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	12/01/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 10770 Based on record review and interview, the facility failed to protect a resident's right to be free from physical abuse by a staff member which resulted in a cognitively impaired resident sustaining a fractured skull and head laceration requiring staples for 1 of 3 residents reviewed for abuse. (Resident B) The immediate jeopardy began on 9/11/22 when the physical abuse of a QMA punching a resident occurred to Resident B. The Executive Director was notified of the immediate jeopardy at 1:37 p.m., on 11/30/22. The immediate jeopardy was removed and the deficient practice was corrected by 9/13/22, prior to the start of the survey, and was therefore past noncompliance. Finding includes: The record for Resident B was reviewed on 11/29/22 at 1:20 p.m. Diagnoses included, but were not limited to, type 2 Diabetes Mellitus, history of falling, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, and dementia without behaviors. The Annual Minimum Data Set (MDS) assessment, dated 11/1/22, indicated the resident was not cognitively intact. He was a limited assist with 1 person physical assist with bed mobility, transfers, dressing, toileting, and personal hygiene. The resident had 1 fall with major injury since the last assessment. A Care Plan, dated 9/13/22, indicated the resident had the potential for falls related to confusion, incontinence, diagnosis of dementia, and impaired mobility. A Care Plan, dated 7/13/22, indicated the resident had a close friendship with a co-resident. The resident may be seen walking in the hallways holding hands with co-resident. The resident had the potential to get upset when staff attempted to separate them. The interventions were to approach the resident calmly and speak clearly and slowly using short sentences, avoid reality orientation with the resident, redirect the resident to common areas to spend time with friend and staff should not intervene when residents were holding hands. A Fall Initial Occurrence Note, dated 9/11/22 at 7:15 p.m., indicated the resident had a witnessed (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	fall on 9/11/22 at 7:15 p.m., by the nurse's station. The resident was resisting and fell with QMA 1 to the floor. A Behavior Progress Note, dated 9/11/22 at 7:32 p.m., indicated the resident was attempting to lure a female to his room. The QMA noticed a female resident needed personal attention. The QMA informed the resident he could not take her to the room because she needed personal care. The male resident was holding the female resident's hands tightly and she was yelling You are hurting me. Let me go. The QMA pulled his hands loose from hers and the male resident began pulling the QMA's hair. At that time, the male resident and QMA fell to floor. The resident had a contusion to the back of the head that was bleeding. The Physician was called by the LPN. The POA (Power of Attorney) was notified and requested the resident be sent to the hospital. A Nurses' Note, dated 9/11/22 at 11:38 p.m., indicated at 7:15 p.m., the nurse was requested on 100 unit. Upon entering, the resident was sitting on the floor with blood on his clothing and the floor. The blood was coming from his head. There were 2 nurses at his side rendering first aid. This nurse did begin necessary documentation and assisted nurses with necessary notifications. The QMA stated that resident had female resident by the hands and was directing her toward his room. QMA noticed resident needed incontinent care and informed male resident that he can't take female resident to his room because she needs care. He would not release female residents hands. Female resident called out it hurt was hurting her hands [sic]. QMA stated that she took his hands from resident and at that time he pulled QMA hair and he fell to floor and QMA fell on top of him. The resident was sent out 911. An investigation by the Executive Director on 9/12/22, indicated the staff member to witness the incident was QMA 1. The QMA's statement indicated the resident pulled her hair and she fell on top of him. The Executive Director asked the QMA why did she think the resident would want to pull her hair. The QMA indicated she was trying to take the female resident that was with Resident B to the restroom, but Resident B became combative and pulled her hair. All staff working on the unit were questioned and interviewed and all deny witnessing the incident. The Executive Director reviewed video surveillance cameras for the 100 nurses' station. There was an altercation with QMA 1 and Resident B observed. In the video, QMA 1 gets up and walks over to Resident B and another resident and they quickly grab a hold of one another. Resident B fell backwards and the QMA was observed striking the resident on the right side of the face twice. The video had no sound, and the Executive Director did not hear the conversation. The police were notified and came to the facility to view the video and started a report. The QMA was notified she was under investigation for physical abuse related to the incident with Resident B. A hospital History and Physical, dated 9/11/22 at 9:13 p.m., indicated Resident B was brought in by EMS from the nursing home. The patient lost his balance, fell , and hit his head. The patient did not recall most of the fall and has a history of dementia. Approximately 3 centimeters (cm) to 4 cm laceration to the to the posterior head was noted. A Cat Scan (CT) of the head indicated there was a right posterior scalp hematoma with underlying occipital fracture without evidence of acute intracranial hemorrhage. The laceration was repaired with staples to the back of the head. The resident's discharge diagnoses were scalp laceration, skull fracture, and acute head injury. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Executive Director on 11/29/22 at 2:00 p.m., indicated after she was notified the resident had fallen and sustained a skull fracture, she wanted to know how that could have possibly happened because he had never had any falls in the past. She interviewed the QMA over the phone and was told the same story regarding her hair being pulled and how the resident fell backwards and hit his head on the floor. She then reviewed the video cameras after the interview with QMA 1 and saw the entire incident of physical abuse with the QMA striking the resident in the face two times. She phoned the QMA again and informed her what she saw the video did not correlate with the story she had told her about her hair being pulled. The QMA never admitted she hit the resident and stuck to her story that her hair was pulled. The police were notified on 9/12/22, came to the facility, reviewed the video, and a police report was initiated. A warrant for QMA 1's arrest was obtained as well. A QAPI meeting was held on 9/12/22 with all department heads to develop an immediate plan of action. Staff inservices began immediately on all types of abuse, staff burn out, and how to approach dementia residents. If staff were not in the facility, they were called. A house wide skin audit was completed and all residents with a Brief Interview of Mental Status greater than 8 were interviewed regarding abuse. The current and updated 10/28/22, Abuse Prevention and Reporting policy, provided by the Nurse Consultant on 12/1/22 at 11:30 a.m., indicated the facility affirms the right of the residents to be free from abuse. The facility therefore, prohibits abuse and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of the policy was to assure the facility was doing all that was within its control to prevent occurrences of abuse. Physical abuse was the infliction of injury on a resident that occurred other than by accidental means and required medical attention. Physical abuse included, hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The past noncompliance immediate jeopardy began on 9/11/22. The immediate jeopardy was removed and the deficient practice corrected by 9/13/22 after the facility implemented a systemic plan that included the following actions: The facility conducted skin assessments on all residents, inserviced all staff on the abuse policy, staff burnout and dementia, interviewed staff and residents regarding abuse, audited resident charts, audited grievance logs and audited employee background checks. This Federal tag relates to Complaints IN00393256 and IN00395083 3.1-27(a)(1)

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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. 45666 Based on observation, record review and interview, the facility failed to provide ADL (activities of daily living) assistance to a dependent resident related to completing scheduled showers for 1 of 3 residents reviewed for ADL care. (Resident E) Finding includes: Resident E's record was reviewed on 11/29/22 at 1:37 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus, anxiety disorder, psychotic disorder, kidney failure, high blood pressure, chronic obstructive pulmonary disease, and heart disease. The Discharge Minimum Data Set assessment, dated 11/18/22, indicated her cognitive patterns had not been assessed. She required supervision for activities of daily living (ADLs) including bed mobility, transfer, walk in room, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene, and bathing. An ADL Care Plan, dated 8/24/22, indicated the resident needed assistance due to impaired mobility related to heart failure. Interventions included, but were not limited to, the resident required limited to total assist with 1-2 staff for bathing/showering. The CNA Task List indicated the resident preferred bathing on Tuesday and Friday during the day. The November 2022 Tasks record and shower sheets indicated the resident did not receive a shower or bed bath on the following dates: 11/8/22, 11/11/22, 11/15/22, and 11/22/22. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. This Federal tag relates to Complaint IN00391437 and IN00393256. 3.1-38(a)(2)(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 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** 10770 Based on record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered for 2 of 3 residents reviewed for pressure ulcers. (Residents L and D) Findings include: 1. During an interview on 11/30/22 at 8:50 a.m., Resident L indicated his pressure ulcer treatments were not always done on the weekends. The record for Resident L was reviewed on 11/30/22 at 9:00 a.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, acute kidney failure, morbid obesity, paraplegia, pressure ulcer, right leg amputation, heart failure, major depressive disorder, G- tube, and colostomy. The 10/12/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident had pressure ulcers. A Care Plan, updated 10/12/22, indicated the resident had a pressure ulcer present to the sacrum, left ischium, left lateral foot, and right ischium due to at history of ulcers, immobility, and paraplegic. The approaches were to administer treatments as ordered and assess for effectiveness. Physician's Orders, dated 10/23/22, indicated Calcium Alginate-Silver Pad 4.25, apply to sacrum, right ischial, left posterior leg, left lateral foot, and left ischial topically one time a day for wound care. Cleanse with normal saline, pat dry, apply calcium alginate with silver to wound bed, super absorbent pad and cover with dry dressing. The Treatment Administration Record for 11/2022, indicated the treatments were not signed out as being completed on 11/10, 11/12, 11/13, 11/16, 11/17, 11/18, 11/23 and 11/27/22. Interview with the Wound Nurse on 11/30/22 at 2:30 p.m., indicated she was in the facility on 11/16 and 11/17/22 and completed his treatments. She had forgotten to sign the treatments out as being completed. Interview with the Executive Director on 12/1/22 at 9:52 a.m., indicated she had spoken with the staff who worked on the above days and they told her they had completed the pressure ulcer treatments, but did not document. The ED had staff sign the treatment record on 11/23 and 11/27/22 for all the treatments being completed. Interview with the Director of Nursing on 12/1/22 at 2:00 p.m., indicated the pressure ulcer treatments were to be completed as ordered by the Physician. 45666 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident D's closed record was reviewed on 11/30/22 at 2:05 p.m. Diagnoses included, but were not limited to, cutaneous abscess of abdominal wall, sepsis, chronic obstructive pulmonary disease, major depressive disorder, anxiety, heart failure, and heart disease. The Admission Minimum Data Set (MDS) assessment, dated 10/25/22, indicated the resident was cognitively intact for daily decision making. The resident had 1 stage 2 pressure ulcer that was present upon admission, and 2 stage 3 pressure ulcers that were present upon admission. A Physician's Order, dated 10/24/22 at 8:00 a.m., indicated apply kerlix to right lower leg as preventative one time a day every Monday, Wednesday, and Friday for wound care. The November 2022 Treatment Administration Record (TAR), indicated the kerlix to the right lower leg was not signed out as being completed and was blank on 11/11/22 and 11/16/22. A Physician's Order, dated 11/22/22 at 12:06 p.m., indicated calcium alginate silver pad 4, apply to right lateral lower leg topically one time a day. The November 2022 TAR indicated the calcium alginate treatment to the right lateral lower leg was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. A Physician's Order, dated 10/22/22 at 8:00 a.m., indicated calcium alginate silver pad 4 apply to sacrum topically one time a day. The November 2022 TAR indicated the calcium alginate treatment to the sacrum was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. A Physician's Order, dated 10/22/22 at 8:00 a.m., indicated Curity Iodoform Packing Strip miscellaneous (gauze pads and dressings) apply to left ischial topically one time a day for wound care, cleanse with normal saline, pat dry, apply iodoform packing strip to wound bed and cover with dry dressing. The November 2022 TAR indicated the iodoform packing treatment to the left ischial was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. A Physician's Order, dated 10/22/22 at 8:00 a.m., indicated Curity Iodoform Packing Strip Miscellaneous (gauze pads and dressings), apply to right ischial topically one time a day for wound care Cleanse with normal saline, pat dry, and apply iodoform packing strips to wound bed and cover with dry dressing. The November 2022 TAR indicated the Iodoform packing treatment to the right ischial was not signed out as being completed and was blank was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 10/27/22 at 8:00 a.m., indicated Santyl ointment 250 unit/gram apply to right lower posterior leg topically one time a day for wound care, cleanse with normal saline, pat dry, apply Santyl to wound bed and cover with dry dressing. The November 2022 TAR indicated the Santyl ointment to the right lower posterior leg was not signed out as being completed and was blank on 11/9/22, 11/11/22, 11/12/22, 11/14/22, 11/16/22, 11/17/22, and 11/19/22. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. Interview with the Wound Nurse on 12/1/22 at 11:27 a.m., indicated the resident went out to the wound clinic on Tuesday and Friday each week, but it was not noted in the chart. She indicated on 11/9/22, she must have been rushing and did not sign out the treatment on the TAR. This Federal tag relates to Complaint IN00393256. 3.1-40(a)(2)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to ensure a resident was free from unnecessary medications, related to not administering antibiotics, insulin, and blood pressure medications as ordered for 4 of 4 residents reviewed for unnecessary medications. (Residents L, E, G, and D) Findings include: 1. The record for Resident L was reviewed on 11/30/22 at 9:00 a.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, acute kidney failure, morbid obesity, paraplegia, pressure ulcer, right leg amputation, heart failure, major depressive disorder, G- tube, and colostomy. The 10/12/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Physician's Orders, dated 11/16/22, indicated Clindamycin (an antibiotic medication) HCl 300 milligrams (mg), 1 capsule every 8 hours for 7 days for a wound infection. The Medication Administration Record (MAR), dated 11/2022, indicated the medication was first administered on 11/16/22 at 4:00 p.m., and signed out through 11/23/22 at 8:00 a.m. Physician's Orders, dated 11/24/22, indicated Clindamycin HCl 300 mg, 1 capsule two times a day for a wound infection. The 11/2022 MAR indicated the antibiotic was not signed as being administered at 8 a.m. on 11/27/22, and at 4 p.m. on 11/25 and 11/27/22. On 11/30/22 at 9:30 a.m., LPN 1 removed all of the antibiotic punch cards that were in the medication cart for the resident. There was 1 Clindamycin punch card with a pharmacy delivery date of 11/16/22 that had 1 pill remaining in the package. A total of 20 capsules were sent. Another Clindamycin punch card with a pharmacy delivery date of 11/24/22 had 6 pills remaining out of the 10 pills that were sent. Interview with the Director of Nursing on 12/1/22 at 2:00 p.m., indicated the antibiotic was to be administered as ordered by the Physician. 45666 2. Resident E's record was reviewed on 11/29/22 at 1:37 p.m. Diagnoses included, but were not limited to, peripheral vascular disease, diabetes mellitus, anxiety disorder, psychotic disorder, kidney failure, high blood pressure, chronic obstructive pulmonary disease, and heart disease. A Physician's Order, dated 11/21/22 at 10:00 p.m., indicated Amoxicillin (an antibiotic) tablet 500-125 milligram (mg) 1 tablet by mouth three times a day. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The November 2022 Medication Administration Record (MAR) indicated the resident did not receive the Amoxicillin on 11/22/22 at 6:00 a.m., 11/25/22 at 8:00 p.m., and 11/29/22 at 6 a.m. A Physician's Order, dated 11/12/22 at 9:00 p.m., indicated Insulin Glargine 300 unit/milliliter 25 units at bedtime. The November 2022 MAR indicated the resident did not receive the Insulin Glargine at 9:00 p.m. on 11/12/22, 11/13/22, 11/14/22, 11/15/22, 11/25/22, 11/26/22, and 11/27/22. The MAR was left blank. Interview with the Administrator on 12/1/22 at 1:58 p.m., indicated she had spoken with the resident today and she indicated the medications were not administered. 3. Resident G's record was reviewed on 11/29/22 at 1:45 p.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, and heart failure. A Physician's Order, dated 11/23/22 at 9:00 p.m., indicated Lantus SoloStar (an antidiabetic medication) 40 units at bedtime. The November 2022 Medication Administration Record (MAR) indicated the resident did not receive the Lantus SoloStar medication at 9:00 p.m. on 11/25/22, 11/26/22, 11/27/22, and 11/29/22. A Physician's Order, dated 11/23/22 at 9:00 p.m., indicated Humalog Insulin (an antidiabetic medication) inject per sliding scale before meals and at bedtime as followed: - 0 - 150 = 0 - 151 - 200 = 2 - 201 - 250 = 4 - 251 - 300 = 6 - 301 - 350 = 8 - 351 - 400 = 10 - 401+ = 12 Call Physician The November 2022 MAR indicated the Humalog Insulin was blank and not signed out at all on 11/25/22 at 9:00 p.m., 11/26/22 at 4:00 p.m., 11/26/22 at 9:00 p.m., 11/27/22 at 9:00 p.m., 11/29/22 at 4:00 p.m. and 9:00 p.m. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The closed record for Resident D was reviewed on 11/30/22 at 2:05 p.m. Diagnoses included, but were not limited to, cutaneous abscess of abdominal wall, sepsis, chronic obstructive pulmonary disease, major depressive disorder, anxiety, heart failure, and heart disease. The Admission Minimum Data Set (MDS) assessment, dated 10/25/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 10/20/22, indicated Midodrine (blood pressure medication) 10 milligram tablet by mouth every 8 hours. The November 2022 Medication Administration Record (MAR) indicated the resident did not receive the Midodrine on the following dates and times: - 11/15/22 5:00 p.m. coded 9 - See Progress Notes - 11/16/22 1:00 a.m. coded 9 - See Progress Notes - 11/17/22 9:00 a.m. coded 2 - Drug Refused - 11/17/22 5:00 p.m. coded 5 - Hold/See Progress Notes - 11/18/22 1:00 a.m. coded 5 - Hold/See Progress Notes - 11/21/22 1:00 a.m. coded 5 - Hold/See Progress Notes - 11/21/22 5:00 p.m. coded 5 - Hold/See Progress Notes There were no corresponding progress notes. Interview with the Director of Nursing and Administrator on 12/1/22 at 9:50 a.m., indicated they had no further information to provide. This Federal tag relates to Complaint IN00391437 and IN00393256. 3.1-48(a)(6)