

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2025
NAME OF PROVIDER OR SUPPLIER  Aperion Care Arbors Michigan City		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on record review and interview, the facility failed to ensure a dependent resident's family or representative was notified of changes related to a dislodged gastrostomy tube (g-tube; a tube inserted through the skin into the stomach to provide nutrition and medications) and antibiotic orders for 1 of 3 residents reviewed for g-tubes. (Resident C) Finding includes: Resident C's record was reviewed on 10/8/25 at 9:34 a.m. Diagnoses included, but were not limited to, flaccid hemiplegia affecting the right side, aphasia (a language disorder that affects communication), dysphagia (swallowing difficulty) and g-tube status. The Quarterly Minimum Data Set assessment, dated 8/4/25, indicated the resident had severe cognitive deficits and was dependent for bed mobility and transfers. A care plan dated 11/14/21, indicated the resident had impaired cognition related to impaired short term and long-term memory and decision making. The family manages her care. The resident's profile indicated she was her own responsible party. Her family members were listed as emergency contacts. A Nurse Note, dated 9/1/25 at 5:56 a.m., indicated the resident's g-tube had become dislodged. The Nurse Practitioner (NP) had been notified, there was no documentation family had been notified. A Nurse Note, dated 9/1/25 at 9:15 a.m., indicated the NP had given orders to cleanse the g-tube site with normal saline, pat dry and cover with a dry dressing daily and as needed. The resident was her own responsible party and aware. A Nurse Note, dated 9/11/25, indicated the Physician had given an order for amoxicillin-pot clavulanate (an antibiotic) 875-125 milligrams (mg), twice daily for ten days and doxycycline hyclate (an antibiotic) 100 mg, twice daily for ten days related to an infection of the g-tube site. The resident was her own responsible party and aware. A Nurse Note, dated 9/22/25, indicated the NP had given an order for Levaquin (an antibiotic) 500 mg, daily for seven days related to an infection of the g-tube site. The resident was her own responsible party. During an interview on 10/8/25 at 1:20 p.m., the Nurse Consultant indicated the resident should not be listed as her own responsible party as the family managed her care. The citation relates to Intake 2632273.3.1-5(a)(3)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure residents received the necessary care and treatment related to antibiotics not given as ordered, wound treatments not provided as ordered and incomplete wound assessments for 3 of 3 residents reviewed for infections. (Residents C, B and D) Findings include: 1. Resident C's record was reviewed on 10/8/25 at 9:34 a.m. Diagnoses included, but were not limited to, flaccid hemiplegia affecting the right side, aphasia (a language disorder that affects communication), dysphagia (swallowing difficulty) and g-tube status.</p> <p>The Quarterly Minimum Data Set assessment, dated 8/4/25, indicated the resident had severe cognitive deficits and was dependent for bed mobility and transfers.</p> <p>A Physician's Order, dated 9/11/25, indicated to give amoxicillin-pot clavulanate (an antibiotic) 875-125 milligrams (mg), twice daily for ten days and doxycycline hyclate (an antibiotic) 100 mg, twice daily for ten days related to an infection of the g-tube site.</p> <p>The September 2025 Medication Administration Record indicated the medications had not been given on the evening of 9/20/25. There were no progress notes or medication notes that indicated why the medications were not given.</p> <p>During an interview on 10/8/25 at 2:00 p.m., the Nurse Consultant indicated she did not know why the medications were not signed out, there was no additional information provided.</p> <p>2. Resident B's record was reviewed on 10/8/25 at 9:57 a.m. Diagnoses included, but were not limited to, fracture of the left acetabulum (part of the pelvis). The resident admitted to the facility on [DATE].</p> <p>The admission Minimum Data Set (MDS) assessment, dated 9/24/25, indicated the resident was cognitively intact.</p> <p>A Care Plan, dated 9/18/25, indicated the resident had a surgical incision/wound. Interventions included, but were not limited to, keep incision site clean and dry, monitor for signs or symptoms of infection, and treatment as ordered.</p> <p>The Wound Assessment Details Report, dated 9/18/25 at 2:15 p.m., indicated the resident had a surgical incision present on admission to the left hip. There was a non-removable dressing in place. There was moderate serous exudate (drainage from wound). There was no other documentation included in the assessment.</p> <p>The Wound Assessment Details Report, dated 9/26/25 at 2:36 p.m., indicated the left hip surgical incision had a non-removable dressing in place. There was moderate serous exudate. There was no other documentation included in the assessment. The photograph of the wound showed visible staples as the dressing had been removed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Wound Assessment Details Report, dated 10/6/25 at 11:28 a.m., indicated the left hip surgical incision had 95% intact skin and 5% slough loosely adherent tissue. There was light serous exudate. The periwound (surrounding tissue) was reddened in color and macerated (breakdown of skin due to prolonged exposure to moisture) There were signs of infection present, and the resident was on antibiotics. The wound was 23 centimeters (cm) long by 0.30 cm wide.</p> <p>The Nurse to Nurse Transfer Report, dated 9/18/25, indicated the resident had a surgical wound with left hip incision with a treatment Mepilex (absorbent foam dressing) to be changed every 5 days.</p> <p>A Long Term Care &amp;ndash; admission Orders, dated 9/18/25, indicated Physician Orders.21. Treatment &amp; wound care change dressing every 5 days or PRN for drainage/soiled dressing.</p> <p>A Physician's Order, dated 9/18/25, indicated to monitor the non-removable dressing to the left hip. Notify the physician if any increased redness or swelling occurs, dressing dislodgment/damage, or any other signs or symptoms of possible infection every shift. The order was discontinued on 9/23/25.</p> <p>The September 2025 Treatment Administration Record (TAR) indicated the non-removable dressing to the left hip was monitored as ordered.</p> <p>A Physician's Order, dated 9/30/25, indicated to cleanse the left hip with normal saline/wound wash, pat dry, and cover with dry dressing every Tuesday and Friday and may replace dressing PRN for damage, soilage, or dislodgement.</p> <p>The September 2025 Treatment Administration Record (TAR) indicated the order for the left hip was completed on Tuesday 9/30/25.</p> <p>There were no other treatments to the left hip administered per the September 2025 TAR.</p> <p>A Nurse Practitioner Progress Note &amp;ndash; Follow Up, dated 10/3/25, indicated the chief complaint was redness to the surgical site. The resident had some redness and pain to the lower part of the surgical site. The staples were embedded in the lower half of the incision.</p> <p>During an interview on 10/8/25 at 2:03 p.m., the Nurse Consultant indicated the physician's orders for the dressing changes were not followed and documented as ordered. The wound assessments were to be completed weekly.</p> <p>A facility policy titled, Skin Condition Assessment &amp; Monitoring &amp;ndash; Pressure and Non-Pressure, indicated, .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.7. Physician ordered treatments shall be initialed by the staff on the electronic Treatment Administration Record after each administration.</p> <p>3. Resident D's record was reviewed on 10/8/25 at 11:22 a.m. Diagnoses included, but were not limited to, surgical aftercare following surgery on the digestive system and peritoneal abscess.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 9/30/25, indicated the resident was cognitively intact and was receiving antibiotics.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Care Plan, dated 9/25/25, indicated the resident was on intravenous antibiotic therapy for an abdominal abscess. Interventions included, but were not limited to, administer antibiotic medications as ordered by the physician.</p> <p>A Physician's Order, dated 9/25/25, indicated meropenem intravenous solution reconstituted, 500 milligrams (mg) intravenously every 6 hours until 10/6/25.</p> <p>A Physician's Order, dated 10/6/25, indicated meropenem intravenous solution reconstituted, 500 milligrams (mg) intravenously every 6 hours until 10/20/25.</p> <p>The September and October 2025 Medication Administration Record indicated the meropenem antibiotic was not administered as ordered on 9/25/25 at 6:00 a.m., 10/5/25 at 12:00 p.m. and 10/7/25 at 12:00 a.m.</p> <p>During an interview on 10/8/25 at 2:15 p.m., the Nurse Consultant indicated she had no further information to provide.</p> <p>This citation relates to Intake 2632273.</p> <p>3.1-37(a)</p>