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	04/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00259084. Complaint IN00259084 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686. Survey date: April 18, 2018 Facility number: 000076 Provider number: 155156 AIM number: 200064830 Census Bed Type: SNF/NF: 96 SNF: 25 Total: 121 Census Payor Type: Medicare: 23 Medicaid: 73 Other: 25 Total: 121 This deficiency reflects State Findings cited accordance with 410 IAC 16.2-3.1. Quality review completed on 4/19/18.	F 0000		
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	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 observation, record review, and interview, the facility failed to ensure a pressure ulcer dressing was changed as ordered by the Physician for 1 of 3 residents reviewed for pressure ulcers. (Resident J) Finding includes: During Orientation Tour with the Assistant Director of Nursing on 4/18/18 at 8:25 a.m., Resident J was observed in bed. A foam dressing was in place to the left hip area. The date of 4/15/18 was written on the dressing with initials next to the date. The Assistant Director of Nursing verified the date on the dressing was 4/15/18. The initials were identified as RN 1's. Wound care was observed by the Wound Care Physician and the Wound Nurse on 4/18/18 at 8:40 a.m. The dressing was removed. The Wound Care Physician assessed and measured the open area as 0.6cm x 0.6cm with a depth of 1.7 cm. Undermining of 2.5 cm at 5 o'clock to 10 o'clock present. No drainage was observed at the wound site. The Wound Care Physician indicated the wound had decreased in size and had improved since last week. The resident had also completed antibiotics for a wound infection recently. The clinical record for Resident J was reviewed on	F 0686	**F 686 Treatment/Svcs to prevent/Heal Pressure Ulcer** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident J dressing change was immediately completed. **2) How the facility identified other residents:**	04/27/2018

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	4/18/18 at 12:35 p.m. Diagnoses included, but were not limited to, paraplegia, anemia, and depressive disorder. A Physician's order, obtained 4/5/18, indicated the left hip ulcer was to be cleansed with wound cleanser, packed with plain packing strip, and covered with a foam dressing daily. A Physician's order, obtained on 4/11/18, indicated Ciprofloxacin (an antibiotic) 500 mg(milligrams) every (12) hours for a wound infection was to be initiated. The 4/2018 Medication Administration Record was reviewed. The above ordered treatment was last signed out as completed on 4/15/18. When interviewed on 4/18/18 at 12:30 p.m., RN 1 indicated she did not work the past two days (4/16/18 or 4/17/18). When interviewed on 4/18/18 at 12:45 p.m., the Director of Nursing indicated the treatment had not been completed on 4/16/18 or 4/17/18 as ordered by the Physician. This Federal tag relates to Complaint IN00259084. 3.1-40(a)(2)		All resident's requiring treatments/dressing changes were completed as ordered. **3) Measures put into place/ System changes:** Staff were educated on completing resident treatments as orders. **4) How the corrective actions will be monitored:** An audit tool was created to monitor residents who require treatments/dressing changes. Audit will be completed by DON or designee by observing treatments/dressing changes on residents 5 times weekly at various times and days. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance 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.	