STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. Building B. Wing	12/13/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 10326 Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to wearing a hospital gown while in bed during the day and a personal care sign posted above the bed for 2 of 4 residents reviewed for dignity. (Residents P and F) Findings include: 1. On 12/9/24 at 10:07 a.m. and 2:00 p.m., Resident P was observed in her room in bed. The resident was wearing a hospital gown at the time. On 12/10/24 at 9:23 a.m., 2:15 p.m. and 3:20 p.m., Resident P was in bed wearing a hospital gown. There was also a sign posted above the head of the resident's bed which indicated the pads were to be removed from the resident's hipsters (hip protectors) prior to them being sent down to laundry and the pads were to be put in the resident's drawer. On 12/11/24 at 9:43 a.m., 10:25 a.m., 1:35 p.m. and 3:15 p.m., the sign remained above the resident's bed. On 12/12/24 at 8:58 a.m., 11:55 a.m. and 2:00 p.m., the sign remained above the resident's bed. The record for Resident P was reviewed on 12/12/24 at 2:11 p.m. Diagnoses included, but were not limited to, pressure ulcer of the sacral region, major depressive disorder, and dementia without behavior disturbance. The Significant Change Minimum Data Set (MDS) assessment, dated 11/1/24, indicated the resident was cognitively impaired for daily decision making. She required substantial/maximum assistance for upper body dressing and she was dependent on staff for lower body dressing. A Care Plan, dated 8/6/24 and reviewed on 11/1/24, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to impaired balance, limited mobility, chronic obstructive pulmonary disease (COPD), and confusion. Interventions included, but were not limited to, the resident required 1-2 staff assistance as needed for dressing. There was no care plan related to wearing a hospital gown during the day while in bed and there was no care plan related to signs being posted above the resident's bed. (continued on next page)

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

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 12/13/2024
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/24 at 3:15 p.m., the Director of Nursing indicated the resident should have been dressed and her care plan updated. The sign above the bed should have been removed. 10770 2. During random observations on 12/9/24 at 10:00 a.m. and 1:56 p.m., on 12/10 at 9:05 a.m., and on 12/11 at 9:00 a.m., 11:30 a.m., 1:05 p.m. and 2:50 p.m., Resident F was observed in bed wearing a hospital gown. The record for Resident F was reviewed on 12/11/24 at 11:55 a.m. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes, major depressive disorder, atrial fibrillation, cardiac pacemaker, heart disease, anemia, depression, high blood pressure, and dementia without behaviors. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making, needed substantial to max assist for personal hygiene and partial assistance for upper body dressing. There was no care plan indicating the resident preferred to wear a hospital gown during the day time. During an interview on 12/11/24 at 1:05 p.m., CNA 5 indicated the resident had very limited clothing, which were obtained from the social service department. The CNA opened the resident's closet and there were four shirts inside. During an interview on 12/11/24 at 2:30 p.m., the Director of Nursing indicated she was unaware the resident was not dressed in regular clothing every day. She did not have a care plan for preferences on how she wanted to be dressed during the day. 3.1-3(t)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 43293 Based on observation, record review and interview, the facility failed to ensure a resident's right to participate in his care related to not being able to receive medications during their scheduled time window for 1 of 8 residents observed for medication administration. (Resident L) Finding includes: During medication administration on 12/11/24 at 8:57 a.m., LPN 3 prepared the following medications for Resident L after a staff member indicated the resident was outside smoking: Amlodipine Besylate 10 milligrams (mg) (a blood pressure pill), Furosemide 40 mg (a water pill), Losartan Potassium-HCTZ 100-25 mg (a blood pressure pill), Aspirin 81 mg, Flomax 0.4 mg (a prostate medication), Metformin 500 mg (a blood sugar pill), Sertraline HCl 100 mg (an anti-depressant), Trelegy Ellipta (an inhaler), Metoprolol Tartrate 50 mg (a blood pressure pill), and Potassium Chloride 10 milliequivalents (meq). The LPN took the medication to the door to the outside smoking area and called out to the resident that she had his pills for him. The resident indicated he had just started smoking. The LPN disposed of the cup of pills and reported to the Nurse Practitioner the resident had refused his morning medications. During an interview on 12/11/24 at 8:59 a.m., LPN 3 indicated she would normally ask the resident if he wanted his medications after smoking. Resident L's record was reviewed on 12/11/24 at 1:47 p.m. Diagnoses included, but were not limited to, high blood pressure, alcohol use, heart failure, COPD (Chronic Obstructive Pulmonary Disease) and tobacco use. The 12/2024 Medication Administration Record (MAR) indicated the resident refused his morning medications on 12/11/24, and lacked evidence the nurse attempted to administer medications after the smoking time. During an interview on 12/12/24 at 10:58 a.m., the resident indicated the nurse would normally bring his morning medications before or after smoking time, which was his preference. During an interview on 12/11/24 at 11:05 a.m., the Director of Nursing (DON) indicated the residents received minimal time to smoke, it was important to them, and the nurse should have offered the medications before or after the designated smoking time. This citation relates to Complaint IN00442238. 3.1-3(n)(2)(3)

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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. 32664 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications and had Physician's Orders for the medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 60) Finding includes: On 12/9/24 at 10:18 a.m. and 1:45 p.m., Resident 60 was observed in her room. There was a package of Gas-X (medication to relieve symptoms of extra gas), Systane eye drops (lubricating eye drops), and a bottle of Jet-Alert pills (caffeine pills) on a shelving unit across from the resident's bed. The resident indicated she used the Systane eye drops and would only use the Gas-X as needed. On 12/10/24 at 9:03 a.m., and again at 2:01 p.m., the medications were still observed on the resident's shelving unit across from her bed. Record review for Resident 60 was completed on 12/10/24 at 2:16 p.m. Diagnoses included, but were not limited to, diabetes mellitus, depression, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 12/2/24, indicated the resident was cognitively intact. A Medications Self-Administration Assessment, dated 6/20/23, indicated the resident was unable to safely self-administer her medications. The record lacked any indication there were Physician's Orders for the above medications or a recent medication self-administration assessment completed for the resident to self administer her medications without supervision. During an interview on 12/10/24 at 2:30 p.m., the 200 Unit Assistant Director of Nursing (ADON) was made aware of the resident's medications in her room. She indicated she was unaware of the medications and would have to look into it. On 12/10/24 at 3:00 p.m., the 200 Unit ADON indicated the resident had gone to see an eye doctor two weeks ago and was given the eye drops. There were no Physician's Orders for the medications observed or a self-administration assessment completed. A policy titled, Self-Administration Of Medication, and received as current from Nurse Consultant 1 on 12/13/24, indicated, .1. A resident may not be permitted to administer or retain any medications in his/her room unless so ordered, in writing, by the attending physician .2 c. A self-administration of medications assessment will be completed that includes that the resident is capable of self-administering drugs . 3.1-11(a)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48383 Based on record review and interview, the facility failed to file a grievance form, thoroughly investigate, and resolve grievances for missing personal items that were reported to staff for 1 of 1 resident reviewed for grievances. (Resident S) Finding includes: During an interview on 12/9/24 at 11:46 a.m., Resident S indicated she had lost two cell phones and the first missing phone was reported to staff at the nurses' station. The second phone was not yet reported. The record for Resident S was reviewed on 12/12/24 at 11:55 a.m. Diagnoses included but were not limited to, anxiety, respiratory failure, kidney disease and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 12/12/24, indicated the resident was cognitively intact for daily decision making. There was no grievance/concern form filed for the resident's first missing cell phone. A Grievance/Concern form, dated 12/10/24 was filed for the resident's second missing cell phone. During an interview on 12/10/24 at 9:33 a.m., the 300 Unit Assistant Director of Nursing (ADON) indicated she was aware the resident was missing the first phone, but was not aware the second phone was missing. She was unsure if a grievance was filed for the first missing phone. During an interview on 12/10/24 at 2:21 p.m., the 300 Unit ADON indicated she followed up with the resident and she now had a second missing phone. A grievance/concern form was filed with social services. During an interview on 12/10/24 at 2:38 p.m., the Director of Social Services (DSS) indicated she had just received a grievance/concern form for a missing phone today. This was the first grievance/concern form she had received for the resident's missing phones. During an interview on 12/12/24 at 2:48 p.m., Nurse Consultant 1 indicated a grievance/concern form should have been filed for the resident's first missing phone. 3.1-7(a)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48383 Based on record review and interview, the facility failed to ensure a resident was invited to attend and participate in care planning conferences for 1 of 4 residents reviewed for participation in care planning. (Resident U) Finding includes: During an interview on 12/9/24 at 2:57 p.m., Resident U indicated they had not attended a care plan meeting. The record for Resident U was reviewed on 12/12/24 at 8:52 p.m. Diagnoses included, but were not limited to, kidney disease, asthma, respiratory failure, depression, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/18/24, indicated the resident was cognitively intact for daily decision making. A Care Plan Progress Note, dated 10/28/24 at 4:08 p.m., indicated the Director of Social Services met with the resident's son to discuss the resident's quarterly assessment. There was no documentation the resident attended the care conference. There was no documentation the resident was invited to attend a care conference. During an interview on 12/12/24 at 11:25 a.m., the Director of Social Services indicated the resident was not invited to the 10/28/24 care plan conference. During an interview on 12/12/24 at 2:33 p.m., the Director of Nursing (DON) indicated the resident should have been invited to attend their care plan meeting. 3.1-35(d)(2)(B)

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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 ensure activities of daily living (ADLs) were completed for dependent residents related to greasy hair, incontinence care, providing assistance in getting out of bed, facial hair, dirty fingernails, assistance with turning and repositioning, and assistance with dressing for 7 of 9 residents reviewed for ADLs. (Residents Q, P, G, C, F, H, and R) Findings include: 1. On 12/9/24 at 10:07 a.m. and 1:51 p.m., Resident Q was observed ambulating in the hallway. His hair was in need of brushing and was greasy in appearance. At 3:11 p.m., the resident continued to ambulate up and down the hallway. His hair remained disheveled and greasy. The resident was also noted to have a strong urine odor. At 3:20 p.m., LPN 2 and CNA 2 took the resident to his room for incontinence care. The resident's incontinence brief was saturated with urine and had already started to fall down his legs. On 12/10/24 at 9:02 a.m., 2:03 p.m. and 3:15 p.m., the resident's hair remained in need of brushing and was greasy in appearance. On 12/11/24 at 11:16 a.m., the resident's hair was in need of brushing but it was clean in appearance. The record for Resident Q was reviewed on 12/10/24 at 2:17 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, Parkinson's disease, anxiety disorder, psychotic disorder with hallucinations, and history of falling. The Quarterly Minimum Data Set (MDS) assessment, dated 10/31/24, indicated the resident was cognitively impaired for daily decision making. He required substantial/maximum assistance with bathing, personal hygiene, and toileting hygiene. A Care Plan, dated 5/17/23 and reviewed on 10/31/24, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to confusion, impaired balance, limited mobility, and dementia. Interventions included, but were not limited to, one staff assistance for bathing and showering and one to two staff assistance with toilet use. The Shower Sheets for December 2024 indicated the resident refused his shower on 12/4/24 and 12/11/24. The resident received a shower and shampoo on 12/7/24. During an interview on 12/12/24 at 12:13 p.m., the resident's sister indicated she thought he could be cleaner. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/24 at 3:15 p.m., the Director of Nursing indicated the resident should have been assisted with incontinence care in a more timely manner and his hair shouldn't have looked greasy if it was washed on 12/7/24. 2. On 12/9/24 at 10:07 a.m. and 2:00 p.m., Resident P was observed in her room in bed. The resident's wheelchair was next to the bed. On 12/10/24 at 9:23 a.m., 2:15 p.m. and 3:20 p.m., Resident P was again observed in bed. The resident's wheelchair was next to the bed. On 12/11/24 at 9:43 a.m., 10:25 a.m., 1:35 p.m. and 3:15 p.m., the resident remained in bed and the wheelchair was present in the room. On 12/12/24 at 8:58 a.m., 11:55 a.m. and 2:00 p.m., the resident remained in bed and the wheelchair remained in the room. The record for Resident P was reviewed on 12/12/24 at 2:11 p.m. Diagnoses included, but were not limited to, pressure ulcer of the sacral region, major depressive disorder, and dementia without behavior disturbance. The Significant Change Minimum Data Set (MDS) assessment, dated 11/1/24, indicated the resident was cognitively impaired for daily decision making. She required substantial to maximum assistance with bed to chair transfers. A Care Plan, dated 8/6/24 and reviewed on 11/1/24, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to impaired balance, limited mobility, chronic obstructive pulmonary disease (COPD), and confusion. Interventions included, but were not limited to, the resident required one to two staff assistance as needed for transfers. During an interview on 12/12/24 at 3:15 p.m., the Director of Nursing indicated the resident had not been assisted out of bed all week and an attempt should have been made to get her out of bed. 10770 3. During random observations on 12/09/24 at 10:31 a.m. and 2:09 p.m., on 12/10/24 at 8:58 a.m. and 2:03 p.m., and on 12/11/24 at 9:03 a.m. and 11:35 a.m., Resident G was observed with dirty fingernails to both hands. On 12/11/24 at 1:00 p.m., the resident was observed in bed with a dried orange substance on her face as well as the dirty fingernails. CNA 9 was observed in the resident's room and was shown the fingernails and the dried substance on her face. During an interview at that time, CNA 9 indicated she was not taking care of the resident that day, nor did she lay the resident down after lunch. The resident had orange sherbet for lunch. The record for Resident G was reviewed on 12/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, type 2 diabetes, anxiety, stroke, vascular dementia, high blood pressure, rheumatoid arthritis, major depressive disorder, and osteoarthritis. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/18/24 Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had an impairment to one side of her upper and lower extremities for functional limitation of range of motion and was dependent on staff for personal hygiene. A Care Plan, revised on 9/20/24, indicated the resident had and ADL self care deficit related a stroke. The approaches were to provide assistance as needed for personal hygiene. There was no care plan the resident refused care. The resident had no documented behaviors of refusal or resisting care. The resident had a shower on 11/29, 12/3, 12/6 and 12/10/24. During an interview on 12/11/24 at 1:00 p.m., CNA 9 indicated the resident's nails and face were dirty and in need of cleaning. During an interview on 12/12/24 at 8:40 a.m., the Director of Nursing indicated the resident's nails should have been trimmed as needed. There was no care plan the resident refused care. 4. During random observations on 12/09/24 at 10:41 a.m. and 2:40 p.m., and on 12/10/24 at 9:20 a.m. and 2:02 p.m., Resident C was observed in bed. At those times, the resident's right hand was closed in the shape of a fist. The resident's fingernails on her right hand were long and digging into the palm of the hand. On 12/10/24 at 3:00 p.m., LPN 6 was in the resident's room and had observed the long fingernails digging into the palm of the right hand. During an interview at that time, LPN 6 indicated the resident's nails were in need of being trimmed. The record for Resident C was reviewed on 12/10/24 at 2:05 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis or weakness) right side, stroke, high blood pressure, anemia, and peg tube (a tube inserted directly into the stomach for nutrition). The 11/1/24 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had a range of motion impairment to one side, and was dependent on staff for personal hygiene. A Care Plan, revised on 11/12/24, indicated the resident had an ADL self care deficit related to a stroke. There was no care plan indicating the resident refused care having her nails trimmed or filed. During an interview on 12/11/24 at 1:19 p.m., the Director of Nursing indicated she had told the nursing staff to put a note in the chart if the resident refused to have her nails filed or trimmed. The resident's fingernails were to be trimmed or filed as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During random observations on 12/9/24 at 10:00 a.m., 12/9/24 at 1:56 p.m., 12/10 at 9:05 a.m., and 12/11 at 9:00 a.m., 11:30 a.m. and 1:05 p.m., Resident F was observed in bed wearing a hospital gown. At those times, she had a large amount of long facial hair under her chin. The record for Resident F was reviewed on 12/11/24 at 11:55 a.m. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes, major depressive disorder, atrial fibrillation, cardiac pacemaker, heart disease, anemia, depression, high blood pressure, and dementia without behaviors. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed substantial to max assist for personal hygiene and partial assistance for upper body dressing. A Care Plan, revised on 3/18/24, indicated the resident had an ADL self care deficit. There was no care plan the resident preferred to have facial hair or refused to be shaved. During an interview on 12/11/24 at 1:05 p.m., CNA 9 indicated they have asked the resident if they could shave her and she had told them no in the past because it will grow back thicker. During an interview on 12/11/24 at 2:30 p.m., the Director of Nursing indicated she was unaware the resident did not have a care plan for refusing to be shaved or a preference of long facial hair. 43293 6. On 12/11/23 at 2:03 p.m., CNA 3 was observed giving Resident H a bed bath without assistance. The resident was unable to move his arms or legs to assist with turning. When CNA 3 turned the resident to his side, the resident's face hit the arm of his air puff call light (a call system triggered by the user blowing on or into the device). The record for Resident H was reviewed on 12/11/24 at 3:27 p.m. Diagnoses included, but were not limited to, quadriplegia, urinary tract infection, pressure ulcer of sacrum stage 4, gastrostomy status (a feeding tube inserted through the abdomen into the stomach), dysphagia (difficulty swallowing), and neuromuscular dysfunction of bladder. The 11/6/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and totally dependent in activities of daily living. A Care Plan, revised on 9/26/24, indicated the resident had an ADL self-care performance deficit related to impaired balance, limited mobility, weakness, and quadriplegia. A Care Plan, dated 4/10/24, indicated staff was to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. During an interview on 12/11/24 at 2:30 p.m., CNA 3 indicated she normally had someone assist her with the resident's bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/24 at 3:38 p.m., the Director of Nursing was informed of the findings and offered no further information. 48383 7. On 12/10/24 at 2:16 p.m. and 3:11 p.m., Resident R was observed wearing a dirty shirt with food stains and debris on it and there was dried blood underneath the nail beds. On 12/11/24 at 9:22 a.m., 10:09 a.m. and 1:14 p.m., the resident was observed wearing the same dirty and stained shirt as the day before and had dried food on their face. On 12/12/24 at 1:28 p.m., the resident was observed wearing the same stained and dirty shirt that they had been wearing since 12/10/24. The resident's hair was greasy and matted to her head. On 12/13/24 at 9:59 a.m., the resident was observed sitting on the side of the bed. Their hair was dirty and greasy in appearance and they wore the same stained dirty shirt that they had on since 12/10/24. The resident indicated she requested a shower that morning and had not had one yet. Resident R's record was reviewed on 12/10/24 at 3:14 p.m. The diagnoses included, but were not limited to, dementia, chronic pain, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 10/24/24, indicated the resident was cognitively intact for daily decision making. The resident required one person assistance with dressing and 1-2 person assistance with showers and bathing. A Care Plan, dated 10/23/24, indicated the resident had an activities of daily living (ADL) self care performance deficit related to impaired mobility. Interventions were to assist with shower/bathing, dressing, bed mobility, transfer and toilet use. There were no care plans or documentation the resident refused care. During an interview on 12/12/24 at 3:39 p.m., the Director of Nursing (DON) indicated she understood the concern and indicated the resident would be changed and showered immediately. During an interview on 12/13/24 at 9:57 a.m., CNA 4 indicated she did not document the change of the resident's pants on Wednesday and the resident's refusal to change their shirt. During an interview on 12/13/24 at 11:00 a.m., Nurse Consultant 1 indicated the resident refused a shower and refused to change her clothes on 12/12/24. The refusals were not documented. This citation relates to Complaint IN00446198. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. Building B. Wing	12/13/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-38(a)(3)(E)

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 12/13/2024
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure treatments were completed as ordered and bruises were assessed and monitored for 4 of 4 residents reviewed for non-pressure related skin conditions, medications were signed out as ordered for 2 of 5 residents reviewed for unnecessary medications, signs and symptoms of constipation were addressed for 2 of 2 residents reviewed for constipation, and assessments were documented prior to being discharged to the hospital for 1 of 1 resident reviewed for hospitalization . (Residents Q, G, F, D, B, M, N, and R) Findings include: 1. On 12/9/24 at 3:11 p.m., Resident Q was observed ambulating up and down the hall. At 3:20 p.m., LPN 2 and CNA 2 took the resident to his room for incontinence care. As the resident's pants were pulled down, a scabbed area was observed below the right knee and a reddish/purple area of discoloration was observed to the right lower shin. On 12/10/24 at 3:15 p.m., the resident was ambulating on the unit. He had no sock on his right foot and his right pant leg was raised. The discoloration remained to the right lower shin area and there was no dressing to the scratch below the right knee. On 12/12/24 at 10:45 a.m., LPN 4 entered the resident's room. She was trying to get the resident to put his pants on. The LPN was shown the area below the right knee and was told there was no dressing in place. The LPN was also shown the area of discoloration to the right lower shin area. During an interview at that time, the LPN indicated the area below the knee looked scabbed over and maybe the treatment was discontinued. She also indicated the area of discoloration to the lower right shin could have been from a previous fall. The record for Resident Q was reviewed on 12/10/24 at 2:17 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, Parkinson's disease, anxiety disorder, psychotic disorder with hallucinations, and history of falling. The Quarterly Minimum Data Set (MDS) assessment, dated 10/31/24, indicated the resident was cognitively impaired for daily decision making. The resident had one fall with no injury since the last assessment and no skin issues. A Care Plan, dated 5/9/24 and reviewed on 10/31/24, indicated the resident had a potential for impairment to his skin integrity related to aging, the disease process, fragile skin, impaired mobility, and incontinence. Interventions included, but were not limited to, assess and record changes in skin status and report pertinent changes in skin status to the physician. A Physician's Order, dated 12/1/24, indicated to cleanse the skin tear to the right anterior lower leg below the knee with normal saline, pat dry, and apply Xerofoam (a type of dressing) gauze, and then a dry dressing in the evening every Monday, Wednesday, and Friday for a skin tear and change when compromised as needed (PRN). (continued on next page)

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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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/2024 Treatment Administration Record (TAR) indicated the treatment was signed out as being completed on 12/9/24 and 12/11/24. There was no assessment of the discoloration to the right lower shin and no orders to monitor the area. The 12/2024 Medication Administration Record (MAR), indicated the resident was to receive Trazodone (an antidepressant) 75 milligrams (mg) at bedtime, Zyprexa (an antipsychotic) 10 mg at bedtime, Namenda (a dementia medication) 10 mg at 7:00 p.m., Rifaximin (a medication to treat irritable bowel syndrome) 550 mg at 4:00 p.m., and Lactulose (a laxative) 1 gram at 4:00 p.m. and 8:00 p.m. The following medications were not signed out as being administered: -12/5/24 Trazodone at 8:00 p.m. -12/5/24 Zyprexa at 7:00 p.m. -12/5/24 Namenda at 7:00 p.m. -12/5/24 Rifaximin at 4:00 p.m. -12/5/24 Lactulose at 8:00 p.m. - 12/10/24 Lactulose at 4:00 p.m. and 8:00 p.m. During an interview on 12/12/24 at 3:15 p.m., the Director of Nursing indicated the treatment below the right knee should have been in place since the treatment was signed out, and she would clarify the order. She indicated she would observe the area to the resident's right lower shin and the medications should have been given as ordered. 10770 2. The record for Resident G was reviewed on 12/10/24 at 3:30 p.m. Diagnoses included, but were not limited to, Parkinson's disease, type 2 diabetes, anxiety, stroke, vascular dementia, high blood pressure, rheumatoid arthritis, major depressive disorder, and osteoarthritis. The 9/18/24 Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had no constipation, was always incontinent of bowel, and was not on a bowel program. A Care Plan, revised on 9/20/24, indicated the resident was at risk for pain related to the diagnoses of rheumatoid arthritis and osteoarthritis. The approaches were monitor for side effects such as constipation. A Care Plan, revised on 9/20/24, indicated the resident had the potential for constipation related to decreased safety awareness and vascular dementia. The approaches were to administer the as needed (prn) laxative as ordered, assess for signs and symptoms of constipation, and initiate the facility's bowel protocol after two days without a bowel movement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 3/13/23 and on the current 12/2024 Physician Order Summary, indicated DOK (Docusate Sodium) (a stool softener) tablet 100 milligrams (mg), give 1 tablet by mouth two times a day for constipation. A Physician's Order, dated 5/4/23 and on the current 12/2024 Physician Order Summary, indicated Hydromorphone HCl (an opioid medication) oral liquid 1 mg/ml (milliliters), give 0.5 ml by mouth every two hours as needed for pain. A Physician's Order, dated 3/14/24 and on the current 12/2024 Physician Order Summary, indicated Ferrous Sulfate (iron medication) Elixir 220, give 7.5 ml by mouth one time a day for supplementation. There were no prn medications ordered for constipation. The 11/2024 Medication Administration Record (MAR) indicated the resident received the Hydromorphone on 11/6, 11/10, 11/12, 11/16 and 11/27/24. The 12/2024 MAR indicated the resident received the Hydromorphone on 12/1 and 12/7/24. The bowel movement (bm) record indicated no bm was recorded on the following days: -10/28-10/31, 11/9-11/13, 11/20-11/22, and 11/25-11/28/24. During an interview on 12/12/24 at 3:00 p.m., the Director of Nursing indicated the resident had gone longer than three days without a bowel movement. It was the facility's policy to check or initiate the bowel protocol after two days without a bm. 3. During random observations on 12/9/24 at 10:00 a.m., 12/9/24 at 1:56 p.m., 12/10 at 9:05 a.m., and on 12/11 at 9:00 a.m., 11:30 a.m. and 1:05 p.m., Resident F was observed in bed wearing a hospital gown. At those times, there were red and purple bruises observed to her left forearm and the back of her left hand. On 12/11/24 at 2:50 p.m., RN 3 was observed in the resident's room. At that time, the multiple bruised areas were observed. During an interview at that time, RN 3 indicated she was not made aware of any bruised areas during shift report. She had worked with the resident last week and was aware she had a bruise to her right arm, but none to the left arm. She indicated the protocol was to assess the bruises, measure them, notify the wound nurse, the NP (Nurse Practitioner), and to get orders to monitor them. The record for Resident F was reviewed on 12/11/24 at 11:55 a.m. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes, major depressive disorder, atrial fibrillation, cardiac pacemaker, heart disease, anemia, depression, high blood pressure, and dementia without behaviors. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident had no skin issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, revised on 3/18/24, indicated the resident received an anticoagulant medication related to atrial fibrillation. The approaches were to monitor for adverse reactions such as bruising. A Physician's Order, dated 11/10/24, indicated Eliquis (an anticoagulant medication) tablet 2.5 milligrams (mg), give one tablet by mouth every 12 hours. The Weekly Skin Observation Assessments, dated 11/26 and 12/5/24, indicated the resident had no skin issues. There was no documentation in nursing notes from 12/1-12/11/24/24 regarding any bruised areas to the left arm or hand. During an interview on 12/11/24 at 2:55 p.m., the 200 Unit Assistant Director of Nursing was unaware the resident had any bruising to the left arm and the back of the left hand. During an interview on 12/11/24 at 3:09 p.m., the Director of Nursing (DON) indicated the bruise was probably from a lab draw, but they did not specify where they drew the blood. During an interview on 12/12/24 at 8:40 a.m., the DON indicated the resident had two blood draws in the last week on 12/5 and 12/9/24, and that was the cause of the bruises. 4. The closed record for Resident D was reviewed on 12/11/24 at 10:44 a.m. The resident was admitted on [DATE] and discharged to the hospital on 8/11/24. The resident returned on 9/24/24 and was discharged to the hospital on 10/5/24. The resident returned on 10/7/24 and was discharged to the hospital on 11/4/24. The resident returned on 11/9/24 and then was discharged again on 12/5/24. Diagnoses included, but were not limited to, epilepsy, high blood pressure, dysphagia (difficulty swallowing), gastritis, peg tube (a tube inserted directly into the stomach for nutrition), and stroke. The 11/15/24 Quarterly MDS assessment indicated the resident was not cognitively intact for daily decision making and had a peg tube for nutrition. A 12/5/24 census review indicated the resident was currently admitted to the hospital. There was no documentation in the nursing progress notes of an assessment, the condition of the resident, why the resident was sent out to the hospital, and the time the resident left the faciity on [DATE]. An emergency room note, dated 12/5/24, indicated the patient arrived to the ER at 11:29 p.m. via ambulance. EMS indicated there were clots of blood coming out of the patient's mouth when he was coughing. They were unsure if the patient was on blood thinners. The patient presented to the ER with complaints of a fever, hemoptysis (coughing up blood or bloody mucus from the lungs or throat), tachycardia (high heart rate), and tachypnea (rapid or shallow breathing). He appeared ill and was nonverbal, with dried blood around the right side his mouth and on his gown. The resident's ER diagnoses included upper gastrointestinal bleed, gastritis and blood loss. The resident was admitted to the hospital on 12/6/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/24 at 1:20 p.m., the Director of Nursing (DON) indicated there was no documentation in the resident's record regarding the most recent hospitalization . During an interview on 12/12/24 at 8:40 a.m., the DON indicated she could find no documentation of what happened to the resident and why he was sent out on 12/5/24 except from the ER notes. There was no documentation of any family or physician notification. The revised and current 5/8/23 Notice of Transfer and Discharge policy, provided by the DON on 12/13/24 at 8:40 a.m., indicated, when the facility transferred or discharged a resident under any circumstances, the facility must ensure the transfer or discharge was documented in the resident's medical record. Documentation in the resident's medical record must include the reason for transfer. 5. The closed record for Resident B was reviewed on 12/11/24 4:13 p.m. The resident was admitted to the facility on [DATE] and discharged home on 11/26/24. Diagnoses included, but were not limited to, hyperactivity disorder, seizures, nicotine dependence, bipolar disorder, and chronic pain. The Admission Minimum Data Set (MDS) assessment, dated 9/30/24, indicated the resident was cognitively intact for daily decision making and received an opioid medication in the last seven days. Physician's Orders indicated the following medication orders: - 9/25/24 Metoclopramide (a medication used to treat slow stomach emptying) HCl tablet 5 milligrams (mg), give one tablet by mouth two times a day. The 10/2024 Medication Administration Record (MAR) indicated the Metoclopramide was not signed out as being administered on 10/3, 10/20, 10/28, 10/30 and 10/31/24 at 5:45 a.m. - 9/25/24 Adderall (a medication used to treat attention deficit disorder) tablet 30 mg, give one tablet by mouth two times a day. The 10/2024 and 11/2024 MAR indicated the Adderall was not signed out as being administered on 10/7 at 8:00 a.m., and 10/29/24 at 4:00 p.m. A 9 (other see progress notes) was coded for the 4:00 p.m., dose on 11/5, 11/9, 11/24 and 11/25/24. A 9 was coded for the 8:00 a.m. dose on 11/24 and 11/25/24. The controlled drug administration record indicated the Adderall was not signed out on 10/7/24. A total of 14 tablets arrived on 11/11/24 and the last documented sign out on the sheet was on 11/24/24 at 7:15 a.m. - 9/25/24 Gabapentin (a medication used to treat nerve pain) Capsule 300 mg, give three capsules by mouth three times a day. The 10/2024 MAR indicated the Gabapentin was not signed as being administered on 10/7/24 at 9:00 a.m., and 10/29/24 at 9:00 p.m. - 9/25/24 Famotidine (a medication used to treat stomach ulcers) 20 mg, give one tablet by mouth two times a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/2024 and 11/2024 MAR indicated the Famotidine was not signed out as being administered on 10/3, 10/20, 10/28, 10/30, 10/31/24 at 5:45 a.m. and on 11/5/24 at 5:45 a.m. A 9 was coded on 11/5 and 11/9/24 at 4:30 p.m. -10/10/24 Cyclobenzaprine (a medication used to relax muscles) HCl tablet 5 mg at bed time. The 11/2024 MAR indicated a 9 was coded on 11/9 at 9:00 p.m. and on 11/10/24 at 9:00 p.m. for the Cyclobenzaprine. -11/6/24 Pregabalin (a medication used to treat nerve pain) Capsule 150 mg, give one capsule by mouth three times a day. The 11/2024 MAR indicated a 9 was coded on 11/9 at 3:00 p.m. and on 11/10/24 at 7:00 p.m. for the Pregabalin. During an interview on 12/13/24 at 3:00 p.m., the Director of Nursing indicated the resident's Adderall was not ordered because the Nurse Practitioner (NP) did not feel comfortable ordering the medication as she was also asking her own physician for the medication to be ordered. They did speak with the pharmacy and have added more medications to their Pyxis machine. The resident did not receive the medications timely as ordered by the physician. 32664 6. Record review for Resident M was completed on 12/11/24 at 1:16 p.m. Diagnoses included, but were not limited to, cancer, Alzheimer's, dementia, anxiety, depression, and psychotic disorder. The Quarterly MDS assessment, dated 9/18/24, indicated the resident was cognitively impaired. The resident required maximal assistance for toileting and was frequently incontinent of bowel. The resident had scheduled and prn (when necessary) pain medications. A Care Plan, dated 5/3/21 and revised 3/24/22, indicated the resident was at risk for impaired fluid balance. An intervention included to monitor bowel movements, check for abnormalities such as diarrhea or indications of impaction. A Care Plan, dated 5/13/21 and revised 12/29/21, indicated the resident was at risk for constipation related to decreased mobility and medication use. An intervention included to administer medications and bowel protocol as ordered, and to observe bowel movement for amount and consistency. The December 2024 Physician's Order Summary indicated the resident had the following orders: - Norco (opioid pain medication) 7.5-325 mg (milligrams) every 6 hours - Monitor side effects of opioids. Monitor for sedation, dizziness, nausea, vomiting, constipation, physical dependence, tolerance, and respiratory depression every shift. - stimulant laxative 8.6-50 mg twice a day and 1 tablet every 24 hours as needed for laxative (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- MiraLax Oral Powder (can treat constipation); give 1 scoop by mouth every 24 hours as needed for constipation - Fleet Oil Rectal Enema; every 24 hours as needed for laxative The Bowel and Bladder Elimination Task for the past 30 days indicated the resident did not have a bowel movement (BM) from 11/20/24 thru 11/23/24. The November 2024 Medication Administration Record lacked any documentation the resident had received any as needed laxatives from 11/20-11/23/24. During an interview on 12/13/24 at 11:28 a.m., the Director of Nursing indicated staff should have been running the bowel and bladder reports and catching any residents who had not had a bowel movement for multiple days. A policy, titled, Bowel Elimination Protocol and received as current from Corporate Nurse 1 on 12/13/24, indicated, .Residents who have had no documented BM for 48 hours will be observed for signs and symptoms of constipation which may include but is not limited to bowel sounds, abdominal distention, watery stool, nausea/vomiting, etc. and review of record. If signs and symptoms of constipation are present, may offer non-pharmacological interventions such as prune juice, natural laxative or encourage increased fluids. Residents who have had no BM for 72 hours will be considered for pharmacological intervention or increased non-pharmacological intervention. If resident continues to have no BM after additional intervention, notify MD for further instructions . 7. On 12/9/24 at 3:09 p.m., Resident N was observed lying in bed. The resident had a large dark discoloration observed to her outer left forearm/wrist area. The resident indicated she thought she had bumped her arm on something. On 12/10/24 at 2:05 p.m. and on 12/13/24 at 9:27 a.m., Resident N was observed lying in bed. The dark discoloration was still observed. Record review for Resident N was completed on 12/13/24 at 9:33 a.m. Diagnoses included, but were not limited to, anemia, hypertension, stroke, dementia, and anxiety. The Quarterly MDS assessment, dated 9/9/24, indicated the resident was cognitively moderately impaired. The resident required a substantial maximal assist for bathing and personal hygiene. The resident had received an antiplatelet. A Care Plan, undated, indicated the resident was at risk for bleeding and bruising related to aspirin use. An intervention included to observe skin and report any skin issues and changes to the nurse and physician. The Weekly Skin Assessment, dated 12/12/24, indicated no new skin issues. The record lacked any indication the discoloration had been assessed or was being monitored. During an interview on 12/13/24 at 11:45 a.m., LPN 1 indicated the resident's discoloration had not been assessed or monitored and she would complete that assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48383 8. On 12/9/24 at 11:03 a.m., Resident R was observed with a small amount of bleeding to the right forearm due to scratching. On 12/10/24 at 3:11 p.m., the resident had small amount of bleeding coming from a few scabs on her right forearm. On 12/11/24 at 1:14 p.m., the resident was observed picking at her scabs on the right forearm. Resident record was reviewed on 12/10/24 at 3:14 p.m. The diagnoses included, but were not limited to, dementia, chronic pain, and anxiety. The Admission Minimum Data Set (MDS) assessment dated [DATE], indicated the resident was cognitively intact for daily decision making. There was no monitoring in place for the right forearm open scabs. During an interview on 12/12/24 at 3:39 p.m., the Director of Nursing (DON) indicated she understood the concern and had no additional information to provide. The current and revised Pressure Injury and Skin Condition Assessment policy, provided by the Director of Nursing on 12/13/24 at 8:40 a.m., indicated care givers were responsible for promptly notifying the charge nurse of skin breakdown. This citation relates to Complaint IN00446198 and IN00447078. 3.1-37(a)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure interventions to provide effective pressure relief to the coccyx were implemented for a resident readmitted with a stage two (a partial thickness loss of skin) pressure injury on the coccyx and failed to ensure the physician was notified when the wound deteriorated. (Resident F) This deficient practice resulted in the wound deteriorating to a stage four pressure injury (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) that required two surgical debridements. The facility also failed to ensure treatments were signed out as being completed, antibiotics for a wound infection were started promptly, the physician was notified of treatment refusals, and turning and repositioning a resident with a pressure ulcer was completed for 5 of 10 residents reviewed for pressure ulcers. (Residents F, E, T, O, and H) Findings include: 1. On [DATE] at 9:30 a.m., the Wound Nurse was observed changing the bandage to Resident F's pressure ulcer. The bandage was removed from the resident's coccyx area and the wound was foul smelling with a large amount of bloody drainage. There was slough (necrotic tissue) observed inside and around the wound, which was red and pink in color. The record for Resident F was reviewed on [DATE] at 11:55 a.m. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes, major depressive disorder, atrial fibrillation, cardiac pacemaker, heart disease, anemia, depression, high blood pressure, and dementia without behaviors. The [DATE] Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and needed substantial to maximum assistance for bed mobility and transfers. The resident had no pressure ulcers. The resident returned to the facility on [DATE] after being hospitalized . A Stage 2 (a partial thickness loss of skin) pressure ulcer was present to the coccyx that measured 1.30 centimeters (cm) in length by 1 cm in width and had 100% pale pink non-granulating tissue (a smooth, moist, red or pink tissue that appeared in wounds that were not healing). While in the hospital, the resident tested positive for Clostridioides difficile (C-diff) and was readmitted on transmission-based precautions (contact isolation). She was being treated for the C-diff with the antibiotic of Vancomycin 125 milligrams (mg) four times a day for six days. Physician's Orders, dated [DATE], indicated Stage 2 Wound Site: cleanse coccyx with normal saline, apply skin prep barrier and wipe around periwound. Apply Hydrocolloid (used to treat wounds by creating a moist environment that promotes healing and protects new tissue) dressing every Monday, Wednesday and Friday one time a day. A Care Plan, initiated upon readmission to the facility, indicated the resident was at risk for pressure ulcers and had a stage 2 pressure ulcer. Interventions included turning and repositioning, good nutrition, and treatments as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A coccyx wound measurement, dated [DATE], indicated the wound measured 1.5 cm in length by 1 cm in width and had 100% pink or red non-granulating tissue. The presence of odor or drainage was not addressed. A coccyx wound measurement, dated [DATE], indicated the wound now deteriorated and measured 2 cm in length by 3 cm in width and was classified as an unstageable (full thickness tissue loss that was covered by necrotic tissue) pressure ulcer with 100% loosely adhered slough. The presence of odor or drainage was not addressed. There was no documentation that the physician was notified of the wound deterioration and the increase in size. There was no documentation that a physician had assessed the wound when the deterioration was identified. The Treatment Administration Record (TAR) for ,d+[DATE] and ,d+[DATE] indicated the Hydrocolloid dressing was signed out as being completed as ordered from ,d+[DATE]-[DATE] and on [DATE]. The TARs indicated a hydrocolloid dressing was applied to the unstageable wound three times a week on 4 of 4 days between [DATE] and [DATE]. A Wound Physician initial note, dated [DATE], indicated the resident had an unstageable wound on the coccyx that measured 2.8 cm in length by 3.8 cm in width with 80% thick adherent necrotic tissue. There was a moderate amount of serous drainage observed to the wound. Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis prior to this point. This wound has now revealed itself to be a Stage 4 (damage through all layers of the skin) pressure injury. The etiology (cause) was identified as pressure. A Wound/Skin Note, dated [DATE] at 1:02 p.m., indicated the resident was seen by the Wound Physician for the coccyx wound. Surgical debridement was done, which the resident tolerated well, and a new order was obtained for the treatment to be changed. A Physician's Order, dated [DATE], indicated cleanse the coccyx wound with normal saline, apply calcium alginate (a wound dressing material that absorbs excess moisture and promotes healing) and cover with dry dressing twice a week every Monday and Friday. A Physician's Order, dated [DATE], indicated a low air loss mattress (an air mattress covered with tiny holes designed to let out air very slowly, which helps keep the skin dry and [NAME] away any moisture) The ,d+[DATE] TAR indicated the treatment of the calcium alginate was not signed out as being done on [DATE], which was 1 of 4 treatments from ,d+[DATE]-[DATE] A Wound Nurse Note, dated [DATE] at 10:15 p.m., indicated the resident was seen by the Wound Physician on [DATE]. The pressure ulcer had increased in size, so a new treatment was obtained as well as a low air loss mattress was now in place. The RD (Registered Dietitian) was notified as the resident had lost 11.6% weight in the last 6 months, and new labs were ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A [DATE] RD note indicated the resident was seen due to a decline in a pressure ulcer and an unplanned weight loss of 11.9% in 6 months. Megace was in place to enhance appetite, and the RD reviewed the plan of care with the treatment nurse. Protein modular may not be indicated at this time secondary to fragile kidney function. The plan of care was appropriate; however, disease progression may make the wound decline and weight loss unavoidable. Please add a house nutritional supplement three times a day. A Care Plan, revised on [DATE], indicated the resident had a pressure ulcer to the coccyx area related to immobility. The approaches were to follow facility policies/protocols for the prevention/treatment of skin breakdown and to monitor/document/report as needed any changes in skin status such as appearance, color, wound healing, infection, wound size stage and report results to the physician and follow up as indicated. A Physician's Order, dated [DATE], indicated Complete Blood Count, Chemical Metabolic Panel, a pre-albumin and a glycosylated hemoglobin was to be obtained from lab services. The Progress Notes and Care Plan [DATE]-[DATE] did not include interventions for pressure relief to the coccyx. A Wound Physician Note, dated [DATE], indicated the wound measured 4.8 cm by 3.2 cm by not measurable. There was 30% thick necrotic tissue, 20% slough, and 20% granulation tissue. The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to surgically excise 7.68cm^2 of devitalized tissue and necrotic subcutaneous level tissues along with slough and biofilm were removed at a depth of 0.4 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 50 percent to 0 percent. Hemostasis was achieved and a clean dressing was applied. The etiology (cause) was identified as pressure. A Wound/Skin Note, dated [DATE] at 11:11 a.m., indicated the resident was seen by the Wound Physician and another surgical debridement was completed. During an interview on [DATE] at 11:55 a.m., the Wound Nurse indicated the regular Wound Physician was on vacation for two weeks so there was a sub who performed telehealth medicine on [DATE], however, the physician did not see Resident F's wound that day. The Wound Nurse measured and assessed the wound herself and placed the Hydrocolloid bandage on the wound as ordered. She did not notify the resident's doctor for a treatment change or the decline in wound status after the wound had deteriorated. The first time a physician saw the wound was on [DATE] and the treatment was changed at that time. Laboratory tests, implementation of the low air loss mattress, and the RD notification were all done after [DATE]. Nothing had been completed on [DATE] when the wound initially deteriorated. During an interview on [DATE] at 3:00 p.m., the Director of Nursing indicated the resident's physician and family were notified today of the worsening pressure ulcer. The resident had a bacterium Clostridioides difficile (C-diff) infection when she returned from the hospital and the pressure ulcer was only a Stage 2 at that time. The treatment should have been changed when it had become an unstageable ulcer. The change in treatment, mattress, laboratory tests and RD consultation were all ordered after the wound physician had seen the resident on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The current and revised Pressure Injury and Skin Condition Assessment policy, provided by the Director of Nursing as current on [DATE] at 8:40 a.m., indicated care givers were responsible for promptly notifying the charge nurse of skin breakdown. When there were weekly changes which required physician and responsible party notification, documentation of findings will be made in the clinical record. Physician and responsible party will be documented in the clinical record. These changes include, but were not limited to, new onset of purulent drainage, new onset of odor, significant increase in wound measurements and onset of new ulcers. The attending physician shall be notified within seven to 14 days of the resident's lack of response to treatment. 2. The closed record for Resident E was reviewed on [DATE] at 9:33 a.m. Diagnoses included, but were not limited to, stroke, peg tube (a tube inserted directly into the stomach for nutrition), vascular dementia, dysphasia (difficulty swallowing), major depressive disorder, anxiety, pain, and bilateral amputee. The resident expired in the facility on [DATE]. The [DATE] Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had one unstageable pressure ulcer. The Care Plan, revised on [DATE], indicated the resident had an impairment of skin integrity related to a pressure ulcer to the sacrum. A Physician's Order, dated [DATE], indicated to cleanse the sacrum pressure ulcer with normal saline, gently pat periwound dry, apply calcium alginate to wound bed and cover with Island dressing every day shift. The Wound Physician Note, dated [DATE], indicated a Stage 4 Pressure Ulcer to the coccyx that measured 9 centimeters (cm) by 15 cm by 0.5 cm with undermining of 1.0 cm at 9 o'clock. There was heavy drainage noted and 30% thick adherent devitalized necrotic tissue, 20% slough, and 10%granulation tissue. The wound progress has exacerbated and worsened. The plan and new treatment was to add Metronidazole (an antibiotic) sprinkled on top of the wound once daily for 30 days with the Calcium Alginate. A Nurse's Note, dated [DATE] at 6:53 p.m., indicated the resident was seen by the Wound Physician and a new order was obtained for Metronidazole to be sprinkled on wound daily and calcium alginate with island dressing daily. A Physician Order, dated [DATE], indicated Metronidazole powder apply to coccyx one time a day. A Nurse's Note, dated [DATE] at 10:59 a.m., indicated medication was not available. A Nurse's Note, dated [DATE] at 12:41 p.m., indicated the order was clarified per pharmacy recommendations. A Physician Order, dated [DATE], indicated Metronidazole 500 milligrams (mg), apply to coccyx wound topically one time a day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Treatment Administration Record (TAR) for ,d+[DATE] indicated the antibiotic had not been initiated until [DATE] (three days after it was ordered). During an interview on [DATE] at 2:33 p.m., the Wound Nurse indicated the pharmacy told them they did not have the powder form of the antibiotic, so they had to wait for the pill form to be delivered. During an interview on [DATE] at 11:28 a.m., the Director of Nursing indicated the pharmacy did not have the powder and they recommended the sprinkles, however, that alternative was not sent until later. There was no documentation from nursing regarding the conversations with pharmacy and the change from powder to sprinkles. The medication was not initiated timely. 10326 3. The record for Resident T was reviewed on [DATE] at 2:11 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, Alzheimer's disease, major depressive disorder, and stress incontinence. The Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively impaired for daily decision making. She required partial to moderate assistance with rolling left and right in bed and had one Stage 2 (a partial thickness loss of skin) pressure ulcer, one Stage 4 (damage through all layers of the skin) pressure area, and one Unstageable (full thickness tissue loss that is covered by necrotic tissue) pressure ulcer. A Care Plan, dated [DATE], indicated the resident had a pressure ulcer to her right and left hip and right knee related to history of ulcers, immobility, and progression of disease process. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness. The [DATE] Physician's Order Summary (POS) indicated the pressure ulcers to the resident's right and left hips were to be cleansed with normal saline, packed with Iodoform (a wound packing) packing strips, and cover with a dry dressing daily and as needed (PRN) for dislodgement or soiling. The [DATE] Treatment Administration Record (TAR) indicated the treatment to the right and left hips were not signed out as being completed on [DATE], [DATE], and [DATE]. The [DATE] TAR indicated the treatment to the right and left hips were not signed out as being completed on [DATE]. During an interview on [DATE] at 3:15 p.m., the Director of Nursing indicated the treatments should have been signed out as being completed. 32664 4. On [DATE] at 11:05 a.m., Resident O was observed sitting in her room. During an interview at that time, the resident indicated she was admitted with a pressure ulcer wound to her coccyx. She had problems with the bandage always falling off and the nursing staff did not do her treatments when they were supposed to. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review for Resident O was completed on [DATE] 3:33 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, and arthritis. The Admission MDS assessment, dated [DATE], indicated the resident was cognitively intact. The resident was independent for bed mobility. The resident had an unstageable pressure ulcer on admission to the facility. A Care Plan, dated [DATE] and revised [DATE], indicated the resident had a pressure ulcer to the coccyx. Interventions included to assess/record and monitor for wound healing and report improvements and declines to the physician. If the resident refused treatment, confer with the resident, IDT (interdisciplinary team) and family to determine why and try alternative methods to gain compliance. The [DATE] Physician's Order Summary (POS) indicated an order to cleanse the open area to the coccyx with normal saline, pat dry, and apply a foam dressing one time a day on Mondays, Wednesdays, and Fridays and every 24 hrs as needed for soilage or dislodgement. A Wound Rounds Assessment, dated [DATE], indicated the resident had an unstageable pressure ulcer to the coccyx. The wound measured 3.5 cm (centimeters) x 1.5 cm. The wound was covered in 100% slough (dead tissue). The wound was present on the resident's admission. Wound Rounds Assessments, dated [DATE] and [DATE], indicated the resident had refused treatment and picture of the wound. The resident indicated the dressing came off frequently and there was no need for it. The [DATE] Treatment Administration Record (TAR) indicated the resident refused treatment for the coccyx on ,d+[DATE] and [DATE]. The [DATE] TAR treatment for the pressure ulcer indicated, on [DATE], the resident left the facility for an appointment and the treatment was not completed. The TAR was blank on [DATE], and on [DATE], the TAR indicated the resident did not receive treatment and had refused. There was a lack of documentation to indicate the Physician had been notified of the resident's refusal of wound treatments or that education about the importance of the treatments was provided to the resident. During an interview on [DATE] at 9:11 a.m., the 200 Unit Assistant Director of Nursing (ADON) indicated the Wound Nurse had told her the resident had refused her wound treatment that day. During an interview on [DATE] at 10:28 a.m., the Director of Nursing indicated she was unaware the resident had been refusing her pressure ulcer treatments. She would expect the staff to provide education to the resident about the importance of the treatments and to notify the Physician about the refusals. During an interview on [DATE] at 11:30 a.m., the Social Services Director indicated she had a Care Plan Conference with the resident on [DATE]. The resident did not express to her anything related to her pressure ulcer treatments. Nursing did not inform her the resident had been refusing her wound treatments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:09 p.m., the Wound Nurse indicated she had not documented the resident had been refusing her wound treatments or that education was provided. She had not measured the resident's wound since the first Wound Round Assessment, dated [DATE]. 43293 5. During observations at the following times, Resident H was observed lying flat on his back in bed: [DATE] at 11:22 a.m., 2:16 p.m., 2:35 p.m. and 3:30 p.m.; [DATE] at 2:16 p.m. and 3:30 p.m.; [DATE] at 8:34 a.m., 11:00 a.m., 2:03 p.m. and 2:57 p.m.; and [DATE] at 10:48 a.m. The record for Resident H was reviewed on [DATE] at 3:27 p.m. Diagnoses included, but were not limited to, quadriplegia, urinary tract infection, pressure ulcer of sacrum stage 4, gastrostomy status (a feeding tube inserted through the abdomen into the stomach), dysphagia (difficulty swallowing), and neuromuscular dysfunction of bladder. The [DATE] Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and dependent in activities of daily living. A Care Plan, revised on [DATE], indicated the resident had a pressure ulcer on his coccyx due to immobility, and the CNAs were to turn and reposition the resident at regular intervals as he allowed/ tolerated. During an interview on [DATE] at 2:16 p.m., the resident indicated the staff only turned him when cleaning him up or performing wound care. During an interview on [DATE] at 10:48 a.m., the resident indicated the staff used to turn him regularly and had used wedges to keep him on his side. He did not know why they stopped repositioning him, but he was agreeable to resuming it. During an interview on [DATE] at 3:30 p.m., the Director of Nursing (DON) was informed of the findings and offered no further information. This citation relates to Complaints IN00446198 and IN00447156. 3XXX,d+[DATE](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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32664 Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place to prevent injury from a fall for 1 of 2 residents reviewed for accidents. (Resident J) Finding includes: On 12/10/24 at 8:53 a.m., Resident J was observed lying in bed with her eyes closed. The resident's wheelchair was observed at the end of the bed. The resident had a cushion to the wheelchair with no Dycem (non-slip gripper pad) observed in the wheelchair. On 12/10/24 at 2:49 p.m., the resident was observed propelling herself down the hallway in her wheelchair. During this time, CNA 1 was interviewed regarding whether the resident had a Dycem in her wheelchair. CNA 1 indicated she was unsure. She asked CNA 2 to help her lift up the resident to see if there was a Dycem on the cushion. The CNAs assisted the resident to a standing position and both indicated there was not a Dycem on top of the cushion. They then lifted the cushion and there was a Dycem pad underneath the cushion. Both CNAs indicated they were unsure if the Dycem should be above or below the cushion. Record review for Resident J was completed on 12/10/24 at 2:42 p.m. Diagnoses included, but were not limited to, hypertension, dementia, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 10/3/24, indicated the resident was cognitively impaired. The resident required a substantial maximal assistance with transfers and the resident could propel themselves in a wheelchair. The resident had 1 fall with no injury and 1 fall with major injury since the last assessment. A Care Plan, dated 4/25/23 and revised 5/4/23, indicated the resident had a potential for falls related to confusion, incontinence, unfamiliar environment, and dementia. An intervention, dated 2/6/24, indicated to provide staff education for proper use of Dycem to prevent falls. An intervention, dated 6/25/24, indicated Dycem to wheelchair. A Physician's Order, dated 7/15/24, indicated to keep Dycem in the wheelchair every shift for fall intervention. A Fall-Initial Occurrence Note, dated 2/5/24 at 7:01 p.m., indicated the resident had a witnessed fall. The resident was sitting on the edge of her chair as the nurse was walking out of another resident's room. The resident said help-me! The nurse ran to assist the resident, but before she could reach her, the resident had slipped from the edge of her wheelchair to the floor. She was holding the left arm of the wheelchair as she fell which caused a skin tear to the left forearm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Fall IDT (Interdisciplinary Team) Committee Meeting note, dated 2/6/24, indicated the resident was wheeling herself down the hall in a wheelchair and had a witnessed fall. The Root Cause of the fall was determined the resident did not have a Dycem in her wheelchair. The new interventions and changes suggested by the IDT were staff education to ensure the Dycem was in the wheelchair, and place a larger piece of Dycem into the wheelchair. A Fall-Initial Occurrence Note, dated 9/22/24 at 5:50 p.m., indicated the resident had an un-witnessed fall. The CNA alerted the nurse the resident was on the floor. Upon assessment, the resident was observed sitting on her buttocks with her legs straight out. A purple, round, slightly raised area to the left side of her head between the eyebrow and temple area was observed. The resident complained of discomfort to the left hand. The resident was able to move her fingers but unable to make a fist. The physician was notified, ice was applied to the hematoma, Tylenol was given, neurological checks were initiated and x-rays of the left wrist and hand were ordered. Radiology results were completed on 9/23/24. The resident had received x-rays on the left hand and the report indicated there was a nondisplaced oblique fracture lucency along the articular base of the left 4th and 5th metacarpals. The Fall IDT Note Summary of Incident, dated 9/24/24, indicated a CNA had alerted the nurse the resident was on the floor. The Root Cause of the fall was determined by the IDT to be the resident did not have a Dycem in her wheelchair. A new intervention suggested by the IDT was to re-educate staff on fall interventions. During an interview on 12/10/24 at 2:52 p.m., LPN 2 indicated she was unsure if the Dycem was ordered to be put above or below the cushion. The Dycem should have at least been put on top of the cushion to prevent the resident from potentially sliding off her cushion. During an interview on 12/11/24 at 10:00 a.m., the Director of Nursing (DON) indicated she had talked with staff and the resident moved a lot and they thought she was removing her Dycem out of the wheelchair. The staff did not periodically check to see if the Dycem was in her wheelchair. Staff should have placed the Dycem above the resident's cushion in the wheelchair. The resident had 2 falls from her wheelchair previously and both times the root cause of the falls was determined to be that the resident's Dycem was not in her wheelchair and she slipped off her cushion to the floor. A policy, titled, Fall Prevention Program and received as current from the DON on 12/11/24, indicated, . Safety interventions will be implemented for each resident identified at risk .All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained . This citation relates to Complaints IN00444644 and IN00444695 3.1-45(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. 32664 Based on record review and interview, the facility failed to ensure food consumption logs were completed for a resident with a history of weight loss for 1 of 1 residents reviewed for nutrition. (Resident 3) Finding includes: Record review for Resident 3 was completed on 12/12/24 at 11:53 a.m. Diagnoses included, but were not limited to, dementia, hypertension, anxiety, bipolar, and schizophrenia. The Quarterly Minimum Data Set (MDS) assessment, dated 11/1/24, indicated the resident was cognitively impaired. The resident required a partial to moderate assistance for eating and was on a mechanically altered therapeutic diet. A Care Plan, dated 6/28/21 and revised 12/22/21, indicated the resident had a nutritional problem or potential problem related to the need for mechanically altered diet and thickened liquids. Interventions included to monitor/record and report to the physician any signs or symptoms of malnutrition, significant weight loss of 3 lbs (pounds) in 1 week, or greater than 7.5% loss in 3 months. An intervention also included to monitor intake and record every meal. The resident's weight on 9/4/24 was 191.6 lbs. On 12/4/24, the resident weighed 174.6 lbs. This was a weight loss of 8.87% in 3 months. The Task Nutrition-Amount Eaten Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals: - Breakfast: 12/3/24. - Lunch: 12/3/24. - Dinner: 11/17, 11/18, 11/22, 11/23, 11/30, and 12/4/24. During an interview on 12/13/24 at 11:28 a.m., the Director of Nursing indicated the staff should be documenting the amount eaten for every meal. She had no additional information to provide. No facility policy was provided for meal consumption logs. 3.1-46(a)(1) 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 a resident's peg tube (a tube inserted directly into the stomach for nutrition) was monitored, assessed and being cleaned as ordered for 2 of 4 residents reviewed for tube feeding. (Residents C and H) Findings include: 1. During an observation on 12/10/24 at 3:00 p.m., LPN 6 was asked to perform an assessment to the peg tube stoma site for Resident C. At that time, the resident was observed in bed and the tube feeding was turned off. The LPN lifted the resident's gown and there was a white split gauze bandage with a date of 12/10/24 to the stoma site. The LPN attempted to remove the bandage, however, it was sticking to her skin, so she poured normal saline on the bandage and it was removed. The stoma site was clean with a moderate amount of drainage noted. The record for Resident C was reviewed on 12/10/24 at 2:05 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis or weakness) right side, stroke, high blood pressure, anemia, and peg tube (a tube inserted directly into the stomach for nutrition). The 11/1/24 Annual Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making. The resident had no oral problems, received a mechanically altered diet and had a feeding tube in which she received 51% or more nutrition. Care Plan, revised on 11/12/24, indicated the resident had required a feeding tube related to a stroke. The approaches were to monitor and document infection at the tube site. Physician's Orders, dated 5/1/24, indicated cleanse around the peg tube site with soap and water, pat dry and apply a peg tube dry dressing every day shift or prn. A Nurse's Note, dated 10/10/24 at 9:13 a.m., indicated three calls were placed to the gastrointestinal health group for an appointment for a gastric tube evaluation. A return call was requested each time. A Nurse's Note, dated 10/12/24 at 3:44 p.m., indicated there had been no return calls from the digestive health physician group regarding the peg tube site. A Weekly Skin Observation, dated 10/14/24 and 10/21/24, indicated there were no skin concerns. The Gastrointestinal Visit Summary, dated 10/23/24, indicated the resident was there for a possible peg tube infection. The physical exam indicated the peg tube site presented with erythema (skin or mucous membrane redness caused by increased blood flow to the area) and induration (the thickening and hardening of soft tissue, especially the skin) around it. There was no pus, purulent discharge, or leakage. The visit diagnosis was cellulitis (a bacterial skin infection that can occur around a stoma, or surgically created opening in the abdomen) at the gastrostomy tube site. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, dated 10/23/24 at 1:44 p.m., indicated the resident had returned to the facility via stretcher from the digestive health group. New orders were obtained for Amoxicillin-Pot Clavulanate (an antibiotic) 875-125 milligrams (mg) and Doxycycline Hyclate (an antibiotic) capsule 100 mg twice a day times 10 days for peristomal cellulitis. Physician's Orders, dated 10/23/24, indicated the following: - Amoxicillin-Pot Clavulanate 875-125 mg, give one tablet via peg tube every 12 hours for peristomal cellulitis for 10 days. - Doxycycline Hyclate capsule 100 mg, give one capsule via peg tube two times a day for peristomal cellulitis for 10 days. There was no documented assessment of the peg tube stoma site before the resident went out to the doctor's office or after she had returned. During an interview on 12/12/24 at 8:40 a.m., the Director of Nursing had no additional information to provide. The facility had no policy regarding assessing the peg tube site. 43293 2. CNA 3 was observed completing a bed bath for Resident H on 12/11/23 at 2:03 p.m. The skin around the insertion site of the resident's gastrostomy tube was reddened. During an interview at that time, CNA 3 indicated the area looked newly irritated and swollen, and that she would inform LPN 3. On 12/11/24 at 3:00 p.m., CNA 3 was observed putting on her coat and walking off the unit. During an interview on 12/11/24 at 3:12 p.m., LPN 3 indicated CNA 3 had left the building and did not inform her of the redness/irritation around the gastrostomy tube site, but she would go assess the resident. The record for Resident H was reviewed on 12/11/24 at 3:27 p.m. Diagnoses included, but were not limited to, quadriplegia, urinary tract infection, pressure ulcer of sacrum stage 4, gastrostomy status (a feeding tube inserted through the abdomen into the stomach), dysphagia (difficulty swallowing), and neuromuscular dysfunction of bladder. The 11/6/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and dependent in activities of daily living. A Care Plan, dated 1/12/24, indicated the CNA should report any changes in skin status. During an interview on 12/11/24 at 3:38 p.m., the Director of Nursing (DON) was informed of the findings and offered no further information. The Bed Bath policy, received as current from Nurse Consultant 1 on 12/13/24 at 2:45 p.m. indicated, . Call for nurse to report any reddened areas, skin discoloration, or breakdown . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaints IN00444644 and IN00446198 3.1-44

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 10770 Based on record review and interview, the facility failed to ensure residents' pain medications were available for administration for 2 of 3 residents reviewed for pain. (Residents K and 101) Findings include: 1. During an interview on 12/10/24 9:42 a.m., Resident K indicated the facility had issues with running out of her scheduled pain medications. The record for Resident K was reviewed on 12/12/24 at 2:06 p.m. Diagnoses included, but were not limited to, morbid obesity, type 2 diabetes, respiratory failure, cellulitis of the left lower limb, non pressure chronic ulcers, pain disorder, adult failure to thrive, pressure ulcers, anxiety disorder, major depressive disorder, and fibromyalgia (chronic condition that caused widespread pain and tenderness in the muscles and soft tissues of the body). The 11/7/24 Quarterly Minimum Data Set (MDS) assessment indicted the resident was cognitively intact for daily decision making and received scheduled pain medication. The resident had pain occasionally and rated the pain a 4 out of 10. A Care Plan, dated 2/5/24, indicated the resident received pain medication. The approaches were to administer pain medications as ordered by the physician. A pain assessment, dated 11/6/24, indicated the resident had no current pain. Physician's Orders, on the current 12/2024 Physician Order Summary, indicated the following: - MS Contin Extended Release 30 milligrams (mg), give 1 tablet by mouth every 12 hours. - Oxycodone-Acetaminophen 10-325 mg, give one tablet by mouth every six hours as needed for pain. The 10/2024 Medication Administration Record (MAR), indicated the MS Contin was coded with a 9 (see progress notes) on 10/3 at 6:00 a.m., and 2:00 p.m., on 10/13 at 6:00 a.m., and on 10/20 at 2:00 p.m. The 10/2024 MAR indicated the Oxycodone was blank and not signed out as being administered on 10/8/24 at 10:00 a.m., on 10/24 and 10/30/24 at 6:00 p.m. On 10/24 a 9 was coded at 10:00 a.m. The 11/2024 MAR indicated the MS Contin was coded with a 14 (sleeping) on 11/6/24 at 6:00 a.m., and was blank on 11/21/24 at 6:00 a.m. During an interview on 12/12/24 at 3:00 p.m., the Director of Nursing indicated there were some times when the pain medication was not available from pharmacy. 48383 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 12/09/24 at 10:39 a.m., Resident 101 indicated she was out of pain medication and she was in pain. She had no pain medication available over the weekend. On 12/09/24 at 1:50 p.m., the resident was observed in the hallway in her wheelchair. She indicated she was in pain and the nurse said it would be delivered by midnight. The record for Resident 101 was reviewed on 12/10/24 at 1:53 p.m. The diagnoses included, but were not limited to, depression, anxiety, hypertension (high blood pressure), and anemia (low iron). The Admission Minimum Data Set (MDS) assessment, dated 10/4/24, indicated the resident was cognitively intact. A Care Plan, dated 10/4/24, indicated the resident had a potential for pain related to a history of a duodenum ulcer and anemia. Interventions were to administer medications as ordered and to encourage the resident to ask for pain medication. A Physician's Order, dated 9/28/24, indicated to complete a pain assessment every shift. A Physician's Order, dated 10/24/24, indicated to administer Tramadol (pain medication) 25 milligrams by mouth every four hours as needed for moderate to severe pain. The 12/2024 Medication Administration Record (MAR) indicated the resident's Tramadol was not given on 12/8/24 and 12/9/24. During an interview on 12/9/24 at 2:52 p.m., QMA 1 indicated the resident was out of her medication but it had been ordered. During an interview on 12/12/24 at 12:19 p.m., RN 2 indicated the medication could be filled by the nurse or the qualified medication aide (QMA), and if they put in an order before 2:00 p.m., they would get a medication drop off that evening. During an interview on 12/12/24 at 12:26 p.m., the 300 Assistant Director of Nursing indicated the resident did not have a Tramadol script on file and the physician had to call one in before the medication was refilled. During an interview on 12/12/24 at 3:50 p.m., the Director of Nursing (DON) indicated she understood the concern and had no further information to provide. 3.1-37(a)

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

43293

Based on observation, record review and interview, the facility failed to ensure medications were given as ordered to prevent significant medication errors for 1 of 8 residents observed for medication administration. (Resident L)

Finding includes:

During a medication administration observation on 12/11/24 at 8:37 a.m., LPN 3 indicated she was preparing a dose of Furosemide 40 mg (a diuretic) for Resident L. LPN 3 was observed dispensing four tablets of Amlodipine 10 mg (a blood pressure pill) into a medicine cup. The LPN then indicated she did not see the resident's Amlodipine in the cart, so she went to the med storage room, got another card of Amlodipine, and dispensed one tablet into the medication cup. The LPN took the cup of pills to the resident's room, knocked and called out that she was bringing the resident his pills. She was stopped at that point. After returning to the cart and reviewing the medications she had prepared, LPN 3 indicated she accidentally put 40 mg (four tabs) of Amlodipine instead of Furosemide into the medicine cup, and if given as prepared, she would have administered five times the resident's ordered dose of Amlodipine. LPN 3 then disposed of the entire cup of pills.

Resident L's record was reviewed on 12/11/24 at 1:47 p.m. Diagnoses included, but were not limited to, high blood pressure, alcohol use, heart failure, COPD (Chronic Obstructive Pulmonary Disease) and tobacco use.

A Physician's Order, dated 3/15/24, indicated Furosemide 40 mg, 1 tab daily.

A Physician's Order, dated 6/7/24, indicated Amlodipine Besylate 10 mg, one tab daily.

During an interview on 12/11/24 at 11:05 a.m., the Director of Nursing (DON) indicated she was aware of the medication error and was following up with LPN 3.

An agency Medication Administration policy, received as current on 12/11/24 at 11:41 a.m. from the DON indicated, . Five Rights--Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 rights is recommended at 3 steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away .

This citation relates to Complaint IN00442238.

3.1-48(c)(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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43293 Based on observation and interview, the facility failed to ensure medications were properly stored in clean, sanitary conditions for 4 of 4 medication carts observed (Even Cart for 400 hall, Cart 1 for 200 hall, Odd Cart for 400 hall, and Cart 1 for 300 hall) and 1 of 2 medication storage rooms observed (200 hall). Findings include: 1. On 12/12/24 at 1:53 p.m., the Even Medication Cart for the 400 hall was observed with LPN 1. There were 2.5 pills of different sizes and colors that were loose and out of the packages in the bottoms of the drawers in the cart. 2. On 12/12/24 at 2:27 p.m., Medication Cart 1 for the 200 hall was observed with QMA 1. There were multiple pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The QMA indicated she wasn't sure who was responsible for cleaning the carts. 3. On 12/12/24 at 2:40 p.m., the 200 hall Medication Storage Room was observed with QMA 1. The floor was visibly dirty with tiles missing and old adhesive exposed. There was trash on the floor and the bottoms of the doors of a tall cabinet were covered in dark colored spillage. The QMA indicated she did not know what was on the cabinet, and she did not think anyone cleaned the room because housekeeping did not have a key for it. 4. On 12/12/24 at 2:55 p.m., the Odd Medication Cart for the 400 hall was observed with RN 1. There were multiple pills of different sizes and colors that were loose and out of the packages in the bottoms of the drawers in the cart. RN 1 indicated she thought nursing was responsible for cleaning the carts. 5. On 12/12/24 at 3:13 p.m., Medication Cart 1 for the 300 hall was observed with RN 2. There were multiple pills of different sizes and colors that were loose and out of the packages in the bottoms of the drawers in the cart. The RN indicated she did not see the bottoms of the drawers because they were so full. During an interview on 12/12/24 at 3:35 p.m., the Director of Nursing (DON) and Nurse Consultant 1 were informed of the findings. The DON indicated she had just cleaned the medication carts, and was not sure who was responsible for cleaning the medication storage rooms. 3.1-25(j) 3.1-25(o)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48383 Based on observation, record review and interview, the facility failed to ensure residents had snacks available for 8 of 8 residents who attended the Resident Council meeting. (Residents 8, 13, 29, 39, 52, 63, 109 and 110) This had the potential to affect all residents who were able to request and receive oral snacks. Finding includes: During the Resident Council meeting on 12/12/24 at 1:35 p.m., the Activities Director indicated all eight residents in attendance (Residents 8, 13, 29, 39, 52, 63, 109 and 110) were cognitively intact for daily decision making. When the group was asked if snacks were offered to residents who asked for them, all eight residents responded that they do not ever get snacks. During an interview on 12/12/24 at 1:59 p.m., the Dietary Manager indicated snacks were prepared daily and delivered by 7:30 p.m. every night since the kitchen closed at 8:00 p.m. She indicated there was enough snacks on the trays delivered for every resident to get a snack if they wanted one. During an interview on 12/12/24 at 2:07 p.m., CNA 7 indicated she worked the second shift and there was rarely snacks available to give the residents. She indicated the kitchen would deliver snacks occasionally, but generally there was none available. During an interview on 12/12/24 at 2:27 p.m., CNA 6 indicated she worked second shift and snacks were generally not available during the week and there were no snacks ever on the weekends. During an interview on 12/12/24 at 3:32 p.m., the Director of Nursing (DON) indicated snacks should be available every day for all residents who requested them. 3.1-21(a)

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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 practices were in place and implemented related to having no personal protective equipment (PPE) in enhanced barrier precaution rooms, staff failing to perform hand hygiene after glove removal, using gloved hands to apply ointment for 1 of 10 pressure ulcer treatments observed, not cleaning multi-use equipment, soiled washcloth used during bathing to clean urinary catheter tubing and a gastrostomy tube site, and staff failing to remove soiled PPE during a treatment during random infection control observations. (Residents K, C, H, and U) Findings include: 1. During a random observation on 12/11/24 at 2:17 p.m., Resident K had her call light activated and asked to be laid down in the bed. At that time, CNA 5 and CNA 6 entered the room with the Hoyer (mechanical lift) lift to put the resident back in her bed. CNA 5 hooked the resident's lift pad to the machine and lifted her up in the air and placed her in the bed. After finishing with the resident, CNA 5 pushed the Hoyer lift out of the room and parked it in the hallway by the lounge area and walked away. The Hoyer lift was not wiped down after being used for the resident. On 12/12/24 at 6:45 a.m., Resident K was observed in bed and the Wound Nurse was preparing to perform a bandage change on her pressure ulcers. The Wound Nurse performed hand hygiene and donned clean gloves to both hands. She removed the bandages on the back of the resident's thighs and coccyx areas, removed her gloves and performed hand hygiene. She donned a clean pair of gloves and cleaned the wounds. She removed her gloves and performed hand hygiene and donned another pair of clean gloves to both hands. With her gloved hand she removed an ointment that was in plastic cup on the over bed table and spread it on the pressure ulcers. She did not use a tongue blade or a Q-tip to spread the ointment over the ulcers. The record for Resident K was reviewed on 12/12/24 at 2:06 p.m. Diagnoses included, but were not limited to, morbid obesity, type 2 diabetes, respiratory failure, cellulitis of the left lower limb, non pressure chronic ulcers, pain disorder, adult failure to thrive, pressure ulcers, anxiety disorder, major depressive disorder, and fibromyalgia (a chronic condition that caused widespread pain and tenderness in the muscles and soft tissues of the body). The 11/7/24 Quarterly Minimum Data Set (MDS) assessment indicted the resident was cognitively intact for daily decision making and had four Stage 3 pressure ulcers, and two unstageable deep tissue injury ulcers. Physician's Orders, dated 11/12/24, indicated apply Balsum [NAME]-[NAME] oil ointment to the right and left posterior thighs, both buttocks and coccyx area daily and cover with a foam dressing. During an interview on 12/12/24 at 12:22 p.m., Nurse Consultant 2 indicated the wound nurse should have used something else rather than her gloved hand to apply the cream on the pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on 12/10/24 at 3:00 p.m., LPN 6 was asked to perform an assessment to the peg tube stoma site for Resident C. At that time, the resident was observed in bed and the tube feeding was turned off. The LPN donned a clean pair of gloves to both hands and did not perform hand hygiene. She did not don an isolation gown prior to observing the stoma site. The LPN attempted to remove the bandage, however, it was sticking to her skin, so removed her gloves, threw them away and walked out of the resident's room without performing hand hygiene. She returned with normal saline and donned a clean pair of gloves to both hands and poured a small amount of the normal saline on the bandage and it was removed. She removed her gloves and donned a clean pair of gloves without performing hand hygiene, then placed a clean sponge to the site. During an interview on 12/10/24 at 3:09 p.m., LPN 6 indicated she was aware she was supposed to wear a gown while providing care to the peg tube. She was also aware she was to perform hand hygiene before and after glove removal. The record for Resident C was reviewed on 12/10/24 at 2:05 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis or weakness) right side, stroke, high blood pressure, anemia, and peg tube (a tube inserted directly into the stomach for nutrition). The 11/1/24 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had no oral problems, received a mechanically altered diet and had a feeding tube in which she received 51% or more nutrition. A Physician's Order, dated 5/1/24, indicated cleanse around the peg tube site with soap and water, pat dry and apply a peg tube dry dressing every day shift or prn. A Physician's Order, on the current 12/2024 Physician Order Summary, indicated Enhanced Barrier Precautions (EBP). During an interview on 12/12/24 at 8:40 a.m., the Director of Nursing had no additional information to provide. The current and revised 5/1/23 Infection Control policy, provided by the Director of Nursing on 12/9/24 at 9:15 a.m., indicated healthcare personal should perform hand hygiene before putting on personal protective equipment (PPE) and after removing PPE. The current and revised 5/7/24 Enhanced Barrier Precautions policy, provided by Nurse Consultant 1 on 12/13/24 at 3:03 p.m., indicated EBP should be used for any resident with feeding tubes 43293 3. On 12/11/23 at 2:03 p.m., CNA 3 was observed giving Resident H a bed bath. After washing the rest of the resident's body while he was on his back, the CNA used the soiled washcloth to wash around the gastrostomy tube site. The CNA then rinsed the washcloth in the same water that had been used for the rest of the body, washed the resident's genitals and then wiped up and down the urinary catheter. The CNA used only two towels, one unchanged basin of water, and one unchanged pair of gloves throughout the bath. When finished with the bath, the CNA removed her gloves, put on clean gloves without performing hand hygiene, and put a clean gown on the resident. The CNA indicated she normally would use more towels and washcloths, but the two towels were all that was available. (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 12/13/2024
NAME OF PROVIDER OR SUPPLIER Aperion Care Arbors Michigan City		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E Coolspring Ave Michigan City, IN 46360	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident H was reviewed on 12/11/24 at 3:27 p.m. Diagnoses included, but were not limited to, quadriplegia, urinary tract infection, pressure ulcer of sacrum stage 4, gastrostomy status (a feeding tube inserted through the abdomen into the stomach), dysphagia (difficulty swallowing), and neuromuscular dysfunction of bladder. The 11/6/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and dependent in activities of daily living. During an interview on 12/11/24 at 2:30 p.m., CNA 3 indicated she should not have re-used the washcloth to clean around the urinary catheter, but that was all she had. During an interview on 12/11/24 at 3:38 p.m., the Director of Nursing (DON) was informed of the findings, indicated there was no shortage of linen, and offered no other information. An agency Bed Bath Policy, received as current from Nurse Consultant 1 on 12/13/24 at 2:45 p.m. indicated the following instructions for perineal care, . Change water in basin . If resident has catheter, check for leakage, secretions or irritations. Gently wipe four inches of catheter from meatus (opening) out. Wipe from front to back and from center of perineum to thighs. Change washcloth as necessary . With a clean washcloth, rinse area thoroughly in the same direction as when washing 48383 4. On 12/12/24 at 9:59 a.m., Resident U was observed lying in bed waiting for a wound treatment to be completed. The Wound Nurse and CNA 10 were preparing to start the treatment. When they removed the resident's brief, a large amount of liquid stool poured out toward the wound nurse. The residents brief, gown, and bedding was soiled with stool. The wound nurse began to clean up the stool with warm wash cloths while CNA 10 went to get more supplies. Once the CNA returned and donned new personal protective equipment (PPE), the wound nurse began to wash the resident with soapy wash cloths. The CNA was holding the resident while the wound nurse finished cleaning up the resident. After a full bed change was completed, the wound nurse removed her soiled gloves and completed hand hygiene. At 10:27 a.m., new gloves were donned and the resident's treatment began. The left ischial tuberosity wound and coccyx wound treatments were completed. The wound nurse did not change her soiled gown prior to starting the wound treatment. The record for Resident U was reviewed on 12/12/24 at 8:52 p.m. The diagnoses included, but were not limited to, kidney disease, asthma, respiratory failure, depression, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/18/24, indicated the resident was cognitively intact for daily decision making and had a Stage 3 pressure ulcer. A Physician's Order, dated 12/4/24, indicated to cleanse the left ischial tuberosity with normal saline and to apply a foam dressing daily. A Physician's Order, dated 12/12/24, indicated to cleanse the coccyx with normal saline, soak gauze with Dakins solution and cover with sacral foam daily. (continued on next page)

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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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/24 at 10:58 a.m., Nurse Consultant 2 indicated she would expect a gown change prior to a wound treatment after incontinence care for diarrhea was provided to the resident. During an interview on 12/12/24 at 4:10 p.m., the Wound Nurse indicated she was unaware her gown was soiled or she would have changed it. This citation relates to Complaint IN00446198. 3.1-18(b)