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	01/04/2019

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 a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/20/18. Survey dates: 1/3 and 1/4/19 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 112 SNF: 22 Total: 134 Census Payor Type: Medicare: 18 Medicaid: 88 Other: 28 Total: 134 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/7/19.	F 0000		
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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

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	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure medications were obtained and dispensed as ordered related to psychotropic and pain medications for 2 of 2 residents reviewed. (Residents 1 and 2) Findings include: 1. The record for Resident 1 was reviewed on 1/4/19 at 11:13 a.m. Diagnoses included, but were not limited to, chronic pain, osteoarthritis, bipolar, borderline personality disorder, and major depressive disorder. The January 2019 Physician's Order Summary	F 0755	**F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records** **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*	01/30/2019

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	(POS) indicated the resident received the following medication: - Ativan (an anti-anxiety medication) 1 milligram (mg) twice a day for anxiety. The December 2018 Medication Administration Record (MAR) indicated the resident did not receive her Ativan on the following dates: - 12/27/18 at 10:00 p.m. - 12/28/18 at 8:00 a.m. and 10:00 p.m. - 12/30/18 at 8:00 a.m. An entry in the nursing progress notes, dated 12/27/18 at 9:45 p.m., indicated, "awaiting from pharmacy." Documentation in the nursing progress notes, dated 12/28/18 at 7:14 a.m., indicated, "awaiting for arrival from pharmacy, Physician notified." An entry at 11:49 a.m. indicated the Assistant Director of Nursing had attempted to reach the resident's Physician several times but was only getting the answering machine. Documentation indicated it was the family preference to go through that particular Physician for the Ativan prescription and refills. The resident's mother was contacted and she indicated that she would also attempt to reach the Physician. At 12:29 p.m., the Physician's office was notified of the need for an Ativan refill and prescription. Documentation at 3:28 p.m. indicated a message was left with the resident's Physician related to needing a prescription for the Ativan as soon as possible due to the resident being out.		*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 1 and Resident 2 had no harmful effects from medication missed **2) How the facility identified other residents:** All residents receiving medication could be affected. All residents were reviewed for medications missed and appropriate notifications done. **3) Measures put into place/ System changes:** Licensed nurses and QMA's will be re- educated on the availability of medications, including procedure for re-ordering medications and use of Emergency drug kit and Nexsys medication system. **4) How the corrective actions will be monitored:**	

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	An entry at 7:59 p.m. indicated, "not available." Documentation in the nursing progress notes on 12/30/18 at 10:20 a.m. indicated, "waiting." Interview with the Assistant Director of Nursing on 1/4/19 at 12:30 p.m., indicated that she had attempted several times to contact the resident's Physician to get the prescription for the Ativan refill. She also indicated there was no Ativan available for use in the Emergency Drug Kit (EDK). Interview with the Director of Nursing on 1/4/19 at 1:00 p.m., indicated the resident did not receive her Ativan on the above dates because the medication was not available from pharmacy and was not in the EDK. Multiple attempts were made to contact the resident's Physician, and when he could not be reached, the Nurse Practitioner was contacted to write the prescription. 2. Interview with Resident 2 on 1/4/19 at 9:26 a.m., indicated he had concerns related to his medications not being available. On or about last week, his Morphine (a pain medication) was not refilled on time and he had missed 2-3 doses. The record for Resident 2 was reviewed on 1/4/19 at 10:04 a.m. Diagnoses included, but were not limited to, myoneural disorder, shoulder pain, major depression, and anxiety. The Annual Minimum Data Set (MDS) assessment, dated 8/28/18, indicated the resident was alert and oriented and he received scheduled pain medications. A Physician's order, dated 9/6/17, indicated Morphine Sulfate ER 30 mg (milligrams), give every 8 hours (12 a.m., 8 a.m., and 4 p.m.) for		The DON/designee will audit for medication availability on 3 residents 3 x per week to ensure medications are obtained and dispensed as ordered. 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.	

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	chronic pain. The December 2018 Medication Administration Record (MAR) indicated the resident did not receive his pain medication on 12/28/18 at 8 a.m. and 4 p.m. A nursing progress note, dated 12/28/2018 at 5:21 a.m., indicated "Morphine not available for midnight dose - has not been delivered from pharmacy yet." Interview with the Director of Nursing on 1/4/19 at 11:17 a.m., indicated the pharmacy was only sending a 4-day supply of the pain medication and she was aware of the concern. Continued interview at 11:25 a.m., indicated she had spoken with the Nurse Practitioner (NP), there was an insurance payment issue with the way the script was being written, the NP will now write the script to indicate a 30-day supply. This deficiency was cited on 11/20/2018. The facility failed to implement a systematic plan of correction to prevent recurrence. 3.1-25(g)(3)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was properly stored and labeled in sanitary conditions in the cooler and in the main Kitchen area for 1 of 1 kitchen. The main Kitchen) Findings include: 1. During the Kitchen sanitation tour on 1/3/19 at 9:43 a.m. with the Dietary Manager (DM), the following was observed: a. There were 2 containers of thickened apple juice, 3 containers of thickened water, and 2 containers of thickened dairy drink that were open without an open date. b. There was a pitcher of ice tea in the cooler with a use by date of 1/2/19. c. There was a container of white and a container of yellow shredded cheese in the cooler with a use by date of 12/24/18. d. In the Kitchen area, there were 2 bulk cereal containers that were not labeled or dated when opened.	F 0812	**F 812 Food Procurement, Storage** **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:** Thickened apple juice, thickened water, containers of thickened	01/30/2019

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	e. In the Kitchen area, there was a bin of oatmeal and a bin of sugar with use by dates of 1/2/19. Interview with the DM at that time, indicated food and beverages were to be labeled with an open date after opening and all food past the use by date should be discarded. This deficiency was cited on 11/20/2018. The facility failed to implement a systematic plan of correction to prevent recurrence. 3.1-21(i)(3)		dairy drink, pitcher of iced tea, bulk containers of cereal, white and yellow shredded cheese, bin of oatmeal, and bin of brown sugar, as identified by the 2567 were discarded. **2) How the facility identified other residents:** All residents receiving an oral diet have the potential to be affected. **3) Measures put into place/ System changes:** Dietary and nursing staff will be re-educated on food storage and labeling policy and procedure. **4) How the corrective actions will be monitored:** Kitchen food storage areas and nutrition pantries on the units will be audited at least 5 times per week to ensure food is properly stored and labeled. The Dietary Manager and Administrator are responsible for oversight of these audits.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and	F 0921	**F F921**	01/30/2019

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	interview, the facility failed to ensure the residents' environment and the kitchen was clean and in good repair related to marred walls, and doors, dusty bathroom vents, lime buildup on faucets, stained privacy curtains, peeling paint, dirty floors, and dirty air vents for 4 of 4 units and 1 of 1 kitchen. (The Special Care, 200, 300, and 400 units, and Main Kitchen) Findings include: 1. During the Environmental tour on 1/4/19 at 10:17 a.m. with the Maintenance Supervisor, the following was observed: Special Care Unit: a. Room 123, the bathroom door was marred. Four residents shared the bathroom. b. Room 109, the bathroom door and wall were marred. Two residents shared the bathroom. d. Room 102, the carpet was frayed by the threshold at the door entrance. Three residents shared the bathroom. e. Room 108, the door frame was marred and had peeling paint. Two residents shared bathroom. f. Room 122, the baseboard was pulling away from the wall in the bathroom. There was a moderate amount of debris and discolorations on the bathroom floor. The ceiling vent was dusty and there were cobwebs on the sprinkler head. Two residents resided in the room and shared the bathroom. 200 unit		**Safe/Functional/Sanitary, Comfortable Environment** **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:** A maintenance, housekeeping and administrative tour was conducted and items easily repairable were initiated prior to survey completion. Rooms 123, 109 and 108 areas identified as having marred walls were covered or patched and painted. Room 102 frayed carpet was repaired. Room 122 baseboard was repaired, debris was cleaned, discoloration to bathroom floor was corrected. Ceiling vent was cleaned and cobwebs on sprinkler head removed. Room 213 privacy curtain and hooks replaced,	

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	a. Room 213, the privacy curtain was missing hooks. The bathroom ceiling vent was dusty. One resident resided in the room and used the bathroom. b. Room 201, the privacy curtain was stained and missing hooks. There was a moderate amount of lime build up around the faucet. Two residents resided in the room and 4 residents shared the bathroom. d. Room 206, the privacy curtain was stained. There was lime build up on the faucet. Two residents resided in the room and 3 residents shared the bathroom. e. Room 220, The bedroom walls were scratched and marred in corner by the bathroom door. Two residents resided in the room and 3 shared the bathroom. 300 unit a. Room 301, the wood was chipped on the bathroom door. Two residents resided in the room and shared the bathroom. c. Room 302, there was dried brown enteral feeding on the wall and register near bed 2. Two residents resided in the room. d. Room 319, the bathroom vinyl flooring was cracked by the toilet bowl. No residents resided in the room or used the bathroom. e. Room 317, the floor had a large amount of dried enteral feeding. No residents resided in the room. 400 unit		ceiling vent cleaned. Room 201 and 206 privacy curtains and hooks replaced and lime buildup in faucets removed. Room 220 scratched and marred walls repaired. Room 301 wood chipped on bathroom door was repaired. Room 302 and 317 enteral feeding on floor, wall and register were cleaned. Room 319 vinyl floor and cracked toilet was repaired. Room 422-bathroom wall widened seam repaired. Kitchen walls were resurfaced, floors were cleaned, vents were cleaned, storage of cutting boards was corrected, ceiling area scraped and painted. **2) How the facility identified other residents:** A maintenance, housekeeping and administrative tour was conducted on all resident rooms and common areas of the facility. **3) Measures put into place/ System changes:** Based on the facility wide inspection, a list was made for all necessary areas needing additional cleaning, repaired or replacement. The housekeeping and laundry Manager will conduct, and document rounds at least 3 times per week to inspect cleanliness of the facility and include at least 3	

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	a. Room 422, the wall in the bathroom by the ceiling had a widened seam and was not repaired. One resident used the bathroom. Interview with the Maintenance Supervisor at that time, indicated he was unaware of the housekeeping issues. He indicated all of the above was in need of cleaning and/or repair. Interview with the Administrator on 1/4/19 at 11:15 a.m., indicated the contracted housekeeping services was terminated as of 12/28/18. The Maintenance Supervisor was not given a copy of the housekeeping issues from the survey, therefore, none of those concerns were cleaned or repaired. 2. During the Kitchen sanitation tour on 1/3/19 at 9:43 a.m. with the Dietary Manager (DM), the following was observed: a. On the floor under the tilt skillet, there was a build up of a black substance. b. In the corners of the kitchen floor, there was a dark build up with food debris. c. There were gouges in the wall with chipped paint by the tilt skillet. d. A dark green substance covered 3 of the 4 ceiling vents. e. The clean cutting boards were stored below waist level uncontained. f. There was peeling paint throughout the kitchen's ceiling. Interview with the DM at that time, indicated all of		resident rooms on each unit. Department managers will complete Angel Rounds to observe for cleanliness and any maintenance or housekeeping concerns noted will be reported and documented in the morning manager meeting at least 3-5 times per week. Maintenance work orders will be completed and placed on the repair log for issues identified through observations and rounds. The repair log will be reviewed weekly by the Maintenance Director for completion. Kitchen areas were placed on a routine cleaning schedule. The Food Services manager will complete observations and audit of cleaning schedule at least 3 times per week. The Administrator will be responsible for oversight of all audits. **4) How the corrective actions will be monitored:** 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	

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	the above was in need of cleaning. Interview with the Administrator on 1/3/19 at 10:30 a.m., indicated they had just hired a new DM and had terminated the housekeeping services contract at the end of December 2018, therefore, the maintenance department had been doing extra work. He indicated the kitchen had not been entirely cleaned by the plan of correction date. This deficiency was cited on 11/20/2018. The facility failed to implement a systematic plan of correction to prevent recurrence. 3.1-19(f)		recommendations to revise the plan of correction as indicated.	