Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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 06/28/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 10770 Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident 86) Finding includes: During random observations on 6/24/24 at 9:50 a.m., and 1:45 p.m., on 6/25/24 at 9:00 a.m., 12:26 p.m., and on 6/26/24 at 11:10 a.m., Resident 86 had a bottle of Tums on his nightstand, 1 package of Tagamet (an antacid), and 1 tube of Bacitracin (an antibiotic ointment) on his dresser. During an interview on 6/24/24 at 1:45 p.m., the resident indicated he used the Tums when he had heartburn. The record for Resident 86 was reviewed on 6/25/24 at 12:35 p.m. Diagnoses included, but were not limited to, seizures, cirrhosis of the liver, paranoid schizophrenia, anxiety, psychosis, major depressive disorder, high blood pressure, Parkinson's disease, and substance abuse. The 5/1/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. There was no Care Plan indicating the resident could self-administer his own medications. There was no self-administration of medication assessment completed for the resident. There were no Physician's Orders for the medications Tums, Tagamet, or Bacitracin. During an interview on 6/26/24 at 3:15 p.m., the Nurse Consultant indicated the resident was not allowed to self-administer his own medications. There were no orders for the medications as well. The current 4/2024, Self-Administration of Medication policy, provided by the Director of Nursing on 6/25/24 at 3:50 p.m., indicated a resident may not be permitted to administer or retain any medication in his or her room unless ordered, in writing, by the attending physician. 3.1-11(a)

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 10326 Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents related to bathing, incontinence care, nail care, oral care, and dressing for 5 of 7 residents reviewed for ADL care. (Residents B, E, C, D, and F) Findings include: 1. During an interview on 6/24/24 at 10:06 a.m., Resident B indicated she didn't always get two bed baths and/or showers a week. The record for Resident B was reviewed on 6/26/24 at 1:53 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), right above the knee amputation, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 5/9/24, indicated the resident was cognitively intact and required maximum assist for bathing. A Care Plan, dated 2/5/24, indicated the resident had an ADL self-care/mobility performance (functional abilities) deficit that could fluctuate with activity throughout the day related to impaired balance, limited ability, shortness of breath (SOB), COPD, weakness, and sleep disorder. The resident's bathing preference was a bed bath every Tuesday and Friday evenings. The bath sheets dated June 2024, indicated the resident received a bath on 6/8, 6/18, and 6/28/24. During an interview on 6/28/24 at 11:20 a.m., the Director of Nursing indicated the resident was to receive a bed bath twice a week and the shower sheets were to be completed. 10770 2. During an interview on 6/24/24 at 11:30 a.m., Resident E indicated he did not get changed after incontinence like he should. During a random observation on 6/25/24 at 12:27 p.m., the resident was observed eating lunch in the main dining room. At 12:32 p.m., he wheeled himself to the activity room. At 2:00 p.m., he was still observed in the activity room. At 4:55 p.m., he was observed coming in from being outside with his wife. At that time, the front of his pants were wet. During an interview on 6/26/24 at 11:10 a.m. the resident indicated he was not changed on 6/25/24 after lunch. His wife came in and they went outside for awhile. He was changed after he came in and before dinner. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During random observations on 6/26/24 from 1:30 to 2:34 p.m., the resident was in the activity room for the resident council meeting. At 2:35 p.m., the resident was observed in his wheelchair going back to his room with his wife. At 2:42 p.m., he was taken to the shower room for an incontinence change. The CNA was observed with a clean shirt and pants for the resident. During an interview on 6/26/24 at 2:45 p.m., the resident's spouse indicated the resident was getting changed in the shower room and they had to take a whole new set of clothes for him because he was wet all the way up the front of pants and shirt. She indicated he told her all of the time, he did not get changed like he should especially on midnights. During random observations on 6/27/24 at 4:37 a.m., 2 CNA's went into the resident's room to provide incontinence care and get him up as he was an early morning get up. The resident was wet with urine in his incontinent brief. At 7:30 a.m. the resident was observed in his wheelchair waiting for breakfast to be served. He indicated he had not been checked or changed since he was gotten up. The record for Resident E was reviewed on 6/25/24 at 1:15 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (muscle weakness), morbid obesity, diabetes, high blood pressure, and major depressive disorder. The 5/6/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident had a range of motion impairment to one side for both lower and upper extremities and needed substantial to max assist for toilet hygiene and toilet transfer. The resident was always incontinent of bladder and frequently incontinent of bowel. A Care Plan, revised on 5/7/24, indicated the resident was incontinent of bowel and bladder related to a stroke. The bladder elimination task, completed by facility staff, had only 2 documented entries the resident was incontinent on 5/27, 5/28, 6/1, 6/4, 6/5, 6/6, 6/8, 6/10, 6/11, 6/12, 6/14, 6/15, 6/16, 6/17, 6/21, 6/22, and 6/23/24. There was only 1 documented entry the resident was incontinent on 5/31, 6/7, 6/13, 6/19, and 6/24/24. There was no documentation the resident was incontinent on 6/9/24. Toilet Use in the task section indicated as above with the amount of times the resident was changed or taken to the toilet. There was no documentation in the last 30 days the resident refused to be checked or changed for incontinence. During an interview on 6/27/24 at 4:37 a.m., CNA 2 indicated the resident did not like to be touched during the midnight shift. The CNA indicated she normally worked 2 to 10 shift, but was working a double that day. She indicated the resident did not get changed like he should during the day shift. When she came in at 2:00 p.m., the resident usually needed a complete clothing change because he had not been changed all day. During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing indicated the resident should have been checked or changed at least every 2 hours. The task section for urinary incontinence was not completed by the facility staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a random observation on 6/24/24 at 9:41 a.m., Resident C was observed with long dirty fingernails on both hands. During an interview at that time, the resident indicated he would scratch himself and his nails would get dirty. He indicated his nails were in need of trimming. During random observations on 6/25/24 at 12:25 p.m., and 2:00 p.m., and on 6/26/24 at 11:00 a.m., the resident's nails were long and dirty. The record for Resident C was reviewed on 6/25/24 at 3:51 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (muscle weakness), and major depressive disorder. The 4/24/24 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. The resident had a limitation in range of motion to one side for both upper and lower extremities and needed substantial to max assist for personal hygiene. The task section under the manicure activity, indicated the resident was an active participant on 5/30, 6/8, 6/10, 6/12, and 6/17/24. During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing indicated the resident's nails should have been cleaned and trimmed as needed. 4. During an interview on 6/24/24 at 11:00 a.m., Resident D indicated he only got his teeth brushed when a certain nurse worked or when his sister visited. During interviews on 6/25/24 at 9:16 a.m., and 2:00 p.m., on 6/26/24 at 2:00 p.m., and 6/27/24 at 7:15 a.m., the resident indicated he had not received oral care at least two times a day. The record for Resident D was reviewed on 6/26/24 at 2:35 p.m. Diagnoses included, but were not limited to, peg tube (a tube inserted directly into the stomach to provide nutrition), quadriplegia (paralysis), and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 6/12/24, indicated the resident was cognitively intact for daily decision making and was totally dependent on staff for personal hygiene. Physician's Orders on the current 6/2024 Physician Order Summary, indicated the resident was NPO (Nothing by Mouth). The oral care task, completed by facility staff, had only 1 entry completed on 6/16, 6/23, and 6/26/24. There were only 2 documented entries on 5/30, 6/4, 6/7, 6/10, 6/11, 6/12, 6/13, 6/14, 6/17, 6/18, and 6/25 and oral care was not documented on 6/6, 6/8, 6/9, 6/20, 6/21, and 6/22/24. During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing indicated oral care was to be done every shift for the resident. The current Oral Hygiene policy, provided by the Nurse Consultant on 6/27/24 at 12:30 p.m., indicated oral care was an essential part of morning and evening care and note that some residents may need oral hygiene after every meal. 48383 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 6/24/24 at 10:13 a.m., Resident F was observed asleep in bed wearing a hospital gown. The resident's nails were dirty and debris was present underneath the fingernails. On 6/24/24 at 1:38 p.m., the resident was observed sitting up in bed and wearing a hospital gown. The resident's fingernails had debris underneath. On 6/25/24 at 8:54 a.m., the resident was observed in bed watching television. A hospital gown was worn and the resident's fingernails were still dirty. At 12:17 p.m., the resident was sitting up in bed eating lunch. The resident was wearing a hospital gown and debris was observed underneath the resident's fingernails. The resident had dropped food onto the front of the hospital gown. At 1:16 p.m., the resident was in bed watching television, there was a moderate amount of food smeared over the top of the hospital gown. At 2:05 p.m., the resident was observed in bed asleep. The hospital gown had not been changed and there was a moderate amount of dried smeared food on the front. At 2:23 p.m., the resident was observed asleep. Resident F's hospital gown was changed and was clean. The record for Resident F was reviewed on 6/25/24 at 2:08 p.m. The diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), depression, abnormal posture, dementia, and a communication deficit. The Annual Minimum Data Set (MDS) assessment, dated 12/19/23, indicated it was very important to choose what clothes to wear. The Quarterly MDS assessment, dated 6/12/24, indicated the resident was moderately impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. The resident required supervision and touching assistance with eating. The resident required substantial/maximum assistance with upper body dressing, lower body dressing, and personal hygiene. A Care Plan, dated 6/12/24, indicated Resident F had daily preferences which included choosing their own clothing, caring for personal belongings, and showering twice a week. The intervention was for staff to assist resident with daily preferences. During an interview on 6/27/24 at 10:45 a.m., the Director of Nursing (DON) indicated Resident F had a care plan for dressing preferences and should not have been wearing a hospital gown and the resident's nails should have been cleaned. This citation relates to Complaint IN00433276. 3.1-38(a)(3)(A) 3.1-38(a)(3)(C) 3.1-38(a)(3)(E) 3.1-38(b)(2) 3.1-38(b)(4)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 10770 Based on observation, record review, and interview, the facility failed to ensure residents were treated for constipation for 4 of41 residents reviewed for quality of care concerns related to constipation and skin care concerns. (Residents 20, C, 45, and 329) Findings include: 1. The record for Resident 20 was reviewed on 6/25/24 at 2:25 p.m. Diagnoses included, but were not limited to, dementia, major depressive disorder, anxiety, high blood pressure, chronic pain, stroke, and hemiplegia (muscle weakness). The 5/8/24 Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact, was always incontinent of bowel and was not on bowel toileting program. A Care Plan, revised on 5/9/24, indicated the resident was at risk for constipation related to decreased mobility and opioid use. The approaches were to administer meds and bowel protocol as ordered, observe bowel movement for amount and consistency, and observe for medications that may cause constipation. The bowel elimination task, dated 6/2024, indicated the resident had no bowel movement on 6/17, 6/18, 6/19, 6/20, and 6/21/24. A small bowel movement was recorded on 6/22/24. Physician's Orders dated 3/25/22, listed as current on the June 2024 Physician's Order Summary (POS), indicated Milk of Magnesia (MOM) (a medication used for constipation) suspension 400 milligrams (mg)/5 milliliters (ml), give 30 ml by mouth every 24 hours as needed for constipation. Physician's Orders dated 11/21/23, listed as current on the June 2024 POS, indicated Docusate Sodium (a stool softener) capsule 100 mg, give 1 capsule by mouth two times a day for constipation. Physician's Orders, dated 4/9/24, indicated Hydrocodone Acetaminophen (an opioid) tablet 5-325 mg, give 1 tablet by mouth in the morning for arthritis. The 6/2024 Medication Administration Record (MAR), indicated the MOM was not signed out as being administered on 6/17 - 6/22/24. During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing was informed and had no additional information to provide. 2. The record for Resident C was reviewed on 6/25/24 at 3:51 p.m. Diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat), heart failure, stroke, hemiplegia (muscle weakness), major depressive disorder, and high blood pressure. The 4/24/24 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. The resident had a limitation in range of motion to one side for both upper and lower extremities. He had no unhealed pressure ulcers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no Care Plan for the resident's arterial ulcer on his toe. Nurses' Notes, dated 6/18/24 at 10:32 a.m., indicated the resident had a new wound on the left great toe that measured 1.5 centimeters (cm) by 1 cm. A new treatment order was obtained. Physician's Orders, dated 6/18/24, indicated Bacitracin (an antibiotic ointment) 500 grams. Apply to the left great toe topically one time a day for wound care. The treatment was discontinued on 6/19/24 at 9:38 a.m. A Physician's Order, dated 6/19/24, indicated to apply Skin Prep to the left foot toe two times a day and leave open to air. The Treatment Administration Record for the month of 6/2024, indicated the Skin Prep was first signed out on the evening shift on 6/19/24. The treatment was left blank and not done for the day shift on 6/20 and 6/21/24 and on 6/23/24 for the evening shift. There was no treatment signed out as being completed on 6/18/24. During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing indicated treatments were to completed as ordered. 3. During random observations on 6/24/24 at 10:36 a.m., 11:10 a.m., and 3:36 p.m., on 6/25/24 at 9:07 a.m., on 6/26/24 at 10:51 a.m., and on 6/27/24 at 4:40 a.m. and 6:34 a.m., Resident 45 was observed in bed. At those times, the resident was wearing geri sleeves to both arms, however, they were positioned down by her wrists and not completely covering her arms. The resident was wearing a short sleeved hospital gown during those times. On 6/28/24 at 10:35 a.m., the resident was observed with no geri sleeves on either hand or arm. The record for Resident 45 was reviewed on 6/26/24 at 9:13 a.m. Diagnoses included but were not limited to, vascular dementia, anxiety, anemia, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/27/24, indicated the resident was not cognitively intact for daily decision making. A Care Plan, revised on 6/25/24, indicated the resident was at risk for skin tears and bruising related to fragile skin. The approaches were to provide geri sleeves to bilateral arms as tolerated. The Medication and/or the Treatment Administration Record for 6/2024 indicated the geri sleeves were not monitored on either record. The CNA task section for geri sleeves to be worn at all times, indicated the sleeves were documented only 2 times a day on 5/28, 5/29, 5/30, 6/2, 6/3, 6/6, 6/8, 6/10, 6/16, 6/18, and 6/24/24. The geri sleeves were documented only 1 time a day on 6/14, 6/20, 6/21, and 6/23/24. During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing indicated the sleeves may be too loose for her small arms and they would try something else to protect her. 48383 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 6/24/24 at 11:33 a.m., Resident 329 indicated the staff changed her dressing on the first day back from the hospital and it had not been changed since. The resident did not have a dressing to the surgical wound on the left side of her head. On 6/25/24 at 9:31 a.m., 12:34 p.m., and 2:26 p.m., the resident was observed in her room. There was no dressing to the surgical wound on the left side of the resident's head. On 6/26/24 at 9:11 a.m., the resident was observed asleep in bed. There was no dressing to the surgical wound on the left side of the resident's head. On 6/26/24 at 11:00 a.m., the resident was observed sitting up in bed and watching television. There was no dressing to the surgical wound on the left side of her head. During an interview at the time, the resident indicated that she did not have a dressing to the surgical wound on her head and they had not offered to put one on after her first day back from the hospital. The record for Resident 329 was reviewed on 6/25/24 at 2:32 p.m. The diagnoses included, but were not limited to, diabetes, depression, insomnia (difficulty sleeping), anemia, and colon cancer. The Quarterly Minimum Data Set (MDS) assessment, dated 5/29/24, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 6/20/24, indicated to change the dry dressing to the surgical wound on the left side of the head daily and as needed for soiling. A Nurses' Note, dated 6/21/24, indicated the resident was receiving antibiotics for a head abscess. A Nurses' Note, dated 6/19/24, indicated weekly skin observations had been completed for the resident. A skin concern observed was a left side head abscess which was currently being treated. The June 2024 Treatment Administration Record (TAR), indicated the dressing to the surgical wound on the left side of the head was signed out daily on 6/21, 6/22, 6/23, 6/24, and 6/25/24. During an interview on 6/26/24 at 11:07 a.m., Assistant Director of Nursing 1 indicated the wound had been closed and the order should have been reconciled. During an interview on 6/26/24 at 11:11 a.m., the Director of Nursing indicated she understood the concern with the resident's wound treatment being signed out and not being completed. 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 10326 Based on observation, record review, and interview, the facility failed to ensure wound care treatments were completed as ordered and treatments were initiated in a timely manner for 2 of 5 residents reviewed for pressure ulcers. (Residents 123 and 45) Findings include: 1. On 6/27/24 at 4:35 a.m., LPN 1 was observed completing a wound care treatment for Resident 123. The LPN cleansed the wound to the sacrum with normal saline and then applied a dry dressing. The record for Resident 123 was reviewed on 6/25/24 at 2:40 p.m. The resident's diagnoses included, but were not limited to, history of stroke, acute kidney failure, and alcohol use with withdrawal delirium. The Admission Minimum Data Set (MDS) assessment, dated 5/2/24, indicated the resident was moderately impaired for daily decision making, dependent for bed mobility, and he was admitted with a Stage 2 (an open wound that occurs when the outer layer of skin or the deeper layer of skin is damaged, causing partial skin loss) pressure ulcer. A Care Plan, dated 5/24/24, indicated the resident had a potential for impaired skin integrity related to, decreased mobility, impaired mobility, incontinence, and nutritional status. The resident had a pressure injury to the sacrum and left outer ankle. Interventions included, but were not limited to, treatment as ordered. The Wound Physician Note, dated 6/25/24, indicated the wound to the sacrum was a Stage 4 (full thickness tissue loss that extends into deep tissues such as muscle, tendon, ligaments, cartilage, or bone) and measured 6 centimeters (cm) x 4.3 cm x 1 cm. A Physician's Order, dated 6/24/24, indicated the sacrum was to be cleansed with normal saline or wound cleanser, gently pat the periwound dry, apply Calcium Alginate (a wound treatment) to the wound bed and cover with a dry dressing daily and as needed (PRN) for soiling, saturation, or accidental displacement of the dressing. During an interview on 6/27/24 at 7:30 a.m., the Regional Nurse Consultant, indicated the LPN should have completed the resident's treatment as ordered. 2. During an observation on 6/28/24 at 10:35 a.m., the Corporate Wound Nurse was changing Resident 45's dressing to the coccyx area. The pressure ulcer was red and was noted to have yellow slough and black necrotic tissue. The record for Resident 45 was reviewed on 6/26/24 at 9:13 a.m. Diagnoses included but were not limited to, vascular dementia, anxiety, anemia, high blood pressure, abnormal weight loss, major depressive disorder, and dysphagia (difficulty swallowing). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 3/27/24, indicated the resident was not cognitively intact for daily decision making. The resident received at least 50% of her nutrition through a peg tube and had no pressure ulcers. A Care Plan, revised on 6/24/24, indicated the resident had a pressure ulcer to the sacrum. The approaches were to complete the treatment as ordered. A Wound Physician Note, dated 5/14/24, indicated the resident had a unstageable deep tissue injury (non-blanchable deep red, purple, or maroon areas of intact skin) that measured 1.5 centimeters (cm) by 2 cm. The skin was intact and the color was purple/maroon. The new treatment ordered was to apply Calcium Alginate over the wound, cover with a gauze island dressing three times a week. The Hydrocolloid was to be discontinued. Physician's Orders, dated 5/10/24, indicated cleanse the coccyx with normal saline, pat dry, and apply hydrocolloid dressing every Tuesday and Friday. The treatment was discontinued on 5/14/24. Physician's Orders, dated 5/14/24, indicated cleanse the coccyx with normal saline, pat dry, and cover with a foam dressing every Tuesday and Friday. The treatment was not discontinued until 5/24/24. Physician's Orders, dated 5/24/24, indicated cleanse the coccyx with normal saline, gently pat periwound dry, apply Calcium Alginate to wound bed and cover with bordered foam dressing three times a week on Monday, Wednesday, and Saturday. Wound Physician Notes, dated 5/28/24, indicated the pressure sore measured 2.5 cm by 1.7 cm and was now open with 30% slough and 70% skin. During an interview on 6/27/24 at 10:30 a.m., the Corporate Wound Nurse indicated the Calcium Alginate treatment was not initiated at the time of the Wound Physician recommendation on 5/14/24. 3.1-40(a)(2)

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	06/28/2024

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 10770 Based on observation, record review, and interview, the facility failed to ensure meal consumption logs were completed for a resident with a history of significant weight loss for 1 of 4 residents reviewed for nutrition. (Resident 83) Finding includes: During a random observation on 6/27/24 at 7:30 a.m., Resident 83 was observed eating breakfast in the dining room. The resident was served coffee, juice, milk, hot cereal, sausage links and french toast casserole. The record for Resident 83 was reviewed on 6/25/24 at 12:50 p.m. Diagnoses included, but were not limited to, dementia, stroke, anemia, and major depressive disorder. The 5/8/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. The resident needed set up assistance with eating and had no oral problems with swallowing. The resident weighed 143 pounds, had a significant weight loss, and received a therapeutic diet. A Care Plan, revised on 5/9/24, indicated the resident had a nutritional problem related to dementia. The resident weighed 152 pounds on 4/8/24 and 143 pounds on 5/7/24 which was a 5.92% weight loss in 1 month. Physician's Orders dated 9/20/23, listed as current on the June 2024 Physician's Order Summary, indicated the resident was to receive a no added salt regular diet. The meal consumption logs in the task section indicated there was no documentation of the breakfast meal on 6/18, 6/20, 6/21, 6/22, and 6/23/24. There was no documentation of the lunch meal on 5/29, 6/12, 6/18, 6/20, 6/21, 6/22, 6/23 and no documentation of the dinner meal on 5/28, 5/31, 6/5, 6/8,6/9, 6/10, 6/11, 6/12, 6/13, 6/14, 6/16, 6/17, 6/18, 6/20, 6/21, and 6/22/24. During an interview on 6/27/24 at 10:00 a.m., the Director of Nursing indicated food consumption was to be completed after every meal. 3.1-46(a)(1)

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 06/28/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Arbors Michigan City		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 a resident was positioned upright at least 45 degrees while an enteral feeding was infusing into a peg tube (a tube inserted directly into the stomach to provide nutrition) for 1 of 1 residents reviewed for tube feeding. (Resident 45) Finding includes: During a random observation on 6/26/24 at 10:51 a.m., Resident 45 was observed lying in bed with the head of the bed elevated. At that time, the enteral tube feeding was infusing at 52 milliliters (ml) per hour. CNA 1 was observed leaving the bathroom with a wash cloth in her hand. The CNA indicated she was going to change the resident's incontinent brief. The CNA raised the entire bed and then lowered the head of the bed all the way down until it was flat while the enteral feeding was still infusing. The CNA was asked to raise the head of the bed up immediately. During an interview at that time, CNA 1 indicated she would go and get the nurse to place the tube feeding on hold. She was aware the resident's head of the bed was not to be flat while the enteral feeding was infusing. The record for Resident 45 was reviewed on 6/26/24 at 9:13 a.m. Diagnoses included but were not limited to, vascular dementia, peg tube, anxiety, anemia, abnormal weight loss, major depressive disorder, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 3/27/24, indicated the resident was not cognitively intact for daily decision making. The resident received at least 50% of her nutrition through a peg tube. A Care Plan, revised on 3/28/24, indicated the resident needed a tube feeding related to dysphagia. The approaches were to elevate the head of the bed at least 30 degrees during feeding and the administration of any medication. Physician's Orders, dated 1/21/24, indicated the resident was to receive an enteral feed every 16 hours of Jevity 1.2 at 52 ml times 16 hours on at 10:00 p.m. and off at 2:00 p.m. During an interview on 6/26/24 at 11:00 a.m., the Director of Nursing indicated the resident's head of the bed should not have been lowered while the enteral tube feeding was infusing. The current and revised 8/3/20 Gastrostomy Tube-Feeding and Care policy, provided by the Nurse Consultant on 6/26/24 at 11:22 a.m., indicated position the resident with the head of the bed elevated at least 30 degrees. 3.1-44(a)(2)

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NAME OF PROVIDER OR SUPPLIER: Aperion Care Arbors Michigan City		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 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. 10770 Based on record review and interview, the facility failed to monitor a fluid restriction for a resident receiving hemodialysis for 1 of 1 residents reviewed for dialysis. (Resident 230) Finding includes: The record for Resident 230 was reviewed on 6/27/24 at 5:14 a.m. Diagnoses included, but were not limited to, renal dialysis, type 2 diabetes, high blood pressure, vascular dementia, anemia, and stroke. The 5/15/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. The resident received dialysis while a resident and was on a therapeutic diet. A Care Plan, revised on 1/18/22, indicated the resident received hemodialysis three times a week. The approaches were to monitor a 1200 cubic centimeters (cc) fluid restriction per nephrology and encourage compliance with her diet. Physician's Orders dated 6/19/23, listed as current on the June 2024 Physician's Order Summary (POS), indicated fluid restriction: 1200 milliliters (ml) total per 24 hours, as follows: dietary, 720 ml on meal trays, Nursing; 480 ml. If resident stayed within the fluid restriction answer Yes If resident did not stay within the allotted fluid restriction answer No and document in progress notes reasons and notifications every shift. The 5/2024 Medication Administration Record (MAR) indicated the following days were checked with a N and there was no documentation in the progress notes regarding reasons why or notifications: day shift: 5/13, 5/18, and 5/27/24 evening shift: 5/2, 5/3, 5/4, 5/6, 5/7, 5/13, 5/17, 5/18, 5/21, 5/27, 5/29 and 5/31/24 night shift: 5/1-5/3, 5/5-5/9, 5/12, 5/17, 5/23, 5/24, 5/26-5/28, 5/30 and 5/31/24 The 6/2024 MAR indicated the following days were checked with a N and there was no documentation in the progress notes regarding reasons why or notifications: day shift: 6/11/24 evening shift: 6/3, 6/4, 6/8, 6/9, 6/14, and 6/25/24 night shift: 6/3, 6/5, 6/8, 6/9, 6/12, and 6/21/24 During an interview on 6/28/24 at 11:15 a.m., the Director of Nursing indicated the physician's orders regarding the fluid restriction were to be followed as ordered. (continued on next page)

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 06/28/2024
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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	3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 10326 Based on record review and interview, the facility failed to ensure sliding scale insulin was administered as ordered and blood sugars were monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident 94) Finding includes: The record for Resident 94 was reviewed on 6/25/24 at 12:30 p.m. Diagnoses included, but were not limited to, type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, indicated the resident was cognitively intact and he had received insulin injections. A Care Plan, dated 5/20/23 and reviewed in 5/2024, indicated the resident had diabetes mellitus and was insulin dependent. Interventions included, but were not limited to, administer diabetes medication as ordered and monitor for side effects. A Physician's Order, dated 4/2/24, indicated the resident had the following sliding scale insulin orders: Humalog KwikPen 100 unit/milliliter (ml) Solution pen-injector inject as per sliding scale: If 70 - 149 = 0 units, call Physician if blood sugar was below 60. 150 - 200 = 1 unit, 201 - 250 = 2 units, 251 - 300 = 3 units, 301 - 350 = 4 units, 351 - 400 = 5 units. Call Physician if blood sugar was above 400. Administer before meals and at bedtime related to type 2 diabetes. The April 2024 Medication Administration Record (MAR), indicated the resident's sliding scale insulin administration and his glucometer results were not documented on the following dates and times: -4/3 at 4:00 p.m. and 9:00 p.m. -4/12 at 4:00 p.m. and 9:00 p.m. -4/16 at 7:30 a.m. -4/17 at 7:30 a.m. and 11:00 a.m. -4/18 at 9:00 p.m. -4/22 at 9:00 p.m. -4/24 at 7:30 a.m. and 11:00 a.m During an interview on 6/27/24 at 12:00 p.m., the Director of Nursing indicated the resident's blood sugars and sliding scale insulin administration should have been monitored as ordered. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48383 Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to monitoring food consumption and conflicting orders related to advance directives for 1 of 4 residents reviewed for nutrition and for 1 of 1 residents reviewed for death. (Residents 36 and 127) Findings include: 1. The record for Resident 36 was reviewed on [DATE] at 1:07 p.m. Diagnoses included, but were not limited to, Parkinson's, anxiety, dementia, depression, and hyperlipidemia (high cholesterol). The Annual Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was severely impaired for daily decision making and required substantial/maximum assistance with eating. A Care Plan, dated [DATE], indicated the resident was unable to consume regular consistency foods and required a mechanically altered diet. The resident was expected to have weight loss due to a terminal diagnosis. Interventions included, but were not limited to, monitor and record intake every shift and provide diet as ordered. A Care Plan, dated [DATE], indicated the resident had an unplanned/unexpected weight loss related to an acute illness. Interventions included, alert the dietician if consumption was poor for more than 48 hours and alert the nurse/dietician if the resident was not consuming supplements on a regular basis. The meal consumption intake logs for May and [DATE], indicated the following: -the breakfast meal was not documented on ,d+[DATE], ,d+[DATE], and [DATE] -the dinner meal was not documented on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE]. During an interview on [DATE] at 2:29 p.m., the Director of Nursing (DON) indicated she understood the concern with incomplete meal consumption logs for Resident 36. No additional information was provided. 2. The closed record for Resident 127 was reviewed on [DATE] at 6:52 a.m. Diagnoses included, but were not limited to, pneumonia, diabetes, respiratory failure, heart failure, sepsis, kidney disease, anemia, and hypertension (high blood pressure). The Admission Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact for daily decision making. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident expired at the facility on [DATE]. A Physician Order's, dated [DATE] at 12:32 a.m., indicated the resident was a full code. A Physician Order's, dated [DATE] at 11:38 p.m., indicated the resident was a Do Not Attempt Resuscitation (DNR). The Indiana Physician's Order for Scope of Treatment (POST) form, dated [DATE], was signed by Resident 127 and indicated the resident's code status was a Do Not Attempt Resuscitation/DNR. During an interview on [DATE] at 6:45 a.m., Assistant Director of Nursing 2 indicated the resident returned from the hospital on [DATE] and a new Physician's Order for Scope of Treatment (POST) form was filled out by the resident on [DATE] indicating his preference for a Do Not Attempt Resuscitation (DNR) status. The full code order was accidentally ordered. During an interview on [DATE] at 9:48 a.m., the Director of Nursing indicated that Resident 127's advance directive order should have been more clear. 3XXX,d+[DATE](a)(1) 3XXX,d+[DATE](a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 10326 Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place related to staff failing to remove personal protective equipment (PPE) prior to leaving a resident's room for a resident who was in enhanced barrier precautions during a random infection control observation. (Resident 123) Finding includes: During a random observation on 6/27/24 at 4:21 a.m., CNA 3 was observed performing incontinence care for Resident 123. The CNA donned a gown and gloves (PPE) when she entered the room due to the resident requiring enhanced barrier precautions (an infection control strategy that uses PPE to reduce the spread of multi-drug resistant organisms). LPN 1 entered the room at 4:22 a.m., she donned a gown and a pair of gloves. She proceeded to place the resident's tube feeding pump on hold. During incontinence care, the dressing to the resident's sacrum was observed to be soiled. At 4:31 a.m., the LPN left the resident's room to get wound care supplies. The LPN did not remove her gown or gloves. The LPN was observed at the treatment cart located next to the nurses' station. She was still wearing the same gown and gloves she had on while in the resident's room. The LPN proceeded back to the resident's room to complete the treatment to the resident's sacrum. After removing the resident's dressing, she removed her gloves and donned a new pair. She did not change gowns when she returned to the resident's room. During an interview on 6/27/24 at 7:30 a.m., the Regional Nurse Consultant indicated the LPN should have removed her gown and gloves prior to leaving the resident's room and PPE was not to be worn in the hallway. 3.1-18(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 10326 Based on observation and interview, the facility failed to maintain comfortable and safe temperature levels for 7 of 14 residents who dined in the main dining room during a random observation. Finding includes: On 6/26/24 at 11:53 a.m., food temperatures from the steam table in the main dining room were being checked with the Assistant Dietary Food Manager. The ambient air temperature was cool and several residents were observed wrapped up in blankets and/or wearing coats while they were waiting for their meal. The thermostat on the wall registered 68 degrees Fahrenheit. The Director of Maintenance was asked to check the temperature in the main dining room. The temperature registered 70 degrees Fahrenheit at the entrance to the dining room. Approximately 5 feet into the dining room, where the residents were seated, the Maintenance Director's thermometer registered 68 degrees Fahrenheit. After proceeding an additional 5 feet into the dining room, the thermometer registered 65 degrees Fahrenheit. At the back of the dining room, the thermometer registered 63 degrees Fahrenheit. During an interview on 6/26/24 at 11:55 a.m., seven of the residents in the dining room indicated they were cold. During an interview on 6/26/24 at 11:59 a.m., the Director of Maintenance indicated he would adjust the temperature in the dining room. He further indicated the temperature should be around 70-71 degrees and he would check the temperature in the dining room at least every 2 hours. 3.1-19(h)