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	02/15/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - 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** 10770 Based on record review and interview, the facility failed to promptly notify the Physician of abnormal laboratory findings, resulting in a delay in treatment for which the resident was hospitalized for septic shock and required intubation and ultimately death for 1 of 4 residents reviewed for a change in condition. (Resident E) Finding includes: The closed record for Resident E was reviewed on [DATE] at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was Minimum Data Set (MDS) assessment available for review. The Admission Nursing Assessment, dated [DATE], indicated the resident was observed with pursed lip breathing and his lung sounds on both sides were clear, diminished with rales. No equipment for respiratory status was checked on the form. A Physician's Order, dated [DATE], indicated to obtain labs: a CBC (Complete Blood Count) with differential and platelets, a CMP (Comprehensive Metabolic Panel), a Glycohemoglobin A1C, a Lipid panel, a renal function panel, a thyroid profile with a T4 and TSH, and a PSA. The lab results were obtained on [DATE] and reported to the facility on [DATE] at 10:24 p.m., however, there was no documentation the Physician was ever notified of the abnormal results. The lab results were as follows: - CBC Hemoglobin was 10.3 grams (gm) (normal 14.0 - 18.0) Hematocrit was 33.7% (normal 42.0 - 52.0) - CMP Blood Urea Nitrogen (BUN) was 132 (normal ,d+[DATE]) (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	Creatinine was 4.02 (normal 0XXX,d+[DATE].32) Sodium was 164 (normal ,d+[DATE]) Glucose was 230 (normal ,d+[DATE]) The lab had suggested the BUN and Sodium be repeated if necessary. The resident's vital signs on [DATE] were documented at 10:37 a.m. The resident's blood pressure was , d+[DATE] and the oxygen saturation was 97% on room air. A Nurses' Note, dated [DATE] at 12:20 p.m., indicated resident is not responding, BP is ,d+[DATE],o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family. [sic] A Nurses' Note, dated [DATE] at 1:20 p.m., indicated report was given to the emergency room (ER) at the hospital. A signed document by the Paramedic, dated [DATE], indicated EMS (Emergency Medical Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen. The patient's dialysis port was uncovered and not secured to the patient. The patient had multiple sores to his body. A History and Physical by the ER Physician, dated [DATE] at 12:33 p.m., indicated .Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per EMS without any oxygen which improved on nonbreather. Patient has a dialysis catheter in his right subclavian that is no longer sutured down. EMS reportedly place a tegaderm over the dialysis catheter to help stabilize it in place. It is unclear how long symptoms have been going on for. A physical exam indicated the patient was ill-appearing and did not respond or follow any commands. The patient had decreased breath sounds bilaterally. At 1:30 p.m., the resident was intubated due to hypoxemia and respiratory failure. Labs were obtained which indicated the resident tested positive for COVID-19. The BUN was 199, Creatinine was 6.2, Sodium was 156, Potassium was 5.8 (normal 3XXX,d+[DATE].0) Glucose was 382, and [NAME] Blood Cells were 15.50 (normal 4XXX,d+[DATE].8). A Lactic Acid lab test was obtained which was 3.4 (normal 0XXX,d+[DATE].0. A high lactic acid meant that body tissues were not getting enough oxygen). The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired in the hospital on [DATE]. Interview with the Director of Nursing on [DATE] at 11:30 a.m., indicated the Physician was not notified of the critical lab results drawn and received on [DATE]. This Federal tag relates to Complaint IN00401271. 3XXX,d+[DATE](a)(3)

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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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview the facility failed to protect a resident's right to be free from neglect related to the failure of monitoring/assessing a dialysis perma catheter, lack of Physician notification of abnormal lab results and failure to administer oxygen for a resident in respiratory distress which resulted in a hospitalization for septic shock and required intubation and ultimately death for 1 of 3 residents reviewed for neglect (Resident E) Finding includes: The closed record for Resident E was reviewed on [DATE] at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was Minimum Data Set (MDS) assessment available for review. The resident was admitted directly to the facility on [DATE] from another Long Term Care facility. Ancillary Physician's Orders on the transfer information, dated [DATE], indicated the resident was receiving oxygen continuously at 2 liters via nasal cannula and had a dialysis perma catheter to the right chest that was to be checked/assessed every shift. The resident had discontinued dialysis treatment on [DATE]. A Nurses' Note, dated [DATE] at 2:01 p.m., indicated the resident arrived via ambulance transport accompanied by two ambulance transporters. Nursing tried to acclimate the resident to the room, call light, surrounding areas and the television, however, the resident did not respond. Vital signs were checked and within normal limits. A rapid COVID-19 test was administered with negative results. The remainder of the new admission process was passed to the oncoming shift. A Nurses' Note, dated [DATE] at 7:34 p.m., indicated all medication was verified with the Physician and entered into the electronic Medication Administration Record (MAR). The Admission Nursing Assessment, dated [DATE], indicated the resident was observed with pursed lip breathing and his lung sounds on both sides were clear, diminished with rales. No equipment for respiratory status was checked on the form. Under the section of Intravenous (IV) therapy, nothing was checked as well for the dialysis perma catheter. Physician's Orders, dated ,d+[DATE]-[DATE], indicated there were no orders for oxygen or to check/assess the dialysis perma catheter to the right chest. Physician's Orders, dated [DATE], indicated the resident was NPO and was to receive an enteral tube feeding of Glucerna 1.5 at 65 cubic centimeters (cc) from 10:00 a.m., until 6:00 a.m. The peg tube was to be flushed with 180 milliliters (ml) of water every 4 hours. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A Physician's Order, dated [DATE], indicated to obtain labs: a CBC (Complete Blood Count) with differential and platelets, a CMP (Comprehensive Metabolic Panel), a Glycohemoglobin A1C, a Lipid panel, a renal function panel, a thyroid profile with a T4 and TSH, and a PSA. The lab results were obtained on [DATE] and reported to the facility on [DATE] at 10:24 p.m., however, there was no documentation the Physician was ever notified of the abnormal results. The lab results were as follows: - CBC Hemoglobin was 10.3 grams (gm) (normal 14.0 - 18.0) Hematocrit was 33.7% (normal 42.0 - 52.0) - CMP Blood Urea Nitrogen (BUN) was 132 (normal ,d+[DATE]) Creatinine was 4.02 (normal 0XXX,d+[DATE].32) Sodium was 164 (normal ,d+[DATE]) Glucose was 230 (normal ,d+[DATE]) The lab had suggested the BUN and Sodium be repeated if necessary. The resident's vital signs on [DATE] were documented at 10:37 a.m. The resident's blood pressure was , d+[DATE] and the oxygen saturation was 97% on room air. A Nurses' Note, dated [DATE] at 12:20 p.m., indicated resident is not responding, BP is ,d+[DATE],o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family. [sic] A Nurses' Note, dated [DATE] at 1:20 p.m., indicated report was given to the emergency room (ER) at the hospital. A signed document by the Paramedic, dated [DATE], indicated EMS (Emergency Medical Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen. The patient's dialysis port was uncovered and not secured to the patient. The patient had multiple sores to his body. A History and Physical by the ER Physician, dated [DATE] at 12:33 p.m., indicated .Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per EMS without any oxygen which improved on nonbreather. Patient has a dialysis catheter in his right subclavian that is no longer sutured down. EMS reportedly place a tegaderm over the dialysis catheter to help stabilize it in place. It is unclear how long symptoms have been going on for. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A physical exam indicated the patient was ill-appearing and did not respond or follow any commands. The patient had decreased breath sounds bilaterally. At 1:30 p.m., the resident was intubated due to hypoxemia and respiratory failure. Labs were obtained which indicated the resident tested positive for COVID-19. The BUN was 199, Creatinine was 6.2, Sodium was 156, Potassium was 5.8 (normal 3XXX,d+[DATE].0) Glucose was 382, and [NAME] Blood Cells were 15.50 (normal 4XXX,d+[DATE].8). A Lactic Acid lab test was obtained which was 3.4 (normal 0XXX,d+[DATE].0. A high lactic acid meant that body tissues were not getting enough oxygen). The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired in the hospital on [DATE]. Interview with the Administrator on [DATE] at 3:30 p.m., indicated the LPN who admitted the resident was asked about the dialysis perma catheter at the time of admission. The LPN indicated she had seen the catheter and it was covered. The Administrator indicated the LPN was fired from the facility. Interview with the Director of Nursing on [DATE] at 11:30 a.m., indicated the Physician was not notified of the labs drawn on [DATE]. There was no documentation/assessment of the dialysis perma catheter and there was no documentation of any oxygen administered when the resident started to have a change in condition before he was sent to the hospital. They had no further information for review. This Federal tag relates to Complaints IN00398992 and IN00401271. 3XXX,d+[DATE](a)(3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on record review and interview, the facility failed to ensure ADL (activities of daily living) care was provided to a dependent resident related to showering as scheduled for 1 of 3 residents reviewed for ADL care. (Resident F) Finding includes: The closed record for Resident F was reviewed on 2/14/23 at 8:48 a.m. She was admitted on [DATE]. Diagnoses included, but were not limited to, orthopedic aftercare, heart failure, and chronic obstructive pulmonary disease. She was discharged to the hospital on 1/12/23. The Admission Minimum Data Set assessment, dated 11/28/22, indicated she required extensive staff assistance for bed mobility and toileting, and only transferred once or twice with extensive assistance. The Point of Care tasks indicated she was scheduled to receive a shower or bath on Mondays and Thursdays. Shower sheets were missing for 11/24/22, 11/28/22, 12/5/22, 12/15/22 and 12/26/22. There were no refusals documented on these dates. Interview with the Administrator on 2/15/23 at 11:30 a.m., indicated there was no additional information for this resident. This Federal tag relates to Complaints IN00396689, IN00398992 and IN00400678. 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 10770 Based on observation, record review, and interview, the facility failed to ensure cognitively impaired residents in isolation for COVID-19 had ongoing activities in the room and a resident was assisted to a favorite activity of church for 3 of 3 residents reviewed for activities. (Residents D, B, and K) Findings include: 1. On 2/14/23 at 9:00 a.m., Resident D was observed curled up in a ball lying on the bed in the room. At that time, the resident was in isolation for COVID-19. The lights were turned off and there was no television or radio in the room. At 12:57 p.m., the resident was laying in bed, again with the lights turned off. There was no television or radio in the room. On 2/14/23 at 10:15 a.m., the resident was observed curled up lying in the bed, wearing a hospital gown. There were several stuffed toys at the foot of the bed. There was no television or radio in the room. The Record for the resident was reviewed on 2/13/23 at 6:15 p.m. Diagnoses included, but were not limited to, epilepsy, schizophrenia, high blood pressure, intellectual disabilities, speech disturbance, and peg tube status. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident was severely impaired for decision making. The resident was able to answer the questions for the activity section. She indicated it was very important for her to choose what clothes to wear, somewhat important to read books or the newspaper, very important to listen to music, and very important to do her favorite activities. The resident received all of her nutrition by the way of a peg tube. An Activity Assessment, dated 1/27/23, indicated current interests included television and music. There was no Care Plan for activities. Physician's Orders, dated 2/11/23, indicated strict isolation for COVID-19. An Activity Participation Sheet for the month of 2/2023, indicated on 2/12/23, current events, music, and sensory were offered to the resident. On 2/14/23, music, sensory and a stop by visit was offered to the resident. Interview with the Activity Director on 2/15/23 at 11:14 a.m., indicated she was unaware there was no television or radio in the resident's room. 45666 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An interview with Resident B on 2/14/23 at 12:49 p.m., indicated the resident only liked to go to the church services the facility provided on Saturdays. The staff kept telling him that they did not have enough people working to get him up and ready to go so that he could attend weekly. He did not enjoy any of the other activities the facility provided. Resident B's record was reviewed on 2/13/23 at 4:26 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) affecting the left side following a stroke and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was moderately cognitively impaired. He required extensive assistance with two persons physical assist for bed mobility, transfer, dressing, and personal hygiene. He had a functional limitation in range of motion with impairment on one side for both upper and lower extremities. A Care Plan, dated 7/26/21, indicated the resident had an interest in watching TV/movies, listening to music, pet interaction, spending time with family, sports, and current events. Interventions included, but were not limited to, one to one activities provided three times weekly and encourage the resident to participate in activities of his choosing. An interview with the Activity Director on 2/15/23 at 2:32 p.m., indicated the resident had been to one church service since the beginning of the year. It was an ongoing issue with the staff not getting the resident up and ready to go to the services every Saturday morning. 3. On 2/13/23 at 4:12 p.m., Resident K was observed in bed with no television on or other activity occurring at the time. On 2/14/23 at 11:06 a.m., the resident was observed in bed with no television on or other activity occurring at the time. On 2/14/23 at 12:48 p.m., the resident was observed in bed with no television on or other activity occurring at the time. On 2/14/23 at 1:55 p.m., the resident was observed in bed with no television on or other activity occurring at the time. On 2/15/23 at 10:23 a.m., the resident was observed in bed with no television on or other activity occurring at the time. Resident K's record was reviewed on 2/14/23 at 10:16 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia, schizophrenia, major depressive disorder, and Asperger's syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 1/3/23, indicated the resident was severely impaired for daily decision making. She required extensive assistance for all activities of daily living including bed mobility, transfer, eating, dressing, toileting, and personal hygiene. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, revised on 11/15/21, indicated the resident had an interest in music, religion, books, and hand massages. Interventions included, but were not limited to, one to one visits three times a week, reading books to the resident, and keep sensory items available to the resident. Interview with the Director of Nursing on 2/15/23 at 1:55 p.m., indicated she would reach out to the Activity Director regarding activities for the resident such as music therapy for during the day. This Federal tag relates to Complaint IN00396040. 3.1-33(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 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** 10770 Based on observation, record review, and interview, the facility failed to ensure a resident received appropriate care and services including new admission follow up nursing assessments and lack of oxygen after a change in condition which resulted in a hospitalization for septic shock and intubation for 1 of 4 residents reviewed for a change in condition (Resident E). The facility also failed to ensure follow up assessments were completed after falls and bruises were monitored until healed for 2 of 3 residents reviewed for falls and 1 of 3 residents reviewed for abuse. (Residents L, J and N) Findings include: 1. The closed record for Resident E was reviewed on [DATE] at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was no Minimum Data Set (MDS) assessment available for review. The resident was admitted directly to the facility on [DATE] from another Long Term Care facility. Ancillary Physician's Orders on the transfer information, dated [DATE], indicated the resident was receiving oxygen continuously at 2 liters via nasal cannula. A Nurses' Note, dated [DATE] at 2:01 p.m., indicated the resident arrived via ambulance transport accompanied by two ambulance transporters. Nursing tried to acclimate the resident to the room, call light, surrounding areas and the television, however, the resident did not respond. Vital signs were checked and within normal limits. A rapid COVID-19 test was administered with negative results. The remainder of the new admission process was passed to the oncoming shift. A Nurses' Note, dated [DATE] at 7:34 p.m., indicated all medication was verified with the Physician and entered into the electronic Medication Administration Record (MAR). The Admission Nursing Assessment, dated [DATE], indicated the resident was observed with pursed lip breathing (helps assist with shortness of breath) and his lung sounds on both sides were clear, diminished with rales (abnormal rattling sound in the lungs). No equipment for respiratory status was checked on the form. There were no further nursing assessments documented either as a new admission or as a follow up to the abnormal admission respiratory assessment. Physician's Orders, dated ,d+[DATE]-[DATE], indicated there were no orders for oxygen. A Nurses' Note, dated [DATE] at 12:20 p.m., indicated resident is not responding, BP is ,d+[DATE],o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family. [sic] A Nurses' Note, dated [DATE] at 1:20 p.m., indicated report was given to the emergency room (ER) at the hospital. (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 0684 Level of Harm - Actual harm Residents Affected - Few	A signed document by the Paramedic, dated [DATE], indicated EMS (Emergency Medical Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen . A History and Physical by the ER Physician, dated [DATE] at 12:33 p.m., indicated .Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per EMS without any oxygen which improved on nonbreather . It is unclear how long symptoms have been going on for. A physical exam indicated the patient was ill-appearing and did not respond or follow any commands. The patient had decreased breath sounds bilaterally. At 1:30 p.m., the resident was intubated due to hypoxemia and respiratory failure. Labs were obtained which indicated the resident tested positive for COVID-19. A Lactic Acid lab test was obtained which was 3.4 (normal 0XXX,d+[DATE].0. A high lactic acid meant that body tissues were not getting enough oxygen). The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired in the hospital on [DATE]. Interview with the Director of Nursing on [DATE] at 11:30 a.m., indicated there was no documentation of any follow up assessments or oxygen administered when the resident started to have a change in condition before he was sent to the hospital. They had no further information for review. 2. The record for Resident L was reviewed on [DATE] at 10:00 a.m. Diagnoses included, but were not limited to, COVID-19, heart disease, atrial fibrillation, high blood pressure, and angina. The [DATE] Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident had a history of 2 or more falls since the last assessment and 1 with a minor injury. A Care Plan, revised on [DATE], indicated the resident was at risk for falls. A Fall Initial Occurrence Note, dated [DATE] at 10:43 a.m., indicated the resident had an unwitnessed fall on [DATE] at 9:05 a.m. in her bathroom. The resident was observed on the floor outside of the bathroom. The resident indicated she did not lift her walker up far enough and fell . The resident was assessed for injuries and none were noted at the time. The resident had no pain and was picked up from the floor with 2 staff members. 72 hour Charting following the fall was completed on [DATE] at 4:35 p.m., [DATE] at 7:20 p.m., [DATE] at 5:00 a.m. and 9:51 a.m., and the last documented fall follow up was on [DATE] at 5:02 a.m. The 72 hour Charting on [DATE] at 4:35 p.m., indicated the resident's temperature, pulse, respirations, and blood pressure were all taken from [DATE] at 11:50 a.m. The 72 hour Charting on [DATE] at 7:20 p.m., and [DATE] at 5:00 a.m., indicated the resident's temperature, pulse, respirations, and blood pressure were all taken from [DATE] at 11:50 a.m. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview with the Nurse Consultant on [DATE] at 3:30 p.m., indicated residents were to be assessed for 72 hours every shift post fall. Interview with the Director of Nursing on [DATE] at 2:00 p.m., indicated staff were to initiate 72 hour charting for every shift after a fall. There was no further information to review. 32582 3. Resident J's record was reviewed on [DATE] at 1:45 p.m. Diagnoses included, but were not limited to, dementia, dysphagia and Diabetes Mellitus. The Annual Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had significant cognitive impairment and required extensive staff assistance for bed mobility and transfers. A Nurses' Note, dated [DATE] at 10:29 p.m., indicated the resident had been found next to his bed on the floor. The resident was assessed and no injury was noted. On [DATE] at 7:58 a.m. and 4:00 p.m., a 72 hour Charting progress note had been completed related to the fall. There were no additional 72 hour assessments related to the fall. Interview with the Nurse Consultant on [DATE] at 3:30 p.m., indicated residents were to be assessed for 72 hours every shift post fall. 45666 4. Resident N's record was reviewed on [DATE] at 2:06 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, Alzheimer's disease, generalized anxiety disorder, and psychosis. The Annual Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was severely cognitively impaired. The resident displayed behavioral symptoms not directed towards others such as physical symptoms like hitting or scratching self, pacing, or verbal/vocal symptoms like screaming or disruptive sounds. A Nurses' Note, dated [DATE] at 4:24 p.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. A Nurses' Note, dated [DATE] at 7:52 p.m., indicated the resident had reddish-purple bruising noted to both arms. A Nurses' Note, dated [DATE] at 10:51 a.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. A Nurses' Note, dated [DATE] at 4:10 p.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. A Nurses' Note, dated [DATE] at 1:25 p.m., indicated the resident had deep purple and reddish-purple bruising noted to both arms. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A Nurses' Note, dated [DATE] at 12:15 p.m., indicated the resident had reddish-purple, green, and yellow bruising noted to both arms. A Nurses' Note, dated [DATE] at 8:32 p.m., indicated the resident had reddish-purple, green, and yellow bruising noted to both arms. A Nurses' Note, dated [DATE] at 3:46 p.m., indicated the resident had deep purple, and reddish-purple, and green bruising noted to both arms. There were no further notes documented. Interview with the Director of Nursing on [DATE] at 1:55 p.m., indicated the bruising should have been monitored until healed. A Policy titled Skin Condition Assessment & Monitoring - Pressure and Non-Pressure and noted as current indicated .Guidelines . Non-pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc.) will be assessed for healing progress and signs of complications or infection weekly . When bruises are healing without complications as indicated on the above table, the nurse will monitor the site weekly. At the point of signs of healing, approximately ,d+[DATE] days, or when the bruise has turned color to green, yellow, brown, the nurse will document a last entry indicating that the normal healing process has taken place without complications, and no further follow-up will be needed. This Federal tag relates to Complaint IN00396040, IN00401271, and IN00401730. 3XXX,d+[DATE](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 record review and interview, the facility failed to ensure new pressure ulcers were assessed and monitored for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: The closed record for Resident F was reviewed on 2/14/23 at 8:48 a.m. She was admitted on [DATE]. Diagnoses included, but were not limited to, orthopedic aftercare, heart failure, and chronic obstructive pulmonary disease. She was discharged to the hospital on 1/12/23. The Admission Minimum Data Set assessment, dated 11/28/22, indicated she required extensive staff assistance for bed mobility and toileting, and only transferred once or twice with extensive assistance. A Nurses' Note, dated 1/8/23, indicated the resident had new open areas on her coccyx and left posterior thigh. Bandages were placed and the Physician was contacted for orders. An IDT (interdisciplinary team) Note, dated 1/11/23, indicated the resident had new wounds to coccyx and posterior thigh and the wound nurse would assess and provide treatment. There were no measurements, staging, or descriptions of the wounds. Interview with the Wound Nurse on 2/15/23 at 1:10 p.m., indicated she had not been aware of the resident's wounds and had not assessed them. This Federal tag is related to Complaint IN00396040. 3.1-40(a)(2)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on record review and interview, the facility failed to ensure vitals signs were monitored every shift for a resident with a urinary tract infection (UTI) for 1 of 4 residents reviewed for a change in condition. (Resident F) Finding includes: The closed record for Resident F was reviewed on 2/14/23 at 8:48 a.m. She was admitted on [DATE]. Diagnoses included, but were not limited to, orthopedic aftercare, heart failure, and chronic obstructive pulmonary disease. She was discharged to the hospital on 1/12/23. The Admission Minimum Data Set assessment, dated 11/28/22, indicated she required extensive staff assistance for bed mobility and toileting, and only transferred once or twice with extensive assistance. A Nurses' Note, dated 1/7/23, indicated the resident was sent to the ER and was diagnosed with a UTI. A Physician's Order, dated 1/7/23, indicated Macrobid (antibiotic) 100 milligrams, twice daily for 7 days for the UTI. Temperatures were recorded on the following dates and times: 1/7/23 8:19 a.m. 1/8/23 8:23 a.m. 1/9/23 9:46 a.m. Pulse rates were recorded on the following dates and times: 1/10/23 8:33 a.m. 1/11/23 3:33 p.m. Interview with the Director of Nursing, on 2/14/23 at 3:30 p.m., indicated vitals should be taken every shift for 72 hours when started on an antibiotic. This Federal tag relates to Complaint IN00398992. 3.1-41(a)(2)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 32582 Based on observation, record review, and interview, the facility failed to ensure a resident with weight loss received nutritional supplements as ordered for 1 of 3 residents reviewed for nutrition. (Resident J) Finding includes: On 2/15/23 at 8:05 a.m., Resident J was observed seated in his room eating breakfast. He had pureed eggs and cereal, and thickened juice and water. There were no supplements on his tray. QMA 1 was passing medications on his hall. There were no supplements observed on her cart. Resident J's record was reviewed on 2/14/23 at 1:45 p.m. Diagnoses included, but were not limited to, dementia, dysphagia and Diabetes Mellitus. The Annual Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident had significant cognitive impairment and required extensive staff assistance for bed mobility and transfers. A Nutritional Assessment, dated 2/2/23, indicated the resident had an unplanned weight loss of 8.6% in 1 month. Recommendation was to increase supplementation to prevent further weight loss. Physician's Order, dated 2/2/23, indicated house supplement, 60 milliliters three times a day. Physician's Order, dated 11/9/21, indicated Magic cup 4 ounces once a day. The resident was on a regular diet, pureed texture and honey thickened liquids. The resident's breakfast tray ticket did not indicate the resident received the Magic cup at breakfast. The lunch ticket indicated he received it then. The February 2023 Medication Administration Record (MAR) indicated the Magic cup was to be given at 8:00 a.m., and the house supplement at 9:00 a.m. At 10:55 a.m., neither had been signed out as given yet that day. At 10:55 a.m., QMA 1 completed passing medications and returned the cart to the station. Interview with the QMA at that time, indicated she did not have any house supplements on her cart because nobody needed it. When asked about Resident J, she then indicated she had given him the house supplement. She entered the medication room and came out with a carton of Nepro (a supplement used for renal patients) and indicated this was what she had given him today during medication pass . She had given the drink to him in a cup, however, the supplement was not honey thickened. LPN 2 was standing nearby and indicated Nepro was not the house supplement. The QMA indicated he also had his Magic cup, she then signed both out on her computer. Interview with the Administrator, on 2/15/23 at 11:40 a.m., indicated the resident received his Magic cup with his lunch, the MAR should have been updated, and the QMA wasn't truthful. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Federal tag relates to Complaint IN00398992. 3.1-46(a)(2)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 10770 Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube (peg tube) care was completed as ordered related to cleaning, bandage changes, and water flushes, enteral feedings were documented and administered, and treatments were obtained for a possible infection at the site for 2 of 3 residents reviewed for peg tubes. (Residents D and B) Findings include: 1. On 2/14/23 at 9:00 a.m., Resident D was observed curled up in a ball lying on the bed in the room. At that time, there was a piston syringe set and bottle with the date of 2/10/23 on the outside in black marker. At 9:15 a.m., LPN 1 was asked to go into the room to assess the resident's peg tube site. The resident's gown was not tied so it fell off of her shoulders. The peg tube was secured in the abdomen, and there was no bandage covering or around the stoma. The Record for the resident was reviewed on 2/13/23 at 6:15 p.m. Diagnoses included, but were not limited to, epilepsy, schizophrenia, high blood pressure, intellectual disabilities, speech disturbance, and peg tube status. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident was severely impaired for decision making. The resident received all of her nutrition by the way of a peg tube. Physician's Orders, dated 1/25/23, indicated change syringe every 24 hours and prn every night shift. Physician's Orders dated 2/7/23, indicated cleanse the peg tube site with normal saline, pat dry, and apply split gauze dressing every night shift. The resident was NPO. May bolus enteral feedings of Jevity 1.5, 5 cans daily. Physician's Orders, dated 2/9/23, indicated flush peg tube with 50 cubic centimeters of water every 4 hours for hydration. The Medication Administration Record (MAR) for the month of 2/2023, indicated the syringe change was signed out as being completed on 2/10 through 2/13/23. The cleaning of the peg tube site and applying the bandage was not signed out as being completed on 2/12/23. There was no documentation on the MAR or the Treatment Administration Record (TAR) to indicate if the resident was getting her enteral feeding of Jevity 1.5 - 5 cans a day. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the peg tube should have had a bandage around the stoma. There was no documentation the enteral feeding bolus was being administered to the resident at least 5 times a day. 45666 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident B's record was reviewed on 2/13/23 at 4:26 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following a stroke, dysphagia (swallowing difficulties), and gastrostomy (g-tube). The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was moderately cognitively impaired and he had a feeding tube. A Physician's Order, dated 8/3/21, indicated flush enteral tube every shift with 60 milliliters (ml) of water. The December 2022 Medication Administration Record (MAR) indicated the water flush was not administered as ordered on 12/16/22 at 8:00 a.m., 12/24/22 at 4:00 p.m., and 12/27/22 at 12:00 a.m. The January 2023 MAR indicated the water flush was not administered as ordered on 1/13/23 at 4:00 p.m. and 1/19/23 at 4:00 p.m. The February 2023 MAR indicated the water flush was not administered as ordered on 2/7/23 at 4:00 p.m. and 2/12/23 at 8:00 a.m. A Nurses' Note, dated 1/23/23 at 7:10 a.m., indicated the resident's g-tube site was observed during a dressing change with a foul odor and drainage noted. The writer indicated they would inform the oncoming nurse to alert the Nurse Practitioner and the wound care nurse. There was no further documentation regarding the foul odor and drainage noted to the g-tube site. Interview with the Director of Nursing on 2/15/23 at 1:47 p.m., indicated there was no follow-up regarding the foul odor and drainage noted on 1/23/23 and the flushes should have been administered as ordered. This Federal tag relates to Complaint IN00396040. 3.1-44(a)(2)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to monitor/assess dialysis perma catheter and fistula sites, obtain orders for hemodialysis, and monitor fluid restriction for 2 of 3 residents reviewed for dialysis. (Residents E and H) Findings include: 1. The closed record for Resident E was reviewed on [DATE] at 4:35 p.m. Diagnoses included but were not limited to, COPD, respiratory failure, acute kidney failure, peg tube, epilepsy, anxiety, and heart failure. There was Minimum Data Set (MDS) assessment available for review. The resident was admitted directly to the facility on [DATE] from another Long Term Care facility. Ancillary Physician's Orders on the transfer information, dated [DATE], indicated the resident was receiving oxygen continuously at 2 liters via nasal cannula and had a dialysis perma catheter to the right chest that was to be checked/assessed every shift. The resident had discontinued dialysis treatment on [DATE]. A Nurses' Note, dated [DATE] at 2:01 p.m., indicated the resident arrived via ambulance transport accompanied by two ambulance transporters. Nursing tried to acclimate the resident to the room, call light, surrounding areas and the television, however, the resident did not respond. Vital signs were checked and within normal limits. A rapid COVID-19 test was administered with negative results. The remainder of the new admission process was passed to the oncoming shift. A Nurses' Note, dated [DATE] at 7:34 p.m., indicated all medication was verified with the Physician and entered into the electronic Medication Administration Record (MAR). The Admission Nursing Assessment, dated [DATE], indicated under the section of Intravenous (IV) therapy, nothing was checked for the dialysis perma catheter. Physician's Orders, dated ,d+[DATE]-[DATE], indicated there was no orders check/assess the dialysis perma catheter to the right chest. A Nurses' Note, dated [DATE] at 12:20 p.m., indicated resident is not responding, BP is ,d+[DATE],o2 is 80/min, respi is 16/min, blood sugar is 347. writer sent him in ER. notified to DON and family. [sic] A Nurses' Note, dated [DATE] at 1:20 p.m., indicated report was given to the emergency room (ER) at the hospital. A signed document by the Paramedic, dated [DATE], indicated EMS (Emergency Medical Service) was dispatched to the extended care facility for a sick person. The patient had been unconscious for over an hour. The patient was not on any oxygen. The patient's dialysis port was uncovered and not secured to the patient. The patient had multiple sores to his body. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A History and Physical by the ER Physician, dated [DATE] at 12:33 p.m., indicated .Patient presents to ED via EMS from (nursing home name) for altered mental status and shortness of breath. Patient was hypoxic down to the 80's per EMS without any oxygen which improved on nonbreather. Patient has a dialysis catheter in his right subclavian that is no longer sutured down. EMS reportedly place a tegaderm over the dialysis catheter to help stabilize it in place. It is unclear how long symptoms have been going on for. The resident was diagnosed with Severe Sepsis/Septic Shock (Severe sepsis develops when the infection caused organ damage. Septic shock was the most severe form in which the infection causes low blood pressure, resulting in damage to multiple organs). The resident expired in the hospital on [DATE]. Interview with the Director of Nursing on [DATE] at 11:30 a.m., indicated the there were no Physician's orders or documentation/assessment of the dialysis perma catheter. 32582 2. Resident H's record was reviewed on [DATE] at 9:20 a.m. The resident was readmitted to the facility after a hospitalization on [DATE]. Diagnoses included, but were not limited to, end stage renal disease and dependence on dialysis. The Admission Minimum Data Set assessment, dated [DATE], indicated he was cognitively intact and required extensive staff assistance for bed mobility and transfers. There were no Physician Orders in place related to dialysis, monitoring of the fistula (access site) or assessing vital signs before and after dialysis. A Physician's Order, dated [DATE], indicated the resident was on a fluid restriction of 1500 milliliters (ml) per 24 hours. Fluid intake logs indicated the following amounts consumed: [DATE] 1,960 mls [DATE] 2,470 mls [DATE] 2,240 mls [DATE] 2,350 mls The Medication Administration Record (MAR) for the month of ,d+[DATE] indicated there was no documentation or monitoring of the fluid restriction or the fistula. Interview with the Director of Nursing, on [DATE], indicated the orders had not been updated when the resident returned from the hospital. This Federal tag relates to Complaint IN00401271. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3XXX,d+[DATE](a)

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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. 45666 Based on observation, interview, and record review, the facility failed to ensure an antibiotic ointment was not used for an excessive duration on a gastrostomy (g-tube) site for 1 of 3 residents reviewed for g-tubes. (Resident B) Finding includes: On 2/13/23 at 4:16 p.m., Resident B's g-tube site was observed to have a split gauze dressing surrounding the site. There was no redness, drainage, or odor noted to the site. Resident B's record was reviewed on 2/13/23 at 4:26 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following a stroke, dysphagia (swallowing difficulties), and gastrostomy (g-tube). The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/22, indicated the resident was moderately cognitively impaired and he had a feeding tube. A Physician's Order, dated 9/28/22, indicated cleanse g-tube insertion site with normal saline and pat dry, apply Bacitracin (topical antibiotic ointment) and cover with split gauze and tape. Change daily and as needed for soiled or dislodged dressing. Interview with the Director of Nursing on 2/15/23 at 1:47 p.m., indicated she followed up with the Nurse Practitioner regarding the Bacitracin ointment and it would be discontinued immediately. 3.1-48(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn before entering COVID-19 positive resident rooms, hand hygiene not completed before donning PPE, and the lack of increased monitoring for residents diagnosed with COVID-19 for random observations for infection control for 4 of 4 residents reviewed for COVID-19 and 1 of 4 units observed. (Residents D, L, C and K and Unit 200) Findings include: 1. During a random observation 2/14/23 at 9:10 a.m., Housekeeper 1 was observed pushing a cleaning cart towards Resident D's room. At that time she was wearing gloves to both hands and asked if there was anyone in the room. There was a sign on the resident's door which indicated Red Zone and proper PPE was to be utilized before entering the room. At the time, the housekeeper was wearing an N95 face mask. She donned a clean isolation gown with the same gloved hands and walked into the room without any protective eyewear. The housekeeper mopped the floor and cleaned the room. The resident was observed in the room lying in the bed. During a random observation on 2/14/23 at 9:15 a.m., LPN 1 was observed preparing to enter the resident's room. The LPN was wearing 2 surgical face masks. She removed an N95 face mask from the drawer and placed it over the surgical masks. She donned a clean isolation gown and donned clean gloves to both hands and entered the resident's room. The LPN did not perform hand hygiene before donning the gloves. She did not wear any protective eye wear. While inside the room, she was asked to lift the resident's gown to observe her peg tube. The record for Resident D was reviewed on 2/13/23 at 6:15 p.m. Diagnoses included, but were not limited to, epilepsy, schizophrenia, high blood pressure, intellectual disabilities, speech disturbance, and peg tube status. The Admission Minimum Data Set (MDS) assessment, dated 1/28/23, indicated the resident was severely impaired for decision making. The resident received all of her nutrition by the way of peg tube. Physician's Orders, dated 2/11/23, indicated strict isolation for COVID-19. A Nurses' Note, dated 2/12/23 at 5:57 a.m., indicated the resident changed rooms due to being COVID-19 positive. The Respiratory Infection Screener Assessment indicated the following assessments were completed after the resident had tested positive for COVID-19: - 2/12/23 at 1:58 p.m. and 8:29 p.m. - 2/13/23 at 2:15 a.m. the pulse respirations, and oxygen saturation were from 2/12/23 at 8:29 p.m. (continued on next page)

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	155156	A. Building B. Wing	02/15/2023

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/13/23 at 6:47 p.m., the pulse and respirations were from 2/12/23 at 8:29 p.m., and the oxygen saturation was from 2/13 at 9:17 a.m. - 2/14/23 at 4:19 a.m., the pulse and respirations were from 2/12/23 at 8:29 p.m., and the oxygen saturation was from 2/13 at 9:17 a.m. Interview with the Nurse Consultant on 2/14/23 at 3:30 p.m., indicated residents who were positive for COVID-19 were to be assessed every shift. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the Respiratory Screening Assessments were not completed every shift as per their policy when a resident had COVID-19. At the time of the respiratory assessment, current vital signs were to be obtained. They had no further information for review. 2. During a random observation on 2/13/23 at 6:30 p.m., CNA 1 was observed passing meal trays to the residents in their rooms. Resident L's room had a sign on the door that indicated Red Zone and proper PPE was to utilized before entering the room. CNA 1 indicated at that time, the resident was positive for COVID-19. The CNA had the resident's meal tray and before entering the room, he donned a clean isolation gown, removed his old N95 face mask and donned a clean N95 face mask, donned clean gloves to both hands and placed a face shield over his eyes. He did not perform hand hygiene before donning any of the PPE. The record for Resident L was reviewed on 2/14/23 at 10:00 a.m. Diagnoses included, but were not limited to, COVID-19, heart disease, atrial fibrillation, high blood pressure, and angina. The 1/24/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident had a history of 2 or more falls since last assessment and 1 with a minor injury. Physician's Orders, dated 2/8/23, indicated droplet and contact isolation for COVID-19 positive. Nurses' Notes, dated 2/8/23 at 4:00 p.m., indicated the resident tested positive for COVID-19. The Respiratory Infection Screener Assessment indicated the following assessments were completed after the resident had tested positive for COVID-19: - 2/9/23 at 9:52 p.m., the temperature was from 2/8/23 - 2/10/23 at 12:57 a.m., the temperature was from 2/8/22 and the oxygen saturation was from 2/9/23 at 9:53 p.m. - 2/10/23 at 11:53 a.m., the temperature was from 2/8/22 and the oxygen saturation was from 2/9/23 at 9:53 p.m. - 2/11/23 at 10:15 a.m. the temperature and oxygen saturation was from 2/11/23 at 12:01 a.m. - 2/11/23 at 9:04 p.m., 2/12/23 at 1:05 a.m., 12:37 p.m., and 8:47 p.m., and 2/13/23 at 1:00 a.m. all vital signs were from 2/11/23 at 12:01 a.m. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/14/22 at 1:52 p.m., and 8:42 p.m., all vital signs were from 2/14/23 at 1:52 p.m. - 2/15/23 at 1:17 a.m., all vital signs were from 2/14/23 at 1:52 p.m. Interview with LPN 1 on 2/14/23 at 9:50 a.m., indicated she was unaware if she could wear 2 surgical face masks at time and the N95 face mask needed to be directly against her face and not over the surgical face masks. She indicated she thought her glasses were fine to wear as protective eye wear. Interview with the Nurse Consultant on 2/14/23 at 3:30 p.m., indicated residents who were positive for COVID-19 were to be assessed every shift. Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., the Respiratory Screening Assessments were not completed every shift as per their policy when a resident had COVID-19. At the time of the respiratory assessment, current vital signs were to be obtained. They had no further information for review. The updated and current 10/31/22 Infection Control interim COVID-19 policy, provided by the Director of Nursing on 2/13/23 at 6:30 p.m., indicated the health care professional should perform hand hygiene before and after all resident contact, contact with potentially infectious material and before putting on and after removing PPE. 45666 3. Resident C's record was reviewed on 2/13/23 at 6:18 p.m. Diagnoses included, but were not limited to, COVID-19, heart disease, and chronic obstructive pulmonary disease. The Quarterly Minimum Data Set (MDS) assessment, dated 1/3/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 2/9/23 at 7:00 a.m., indicated the resident was COVID-19 positive and required strict isolation with droplet and contact precautions. A Physician's Order, dated 2/9/23 at 7:00 a.m., indicated COVID-19 monitoring temperature, oxygen saturation, and symptoms every shift. A Respiratory Infection Screener, dated 2/9/23 at 9:27 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. A Respiratory Infection Screener, dated 2/10/23 at 10:23 a.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. A Respiratory Infection Screener, dated 2/10/23 at 7:53 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. There was no further documentation related to COVID-19 assessments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on 2/15/23 at 11:30 a.m., indicated the resident should have a full assessment completed at least every shift including a respiratory assessment while COVID-19 positive. 4. Resident K's record was reviewed on 2/14/23 at 10:16 a.m. Diagnoses included, but were not limited to, COVID-19, Parkinson's disease, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 1/3/23, indicated the resident was severely impaired for daily decision making. A Physician's Order, dated 2/9/23 at 7:00 a.m., indicated the resident was COVID-19 positive and required strict isolation with droplet and contact precautions. A Physician's Order, dated 2/9/23 at 3:00 p.m., indicated COVID-19 monitoring temperature, oxygen saturation, and symptoms every shift. A Respiratory Infection Screener, dated 2/9/23 at 9:17 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. A Respiratory Infection Screener, dated 2/10/23 at 12:55 a.m., included vital signs noted from previous assessment at 9:18 p.m. A Respiratory Infection Screener, dated 2/10/23 at 10:26 a.m., included vital signs noted from previous assessment on 2/9/23 at 9:18 p.m. A Respiratory Infection Screener, dated 2/10/23 at 7:56 p.m., was completed with temperature, pulse, respirations, oxygen saturation, and a full respiratory assessment. There was no further documentation related to COVID-19 assessments. Interview with the Director of Nursing on 2/15/23 at 1:55 p.m., indicated the Respiratory Infection Screener assessments were to be completed with updated vital signs every shift while COVID-19 positive. 5. During random observations on 2/13/23 on the 200 Unit the following was observed: a. At 6:05 p.m., CNA 2 was observed delivering meal trays to room [ROOM NUMBER]. The door was marked for transmission based precautions as both residents were positive for COVID-19. CNA 2 entered the room without performing hand hygiene. She was wearing a surgical mask. She did not don an N95 mask, eye protection, a gown, or gloves. She did not perform hand hygiene upon exiting the room. b. At 6:09 p.m., CNA 1 was observed delivering a meal tray to Resident C. The door was marked for transmission based precautions as the resident was COVID-19 positive as well as her roommate Resident K. CNA 1 did not perform hand hygiene prior to entering the room. He was wearing an N95 mask. He did not don eye protection, a gown, or gloves. Upon exiting the room, he did not dispose of his N95 mask and he did not perform hand hygiene. (continued on next page)

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