STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED			ETED		
		155156	B. WI	NG		03/16/	/2023
	ROVIDER OR SUPPLIE			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 DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	IN00402309, IN00 This visit was done Survey Revisit (PS Complaints IN003 IN00400678, IN00 completed on 2/15 Complaint IN0040 related to the alleg F757. Complaint IN0040 the allegations are Complaint IN0040 related to the alleg Complaint IN0040	2309 - Federal/State deficiencies ations are cited at F677 and	F 00	000	Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of 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. The fact respectfully request a desk refor these alleged deficient practices.	ot ment the et	
		18992 - Not Corrected. 10678 - Not Corrected.					
	Complaint IN0040						
	Complaint IN0040	01730 - Corrected.					
	Unrelated deficien	cy is cited.					
	Survey dates: Mar	rch 15 and 16, 2023.					
	Facility number: (Provider number:						

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

TITLE

(X6) DATE 04/11/2023

Any defiency statement 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 disclodays 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.

Deana Jordan Collins

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JB4L11 Facility ID: 000076 If continuation sheet Page 1 of 11

Regional Nurse Consultant

• •		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155156	B. W	ING		03/16/	2023	
	ROVIDER OR SUPPLIER		•	1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S BLANGE 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'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
F 0677 SS=D Bldg. 00	AIM number: 1002 Census Bed Type: SNF/NF: 128 Total: 128 Census Payor Type: Medicare: 11 Medicaid: 81 Other: 36 Total: 128 These deficiencies raccordance with 410 Quality review com 483.24(a)(2) ADL Care Provide §483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene; Based on observation interview, the facility (activities of daily livesident related to no reviewed for ADLs. Finding includes: On 3/15/23 at 1:30 gin bed with her eyes fingernails on the rich peg tube site. At	reflect State Findings cited in 0 IAC 16.2-3.1. apleted on 3/24/23. and for Dependent Residents resident who is unable to so of daily living receives the resident and oral con, record review, and ty failed to provide ADL iving) care to a dependent resident and care for 1 of 3 residents. (Resident G) p.m., Resident G was observed as closed. At that time, her ght hand were long and dirty. p.m., CNA 1 was asked to the resident to look at that time, the resident's left	F 00		I. What corrective action(s) will be accomplished 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 be identified and what correctinaction(s) will be taken; All residents have the potential to be affected by the alleged	cted will ve	04/07/2023	
	nutrition, grooming hygiene; Based on observation interview, the facility (activities of daily livesident related to not reviewed for ADLs.) Finding includes: On 3/15/23 at 1:30 pin bed with her eyes fingernails on the ri	g, and personal and oral on, record review, and ty failed to provide ADL iving) care to a dependent ail care for 1 of 3 residents . (Resident G) p.m., Resident G was observed s closed. At that time, her ght hand were long and dirty.	F 00	677	action(s) will be accomplished 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 affect by the same deficient practice be identified and what corrections.	cted will	04/07/202	
	remove the bed line the peg tube site. At	ens from the resident to look at			residents have the potential t	to		

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Event ID:

JB4L11

Facility ID: 000076

If continuation sheet Page 2 of 11

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 B. WING 03/16/2023			
		155156	B. W	_		03/10/2023
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD	
۸۵۲۵۱۵۰	N CARE ARRORS	MICHICANICITY			COOLSPRING AVE	
APERIO	N CARE ARBORS I	VIICHIGAN CH Y		MICHIC	GAN CITY, IN 46360	<u> </u>
(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	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	_	hat hand were extremely long s in the palm of her hand.				
	and left indentation	s in the paint of her hand.			III. What measures will	he
	On 3/16/23 at 9:30	a.m., the resident was observed			put into place and what syster	
		s closed. Her fingernails were			changes will be made to ensu	
	very long and dirty.				that the deficient practice doe	
					recur; DON/designee to educ	ate
		dent G was reviewed on			nursing staff on performing	
		. Diagnoses included, but were			ADL care to include nail care	e.
	· ·	te, dementia, peg tube, and				
	hemiplegia.					
	The 2/14/22 Signifi	cant Change Minimum Data Set			IV. How the corrective action(s) will be monitored to	
	_	indicated the resident was not			ensure the deficient practice v	vill
		nd was dependent on staff for			not recur i.e., what quality	VIII
	ADL care.	na was acpendent on starr for			assurance program will be pu	t into
					place; DON/designee will	
	The resident receive	ed bed baths, however, there			conduct an ADL audit to ens	sure
	was no documentat	ion her nails had been			ADL care, including nail care) ,
	trimmed.				is being rendered per reside	nts
					POC. Visual observation of	
		Director of Nursing on 3/16/23			nails will be completed durir	ng
	_	ed the resident's nails needed se they were too long.			Guardian Angel Rounds to	
	to be soaked becaus	se they were too long.			ensure nails are clean, trimmed and filed. The result	to I
	This Federal tag rel	ates to Complaint IN00402309.			of the angel rounds will be	1.5
	11110 1 000101 005 101				reviewed during the daily	
	3.1-38(a)(3)(E)				clinical meeting to ensure	
					compliance.	
					Audits will be completed 5x/w	
					for 4 weeks, 3x/week for 4 we	eks
					then weekly.	
					The results of these audits w	/III
					be reviewed in Quality	ve
					Assurance Meeting monthly months or until an average of	
					90% compliance or greater is	
					achieved x3 consecutive	
					months. The QA Committee	
					will identify any trends or	

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 09				
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155156	A. BUILDING B. WING	00	COMPLETED 03/16/2023		
		133130			03/10/2023		
NAME OF I	PROVIDER OR SUPPLIE	8		ADDRESS, CITY, STATE, ZIP COD			
APERIO	N CARE ARBORS I	MICHIGAN CITY		1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360			
(X4) ID	SUMMARY	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)			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	patterns and make	DATE		
				recommendations to revise plan of correction as indicat			
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-gatubes, both percurgastrostomy and jejunostomy, and resident's comprefacility must ensure \$483.25(g)(4) Are to eat enough aloued fed by enteral meclinical condition of feeding was clinical consented to by the \$483.25(g)(5) Are means receives the and services to refeating skills and the enteral feeding in aspiration pneumodehydration, metanasal-pharyngeal Based on observation interview, the facility tube dressings were tube feeding was in	estric and gastrostomy taneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the re that a resident- esident who has been able ne or with assistance is not thods unless the resident's demonstrates that enteral ally indicated and ne resident; and esident who is fed by enteral ne appropriate treatment store, if possible, oral or prevent complications of cluding but not limited to onia, diarrhea, vomiting, abolic abnormalities, and	F 0693	I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract Residents E, G and F had no	ice;		
	(Residents E, G, an	d F)		adverse outcomes related to the cited practice.			
	1		1				

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Event ID:

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

JB4L11

Facility ID: 000076

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How other residents having

the potential to be affected by the

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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		03/16/	2023	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
					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	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	II.	DATE	
	wearing a sweatshin	rt and sweatpants and holding			same deficient practice will be			
	a stuffed animal. L	PN 2 was asked to check the			identified and what corrective			
	resident's gastrosto	my tube site for a dressing.			action(s) will be taken; Any			
	The LPN lifted the	resident's shirt and a white			resident with a feeding tube			
	gauze dressing was	observed to the gastrostomy			has the potential to be affect	ed		
	tube site. There we	ere initials on the dressing but			by the alleged deficient			
	not a date. There w	vas also dried drainage on the			practice.			
		indicated the dressing was			An audit was completed to			
	initialed but not dat	ed and she would change it.			ensure any resident with a			
		-			feeding tube had the correct			
	The record for Resi	dent E was reviewed on			infusion rates and dressing i			
	3/15/23 at 1:55 p.m	. Diagnoses included, but were			clean dry and intact.			
	not limited to, dysp	hagia (difficulty swallowing),						
	gastrostomy status,	and intellectual disabilities.			III. What measures will be	put		
					into place and what systemic			
	The Quarterly Mini	mum Data Set (MDS)			changes will be made to ensu	re		
	assessment, dated 2	2/23/23, indicated the resident			that the deficient practice does	s not		
	was severely impair	red for daily decision making			recur; DON/designee will			
	and she required a f	feeding tube.			educate licensed nurses on			
					changing/dating g-tube			
	A Care Plan, dated	2/20/23, indicated the resident			dressings, and setting feedir	ng		
	required a tube feed	ling. Interventions included,			pumps to the correct flow rate	te.		
	but were not limited	d to, provide local care to						
	gastrostomy tube si	te as ordered and monitor for						
	signs and symptom	s of infection.			IV. How the corrective			
					action(s) will be monitored to			
	A Physician's Order	r, dated 2/7/23, indicated to			ensure the deficient practice w	vill		
	cleanse the g-tube s	site with normal saline, pat dry,			not recur i.e., what quality			
	and apply a split ga	uze dressing every night shift			assurance program will be put	tinto		
	for preventative.				place; DON/designee to obse	erve		
					g-tube site for drainage, and			
		reatment Administration Record			any dates are present on			
	, ,	e treatment had not been			dressing, if applicable. Feedi	ing		
	signed out as being	completed on 3/15/23.			pump rate to be verified by			
					observation. DON/designee v	will		
	1	r, dated 3/15/23, indicated to			audit 5x/week for 4 weeks,			
	_	site with normal saline, pat dry,			3x/week for 4 weeks then			
		uze dressing every 24 hours as			weekly.			
	needed (prn).							
					The results of these audits will	l be		

i f		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 03/16/2023			
		155156	B. W			03/16/	2023
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
ΛDEDIΩΝ	N CARE ARRORS	MICHICANI CITY		1	COOLSPRING AVE		
	N CARE ARBORS I			1	GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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)	TE	COMPLETION DATE
TAG		not been signed out as being	+	IAU	reviewed in Quality Assurance	<u> </u>	DATE
		23 on the March 2023 TAR.			Meeting monthly x6 months of		
	•				until an average of 90%		
		Director of Nursing on 3/16/23			compliance or greater is achie		
	_	ted the dressing to the g-tube			x3 consecutive months. The		
		en changed as ordered.2. On			Committee will identify any tre	nds	
		a. and 3:10 p.m., Resident G was th her eyes closed. At those			or patterns and make	•	
		eding was infusing at 30 cubic			recommendations to revise the plan of correction as indicated		
		r hour into the resident's peg			Pian or concodor as indicated		
		d directly into the stomach for					
	nutrition).						
		a.m., the resident was observed					
	was infusing at 60 c	s closed. The enteral feeding					
	was miusing at 00 C	ce per nour.					
	The record for Resi	dent G was reviewed on					
	3/16/23 at 9:05 a.m	. Diagnoses included, but were					
		te, dementia, peg tube, and					
	hemiplegia.						
	The regident was di	scharged to the hospital on					
		ted to the facility on 3/11/23.					
	2. ,, 25 and readmin						
	The 2/14/23 Signifi	cant Change Minimum Data Set					
		indicated the resident was not					
		nd was dependent on staff for					
	ADL care.						
	Physician's Orders	dated 3/11/23, indicated					
	1 -	ty 1.2 infuse at 30 cc per hour					
		e order was discontinued on					
	3/13/23.						
	1	dated 3/13/23, indicated					
		ty 1.2 infuse at 45 cc/hour times					
	rate of 60 cc per ho	and then on 3/15/23 go to goal					
	Tate of oo ee per no	uı.					
	ī		1	J.	i e e e e e e e e e e e e e e e e e e e		1

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Event ID:

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Facility ID: 000076

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/16 /	ETED	
	PROVIDER OR SUPPLIER		1101 E	DDRESS, CITY, STATE, ZIP COD COOLSPRING AVE AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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
	at 1:30 p.m. indicat	Director of Nursing on 3/16/23 ed the resident's enteral feeding wrong rate on 3/15/23.				
	3/16/23 at 9:30 a.m	30 p.m. and 3:30 p.m., and on, Resident F was observed in , the resident's enteral feeding ce per hour.				
	3/16/23 at 11:46 a.ı	dent F was reviewed on m. Diagnoses included, but were inson's disease, dementia, peg				
	assessment, indicat	ly Minimum Data Set (MDS) ed the resident was not nd was dependent on ADL				
	feed of 1.5 at 80 cc	dated 3/3/23, indicated enteral per hour times 16 hours. Start off at 2 p.m. The resident was				
	at 2:50 p.m., indica	Director of Nursing on 3/16/23 ted the resident's enteral ag at the wrong rate.				
	This Federal tag rel 3.1-44(a)(2)	ates to Complaint IN00403392.				
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Flui § 483.25(h) Paren Parenteral fluids r consistent with pr practice and in ac orders, the compr					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		lì í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 03/16/	ETED	
	PROVIDER OR SUPPLIEF			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	ATE	(X5) COMPLETION DATE
	interview, the facili (peripherally inserted bandages were chart was receiving intraval residents reviewed. Finding includes: On 3/15/23 at 1:30 was observed in beet those times, there was upper right arm with 3/7/23. On 3/16/23 at 9:30 in bed with her eyes bandage was dated. The record for Resident was distributed to, strok hemiplegia.	on, record review, and ty failed to ensure PICC ed central catheter) line aged weekly while a resident enous (IV) antibiotics for 1 of d for PICC lines. (Resident G) p.m. and 3:10 p.m., Resident G with her eyes closed. At as a PICC line observed in the habandage over the top dated a.m., the resident was observed as closed. The PICC line 3/7/23. dent G was reviewed on Diagnoses included, but were e, dementia, peg tube, and	F 00	694	Tag number: 694- Parentral/I fluids I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract Resident G's PICC dressing with changed. Resident G had not adverse outcomes related to alleged deficient practice. II. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents with venous accessions dressings will be aud to ensure they are changed ordered. III. What measures will be into place and what systemic	ice; vas the aving the e	04/07/2023
	(MDS) assessment,	cant Change Minimum Data Set indicated the resident was not and was dependent on staff for			changes will be made to ensu that the deficient practice doe recur; DON/designee to educate licensed nursing sta on following physicians orde to include PICC line dressing	s not aff ers,	
	Piperacillin Sod-Ta Intravenous Solutio (3-0.375) grams (Pi Sodium) every 8 ho Weeks. Change Cat	dated 3/11/23, indicated zobactam (antibiotic) n Reconstituted 3.375 peracillin Sodium-Tazobactam urs for wound infection for 4 theter Site dressing every week d) with transparent dressing.			changes. IV. How the corrective action(s) will be monitored to ensure the deficient practice on to recur i.e., what quality assurance program will be pu	vill	

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

PRINTED: 05/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 03/16/	ETED
			1101 E	COOLSPRING AVE		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	ID REFIX TAG	DEFICIENCY)		(X5) COMPLETION DATE
at 1:30 p.m. indicate should have been ch	ed the PICC line bandage			PICC dressing changes by observation 5x/week x 4		
				reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The C Committee will identify any tree or patterns and make recommendations to revise the	ved QA nds	
Drugs §483.45(d) Unnec Each resident's driftom unnecessary drug is any drug w §483.45(d)(1) In eduplicate drug therefor the second	essary Drugs-General. ug regimen must be free drugs. An unnecessary when used- excessive dose (including rapy); or excessive duration; or mout adequate monitoring; enout adequate indications ene presence of adverse ich indicate the dose					
	PROVIDER OR SUPPLIER OF CARE ARBORS MEACH DEFICIENCY REGULATORY OR Interview with the I at 1:30 p.m. indicate should have been characteristic at 1:30 p.m. i	DENTIFICATION NUMBER 155156 ROVIDER OR SUPPLIER N CARE ARBORS MICHIGAN CITY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Interview with the Director of Nursing on 3/16/23 at 1:30 p.m. indicated the PICC line bandage should have been changed every 7 days. 3.1-47(a)(2) 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	DENTIFICATION NUMBER 155156 ROVIDER OR SUPPLIER N CARE ARBORS MICHIGAN CITY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Interview with the Director of Nursing on 3/16/23 at 1:30 p.m. indicated the PICC line bandage should have been changed every 7 days. 3.1-47(a)(2) 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	TOP CORRECTION IDENTIFICATION NUMBER 155156 ROVIDER OR SUPPLIER N CARE ARBORS MICHIGAN CITY SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Interview with the Director of Nursing on 3/16/23 at 1:30 p.m. indicated the PICC line bandage should have been changed every 7 days. 3.1-47(a)(2) 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	DEFORMENTIAL TOP THE ARBORS MICHIGAN CITY ROVIDER OR SUPPLIER N CARE ARBORS MICHIGAN CITY SUMMARY STATEMENT OF DEFCIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Interview with the Director of Nursing on 3/16/23 at 1:30 p.m. indicated the PICC line bandage should have been changed every 7 days. 3.1-47(a)(2) The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated the plan of correction as indicated duplicate drug therapy); or \$483.45(d)(1) In excessive dose (including duplicate drug therapy); or \$483.45(d)(3) Without adequate monitoring; or \$483.45(d)(6) In the presence of adverse consequences which indicate the dose	ROVIDER OR SUPPLIER N CARE ARBORS MICHIGAN CITY SUMMARY STATEMENT OF DEPICIENCIE (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Interview with the Director of Nursing on 3/16/23 at 1:30 p.m. indicated the PICC line bandage should have been changed every 7 days. 3.1-47(a)(2) ### Association of the second of the processory Drug Regimen is Free from Unnecessary S483.45(d)(1) In excessive duration; 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

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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 03/16/2023 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 §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 F 0757 04/07/2023 I. What corrective action(s) failed to ensure medications were administered will be accomplished for those timely as ordered for 1 of 3 residents reviewed for residents found to have been unnecessary medications. (Resident B) affected by the deficient practice; Resident B had no adverse Finding includes: reactions related to cited practice. MD notified of Interview with Resident B on 3/16/23 at 9:58 a.m., medication error. indicated he didn't always get his Parkinson's medication on time. How other residents having The record for Resident B was reviewed on the potential to be affected by the 3/15/23 at 10:04 a.m. Diagnoses included, but same deficient practice will be were not limited to, Parkinson's disease, anxiety, identified and what corrective and depression. action(s) will be taken: all residents have the potential to The Quarterly Minimum Data Set (MDS) be affected by the alleged assessment, dated 1/22/23, indicated the resident deficient practice. was cognitively intact. A Physician's Order, dated 2/22/23, indicated the III. What measures will be put resident was to receive Carbidopa-Levodopa (a into place and what systemic medication to treat Parkinson's disease) 25-250 changes will be made to ensure milligrams (mg), 2 tablets three times a day at 9:00 that the deficient practice does not a.m., 12:00 p.m., and 6:00 p.m. recur; DON/designee to educate nurses/QMA's on proper The March 2023 Medication Administration Audit procedure of med pass report indicated the resident received his administration and Carbidopa-Levodopa late on the following dates documentation. and times: -3/3 the 9:00 a.m. dose was administered at 11:29 IV. How the corrective a.m. The noon dose was administered at 12:09 action(s) will be monitored to p.m., 40 minutes after the 9:00 a.m. dose, and the ensure the deficient practice will 6:00 p.m. dose was administered at 10:08 p.m. not recur i.e., what quality assurance program will be put into -3/5 the 9:00 a.m. dose was administered at 10:36 place; DON/designee to run the

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

PRINTED: 05/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/16/2023		
NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY			1101 E	ADDRESS, CITY, STATE, ZIP COD COOLSPRING AVE GAN CITY, IN 46360			
(X4) ID PREFIX TAG	(EACH DEFICIE	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)	λΤΕ	(X5) COMPLETION DATE
	10:13 p.m. -3/10 the 9:00 a.m administered simu Interview with the at 2:47 p.m., indicate been given timely resident about characteristics.	o.m. dose was administered at dose and noon dose was ltaneously at 11:08 a.m. Director of Nursing on 3/16/23 ated the medication should have and she would talk to the nging the medication times.			late medication administration report to ensure that medications are passed as particular medications and make recommendations to revise the plan of correction as indicated.	per s, I be e r eved QA ends	

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