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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 Complaints IN00233144 and IN00233438. Complaint IN00233144 - Substantiated. Federal/State deficiencies related to the allegations are cited at F329. Complaint IN00233438 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Survey dates: June 28 & 29, 2017 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census bed type: SNF/NF: 80 SNF: 23 Total: 103 Census payor type: Medicare: 24 Medicaid: 65 Other: 14 Total: 103 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000		

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	16.2-3.1. Quality review completed on 7/6/17.			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to ensure assessments and treatments were in place for bruising and skin tears for 1 of 3 residents reviewed for skin conditions in a sample of 7. (Resident D) Finding includes: On 6/28/17 at 10:47 a.m., Resident D was observed in a wheel chair in her room. There were bandages on her right mid forearm and left upper/outer forearm. No dates were written on the dressings. The resident was not wearing any geri gloves or long sleeves. On 6/28/17 at 12:03 p.m., the resident was eating lunch in the 300/400 Dining Room. The bandages remained in place and no geri gloves or long sleeves were on. On 6/28/17 at 3:40 p.m., the Wound Nurse removed the dressing to the right forearm. A small skin tear was present in the middle of a bruise appearing to be	F 0309	*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.* F 309 Resident D was discharged A house wide head to toe assessment was performed. Any resident Identified with a skin concern was addressed by putting the proper assessment, documentation and intervention in place. Nurses and CNA were inserviced on skin assessments policies when a skin condition is identified 10 skin observations will be done weekly on various days and times, observed areas will be checked for documentation. Any discrepancies	07/24/2017

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	approximately 4 cm (centimeters) x 3 cm. The Wound Nurse indicated she had not been aware of the injury to the right forearm and no current treatments were ordered. The record for Resident D was reviewed on 6/26/17 at 3:15 p.m. Diagnoses included, but were not limited to, CVA (stroke), aphasia (difficulty speaking), diabetes mellitus, anemia, and high blood pressure. A Physician's order was written on 6/15/17 to cleanse the skin tear to the left forearm with normal saline, pat dry, and apply xerofoam gauze daily. No orders were in place for any treatments or bandages to the right forearm. A Weekly Skin Assessment was completed on 6/24/17. A skin tear/ bruising was present to the right arm. A treatment was in place. No further assessment or documentation of the right forearm bruise or skin tear was available in the Nursing Progress or Assessment Notes. No Care Plans were in place related to the right arm skin tear or bruise. During an interview on 6/28/17 at 3:50 p.m., LPN 1 indicated she was assigned to care for Resident D and had just		will be addressed by DON/designee. Results of audit will be reviewed monthly in QA x 3 months then quarterly x 3 months for a total of 6 months.	

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	changed the bandages on her right and left forearms. A bruise and skin tear were seen on the right forearm. No orders were in place for treatments to the skin tear nor was an incident completed. The presence of the skin tear was not reported to her at the start of her shift. During an interview on 6/29/17 at 9:41 a.m., the Director of Nursing indicated she had not been aware of the right forearm skin tear. No incidents or investigations were reported. Bruises were to be measured when first observed. The bruise and skin tear to the right forearm were documented on the 6/24/17 Weekly Skin Observation and Nursing staff could not recall the occurrence of the bruise and skin tear. No follow up documentation or assessments were completed. An incident occurrence should have been completed when the bruise and skin tear were first observed and treatments should have been started. Monitoring of the injuries should have been in place also. This Federal tag relates to Complaint IN00233438. 3.1-37(a)			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0329 SS=D Bldg. 00	483.45(d)(e)(1)-(2) 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-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (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; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	these drugs; Based on observation, record review, and interview, the facility failed to ensure monitoring was in place when two pain medications were administered at close intervals and without documentation of potential adverse reactions and effectiveness of the medications for 2 of 3 residents reviewed for the use of pain medications in a sample of 7. (Residents C and E) Findings include: 1. On 6/28/17 at 11:00 a.m., Resident C was observed in her room. The resident was awake and alert. The record for Resident C was reviewed on 6/28/17 at 1:00 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, diabetes mellitus, peripheral vascular disease, anxiety disorder, sleep apnea, and depressive disorder. The admission MDS (Minimum Data Set) assessment, completed on 6/6/17, indicated Resident C required limited assistance with bed mobility, transfers, and personal hygiene. Cognitive skills were intact. Scheduled pain medications were administered.	F 0329	F329 Resident C was discharged Resident E has a current pain scale which identifies which pain medication may be given for the numerical number on the pain scale. All residents who have the potential to be affected were identified and corrective action was taken as follows: Consultant pharmacist reviewed charts of residents on pain management medications for pain relief and effectiveness and that a pain scale directing amount of pain medication was present. All residents quarterly MDS are being reviewed for 3 months. Every resident who triggers pain will be audited by DON or designee to ensure they are on a medication for pain relief and effectiveness and have a pain scale directing amount of pain medication to be given. Nurses were inserviced on pain interventions, management of pain both verbal and nonverbal and pain scale need and asked about pain daily. CNAs were inserviced on reporting	07/24/2017

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	A Care Plan, initiated on 5/31/17, indicated the resident had pain related to arthritis, peripheral vascular disease, and depression. Interventions included, but were not limited to, assess effectiveness of pain medication, therapy as ordered, and notify the Physician and family of any changes. The 5/2017 and 6/2017 Physician Order Summary (POS) included the following medication orders: 5/31/17- Tramadol (narcotic pain medication) 50 milligrams- one tablet by mouth every 4 hours as needed for pain. 5/30/17- Oxycodone HCL ER (Extended Release) (narcotic pain medication) 20 milligrams one tablet by mouth every 12 hours at 9:00 a.m. and 9:00 p.m. 5/30/17- Oxycodone-Acetaminophen 10-325 milligrams-(2) tablets by mouth every 4 hours as needed for pain. Discontinued on 6/19/17. 6/19/17 - Oxycodone-Acetaminophen 10-325 milligrams-(1) tablets by mouth every 4 hours as needed for pain. Medication Administration Records (MAR) for June 2017 indicated pain medications were administered as follows:		pain to licensed nurse immediately if pain is verbalized or witnessed by nonverbal cues. MDS will notify DON or designee electronically (email) when the MDS interview triggers pain that is uncontrolled. MD will be notified of pain management needs and pain scale requirement. DON or designee will follow up in one week to insure that interventions put into place to manage pain are effective. Audits will be reviewed monthly in QAA for 6 months	

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Oxycodone HCL ER 20 mg (milligrams) at 9:00 a.m. and 9:00 p.m. daily from 6/1/17 through 6/27/17. 6/5/17 Oxycodone-Acetaminophen 10-325 mg at 12:16 a.m. Pain level (7) Tramadol 50 mg at 2:14 a.m. Pain level (3) 6/8/17 Tramadol 50 mg at 12:00 p.m. Pain level (9) Oxycodone-Acetaminophen 10-325 mg at 1:30 p.m. Pain level (8) 6/9/17 Oxycodone-Acetaminophen 10-325 mg at 12:46 a.m. Pain level (7) Tramadol 50 mg at 3:21 a.m. Pain level (2) Tramadol 50 mg at 2:00 p.m. Pain level (4) Oxycodone-Acetaminophen 10-325 mg at 2:06 p.m. Pain level (8) 6/10/17 Oxycodone-Acetaminophen 10-325 mg at 9:00 p.m. Pain level (8) Tramadol 50 mg at 10:59 p.m. Pain level (8) 6/20/17			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Oxycodone-Acetaminophen 10-325 mg at 8:00 a.m. Pain level (9) Tramadol 50 mg at 10:30 a.m. Pain level (8) Oxycodone-Acetaminophen 10-325 mg at 3:54 p.m. Pain level (8) Tramadol 50 mg at 4:21 p.m. Pain level (7) 6/22/17 Oxycodone-Acetaminophen 10-325 mg at 12:00 p.m. Pain level (8) Oxycodone-Acetaminophen 10-325 mg at 3:30 p.m. Pain level (8) June 2017 Nursing Progress Notes indicated no documentation of verification for the rationale implemented to determine which of the above two pain medications were given. 2. On 6/28/17 at 11:20 a.m., Resident E was observed in a wheel chair in the Therapy Department. The resident was awake and alert and participating in therapy. The record for Resident E was reviewed on 6/28/17 at 3:59 p.m. The diagnoses included, but were not limited to, spinal stenosis, right below the knee amputation, osteoarthritis, and peripheral			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	vascular disease. The significant change MDS (Minimum Data Set) assessment, completed on 6/11/17, indicated Resident E required staff assistance for bed mobility, transfers, dressing, and personal hygiene. Cognitive skills were intact. A scheduled pain medication regime was in place and the resident had moderate pain frequently in last five days. A Care Plan, initiated on 4/13/17, indicated the resident had pain related to arthritis and spinal stenosis. Care Plan interventions included, but were not limited to, administer analgesics as ordered, evaluate effectiveness of pain interventions, monitor for side effects of pain medications, and monitor/record pain characteristics. The 6/2017 Physician Order Summary (POS) included the following medications: 6/15/17- Gabapentin (used for nerve pain) 600 mg (milligrams) - one tablet three times a day. 6/4/17- Tramadol 50 mg - one tablet every (6) hours as needed for pain. 6/4/17- Oxycodone-Acetaminophen 325 mg - one tablet orally every (4) hours as needed for pain.			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Medication Administration Records for June 2017 indicated pain medications were administered as follows: Gabapentin 600 mg three times a day from 6/15/17- 6/27/17. 6/6/17 Oxycodone-Acetaminophen 7.5 mg/325 mg at 8:30 p.m. Pain level (9) Tramadol 50 mg at 9:00 p.m. Pain level (9) 6/12/17 Oxycodone-Acetaminophen 7.5 mg/325 mg at 5:50 a.m. Pain level (8) Tramadol 50 mg at 9:15 a.m. Pain level (9) 6/17/17 Tramadol 50 mg at 4:43 p.m. Pain level (7) Oxycodone-Acetaminophen 7.5 mg/325 mg at 6:32 p.m. Pain level (7) 6/20/17 Tramadol 50 mg at 5:17 a.m. Pain level (9) Oxycodone-Acetaminophen 7.5 mg/325 mg at 7:00 a.m. Pain level (8) Oxycodone-Acetaminophen 7.5 mg/325 mg at 12:00 p.m. Pain level (7) Tramadol 50 mg at 1:30 p.m. Pain level (8)			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	6/21/17 Oxycodone-Acetaminophen 7.5 mg/325 mg at 4:35 a.m. Pain level (6) Tramadol 50 mg at 5:17 a.m. Pain level (9) 6/24/17 Oxycodone-Acetaminophen 7.5 mg/325 mg at 9:00 a.m. Pain level (8) Tramadol 50 mg at 11:28 a.m. Pain level (8) Tramadol 50 mg at 8:08 p.m. Pain level (8) Oxycodone-Acetaminophen 7.5 mg/325 mg at 9:30 p.m. Pain level (8) 6/26/17 Oxycodone-Acetaminophen 7.5 mg/325 mg at 5:16 a.m. Pain level (8) Tramadol 50 mg at 8:20 a.m. Pain level (8) Tramadol 50 mg at 8:04 p.m. Pain level (4) Oxycodone-Acetaminophen 7.5 mg/325 mg at 11:17 p.m. Pain level (3) 6/27/17 Oxycodone-Acetaminophen 7.5 mg/325 mg at 4:26 p.m. Pain level (8) Tramadol 50 mg at 7:48 p.m.			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	June 2017 Nursing Progress Notes indicated no documentation of verification for the rationale implemented to determine which of the above two pain medications were given. The Nursing 2014 Drug Handbook, 34th edition, indicated Oxycodone-Acetaminophen was an Opioid analgesic/ agonists. Oxycodone adverse reactions included, but were not limited to, confusion, malaise, nervousness, and somnolence. The action of Tramadol HCL was thought to bind to Opioid receptors and was to be used cautiously with any opioid. The Director of Nursing (DON) provided the Pain Management Program policy and the Pain Assessment policies on 6/29/17 at 12:45 p.m. and indicated both polices were the ones currently being used by the facility. The Pain Assessment policy was to be utilized to establish guidelines for appropriate assessment and interventions to manage pain. The Pain Management Program policy indicated accurate and complete documentation of pain assessment and			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	monitoring was required. An Interdisciplinary process was to be developed and implemented based on assessments, pain scale rating, and pain relieving strategies. During an interview on 6/29/17 at 12:20 p.m., the DON indicated the Nursing staff were to utilize the pain scale when determining the use of prn (as needed) pain medication. Oxycodone was for moderate pain. The pain assessment utilizes a 1-10 pain scale. Mild pain is levels 1-4 and Moderate pain is 5-10. There should have been a pain scale included with the order on the MAR for staff to determine which ordered pain medication was given based on the above pain scale. Frequency of more then one prn (as needed) pain medication should be monitored. This Federal tag relates to Complaint IN00233144. 3.1-48(a)(1) 3.1-48(a)(3)			

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	06/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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