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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00402309, IN00403368, and IN00403392. This visit was done in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00396040, IN00396689, IN00398992, IN00400678, IN00401271, and IN00401730, completed on 2/15/23. 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. Complaint IN00396040 - Not Corrected. Complaint IN00396689 - Not Corrected. Complaint IN00398992 - Not Corrected. Complaint IN00400678 - Not Corrected. Complaint IN00401271 - Corrected. Complaint IN00401730 - Corrected. Unrelated deficiency is cited. Survey dates: March 15 and 16, 2023. Facility number: 000076 Provider number: 155156	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
Deana Jordan Collins	Regional Nurse Consultant	04/11/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	AIM number: 100271060 Census Bed Type: SNF/NF: 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.	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

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	Her fingernails on that hand were extremely long and left indentations in the palm of her hand. 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 Federal tag relates to Complaint IN00402309. 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. Visual observation of nails will be completed during Guardian Angel Rounds to ensure nails are clean, trimmed and filed. The results of the angel rounds will be reviewed during the daily 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**	

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			patterns and make recommendations to revise the plan of correction as indicated.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and 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	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	04/07/2023

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	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. 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).		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 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	

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	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. 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.		reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	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. 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 Federal tag relates to Complaint IN00403392. 3.1-44(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and			

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	preferences. Based on observation, record review, and interview, the facility failed to ensure PICC (peripherally inserted central catheter) line bandages were changed weekly while a resident was receiving intravenous (IV) antibiotics for 1 of 1 residents reviewed for PICC lines. (Resident G) Finding includes: 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, there was a PICC line observed in the upper right arm with a bandage over the top dated 3/7/23. On 3/16/23 at 9:30 a.m., the resident was observed in bed with her eyes closed. The PICC line bandage was dated 3/7/23. 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 Piperacillin Sod-Tazobactam (antibiotic) Intravenous Solution Reconstituted 3.375 (3-0.375) grams (Piperacillin Sodium-Tazobactam Sodium) every 8 hours for wound infection for 4 Weeks. Change Catheter Site dressing every week and PRN (as needed) with transparent dressing.	F 0694	Tag number: **694- Parentral/IV fluids** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident G's PICC dressing was changed. Resident G had no adverse outcomes related to the alleged deficient 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; **All residents with venous access points dressings will be audited to ensure they are changed as ordered.** 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 licensed nursing staff on following physicians orders, to include PICC line dressing changes.** 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	04/07/2023

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	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)		place; **DON/designee to very PICC dressing changes by observation 5x/week x 4 weeks, 3x/week x 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 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or			

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	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on 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) 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	F 0757	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **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**	04/07/2023

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	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. This Federal tag relates to Complaint IN00402309. 3.1-48(a)(3)		**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.** 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.	