no						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155156	B. W	ING		02/15/	2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .		1101 E	COOLSPRING AVE		
APERION	N CARE ARBORS I	MICHIGAN CITY		MICHIG	SAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		VID-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						
		h potentially infectious					
		putting on and after removing					
	PPE.	1 .6					
		ord was reviewed on 2/13/23 at					
		s included, but were not limited					
	to, COVID-19, hear	rt disease, and chronic					
	obstructive pulmon	ary disease.					
	The Quarterly Minimum Data Set (MDS)						
		/3/23, indicated the resident					
	was cognitively inta	act for daily decision making.					
	A Dhygiaian's Orda	r, dated 2/9/23 at 7:00 a.m.,					
	1	nt was COVID-19 positive and					
		tion with droplet and contact					
	precautions.	tion with droplet and contact					
	precuations.						
	A Physician's Order	r, dated 2/9/23 at 7:00 a.m.,					
	indicated COVID-1	9 monitoring temperature,					
	oxygen saturation, a	and symptoms every shift.					
		etion Screener, dated 2/9/23 at					
		pleted with temperature, pulse,					
		n saturation, and a full					
	respiratory assessm	ciii.					
	A Respiratory Infec	etion Screener, dated 2/10/23 at					
		npleted with temperature, pulse,					
		n saturation, and a full					
	respiratory assessm						
	• •						
	A Respiratory Infection Screener, dated 2/10/23 at						
	_	pleted with temperature, pulse,					
		n saturation, and a full					
	respiratory assessm	ent.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING		COMPLETED 02/15/2023		
	155156		B. W	ING		02/15/	/2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
APERION CARE ARBORS MICHIGAN CITY					COOLSPRING AVE SAN CITY, IN 46360		
_				Ц	7 N V O I I I , II V 70000		ı
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·			PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ATE COMPLETION DATE	
	COVID-19 assessm	nents.					
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155156	B. W	B. WING		02/15/2023	
NAME OF I	DROVIDED OD STIDDI IEI	2		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF PROVIDER OR SUPPLIER					COOLSPRING AVE		
APERION CARE ARBORS MICHIGAN CITY				MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	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.					
	respiratory assessment.						
	There was no further	There was no further documentation related to					
	COVID-19 assessments.						
	Interview with the Director of Name 2/15/22						
	Interview with the Director of Nursing on 2/15/23 at 1:55 p.m., indicated the Respiratory Infection						
	_	nts 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					
	_	OVID-19. CNA 2 entered the					
	-	rming hand hygiene. She was					
		mask. She did not don an N95					
		n, 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						
		nt C. The door was marked for					
	transmission based	precautions as the resident					
	was COVID-19 pos	sitive as well as her roommate					
	Resident K. CNA 1	did not perform hand hygiene					
		e room. He was wearing an N95					
		on eye protection, a gown, or					
	-	ig 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						
		ent C. The door was marked for					
	transmission based precautions as the resident						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	COMPLETED 02/15/2023	
	155156		B. W.	ING		02/15/	2023	
NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360				
							(X5) COMPLETION DATE	
	indicated if entering COVID-19 transmis must wear full PPE protection, gown an positive for COVID will be increased to vital signs (tempera oxygen saturation)	-						

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