STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00396040, IN00396689, IN00398992, IN00400678, IN00401271, and IN00401730 completed on 2/15/23. This visit was done in conjunction with the Investigation of Complaints IN00402309, IN00403368, and IN00403392. Complaint IN00396040 - Not Corrected. Complaint IN00396689 - Not Corrected. Complaint IN00398992 - Not Corrected. Complaint IN00400678 - Not Corrected. Complaint IN00401271 - Corrected. Complaint IN00401730 - Corrected. Complaint IN00402309 - Federal/State deficiencies related to the allegations are cited at F677 and F757. Complaint IN00403368 - No deficiencies related to the allegations are cited. Complaint IN00403392 - Federal/State deficiencies related to the allegations are cited at F693. Survey dates: March 15 and 16, 2023. Facility number: 000076 Provider number: 155156 AIM number: 100271060	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully request a desk review for these alleged deficient practices.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Attinger	RVP of Operations	04/14/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Census Bed Type: SNF/NF: 128 Total: 128 Census Payor Type: Medicare: 11 Medicaid: 81 Other: 36 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/24/23.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) care to a dependent resident related to nail care for 1 of 3 residents reviewed for ADLs. (Resident G) Finding includes: On 3/15/23 at 1:30 p.m., Resident G was observed in bed with her eyes closed. At that time, her fingernails on the right hand were long and dirty. On 3/15/23 at 3:10 p.m., CNA 1 was asked to remove the bed linens from the resident to look at the peg tube site. At that time, the resident's left hand was observed closed in the shape of a fist. Her fingernails on that hand were extremely long and left indentations in the palm of her hand.	F 0677	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident G's nails were cleaned and trimmed.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/16/23 at 9:30 a.m., the resident was observed in bed with her eyes closed. Her fingernails were very long and dirty. The record for Resident G was reviewed on 3/16/23 at 9:05 a.m. Diagnoses included, but were not limited to, stroke, dementia, peg tube, and hemiplegia. The 2/14/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact and was dependent on staff for ADL care. The resident received bed baths, however, there was no documentation her nails had been trimmed. Interview with the Director of Nursing on 3/16/23 at 1:30 p.m. indicated the resident's nails needed to be soaked because they were too long. This deficiency was cited on 2/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-38(a)(3)(E)		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on performing ADL care to include nail care.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an ADL audit to ensure ADL care, including nail care, is being rendered per residents POC.** Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure a resident admitted with pressure ulcers received the necessary treatment and services to promote healing related to ensuring treatments were completed as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident G) Finding includes: The record for Resident G was reviewed on 3/16/23 at 9:05 a.m. Diagnoses included, but were not limited to, stroke, dementia, peg tube, and hemiplegia. The resident was discharged to the hospital on 3/7/23 and readmitted to the facility on 3/11/23. The 2/14/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact and was dependent on staff for ADL care. Physician's Orders, dated 3/11/23, indicated to offload heels and turn every 2 hours for pressure ulcers. Physician's Orders, dated 3/11/23 and	F 0686	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident G's treatment orders were reviewed and entered on TAR with appropriate times. Resident G has no adverse outcomes related to cited practice. MD and family notified of omitted treatment order.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All new admissions in the last 30 days with wounds will have treatment orders reviewed.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	discontinued on 3/13/23, indicated betadine to heels daily and wrap with kerlix. Physician's Orders, dated 3/14/23, indicated sacrum pressure ulcer; cleanse with normal saline, pat dry, apply Dakin moisture gauze to wound bed and cover with dry gauze two times a day for wound care. The treatment was scheduled for 3:00 a.m., and 7:00 a.m. The Treatment Administration Record (TAR) for 3/2023, indicated the sacral pressure ulcer treatment was signed out as being completed on 3/15/23 at 7:00 a.m. The treatment was blank and not completed on 3/15 and 3/16/23 at 3:00 a.m. There was no documentation on the TAR the betadine was applied to both heels 3/11-3/13/23. The order had not been transcribed onto the TAR. The Wound Measurements on 3/13/23 indicated the following: - Left heel 5.4 centimeters (cm) by 6 cm described as black, necrotic and hard. - Right heel 5 cm by 7 cm described at 90% necrotic and 10% non granulation tissue. - Sacrum 9 cm by 13 cm described as 50% slough and 50% non granulation tissue. All of the above wounds were unstageable. Interview with the Wound Nurse on 3/16/23 at 2:55 p.m., indicated she put the order in for the Dakins solution to be done twice a day, did not realize she had to use the drop down box to put in the times as well as document them in the order. The treatment was to be done at 7 a.m. and 3 p.m. The order for the betadine solution was obtained when the resident was readmitted, however, was not transferred over to the TAR.		recur; **Wound nurse educated on correct procedure for order entry. All licensed nursing staff educated on entering orders upon admission, to include wound treatment orders** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee to audit new admissions and new orders to ensure any treatment order was entered correctly. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly.** The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficiency was cited on 2/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure antibiotic charting for a urinary tract infection was completed with current vital signs and a urinalysis was collected timely for 2 of 3 residents reviewed for urinary tract infections. (Residents M and T) Findings include: 1. The record for Resident M was reviewed on 3/15/23 at 3:03 p.m. Diagnoses included, but were not limited to, secondary hypertension. The resident was admitted to the facility on 3/14/23. A Physician's Order, dated 3/15/23, indicated the resident was to receive Cefuroxime Axetil (an antibiotic) 250 milligrams (mg) every 12 hours for 5 days for a urinary tract infection. The Infection Charting form, dated 3/15/23 at 9:40 a.m., indicated the resident's temperature, pulse, respirations, and blood pressure had been documented as being obtained on 3/14/23 at 6:30 p.m. rather than on 3/15/23 at 9:40 a.m. Interview with the Administrator on 3/16/23 at 1:40 p.m., indicated the resident's vital signs from 3/15/23 should have been documented rather than the vitals documented on 3/14/23. 2. The record for Resident T was reviewed on 3/15/23 at 1:55 p.m. Diagnoses included, but were not limited to, anxiety, altered mental status, dementia, and violent behavior. The 12/26/22 Annual Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making.	F 0690	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents M and T had no adverse outcomes related to omitted antibiotic charting. Resident T had no adverse outcomes related to obtaining late UA. Resident T's UA was obtained on 3/10/2023.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **Any resident receiving an antibiotic in the last 14 days will be reviewed to ensure documentation is present and diagnostics are completed.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee will educate nurses on obtaining a new set of vital signs for infection charting and on UA's being obtained timely.** IV. How the corrective	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Fall IDT Note, dated 2/27/23 at 9:19 a.m., indicated the resident had fall beside the bed. An intervention was to order and obtain an urinalysis. Physician's Orders, dated 2/27/23, indicated urinalysis with reflux. Nurses' Notes, dated 3/6/23 at 3:14 a.m., indicated staff attempted to collect urine for the urinalysis and was not successful. The resident was incontinent of bowel and bladder. Nurses' Notes, dated 3/6/23 a 9:30 a.m., indicated staff attempted to collect urine for lab but was unsuccessful. Nurses' Notes, dated 3/7/23 at 10:00 a.m., indicated staff attempted to collect urine but was unsuccessful. The resident had already urinated in the brief. Nurses' Notes, dated 3/8/23 at 9:10 p.m., indicated staff attempted to straight cath (tube inserted to collect urine) the resident on this shift with no urine output. Nurses' Notes, dated 3/10/23 at 5:48 a.m., indicated staff collected the urine for lab. Nurses' Notes, dated 3/12/23 at 9:43 p.m., indicated staff notified the Physician of urinalysis and culture results. New orders were received for Cipro 250 milligrams (mg) twice a day for 10 days for urinary tract infection (UTI) On 3/13/23 the Nurse Practitioner was notified and clarified the antibiotic orders. Physician's Orders, dated 3/13/23, indicated		action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will review the order listing report for any new UA orders to ensure timely collection. VS/UDAs will be reviewed during clinical meeting to ensure compliance. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks then weekly.** The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ciprofloxacin 500 mg 1 every 12 hours for UTI. The final culture results, dated 3/12/23, indicated 50-100,000 Providencia Stuarti. Interview with the Assistant Director of Nursing on 3/16/23 at 2:50 p.m., indicated she had noticed the nurses had not obtained the urine to be sent out timely, so she wrote an order to straight catheter the resident for urine, however, that was also not done timely. The urine should have been obtained in a more timely manner. This deficiency was cited on 2/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-41(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube dressings were changed as ordered and the tube feeding was infusing at the correct flow rate for 3 of 4 residents reviewed for tube feeding. (Residents E, G, and F) Findings include: 1. On 3/16/23 at 9:54 a.m., Resident E was in her room resting on top of her bed. The resident was wearing a sweatshirt and sweatpants and holding a stuffed animal. LPN 2 was asked to check the resident's gastrostomy tube site for a dressing. The LPN lifted the resident's shirt and a white gauze dressing was observed to the gastrostomy tube site. There were initials on the dressing but not a date. There was also dried drainage on the dressing. The LPN indicated the dressing was initialed but not dated and she would change it. The record for Resident E was reviewed on 3/15/23 at 1:55 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), gastrostomy status, and intellectual disabilities. The Quarterly Minimum Data Set (MDS) assessment, dated 2/23/23, indicated the resident was severely impaired for daily decision making and she required a feeding tube. A Care Plan, dated 2/20/23, indicated the resident required a tube feeding. Interventions included, but were not limited to, provide local care to gastrostomy tube site as ordered and monitor for signs and symptoms of infection.	F 0693	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents E, G and F had no adverse outcomes related to the cited practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **Any resident with a feeding tube has the potential to be affected by the alleged deficient practice.** **An audit was completed to ensure any resident with a feeding tube had the correct infusion rates and dressing is clean dry and intact.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee will educate licensed nurses on changing/dating g-tube dressings, and setting feeding pumps to the correct flow rate.** IV. How the corrective	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's Order, dated 2/7/23, indicated to cleanse the g-tube site with normal saline, pat dry, and apply a split gauze dressing every night shift for preventative. The March 2023 Treatment Administration Record (TAR), indicated the treatment had not been signed out as being completed on 3/15/23. A Physician's Order, dated 3/15/23, indicated to cleanse the g-tube site with normal saline, pat dry, and apply a split gauze dressing every 24 hours as needed (prn). The treatment had not been signed out as being completed on 3/15/23 on the March 2023 TAR. Interview with the Director of Nursing on 3/16/23 at 1:40 p.m., indicated the dressing to the g-tube site should have been changed as ordered.2. On 3/15/23 at 1:30 p.m. and 3:10 p.m., Resident G was observed in bed with her eyes closed. At those times, an enteral feeding was infusing at 30 cubic centimeters (cc) per hour into the resident's peg tube (a tube inserted directly into the stomach for nutrition). On 3/16/23 at 9:30 a.m., the resident was observed in bed with her eyes closed. The enteral feeding was infusing at 60 cc per hour. The record for Resident G was reviewed on 3/16/23 at 9:05 a.m. Diagnoses included, but were not limited to, stroke, dementia, peg tube, and hemiplegia. The resident was discharged to the hospital on 3/7/23 and readmitted to the facility on 3/11/23.		action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee to observe g-tube site for drainage, and any dates are present on dressing, if applicable. Feeding pump rate to be verified by observation. DON/designee will audit 5x/week for 4 weeks, 3x/week for 4 weeks then weekly.** The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The 2/14/23 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact and was dependent on staff for ADL care. Physician's Orders, dated 3/11/23, indicated enteral feed of Jevity 1.2 infuse at 30 cc per hour times 24 hours. The order was discontinued on 3/13/23. Physician's Orders, dated 3/13/23, indicated enteral feed of Jevity 1.2 infuse at 45 cc/hour times 24 hours for 1 day and then on 3/15/23 go to goal rate of 60 cc per hour. Interview with the Director of Nursing on 3/16/23 at 1:30 p.m. indicated the resident's enteral feeding was infusing at the wrong rate on 3/15/23. 3. On 3/15/23 at 1:30 p.m. and 3:30 p.m., and on 3/16/23 at 9:30 a.m., Resident F was observed in bed. At those times, the resident's enteral feeding was infusing at 75 cc per hour. The record for Resident F was reviewed on 3/16/23 at 11:46 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia, peg tube, and anxiety. The 1/3/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact and was dependent on ADL care. Physician's Orders, dated 3/3/23, indicated enteral feed of 1.5 at 80 cc per hour times 16 hours. Start at 10 p.m. and turn off at 2 p.m. The resident was to be NPO.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the Director of Nursing on 3/16/23 at 2:50 p.m., indicated the resident's enteral feeding was infusing at the wrong rate. This deficiency was cited on 2/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-44(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure medications were administered timely as ordered for 1 of 3 residents reviewed for unnecessary medications. (Resident B)	F 0757	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: Interview with Resident B on 3/16/23 at 9:58 a.m., indicated he didn't always get his Parkinson's medication on time. The record for Resident B was reviewed on 3/15/23 at 10:04 a.m. Diagnoses included, but were not limited to, Parkinson's disease, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/23, indicated the resident was cognitively intact. A Physician's Order, dated 2/22/23, indicated the resident was to receive Carbidopa-Levodopa (a medication to treat Parkinson's disease) 25-250 milligrams (mg), 2 tablets three times a day at 9:00 a.m., 12:00 p.m., and 6:00 p.m. The March 2023 Medication Administration Audit report indicated the resident received his Carbidopa-Levodopa late on the following dates and times: - 3/3 the 9:00 a.m. dose was administered at 11:29 a.m. The noon dose was administered at 12:09 p.m., 40 minutes after the 9:00 a.m. dose, and the 6:00 p.m. dose was administered at 10:08 p.m. - 3/5 the 9:00 a.m. dose was administered at 10:36 a.m. and the 6:00 p.m. dose was administered at 10:13 p.m. - 3/10 the 9:00 a.m. dose and noon dose was administered simultaneously at 11:08 a.m. Interview with the Director of Nursing on 3/16/23 at 2:47 p.m., indicated the medication should have been given timely and she would talk to the resident about changing the medication times.		**Resident B had no adverse reactions related to cited practice. MD notified of medication error.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **all residents have the potential to be affected by the alleged deficient practice.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nurses/QMA's on proper procedure of med pass administration and documentation.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee to run the late medication administration report to ensure that medications are passed as per MD order. Audits will be completed 5x/week x 4 weeks, 3x/week for 4 weeks then weekly.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficiency was cited on 2/15/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(3)		The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	