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	12/18/2017

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 a Recertification and State Licensure Survey. Survey dates: December 12, 13, 14, 15, 17, & 18, 2017 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census Bed Type: SNF/NF: 86 SNF: 21 Total: 107 Census Payor Type: Medicare: 18 Medicaid: 70 Other: 19 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/20/17.	F 0000		
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility			

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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	must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.			
	Based on observation, record review and interview, the facility failed to ensure resident preferences were honored related to dressing and waking time for 2 of 3 residents reviewed for choices. (Residents 39 and 9) Findings include: 1. On 12/13/17 at 1:10 p.m., Resident 39	F 0561	**F561** **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*	01/21/2018

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	was observed in bed wearing a hospital gown. On 12/14/17 at 9:30 a.m. and 1:15 p.m., the resident was again observed in bed wearing a hospital gown. On 12/15/17 at 11:15 a.m., the resident was observed in bed wearing a hospital gown. [illegible] 1:49 p.m., indicated he would like to get up at 6:00 a.m., however, he does not get up until almost 7:00 a.m. He has told staff his concern and still gets up late. Interview with the resident on 12/14/17 at 9:40 a.m., he indicated he was not assisted up out of bed until 6:45 a.m. that morning. On 12/15/17 at 6:35 a.m., the resident was observed in bed. At 7:35 a.m., the resident was still observed in bed, he had his call light on and wanted to get up. Interview with CNA 1 and CNA 2 at that time, indicated they were both unaware the resident wanted to be up at 6:00 a.m. CNA 1 removed the CNA care sheet and there was no documentation the resident wanted		*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 9 was assisted to wake up at his preferred time. Resident 39 was dressed in preferred clothing. . **2.) How the facility identified other residents:** All interview able residents were asked for an update on preferences, which will include but not limited to dressing, arising and sleeping times, bathing and food preferences **3.) Measures put into place/System changes:** Staff will be educated on honoring resident preferences. Preferences will be added to care plan. **4.) How the correction actions will be monitored:** An audit tool was created to monitor if residents are assisted with their preferences. Audit will be completed under the supervision of DON or designee 3 times weekly on a sample of three residents to determine if they were assisted in rising/sleeping times, bathing,	

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	to be up at 6:00 a.m. The record for Resident 9 was reviewed on 12/14/17 at 2:03 p.m. The resident was admitted to facility on 11/2/17 with diagnoses that included, but were not limited to, below the knee amputation, muscle weakness, renal dialysis, end stage renal disease, difficulty walking, and chronic pain syndrome. The Admission 11/9/17 Minimum Data Set (MDS) assessment, indicated the resident was alert and oriented. It was somewhat important to choose his own bedtime. The resident needed assistance with transfers. An Activity assessment, dated 11/3/17, indicated the preferred time the resident wanted to be up was 6:00 a.m. The updated 12/2017, CNA care sheet, indicated there was no documentation the resident wanted to get up at 6:00 a.m. Interview with 200 hall Unit Manager on 12/15/17 at 8:30 a.m., indicated she was aware the resident wanted to get up at 6:00 a.m., and had informed the midnight shift CNAs of the resident's preferences. 3.1-3(u)(1)		eatingand clothing preference and any other preferences which the resident has. 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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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review, and interview, the facility failed to ensure the comprehensive assessment was accurate related to dental status for 1 of 3 residents reviewed for dental services. (Resident 36) Finding includes: On 12/13/17 at 1:32 p.m., Resident 36 was observed with broken, missing and caried teeth. The record for Resident 36 was reviewed on 12/14/17 at 9:59 a.m. Diagnoses included, but were not limited to, pleural effusion, muscle weakness, respiratory tuberculosis, end stage renal disease, dependent on renal dialysis, dysphagia, altered mental status, dementia, heart failure, anxiety, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/14/17, indicated the resident was not alert and oriented. She needed supervision with eating with one	F 0641	**F 641 Accuracy of Assessments** **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 36 MDS was corrected and resubmitted and a dental care plan. **2.) How the facility identified other residents:** All residents will have a new oral/dental evaluation assessment completed and care planned if needed. MDS Coordinator will review most recent MDS for accuracy of assessment in all pertinent areas. **3.) Measures put into place/System changes:** Staff will be educated on completing accurate oral/dental evaluation	01/21/2018

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	person physical assist. She weighed 91 pounds with a history of unplanned weight loss. She received a therapeutic diet and had no oral issues. The Annual MDS assessment, dated 1/24/17, indicated the resident had no caried or broken teeth. There was no care plan for dental care. An initial dental exam, dated 2/27/17, indicated the resident was missing 12 teeth and had 6 teeth that were only root tips. Another dental exam, dated 11/29/17, indicated the resident was missing 15 teeth and had 9 teeth that were only root tips. Oral assessments, dated 4/15/17 and 7/19/17, indicated the resident had her own teeth with none broken or missing. Interview with LPN 2 on 12/14/17 at 10:30 a.m., indicated she really did not know if the resident had any missing teeth. She indicated the nurses complete the dental assessments for the residents. Interview with CNA 1 on 12/14/17 at 10:39 a.m., indicated the resident was missing quite a few teeth and only had tips on the		assessments and how to use care plan to review. Staff will be educated on how to fill out assessments properly. **4.) How the correction actions will be monitored:** An audit tool was created to monitor the accuracy of residents' assessments and MDS match in accuracy. Audit will be completed under the supervision of DON or designee 3 times weekly on a sample of three residents to determine accuracy of all pertinent areas of MDS and assessment.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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	bottom of her mouth. Interview with the 200 hall Unit Manager on 12/18/17 at 8:45 a.m., indicated the dental assessments were inaccurate as well as the MDS assessment. Interview with the MDS Coordinator on 12/18/17 at 11:12 a.m., indicated she had corrected the MDS last week. 3.1-31(i)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to monitor and/or assess bruises for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident 46) Finding includes: On 12/12/17 at 10:02 a.m., Resident 46	F 0684	**F 684 Quality of Care** **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*	01/21/2018

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	was observed with a blue and purple bruise to her right inner arm. The record for Resident 46 was reviewed on 12/15/17 at 10:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes, peripheral vascular disease, heart failure, history of falling, atrial fibrillation, dizziness, high blood pressure, prosthetic heart valve, heart disease, and chest pain. The Quarterly Minimum Data Set (MDS) assessment, dated 9/25/17, indicated the resident was alert and oriented. The resident received an anticoagulant medication in the in the last 7 days. Nurse's notes, dated 12/1-12/15, indicated there was no documentation regarding the bruise to her arm. A care plan, updated 9/2017, indicated the resident was at risk for bleeding/bruising related to anticoagulant use. The Nursing approaches were to monitor and report and bruising. The 12/13/17 weekly skin observation indicated the resident's skin was warm, dry and the turgor was good. The resident's skin was intact with no concerns.		*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 46 had a head to toe skin assessment completed and any bruises identified were assessed and documented. **2.) How the facility identified other residents:** A house wide head to toe skin assessment was completed. Any resident identified with a skin concern was addressed by completing the appropriate assessment and initiating an intervention. **3.) Measures put into place/System changes:** Staff educated on skin assessment policy and proper documentation when a skin concern is identified. **4.) How the correction actions will be monitored:** A skin observation audit tool was created. The audit will be completed under the supervision of DON or designee, 5 skin observations will be completed weekly at various	

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	Interview with LPN 1 on 12/15/17 at 12:41 p.m., indicated she was not aware of any bruises to her arm. At 12:48 p.m., LPN 1 had assessed the resident's skin and indicated there was a blue/purple bruise to her right arm. A weekly skin assessment, dated 12/15/17 at 2:01 p.m., was initiated and indicated two bruises. One purple and green bruise located on the left hand at base of index finger which measured 2.4 centimeters (cm) by 2 cm. Another green bruise located below the right wrist which measured 5.4 cm by 4 cm. Interview with the 200 hall Unit Manager on 12/18/17 at 8:45 a.m., indicated the resident was unsure where the bruises came from. Nursing staff were to assess and complete a skin assessment for all new bruises. 3.1-37(a)		days and times, and identified areas will be checked for documentation. 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	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure nutritional supplements were provided as ordered for residents with a history of weight loss for 3 of 3 residents reviewed for nutrition. (Residents 84, 36 and 76) Findings include: 1. On 12/15/17 at 8:42 a.m., Resident 84 was observed in the main dining room seated at a table. The resident received a bowl of hot oatmeal cereal and a can of Nepro (a nutritional supplement). At 8:16 a.m., the resident was served one serving of	F 0692	**F 692 Nutrition/hydration status maintenance** **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*	01/21/2018

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	biscuits and gravy. The portion was not doubled. On 12/15/17 at 12:16 p.m., the resident was observed sitting at a table in the main dining room. She was served 1 roast beef sandwich and broccoli for lunch. The resident did not receive a double portion. Interview with the Dietary Cook 1 on 12/15/17 at 12:21 p.m., indicated if a resident was to receive double protein portions they would have received 2 sandwiches. The record for Resident 36 was reviewed on 12/14/17 at 9:59 a.m. Diagnoses included, but were not limited to, pleural effusion, muscle weakness, respiratory tuberculosis, end stage renal disease, dependent on renal dialysis, dysphagia, altered mental status, dementia, heart failure, anxiety, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/14/17, indicated the resident was not alert and oriented. She needed supervision with eating with one person physical assist. She weighed 91 pounds with a history of unplanned weight loss. She received a therapeutic diet and had no oral problems.		*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 84 supplements are correctly documented as ordered, Resident 36 tray card was updated to her preferences, Resident 76 tray card was updated to include fortified foods at meal times and supplement at breakfast. **2) How the facility identified other residents:** All Resident who have tray cards were reviewed and updated as needed **3) Measures put into place/ System changes:** Dietary and nursing staff educated on weight loss and the need for	

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	A care plan updated on 11/2017, indicated the resident was at risk for weight loss related to fluctuation from dialysis. The Nursing approaches were to provide diet as ordered, assist with meals as needed, protein supplement, and double portions of protein at meals. Physician orders, dated 10/30/17, indicated double portions of food with each meal. The weight record indicated the resident weighed: 9/1 87 pounds 10/4 94 pounds 11/6 92 pounds 12/1 83 pounds 12/6 83 pounds 12/11 85 pounds The last documented Registered Dietitian (RD) progress note, dated 12/5/17, indicated referral due to weight decrease 10% times 1 month. The current Body Mass Index was 15.7, which indicated underweight status. The weight loss was unplanned. Interview with the 200 hall Unit Manager on 12/18/17 at 8:45 a.m., indicated the resident was supposed to receive double protein		dietary supplements to be given as ordered to prevent further weight loss. Educated on meal tickets and how to read and insure correct items are on resident's tray. **4) How the corrective actions will be monitored:** Dietary/nursing will audit, Resident tray cards will be audited 2 cards per meal 3 times a week to insure properly nutritional supplements are being served 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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	portions with her meals. Interview with the Dietary Food Manager on 12/18/17 at 9:00 a.m., indicated the dietary cooks were to follow the tray cards to ensure the correct diet was served. 3. On 12/12/17 at 12:12 p.m., Resident 76 received her meal tray. The resident was served pasta noodles with red sauce, mixed vegetables and a piece of bread. There was no evidence the resident received any fortified foods. On 12/15/17 at 7:35 a.m., the resident was seated in her wheelchair by the medication cart. At that time, LPN 1 was observed administering the resident her medication. The medication was crushed in some type of soft food. LPN 1 placed a spoonful of medicine into her mouth and the resident said "Oh I do not like that." The LPN then proceeded to administer a cup of Ensure (nutritional supplement), in which the resident slapped it out of the nurse's hands and it spilled all over. The nurse then left the resident alone. At 8:00 a.m., the resident was taken to the main dining room for breakfast. At 8:09 a.m., the resident was served a cup of coffee and 2 glasses of milk with a bowl			

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	of oatmeal. The resident was observed drinking both glasses of milk and half of her coffee. The resident received her breakfast of biscuits and gravy. Interview with Dietary Cook 1 at that time, indicated all of the oatmeal was regular and not fortified. The record for Resident 76 was reviewed on 12/15/17 6:53 a.m. Diagnoses included, but were not limited to, dementia with behaviors, high blood pressure, heart failure, history of falling, muscle weakness, dysphagia, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/17, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident needed limited assistance with 1 person physical assist for eating. She weighed 94 pounds with an unplanned weight loss. The resident had no oral problems and received a mechanically altered diet. The updated plan of care, dated 10/2017, indicated the resident had nutritional problems related to underweight status, history of skin breakdown, and poor			

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supplement intake. The Nursing approaches were to provide and serve supplement as ordered.

Physician orders, dated 11/16/17, indicated fortified foods three times a day. Another order, dated 10/19/17, indicated Ensure clear 1 time a day for dietary supplement give with breakfast.

The current weight record indicated:
8/8 110 pounds
9/1 95 pounds
9/7 94 pounds
10/4 96 pounds
11/6 97 pounds
12/6 96 pounds

A Registered Dietitian (RD) nutrition assessment, dated 11/15/17, indicated needs supervision with eating. An 11.3% weight loss occurred in the last 3 months.

Interview with LPN 1 on 12/15/17 12:27 p.m., indicated she usually administered the Ensure clear supplement with her morning medications and not at breakfast.

Interview with the Dietary Food Manager on 12/18/17 at 9:00 a.m., indicated all the oatmeal on the steam table in the main dining room was fortified, however there was no

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	way to identify the difference between the regular oatmeal and fortified oatmeal. 3.1-36(a)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat			

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	a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary medications related to monitoring for adverse effects of psychotropic medication (a medication capable of affecting the mind, mood, and/or behavior) use for 3 of 5 residents reviewed for unnecessary medications. (Residents 58, 63, and 80) Findings include: 1. The record for Resident 58 was reviewed on 12/15/17 at 2:33 p.m. Diagnoses included, but were not limited to, diabetes, dementia, depression, and delusions.	F 0758	**F 758** **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:** Residents 58, 63 and 80 had an	01/21/2018

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	The Quarterly Minimum Data Set (MDS) Assessment, dated 12/7/17, indicated the resident was severely cognitively impaired. She had behaviors toward others and rejections of care. The medications included, but were not limited to, antipsychotic, antidepressant, and anti-anxiety medications. A Physician's Order Summary, dated 12/2017, indicated the resident was to receive the following medications: Olanzapine (an antipsychotic medication) 5 mg (milligrams), give 1.5 tablets by mouth at bedtime. Mitazapine (a antidepressant medication) 7.5 mg, give 1 tablet by mouth at bedtime. Buspirone HCl (an anti-anxiety medication) 5 mg, give 1 tablet by mouth twice daily. A plan of care, revised 11/19/17, indicated the resident received psychotropic medications. The interventions included, but were not limited to, monitor, document, and report as needed any adverse reactions. The 12/2017 Medication Administration Record (MAR) indicated no monitoring for signs and symptoms of adverse reactions for the use of psychotropic medications. Interview with LPN 3, on 12/15/17 at 11:24		order placed for monitoring adverse effects of psychotropic medications. **2.) How the facility identified other residents:** All residents receiving psychotropic medications were reviewed and placed on monitoring for adverse effects of psychotropic medications. **3.) Measures put into place/System changes:** Staff educated on the importance of monitoring for adverse effects of resident receiving psychotropic medications. **4.) How the correction actions will be monitored:** An audit tool was created to ensure residents receiving psychotropic medications are monitored for adverse effects. Audit will be completed by the DON or designee 3 times per week on a sample of three residents to determine if residents are being monitored for adverse effects to psychotropic medications.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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	a.m., indicated the nursing staff monitored residents who were receiving psychotropic medications for adverse reactions daily, the documentation should be found on the MAR. 2. The record for Resident 63 was reviewed on 12/14/17 at 11:43 a.m. Diagnoses included, but were not limited to, Alzheimer's, dementia, anxiety, and delusions. The Quarterly Minimum Data Set (MDS) Assessment, dated 12/6/17, indicated the resident was severely cognitively impaired. She had behaviors toward others. The medications included, but were not limited to, antipsychotic, antidepressant, and anti-anxiety medications. A Physician's Order Summary, dated 12/2017, indicated the resident was to receive the following medications: Escitalopram Oxalate (an antidepressant medication) 10 mg (milligrams), give 1 tablet by mouth daily. Lorazepam (an anti-anxiety medication) 1 mg, give 1 tablet by mouth at bedtime. Mitazapine (an antidepressant medication) 7.5 mg, give 1 tablet by mouth at bedtime. Risperidone (an antipsychotic medication) 1 mg, give 1 tablet by mouth in the morning and the evening.			

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A plan of care, revised 10/14/17, indicated the resident received psychotropic medications. The interventions included, but were not limited to, monitor, document, and report as needed any adverse reactions.

The 12/2017 Medication Administration Record (MAR) indicated no monitoring for signs and symptoms of adverse reactions for the use of psychotropic medications.

Interview with LPN 3, on 12/15/17 at 11:24 a.m., indicated the nursing staff monitored residents who were receiving psychotropic medications for adverse reactions daily, the documentation should be found on the MAR.

3. The record for Resident 80 was reviewed on 12/14/17 at 11:10 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, delirium, depression, delusions, and anxiety.

The Quarterly Minimum Data Set (MDS) Assessment, dated 10/9/17, indicated the resident had moderate cognitive impairment. The medications included, but were not limited to, antipsychotic and antidepressants.

A Physician's Order Summary, dated

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	12/2017, indicated the resident was to receive the following medications: Citalopram (an antidepressant medication) 20 mg (milligrams), give 1 tablet by mouth daily. Quetiapine Fumarate (an antipsychotic medication) 25 mg, give 1 tablet by mouth in the morning and the evening. A plan of care, revised 11/19/17, indicated the resident received psychotropic medications. The interventions included, but were not limited to, monitor, document, and report as needed any adverse reactions. The 12/2017 Medication Administration Record (MAR) indicated no monitoring for signs and symptoms of adverse reactions for the use of psychotropic medications. Interview with LPN 3, on 12/15/17 at 11:24 a.m., indicated nursing staff monitored residents who were receiving psychotropic medications for adverse reactions daily, the documentation should be found on the MAR. Interview with the Director of Nursing and the Nurse Consultant, on 12/18/17 at 1:30 p.m., indicated residents who were receiving psychotropic medications should be monitored for adverse reactions daily, every			

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	shift. 3.1-48(a)(3)			
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, record review, and interview, the facility failed to ensure food was prepared in a form designed to meet individual needs related to following the recipe for pureed food. This had the potential to affect 10 residents who received a pureed diet. Finding includes: On 12/15/17 at 10:10 a.m., the Assistant Dietary Food Manager (ADFM) was observed preparing a beef and cheddar sandwich puree. He washed his hands and donned cleaned gloves. He then placed 7 scoops of cooked beef into the food processor followed by 4 slices of toast. He then blended the contents, checked for consistency, and added 2 more slices of toast. Five slices of provolone cheese was then blended into the mixture and the	F 0805	**F805 Food in form to meet individual needs** **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*	01/21/2018

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	contents then checked for consistency. The ADFM then poured in 2 ladles of broth and again checked for consistency. Finally, he added one 4 ounce (oz) scoop of thickener. Review of the Pureed Beef and Cheddar Sandwich recipe indicated the following: -roast beef and cheese melt/10 servings (2 ounces (oz) protein) -beef broth 1 1/4 cup 1. Measure out 3 tablespoons (tbs) of liquid per each 2-ounce cooked portion of meat and set aside. Measure out 1/2 teaspoon (tsp) of thickener for each 2-ounce cooked portion of meat and set aside. 2. Place the meat in a food processor and process until finely ground. Gradually add enough of the liquid, while continuing to process, to form a very smooth puree. 3. Add thickener, and reprocess, scraping down the sides as needed. If needed, gradually add more liquid to achieve a moist potato consistency. Alternatively, you may need to add a little more thicker to achieve your desired consistency. Interview with the Dietary Food Manager on 12/18/17 at 9:00 a.m., indicated the recipe refers to prepared sandwiches. The ADFM should have added 10 slices of toast		*federal and state law.* **1) Immediate actions taken for those residents identified:** Correct recipe for pureed food was used **2) How the facility identified other residents:** All resident who receive puree foods are affected **3) Measures put into place/ System changes:** Dietary manager to educated dietary staff how to prepare pureed foods by following the pureed recipe **4) How the corrective actions will be monitored:** Dietary manager/designees will	

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	and 10 slices of cheese and followed the correct portion sizes for the broth and thickener. 3.1-21(a)(3)		audit 2 meals a day 3 times a week to insure proper following of pureed recipe. 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.	
F 0812 SS=E 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 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, record review, and interview, the facility failed to ensure food	F 0812	**F812 Kitchen Sanitation**	01/21/2018

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	was stored, prepared, distributed and served under sanitary conditions related to preparing food with gloved hands and touching other items, water and debris in the bottom of the utensil bins, and an accumulation of dust and debris on the steamer and griddle shelves for 1 of 1 kitchens. (The Main Kitchen) Findings include: 1. On 12/12/17 at 8:37 a.m., during the Brief Kitchen Tour with the Assistant Dietary Food Manager (ADFM), the following was observed: a. There was water and debris at the bottom of 7 plastic utensil storage bins. b. There was an accumulation of dust and debris on the steamer and griddle shelves. 2. On 12/15/17 at 10:10 a.m., the Assistant Dietary Food Manager (ADFM) was observed preparing a beef and cheddar sandwich puree. He washed his hands and donned clean gloves. He then placed 7 scoops of cooked beef into the food processor followed by 4 slices of toast, which were crumbled with his gloved hands. He then blended the contents, checked for consistency, and added 2 more slices of		**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:** Water and debris were removed from the 7 plastic utensil storage bins Dust and debris was removed from the steamer and griddle shelves	

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	toast, which were also crumbled with his gloved hands. Five slices of provolone cheese was then added to the blended food, which was also touched with his gloved hands. His gloves remained unchanged between touching all other items. Interview with the Dietary Food Manager on 12/18/17 at 9:00 a.m., indicated the ADFM should not have touched the food with the same gloved hands he used to touch other items while preparing the puree. 3.1-21(i)(3)		**2) How the facility identified other residents:** All residents that receive meals from the kitchen **3) Measures put into place/ System changes:** Executive Director will educate Dietary manger and staff regarding keeping foods covered, labeled, dated correctly as well as keeping dietary and kitchen department in clean sanitary condition and proper procedure for gloved hands when handling food to avoid contamination. **4) How the corrective actions will be monitored:** Audits will be done by dietary manager/designee 5 times a week, different shifts regarding cleanliness of kitchen and preparing foods with gloved hands correctly. Executive Director will audit Dietary manager audits 2 x a	

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			week for accuracy. 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.	
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 and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment related to marred, scuffed, and gouged walls and furniture, peeling paint, stained upholstery, and discolored toilet bowels for 3 of 4 units. (The 100, 200, and 300 Units) Findings include: During the Environmental Tour with the Administrator and the Housekeeping Supervisor, on 12/18/17 at 3:18 p.m., the following was observed: 1. 100 Unit	F 0921	**F921 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*	01/21/2018

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	a. The dining room and common area chairs and love seats had marred and gouged arms and legs, and stained upholstery. b. Room 105, the door frame was chipped and marred. One resident resided in the room. c. Room 111, the walls and door frame were marred and gouged. One resident resided in the room. d. Room 122, the door frame had peeling paint. One resident resided in the room. e. Room 124, the bedroom and bathroom walls were marred. Two residents resided in the room and 3 residents shared the bathroom. 2. 200 Unit [illegible]		*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:** 100 unit Rooms 105,111,122,124 areas were repaired and dining room and common area chairs repaired and cleaned 200 unit rooms 201 and 210 were cleaned to remove urine smell. Rooms206, 212, 220 and 228 were repaired 300Unit room 302,304,308, 309 areas were repaired **2) How the facility identified other residents:** All residents could be affected **3) Measures put into place/**	

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	12/18/2017

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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			System changes: Environmental educated on observing and reporting of areas which require improvement. Maintenance educated regarding need to identify environmental issues while completing other tasks in the building. **4) How the corrective actions will be monitored:** Audit will be done by environmental director/designee 5 rooms per week looking for environmental concerns. Maintenance director or designee will audit 5 areas each week for environmental concerns, these will include outdoors and common areas. 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.	