STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. Building B. Wing	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Arbors Michigan City	1101 E Coolspring Ave Michigan City, IN 46360

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666 Based on interview and record review, the facility failed to ensure a resident's representative was notified for 1 of 1 residents reviewed for a resident to resident altercation. (Resident P) Finding includes: Review of Abuse Allegations on 4/12/22 at 9:00 a.m., indicated Resident P was in an altercation with his then roommate. Interview with Resident P on 4/12/22 at 2:14 p.m., indicated he did not recall the incident with his roommate, except that his roommate stole his coat, returned it the next day, and then the roommate moved out. Resident P's record was reviewed on 4/18/22 at 9:01 a.m. Diagnoses included, but not limited to, stroke, high blood pressure, Parkinson's disease, and Alzheimer's dementia. The Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was moderately cognitively impaired. The Incident Report, dated 3/29/22 at 10:01 a.m., indicated that Resident P had been in an altercation with his roommate. This resulted in the both residents yelling at each other and Resident P received a small scratched on his hand from his roommate. The residents were separated and a room change was completed. The record lacked an indication that Resident P's representative was notified of the resident to resident altercation, and that he had received a small scratch on his hand. Interview with the Assistant Director of Nursing on 4/18/22 at 12:54 p.m., indicated there was not any documentation that the resident's representative was notified regarding the altercation. This Federal tag relates to Complaint IN00370212. 3.1-5(a)(1)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 32788 Based on record review and interview, the facility failed to ensure dependent residents received assistance with ADLs (activities of daily living) related to bathing for 2 of 5 residents reviewed for ADLs. (Residents C and Q) Findings include: 1. Resident C's closed record was reviewed on 4/14/22 at 9:04 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and end stage renal disease. The Quarterly MDS (Minimum Data Set) assessment, dated 3/31/22, indicated the resident was cognitively intact and required extensive assistance with personal hygiene and bathing. The ADL task profile indicated the resident preferred bathing on Mondays and Fridays on the day shift. The ADL task charting, dated 3/1/22 through 4/4/22, indicated the resident had only received bathing on 3/7/22, 3/14/22, 3/21/22, 3/25/22, and 4/1/22. She had refused bathing on 4/4/22. There was lack of documentation bathing had been offered or completed twice a week. Interview with the Interim Director of Nursing (DON) on 4/14/22 at 3:50 p.m., indicated she was unable to find any further documentation of bathing. 33485 2. Interview with Resident Q on 4/12/22 at 11:39 a.m., indicated she had not received a full bed bath or a shower in 2 weeks. They only wipe the important parts. Interview with Resident Q on 4/18/22 at 1:30 p.m., indicated she had not received a full bed bath, and would prefer a shower when she can get up and moving better. Resident Q's record was reviewed on 4/14/22 at 10:09 a.m. Diagnoses were included, but not limited to, heart failure, diabetes mellitus, anxiety, and depression. The Admission Minimum Data Set assessment, completed on 3/24/22, indicated she was impaired on her one lower side, used a wheelchair and a walker for ambulation. An Activities-Preferences interview was completed on 3/21/22 at 3:16 p.m. with the resident. It was very important for her to choose between a shower or bed bath. Her preferred bathing type was a shower, alternating with a bed bath and twice a week was accepted. The ADL task charting indicated she preferred bathing on Tuesday and Friday evenings. The record lacked an indication that the resident received or refused a shower or a full bed bath for the month of April 2022. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, revised on 3/20/22, indicated she had Activities of Daily Living self-care performance deficit. An intervention may include for bathing/showering, for the staff to set up her needed items for a shower or bath and assist her as needed. Interview with CNA 3 and CNA 4 on 4/18/22 at 2:16 p.m., indicated in the Shower Book, her showers were on Tuesdays and Friday evening. If the resident refused, the nurse would have been notified. Staff chart the bathing in the computers. Interview with Administrator on 4/18/22 at 2:30 p.m., indicated the CNA should document the type of bathing that was completed and if the resident had refused the bathing, there should been documentation. The CNA should have notified the nurse and the nurse should have documented in the Nurse Notes that the resident had refused, if that had occurred. This Federal tag relates to Complaint IN00377002. 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on record review and interview, the facility failed to complete a laboratory test, failed to monitor a resident's blood sugars which resulted in hospitalization for hypoglycemia (low blood sugar) and failed to increase monitoring of a resident with low hemoglobin (carries oxygen from the respiratory organs to the rest of the body) laboratory results and on antibiotic therapy for 2 of 4 residents reviewed for discharge. (Residents C and L) Findings include: 1. Resident C's closed record was reviewed on 4/14/22 at 9:04 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and end stage renal disease. The Quarterly MDS (Minimum Data Set) assessment, dated 3/31/22, indicated the resident was cognitively intact and required extensive assistance with activities of daily living. A Care Plan indicated the resident had a diagnosis of diabetes and was insulin dependent. An intervention included to administer diabetes medication as ordered and to monitor for side effects and effectiveness. A Nurse Practitioner Note, dated 2/9/22 at 8:48 p.m., indicated the resident had been experiencing low blood sugars in the morning. She reported experiencing nausea, dizziness, lightheadedness, and diaphoresis when her blood sugars were low. She also complained of diarrhea all day, every day for the past 3 days. The Nurse Practitioner's plan included a decrease in Lantus (insulin) to 28 units at bedtime, monitor blood sugars before meals and at bedtime, and to test the resident's stool for C. diff (clostridium difficile, a bacteria that causes severe diarrhea). A Physician's Order, dated 2/8/22, indicated an order for Lantus 28 units at bedtime. The Medication Administration Record (MAR), dated 2/2022, indicated the resident received the insulin on 2/8/22, 2/9/22, and 2/10/22. There were no HS (bedtime) blood sugar monitoring results documented. A Progress Note, dated 2/10/22 at 2:22 p.m., indicated the resident was to have a CMP (comprehensive metabolic panel, lab test to monitor electrolytes) drawn on 2/11/22 and needed a stool sample to be collected for testing of C.diff. There was lack of any further documentation the stool sample had been collected and the C. diff testing had been completed as ordered by the Nurse Practitioner. A Progress Note, dated 2/11/22 at 7:09 p.m., indicated the resident's glucose at 5:00 a.m. per the CMP lab results was 24. The Nurse Practitioner was notified, and the Lantus was decreased to 20 units at bedtime. A Physician's Order, dated 2/11/22, indicated an order for Lantus 28 units at bedtime, hold for HS blood sugar less than 150. The Medication Administration Record (MAR), dated 2/2022, indicated the resident received the insulin on 2/13/22, 2/14/22, 2/15/22, 2/16/22, 2/17/22, 2/18/22, 2/20/22, 2/21/22, and 2/22/22. There were no HS (bedtime) blood sugar monitoring results documented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Progress Note, dated 2/23/22 at 7:00 a.m., indicated the resident was unresponsive and her blood sugar was 33. She was given orange juice with sugar and 40% glucose. The resident remained unresponsive, and her blood sugar remained low. The Nurse Practitioner was notified and 911 was called. The resident was transported to the hospital at 7:15 a.m. A Progress Note, dated 2/23/22 at 6:42 p.m., indicated the resident had been admitted to the hospital with a diagnosis of altered mental status and hypoglycemia. The resident was readmitted to the facility on [DATE]. A Nurse Practitioner Note, dated 2/28/22 at 3:12 p.m., indicated the resident had been admitted to the hospital for altered mental status and hypoglycemia. All her insulin had been discontinued while in the hospital and she also tested positive for clostridium difficile. Interview with the Interim Director of Nursing (DON) and the Administrator on 4/14/22 at 3:50 p.m., indicated the Nurse Practitioner would put her own orders in the computer. She had not decreased the Lantus to 20 units on 2/11/22 as the Progress Note indicated. She had just added the parameters to hold the Lantus if the resident's blood sugar was below 150. They were unable to provide any documentation of HS blood sugar monitoring for the resident. They indicated the lab test for C. diff had not been completed until the resident was in the hospital. 45666 2. The record for Resident L was reviewed on 4/19/22 at 8:50 a.m. Diagnoses included, but were not limited to COVID-19, anemia (lack of healthy red blood cells), heart failure, respiratory failure, and pneumonia. The Admission Minimum Data Set (MDS), dated [DATE], indicated the resident was moderately cognitively impaired and had received anticoagulants and antibiotics over the last 7 days. A Physician's Order, dated 2/25/22, indicated metoprolol tartrate (to lower blood pressure) 50 mg (milligrams) tablet , 1 tablet by mouth two times a day. A Physician's Order, dated 2/25/22, indicated ceftriaxone sodium solution (an antibiotic) 2000 mg was to be administered one time a day intravenously (in the vein via a tubing) in the evening until 3/20/22. A Physician's Order, dated 3/9/22 at 7:00 a.m., indicated polysaccharide iron complex capsule (an iron supplement) 150 mg was ordered to administer two times a day. The February Medication Administration Record (MAR) indicated the metoprolol tartrate and the ceftriaxone sodium solution were administered as ordered. The March MAR indicated the metoprolol tartrate, the ceftriaxone sodium solution and the polysaccharide iron complex were administered as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Nurse Note, dated 3/5/22 at 4:47 p.m., indicated the resident had a low hemoglobin level of 6.8 -low (normal range 14.0-18.0 grams/deciliter). The physician was notified and new orders were placed to repeat the CBC (complete blood count) again on 3/6/22 and 3/7/22 and call the physician with results. A Nurse Note, dated 3/6/22 at 3:14 p.m., indicated the hemoglobin level was 6.6. Physician was notified and orders were given to repeat the CBC again the next morning. The resident and resident representative were aware. A Nurse Note, dated 3/8/22 at 8:00 a.m., indicated the hemoglobin level was 7.2. The physician and representative were aware and new orders were given to test for occult blood (blood found in stool). A Nurse Note, dated 3/12/22 at 9:05 p.m., indicated the resident was sent to the hospital due to low hemoglobin and blood in stool. The Infection/Antibiotic Charting indicated the resident had daily monitoring due to having an infection and had received antibiotic therapy. On each shift from 3/8/22-3/12/22, the resident's blood pressure document as 136/80 from 3/7/22 at 5:23 p.m. The record lacked an accurate documentation that the resident was being monitored via blood pressures for 3 consecutive laboratory test results for low hemoglobin levels as a Nursing measure. Interview with the Interim Director of Nursing (DON) on 4/19/22 at 1:38 p.m., indicated if a resident had abnormal labs such as a low hemoglobin, the nursing staff would be expected to do a full assessment more often, including taking a current blood pressure. Interview with the Assistant Director of Nursing (ADON) on 4/19/22 at 1:51 p.m., indicated if a resident had an infection or was on antibiotic therapy, the nursing staff were to chart using the Infection/Antibiotic Charting. The charting generated a template which should guide the staff to know what vital signs and assessments to do. The template included, but was not limited to, an updated blood pressure, temperature, respirations, and pulse. The staff should have assessed and monitored the resident's blood pressure with each of the assessments completed. This Federal Tag relates to Complaint IN00377002. 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on observation, record review and interview, the facility failed to implement interventions for a resident with pressure ulcers for 1 of 3 residents reviewed for pressure ulcers. (Resident J) Finding includes: On 4/13/22 at 9:00 a.m., Resident J was observed in her bed. She was again observed in her bed at 10:50 a.m., and during continuous observation from 1:00 p.m. to 3:20 p.m. On 4/14/22 the resident was observed in bed at 8:40 a.m., 11:55 a.m., 1:10 p.m., 1:45 p.m. She was not observed out of bed during these two days. On 4/13/22, during continuous observation from 1:00 p.m. to 3:20 p.m., the resident was in her bed. At 2:02 p.m., two staff members entered the room and assisted her roommate, they did not reposition the resident. At 2:23 CNA 1 entered the room. She checked the resident's brief and adjusted her oxygen tubing, but did not reposition her. The resident's record was reviewed on 4/13/22 at 9:38 a.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, vascular dementia and dysphasia (difficulty swallowing) following a CVA. The Quarterly Minimum Data Set assessment, dated 1/21/22, indicated the resident had severe cognitive impairment, and required extensive two person assistance for bed mobility. She had one stage one pressure ulcer and was identified as at risk for developing pressure ulcers. A Physician's Order, dated 1/7/22, indicated the resident was to be out of bed as tolerated. A Pressure Ulcer Care Plan, dated 3/26/22, indicated to reposition the resident every 2 hours and as needed. Interview with CNA 1 on 4/13/22 at 3:18 p.m., indicated she did not reposition the resident when she checked on her at 2:23 p.m. Interview with CNA 2 on 4/14/22 at 2:10 p.m., indicated they used to get the resident up every other day, but was not sure if they were still doing that. Interview with the Wound Nurse on 1/14/22 at 2:15 p.m., indicated staff should be getting the resident out of bed every day. This Federal tag relates to Complaints IN00371067 and IN00371800. 3.1-40

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on observation, record review, and interview, the facility failed to ensure a resident's pain was effectively managed for 4 of 5 residents reviewed for pain. (Residents J, S, R and E) Findings include: 1. On 4/13/22 at 2:23, CNA 1 entered Resident J's room. She checked the resident's brief and adjusted her oxygen tubing, but did not reposition her. On 4/13/22 at 10:50 a.m., the resident was observed in bed. She was rubbing her right arm and grimacing. When asked if her arm hurt, she nodded her head. On 4/14/22 at 1:45 p.m., wound care was observed with the Wound Nurse and CNA 2. When the resident was rolled from side to side, she would grimace and moan. When the Wound Nurse cleansed the wounds on her buttocks, the resident grimaced and made a verbal sound of pain. When the Wound Nurse lifted her left leg to remove her protective boot, she again showed signs of pain. The resident was asked if she was having pain, she nodded her head and said on her back. The Wound Nurse indicate she had a pain pill an hour and a half ago. The resident's record was reviewed on 4/13/22 at 9:38 a.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, vascular dementia and dysphasia (difficulty swallowing) following a CVA. The Quarterly Minimum Data Set assessment, dated 1/21/22, indicated the resident had severe cognitive impairment, and required extensive two person assistance for bed mobility. She had received scheduled pain medication in the past 5 days. A Physician's Order, dated 3/9/22, indicated to administer Tramadol, (pain medication) 50 milligrams (mg) every six hours for pain. A Physician's Order, dated 3/1/22, indicated to administer Tylenol, 650 mg every 6 hours as needed for pain. Review of the Medication Administration Record indicated the resident received Tylenol one time in March 2022, and two times in April 2022. There was not a care plan related to pain. Interview with CNA 1 on 4/13/22 at 3:18 p.m., indicated she had not repositioned the resident when she checked on her because she had a lot of pain when moved. Interview with the Wound Nurse on 4/14/22 at 2:15 p.m., indicated the resident was still having pain, but it was improved since adding the scheduled Tramadol. She indicated the resident could have Tylenol and would give her some at that time. She also indicated she would discuss the resident's pain with the Physician. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	33485 2. Interview with Resident S on 4/11/22 at 11:23 a.m., indicated he had not received received his pain medications when he was in pain last month. The staff had excuses of they did not have the medication yet, it was on order. Interview with Resident S on 4/18/22 at 10:43 a.m., indicated his pain level was a 10 on a scale of 1-10 with the worst pain on the back of his neck and upper shoulders. The nurse told me the next scheduled pain medication was not until noon and that I had to wait until then. Resident S's record was reviewed on 4/18/22 at 11:00 a.m. Diagnoses included, but were not limited to, neurological conditions, cancer and chronic pain. The Quarterly Minimum Data Set assessment, dated 1/27/22, indicated he had a scheduled pain regimen and had frequent pain. The current Physician Order Summary indicated, on 3/26/22, to administer Hydrocodone-Acetaminophen (to treat pain) tablet 5-325 mg (milligram), 1 tablet by mouth every 6 hours for pain. The March Medication Administration Record (MAR) indicated the Hydrocodone-Acetaminophen 5-325 mg tablet was not administered as ordered and had the documentation of pending delivery, waiting for delivery, not available, waiting on arrival, waiting on Pharmacy, for the following dates and times: - 3/9/2022 at 3:32 a.m. - 3/9/22 at 6:01 a.m. and 11:24 a.m. - 3/10/22 at 11:27 a.m. - 3/10/22 at 7:59 p.m. - 3/11/22 at 4:37 a.m. and 6:12 a.m. - 3/11/22 at 11:47 a.m. - 3/11/22 at 2:01 p.m. - 3/12/22 1:07 a.m. and 5:52 a.m. - 3/12/22 11:29 a.m. and 6:42 p.m. - 3/13/22 at 3:04 a.m. - 3/13/22 at 5:19 a.m., 11:56 a.m. and 6:12 p.m. - 3/14/22 12:39 a.m., 11:40 a.m. and 9:59 p.m. - 3/15/22 at 12:00 a.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record lacked an indication to why the medication was not delivered and that the Physician was notified the resident had not received his pain medications as ordered. A Nurse Practitioner (NP) Note on 3/14/22 at 2:00 p.m., indicated the resident was seen for an acute visit for chronic pain. The NP's assessment indicated the resident had frequent, throbbing pain with a pain of 7 out 10, with 10 being the worst pain. A refill prescription was written for Hydrocodone-Acetaminophen tablet 5-325 mg, 1 tablet by mouth every 6 hours for pain. The Pharmacy's (name of Pharmacy) delivery manifest,dated 3/1/22 at 2:52 a.m., indicated 30 tablets of Hydrocodone-Acetaminophen tablet 5-325 mg was delivered to the facility. The next 30 tablets of Hydrocodone-Acetaminophen tablet 5-325 mg was not delivered to the facility until 3/15/22 at 2:37 a.m. A Care Plan, dated 6/15/20, indicated pain related to alcohol withdrawal and a history of prostate cancer. Interventions included, monitor/record/report to the nurse complaints of pain or requests for pain treatment. Interview with the Interim Director of Nursing on 4/20/22 at 5:36 p.m., indicated the n/a or x on the March MAR. The record indicated the pain medication was pending or waiting on the pharmacy. The Nurse Notes lacked why the medication was not administered on time. The Pharmacy manifest indicated the pharmacy only sent 30 pills and he had them scheduled for 4 times a day, and that would only last him about 7 days. The Director of Nursing was unsure and unaware what had happened with the residents pain medications and it should had been addressed immediately. 45666 3. Resident R's record was reviewed on 4/20/22 at 2:43 p.m. Diagnoses included, but not limited to, stroke, hemiplegia affecting left non-dominant side, and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 3/21/22, indicated the resident was cognitively intact. The resident had received a scheduled pain medication regimen and had frequent pain in the last 5 days. The Physician's Order, dated 2/20/2020 at 7:00 p.m., indicated Hysingla 40 milligram (mg) tablet (opioid pain medication) once in the evening. The Care Plan, revised on 3/27/18, indicated the resident had potential for acute and/or chronic pain and the intervention was to administer pain medications as ordered. The Orders-Administration Notes were reviewed for November 2021, December 2021, January 2022, and February 2022. The record indicated the medication, Hysingla, was unavailable as the facility was waiting for pharmacy to deliver the medication on the following dates and times: - 11/30/21 at 6:46 p.m. - 12/1/2021 8:31 p.m. - 12/29/2021 8:30 p.m. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/30/21 at 9:25 p.m. - 12/31/2021 at 6:42 p.m. - 1/1/2022 at 9:07 p.m. - 1/17/2022 at 7:52 p.m. - 1/18/2022 at 6:37 p.m. - 1/24/2022 at 10:22 p.m. - 2/19/2022 at 9:10 p.m. - 2/20/2022 at 10:02 p.m. - 2/22/2022 at 12:02 a.m. A Physician Progress Note, dated 2/21/22 at 7:00 p.m., indicated the resident had been out of the Hysingla for a few days and had increased generalized pain without it. The note indicated the physician refilled Hysingla 40 mg tablet. Interview with Director of Nursing on 4/20/22 at 5:36 p.m., indicated there was no rational for why the medications were not given for multiple days. 4. Resident E's record was reviewed on 04/14/22 at 10:17 a.m. Diagnoses included, but were not limited to, rhabdomyolysis (breakdown of muscle tissue that releases a damaging protein into the blood), anxiety disorder, abnormal posture, sleep disorder, and anemia. The Discharge Minimum Data Set (MDS) assessment, dated 2/18/22, indicated the resident was cognitively intact. The resident had frequent pain in last 5 days but it did not affect sleep or day to day activities. The Care Plan, dated 3/12/20, indicated the resident had acute/chronic pain. Interventions included, but were not limited to, administration of pain medications per order. The Physician's Order, dated 12/24/19 at 6:00 p.m., indicated Percocet 7.5-325 milligram (mg) tablet four times a day. The Medication Administration Record (MAR) for December 2021 and January 2022 was reviewed on 4/14/22 at 10:17 a.m. The MAR indicated Percocet tablet 7.5-325 mg was not administered on the following dates and times: - 12/8/21 at 6:00 p.m. - 12/18/21 at 6:00 a.m. - 12/21/21 at 12:00 p.m. (continued on next page)

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	155156	A. Building B. Wing	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Arbors Michigan City	1101 E Coolspring Ave Michigan City, IN 46360

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/22/21 at 12:00 a.m., 6:00 a.m., and 12:00 p.m. - 12/23/21 at 12:00 p.m. - 1/3/22 at 12:00 p.m. - 1/4/22 at 6:00 a.m. and 12:00 p.m. - 1/8/22 at 12:00 p.m. - 1/11/22 at 6:00 p.m. - 1/14/22 at 12:00 p.m. and 6:00 p.m. - 1/15/22 at 12:00 a.m. and 6:00 a.m. Interview with Interim Director of Nursing on 4/14/22 at 3:28 p.m., indicated she was made aware of the concern and no further information was available. This Federal tag relates to Complaints IN00370624 and IN00373994. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666 Based on record review and interview, the facility failed to ensure a resident was provided with medically-related social services, related to referrals not sent to prepare a resident for discharge, for 1 of 1 residents reviewed for Social Services. (Resident L) Finding includes: Resident L's record was reviewed on 4/19/22 at 8:50 a.m. Diagnoses included, but not limited to, COVID-19, anemia, heart failure, respiratory failure, and pneumonia. The Admission Minimum Data Set (MDS), dated [DATE], indicated the resident was moderately cognitively impaired. A Care Plan Meeting Note, dated 3/3/22 at 1:19 p.m., indicated the resident's family had requested that referrals be sent to various other facilities to be closer to home. The record lacked an indication of referrals sent to other facilities. Interview with the Social Service Director (SSD) on 4/19/22 at 3:08 p.m., indicated the resident's family wanted the resident to transfer to another facility closer to them. The SSD indicated once referrals were sent, it should be noted in the chart. Interview with the Administrator on 4/19/22 at 4:50 p.m., indicated Social Services should have documented when the referrals were sent. This Federal tag relates to Complaint IN00374801. 3.1-34(a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 33485 Based on interview and record review, the facility failed to ensure medications were administered as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident B) Finding includes: An interview with the resident's representative on 4/11/22 at 3:04 p.m., indicated Resident B had not received medications and patches as ordered by the Physician in December of 2021. The reasons were they ran out of the medications. Resident B was observed on 4/13/22 at 9:41 a.m. in his bed watching TV in his room. The resident had poor memory recall when interviewed. Resident B's record was reviewed on 4/13/22 at 10:30 a.m. Diagnoses included, but were not limited to, stroke, cancer, heart failure, high blood pressure, diabetes mellitus (blood sugars) and dementia. The December 2021 Physician Order Summary indicated the following medications: - atorvastatin calcium 40 mg (milligram) give 1 tablet by mouth in the evening for hyperlipidemia - hydralazine hydrochloride tablet 25 mg, give 1.5 tablets by mouth twice a day for heart failure - senna-docusate sodium tablet 8.6-50 mg give 1 tablet by mouth in the evening for constipation - sertraline hydrogen chloride 25 mg 1 tablet by mouth in the evening for depression related to major depressive disorder - isosorbide dinitrate 20 mg tablet give 20 mg by mouth twice a day for heart failure - alogliptin benzoate tablet 25 mg give 25 mg by mouth once a day related to diabetes mellitus - Probiotic capsule give 1 capsule by mouth one time a day for supplement - Vitamin D3 capsule 50 mcg (micrograms) give 1 capsule by mouth one time a day for supplement - Proheal sugar free twice a day for wound healing sugar free 30 cc (cubic centimeters). - Donepezil hydrochloride 10 mg tablet give 1 by mouth at bedtime for dementia - clonidine patch Weekly 0.3 MG/24 hours, Apply 1 patch transdermally (topically to the skin) one time a day, every Thursday. Remove old patch before applying new patch per scheduled time. The December 2021 Medication Administration Record indicated the following medications were not administered as ordered on the following days and times: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 12/8/21 at 6:00 p.m.: atorvastatin calcium 40 mg, hydralazine hydrochloride tablet 25 mg, senna-docusate sodium tablet 8.6-50 mg, sertraline hydrogen chloride 25 mg, isosorbide dinitrate 20 mg tablet 20 mg, Proheal sugar free 30 cc. - on 12/8/21 at 8:00 p.m.: donepezil hydrochloride 10 mg tablet - on 12/9/21 at 9:00 a.m.: clonidine patch. The MAR indicated a 9 with a Nurse's Note at 10:00 a.m., indicated awaiting delivery and the Physician was aware. The MAR indicated the clonidine patch placed on 12/2/22 9:00 a.m. and was not removed until 12/16/22 at 8:59 a.m. The record lacked an indication the Physician was notified the resident was not administered the clonidine patch for 14 days. The last blood pressure documented was from a Nurse Infection/Antibiotic charting note, dated 10/29/21 at 1:11 p.m., as 10/28/21 2:12 a.m. 147/88. The next documented blood pressure was on 1/31/22, 130/76. - on 12/20/21 at 8:00 a.m.: alogliptin benzoate tablet 25 mg - on 12/20/21 at 9:00 a.m.: hydralazine hydrochloride tablet 25 mg, 1.5 tablets; Probiotic capsule, Vitamin D3 capsule 50 mcg. Interview with the Interim Director of Nursing (DON) on 4/21/22 at 10:15 a.m., indicated per the pharmacy manifest, the clonidine patch was delivered on 12/10/21 at 11:22 a.m. She had no information to why the nurses did not administer the clonidine patch on the resident when it had arrived from the pharmacy. The Nurse Notes lacked documentation that his blood pressures were monitored and his vital signs appeared copied and pasted from previous notes. The DON was unaware and lacked any further information to why mediations were not administered in December of 2021. This Federal tag relates to Complaint IN00371067. 3.1-48(a)(6)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on observation and interview, the facility failed to maintain a sanitary, safe, and homelike environment related to dirty kitchen floors and utility carts, marred walls, peeling paint, broken furniture, and heating unit uncovered in the kitchen and on 2 of 4 units observed. (Main Kitchen, Hallways 100 and 200) Findings include: 1. During the initial kitchen tour, on 4/11/22 at 8:50 a.m. with the Cook, the following was observed: a. In the walk in freezer, there was debris and 3 pancakes on the floor, and the floors were visibly dirty and sticky. b. There was a metal shelf where food processing equipment was kept that had pink and yellow spilled substances and crumbs on it. c. There were 5 utility carts that had food debris, crumbs and spilled substances on them. Interview with the Cook during the kitchen tour, indicated the above items were in need of cleaning. 45666 2. During the Environmental Tour with the Maintenance Director on 04/21/22 at 11:57 a.m., the following was observed: 100 Hallway: a. In room [ROOM NUMBER], the walls and the door were marred. There was one resident who resided in this room. b. In room [ROOM NUMBER], the heating unit cover was on the floor. One resident resided in the room. c. In room [ROOM NUMBER], the pain had peeled on bathroom wall. There were two residents who shared the bathroom. 200 Hallway: a. room [ROOM NUMBER] had a gouged corner wall by the bathroom, caps were missing off of the bottom of the right side enabler bar on the bed and the dresser drawers were broken. There were two residents who resided in this room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. room [ROOM NUMBER]'s dresser drawers were broken. There was one resident who resided in this room. c. In room [ROOM NUMBER], there was a hole in the wall located near the glove container, and a dried brown substance splattered on the same wall. There were two residents who resided in this room. Interview with Maintenance Director on 04/21/22 at 12:12 p.m., indicated he was not previously aware of any of the repairs or cleaning that was presented during the tour. This Federal tag relates to Complaints IN00373994 and IN00374801. 3.1-19(f)(5)