

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Arbors Michigan City		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E Coolspring Ave Michigan City, IN 46360	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain comfortable and safe temperature levels for 27 of 27 residents who resided on the memory care unit.</p> <p>Finding includes:</p> <p>During a confidential resident interview on 5/27/25 at 10:38 a.m., they indicated the unit had been very cold lately and they were informed by staff the heat was turned off earlier in May 2025.</p> <p>During a random observation on 5/29/25 at 9:30 a.m. in the memory care unit, many residents were observed sitting in both dining rooms and in the lounge area. At that time, the ambient air temperature was cold. The residents were dressed in long sleeves, were wearing sweaters and had blankets over them.</p> <p>At 10:50 a.m., the Administrator was asked to have the Maintenance Director check the temperature on the memory care unit. The Maintenance Director and the Administrator entered the memory care unit and the air temperature was 71 degrees right by the entrance to the unit. Walking down the hallway, the temperature was 70 degrees.</p> <p>There were seven residents observed in the dining room with all the blinds closed and the lights off. The ambient air temperature in the dining room was 70 degrees.</p> <p>The following rooms were also checked and there was at least one resident in each of the rooms lying in their bed:</p> <p>room [ROOM NUMBER] was 68 degrees.</p> <p>room [ROOM NUMBER] was 69 degrees.</p> <p>room [ROOM NUMBER] was 69 degrees.</p> <p>During an interview at that time, the Maintenance Director indicated the facility turned the heat off on May 1, 2025 and it was a boiler heating and cooling system. Warming blankets were ordered for the residents due to the cold weather, however, they had not yet arrived to the facility.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview at that time, the Administrator indicated the facility had a boiler heating and cooling system. The heat gets shut off in May and the air gets turned off in October. They do usually struggle with those months as the weather can still be cold in May and hot in October.</p> <p>On 5/29/25 at 1:22 p.m., the Maintenance Director indicated he just checked the temperatures after opening the curtains and blinds and the temperature for the above three rooms, the hallway and dining room was just at 71 degrees. He was then questioned about what would happen when the temperature outside would be a low of 52 degrees over night. The decision was made to turn the boiler heating system back on until the outside air temperature was warm enough.</p> <p>During an interview on 5/29/25 at 1:55 p.m., CNA 1 and QMA 1 indicated it had been cold on the unit the last couple of weeks. During an observation at that time, there was a large black cooling and heating element behind the nursing station. CNA 1 indicated it had been turned on for heat because some of the staff were cold.</p> <p>This citation relates to Complaint IN00460204.</p> <p>3.1-19(h)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on record review and interview, the facility failed to ensure non-pharmacological interventions were documented and attempted prior to administering a PRN (as needed) anti-anxiety medication for 2 of 5 residents reviewed for unnecessary medications. (Residents 89 and 91)</p> <p>Findings include:</p> <p>1. The record for Resident 89 was reviewed on 6/2/25 at 11:05 a.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety, psychotic disorder, dementia, and Parkinson's disease.</p> <p>The 4/23/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and received an antipsychotic and antidepressant medications.</p> <p>A Physician's Order, dated 5/29/25, indicated Ativan (an anti-anxiety medication) 0.5 milligrams (mg), give 0.5 mg by mouth every 6 hours as needed for anxiety or agitation.</p> <p>A Care Plan, revised on 5/30/25, indicated the resident used an anti-anxiety medication as needed for his anxiety disorder.</p> <p>The May 2025 Medication Administration Record (MAR) indicated the Ativan was administered on 5/29/25 at 3:50 p.m. and 5/30/25 at 10:00 a.m.</p> <p>There was no documentation of non-pharmacological interventions attempted prior to the administration of the prn Ativan.</p> <p>During an interview on 6/2/25 at 2:00 p.m., the Director of Nursing indicated documentation of non-pharmacological interventions should be done and attempted prior to administering the prn medication.</p> <p>2. The record for Resident 91 was reviewed on 5/30/25 at 9:20 a.m. Diagnoses included, but were not limited to, stroke, dementia, protein malnutrition, psychotic disorder, osteoporosis, and high blood pressure.</p> <p>The 5/6/2025 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had no behaviors. The resident received antipsychotic and an antidepressant medication.</p> <p>A Physician's Order, dated 5/8/25, indicated Lorazepam 2 milligrams/milliliter (mg) (ml), give 0.25 ml by mouth every two hours as needed for anxiety, restless, and agitation.</p> <p>The Medication Administration Record (MAR) for 5/2025 indicated the Lorazepam was administered on the following dates and times:</p> <p>- 5/9/25 at 8:22 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 5/10/25 at 4:00 p.m.</p> <p>- 5/11/25 at 1:38 a.m.</p> <p>- 5/12/25 at 7:19 p.m.</p> <p>- 5/13/25 at 1:22 a.m. and 4:05 a.m.</p> <p>- 5/18/25 at 8:01 a.m.</p> <p>On the above mentioned dates, the prn medication was administered for behaviors of yelling out loud, rambling and being disruptive with increased anxiety. There was no documentation of any non-pharmacological interventions attempted prior to administering the prn medication.</p> <p>During an interview on 6/2/25 at 11:10 a.m., CNA 3 indicated the resident used to yell out loud non stop for hours, but did not or rarely did that any more.</p> <p>During an interview on 6/2/25 at 11:25 a.m., LPN 1 indicated before giving a prn psychotropic medication, they were supposed to document interventions attempted prior. Before administering the medication, she would try giving the resident food, change their position, or check for incontinence.</p> <p>During an interview on 6/2/25 at 2:00 p.m. the Director of Nursing (DON) indicated documentation of non-pharmacological interventions should be done and attempted prior to administering the prn medication.</p> <p>The current and revised Psychotropic Medication policy, provided by the Nurse Consultant, indicated the plan for alternatives to psychotropic medication and the use of the medication shall be incorporated into the care plan.</p> <p>3.1-48(b)(2)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed ensure only licensed qualified persons poured, prepared, and passed medications for 5 memory care residents on the midnight shift. (Residents 14, 60, 86, 87, and 90)</p> <p>Findings include:</p> <p>1. The record for Resident 14 was reviewed on 6/3/25 at 12:00 p.m. Diagnoses included, but were not limited to, vascular dementia, psychotic disorder and hypothyroidism.</p> <p>The 12/3/24 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making.</p> <p>A Physician's Order, dated 3/17/24, indicated Levothyroxine 150 micrograms daily at 6:00 a.m.</p> <p>The 2/2025 Medication Administration Record (MAR) indicated the medication was signed out on 2/2/25 at 5:45 a.m. by LPN 3.</p> <p>2. The record for Resident 60 was reviewed on 6/3/25 at 11:51 a.m. Diagnoses included, but were not limited to, dementia and hypothyroidism.</p> <p>The 1/7/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making.</p> <p>A Physician's Order, dated 3/8/24, indicated Levothyroxine 25 micrograms daily at 6:00 a.m.</p> <p>The 2/2025 Medication Administration Record (MAR), indicated the medication was signed out on 2/2/25 at 5:46 a.m. by LPN 3.</p> <p>3. The record for Resident 86 was reviewed on 6/3/25 at 10:51 a.m. Diagnoses included, but were not limited to, dementia and hypothyroidism.</p> <p>The 2/3/25 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making.</p> <p>A Physician's Order, dated 1/18/25, indicated Levothyroxine 75 micrograms by mouth daily in the morning. The medication was scheduled for 6:00 a.m.</p> <p>The 2/2025 Medication Administration Record (MAR), indicated the medication was signed out on 2/2/25 at 5:45 a.m. by LPN 3.</p> <p>4. The record for Resident 87 was reviewed on 6/3/25 at 11:47 a.m. Diagnoses included, but were not limited to, dementia and hypothyroidism and she resided on the memory care unit.</p> <p>The 1/21/25 Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Physician's Order, dated 3/16/24, indicated Levothyroxine 75 micrograms daily at 6:00 a.m.</p> <p>The Medication Administration Record (MAR) for 2/2025 indicated the medication was signed out as being administered on 2/2/25 at 5:46 a.m. by LPN 3.</p> <p>5. The record for Resident 90 was reviewed on 06/03/25 11:30 a.m. Diagnoses included but were not limited to, severe intellectual disabilities, hypothyroidism, and tremors.</p> <p>The 1/24/25 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making.</p> <p>A Physician's Order, dated 3/20/24, indicated Levothyroxine 50 micrograms daily at 6:00 a.m.</p> <p>A Physician's Order, dated 3/21/24, indicated Omeprazole 20 milligrams (mg) daily at 6:00 a.m.</p> <p>A Physician's Order, dated 7/9/24, indicated Carbidopa-Levodopa 25-100 mg, 1 tablet three times daily, scheduled to be administered days, evenings, and night shift</p> <p>The 2/2025 Medication Administration Record (MAR) indicated all of the above medications were signed out on 2/2/25 at 5:45 a.m. by LPN 3.</p> <p>An Indiana Department of Health (IDOH) facility reported incident, dated 2/12/25, indicated it was reported on 2/2/25 that LPN 4, who worked on the midnight shift, had a medical emergency and had to leave the facility. She left her medication cart keys for the 100 unit and they were in the possession of CNA 6. It was also reported that LPN 3, who was working on the 300 unit, gave her login information to CNA 6, who then poured, prepared and administered medication to 5 residents and documented such action under LPN 3's name.</p> <p>A hand written statement by LPN 4, dated 2/5/25, indicated The last night I worked, I was on the 100 unit and had to go to the 200 unit to give insulins to numerous residents because a QMA was on the 200 unit and I got sick and threw up and went to the 200 unit and got light headed and was getting worse and my CNA stated that I should go to the ER and I was getting worse. I realized I needed to go. The CNA said I will hold on to them [the med cart keys] and I won't take any meds or narcs and she said I will call the scheduler and I went straight to the ER and was admitted . (sic)</p> <p>A hand written statement by CNA 6, dated 2/6/25, indicated On 2/1/25, at about 10:00 p.m., LPN 4, the 100 unit nurse left the facility to go the hospital. I called the on call scheduler to let her know that we did not have a nurse. She said she would call me back to figure things out. Some time later she called me back to tell me that LPN 3 the nurse on 300 would be overseeing the 100 unit. I did ask LPN 3 if I could have her credentials to pass the medication on the unit so I could be of some help. She did give those credentials to me.Later I did proceed to pass the medications after verifying them with the other CNA. LPN 3 was aware of her being responsible for the 100 unit which is why she gave me the credentials to chart the medication. (sic)</p> <p>A hand written statement by LPN 3, dated 2/6/25, indicated I did not give or allow anyone to use my login information for anything in Point Click Care (PCC). I did not have the keys to any cart on the 100 unit on 2/1/25 or any day. I never had the keys to pass on to anybody on the 100 unit. (sic)</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/3/25 at 9:00 a.m., the Director of Nursing (DON) indicated LPN 4 got sick during her shift, which she worked from 6:00 p.m. to 6:00 a.m., and before leaving, she gave her medication cart keys to CNA 6. LPN 3 was working on the 300 unit and was supposed to take over and pass medications on the 100 unit for LPN 4. CNA 6 told her that LPN 3 gave CNA 6 her credentials to pass the morning medication to the residents, even though LPN 3 denied that allegation and told the DON she must have looked over her shoulder one other time to get her credentials. The CNA was caught on the camera footage preparing and pouring the medications and then administering them to the residents and then she documented the medication pass under LPN 3's name. No staff, including the scheduler, had called to notify her of the situation, as she could have come in to work. All three staff members were terminated.</p> <p>During an interview on 6/3/25 at 11:40 a.m., the DON indicated the night shift medication administration was from 10:00 p.m., to 6:00 a.m.</p> <p>The current and undated Medication Administration General Guidelines policy, provided by the DON on 6/3/25 at 1:41 p.m., indicated medications were administered by persons legally authorized to do so.</p> <p>3.1-35(g)(2)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired and dependent residents for 1 of 1 resident reviewed for activities. (Resident 44)</p> <p>Finding includes:</p> <p>During a random observation on 5/27/25 at 10:31 a.m., Resident 44 was observed in her room in bed. The resident was positioned on her left side, her eyes were open and she was facing the wall. The resident's television was turned off and no music was playing.</p> <p>On 5/28/25 at 10:00 a.m., the resident was again observed in her room in bed. She opened her eyes when her name was called. The resident's television was not turned on and there was no music playing.</p> <p>On 5/29/25 at 9:32 a.m., the resident was in her room in bed. The television was not turned on nor was there music playing. At 11:10 a.m., the resident was seated in a broda chair (a positioning wheel chair) across from the 200 unit nurses's station. At 1:47 p.m., the resident was in bed. Her eyes were open and the television was turned off and there was no music playing.</p> <p>The record for Resident 44 was reviewed on 5/28/25 at 4:47 p.m. Diagnoses included, but were not limited to, Parkinson's disease and vascular dementia with behavior disturbance.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 3/18/25, indicated the resident was cognitively impaired for daily decision making.</p> <p>A Care Plan, reviewed on 3/18/25, indicated the resident relied on staff for socialization, physical, mental, and sensory stimulation. She would receive one-to-one visits three times weekly and she enjoyed watching birds, snacking, coloring, and sensory programming. Interventions included, but were not limited to, staff will encourage her to participate in group activities and one-to-one visits would be completed three times weekly.</p> <p>The Activities Quarterly Assessment, dated 5/22/25, indicated the resident's one-to-one activity participation had been stable in the past 90 days. The resident enjoyed getting her nails done, watching the birds, listening to music, one-on-one conversations, and snacks. The goal was for the resident to continue to participate in one-to-one visits three times weekly for stimulation and socialization. She would also participate in group activities of her choosing.</p> <p>The Task section located in the electronic medical record indicated the resident participated in music on 5/28/25 at 11:57 a.m. The resident was a passive participant.</p> <p>There was no documentation of the resident participating in television during the last 14 days.</p> <p>The May 2025 Activity Participation Sheet located in the one-to-one binder, indicated there was no activity participation documentation on 5/28/25, 5/29/25, 5/30/25, and 5/31/25.</p> <p>The May 2025 Activity Calendar indicated the following scheduled activities:</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5/27/25 - 9:30 a.m. Sittercise, 1:30 p.m. Cooking Corner, 3:00 p.m. Craft, and 6:00 p.m. Movie night</p> <p>5/28/25 - 9:30 a.m. Morning Stretch, 10:00 a.m. Bible Study, 1:30 p.m. Movie and popcorn, 3:00 p.m. Trivia, and 4:00 p.m. Jeopardy</p> <p>5/29/25 - 9:30 a.m. Trivia, 10:15 a.m. Glamour nails, 2:00 p.m. Bingo, 3:00 p.m. Courtyard visit, 3:30 p.m. Craft, and 6:00 p.m. Dice games</p> <p>On 5/29/25 at 10:15 a.m., the resident was not observed in the glamour nail activity.</p> <p>During an interview on 6/3/25 at 11:55 a.m., the Activity Director indicated she had recently taken over the position and she would make sure the resident's television or radio was turned on when she was in her room.</p> <p>3.1-33(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a treatment was completed as ordered for 1 of 2 residents reviewed for non-pressure related skin conditions. (Resident 48)</p> <p>Finding includes:</p> <p>On 5/30/25 at 10:22 a.m., Wound Nurse 1 was observed changing the bandage to Resident 48's trauma wound on the right anterior heel. The dirty dressing was removed and a dry dressing was then placed on the wound and was wrapped in dry gauze. The wound was not cleaned with Normal Saline Solution (NSS) before applying the dry dressing.</p> <p>During an interview at the time, Wound Nurse 1 indicated she thought she did everything right.</p> <p>The record for Resident 48 was reviewed on 5/30/24 at 10:01 a.m. Diagnoses included, but were not limited to, after care following a joint replacement, COPD, seizures, and obstructive sleep apnea.</p> <p>The 5/20/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately intact for daily decision making and had two unstageable pressure ulcers on admission.</p> <p>A Physician's Order, dated 4/27/25, indicated to clean the right anterior foot with normal saline solution (NSS), pat dry, apply a non-adherent pad, and wrap with kerlix dressing every Monday, Wednesday, and Friday and as needed.</p> <p>A Care Plan, dated 5/12/25, indicated the resident had a trauma related wound to the right anterior foot. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness and to follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>During an interview on 5/30/25 at 11:14 a.m., the Nurse Consultant indicated she understood the concern and would re-educate Wound Nurse 1.</p> <p>3.1-37(a)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the appropriate treatment was completed for a resident with an existing pressure ulcer for 1 of 6 residents reviewed for pressure ulcers. (Resident 91)</p> <p>Finding includes:</p> <p>During a pressure ulcer treatment observation on 5/30/25 at 11:07 a.m., Wound Nurse 1 was observed preparing to complete the treatment for Resident 91. The resident was observed lying in bed, and CNA 3 assisted with positioning the resident onto her left side. Wound Nurse 1 removed the bandage from the right hip. The bandage had a quarter-size of dried bloody drainage noted and pressure ulcer was red and open. The Wound Nurse indicated at that time, to her knowledge this was the first time the wound was opened.</p> <p>She cleaned the wound with normal saline and patted it dry. She opened a package of skin prep (a protective interface to prepare intact skin for attachment sites, tapes, films, and adhesive dressings and should not be applied to open wounds). Wound Nurse 1 wiped the open area with the skin prep pad and then covered it with a dry foam bandage.</p> <p>The record for the resident was reviewed on 5/30/25 at 9:20 a.m. Diagnoses included, but were not limited to, stroke, dementia, protein malnutrition, psychotic disorder, osteoporosis, and high blood pressure.</p> <p>A Care Plan, last revised on 1/17/25, indicated the resident had a pressure ulcer to the left and right trochanter areas. The nursing approaches were to administer the treatment as ordered.</p> <p>The 5/6/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had one unhealed unstageable pressure ulcer.</p> <p>A Physician's Order, dated 5/28/25, indicated to clean the left hip with normal saline, pat dry and apply skin prep and cover with foam bandage. Clean the right hip with normal saline, pat dry, apply barrier film, and cover with a foam bandage one time a day.</p> <p>The Wound Physician Notes, dated 5/28/25, indicated the left lateral hip deep tissue injury had 90% intact skin and 10% deep maroon skin. The area measured 1 centimeter (cm) in length by 1.5 cm in width.</p> <p>The Wound Assessment Details Report, dated 5/28/25, indicated the right trochanter hip area had 100% blanchable erythema skin and measured 6 cm in length by 3 cm in width by unknown. The area was intact with no drainage.</p> <p>During an interview on 5/30/25 at 1:30 p.m., Wound Nurse 2 indicated she had changed the resident's bandages on 5/29/25 and both wounds were closed with no drainage.</p> <p>During an interview on 5/30/25 at 2:35 p.m., the [NAME] President of Clinical Operations indicated she had just assessed the wound and it was now a Stage 2 pressure ulcer as it was open. The wound nurse should not have applied skin prep to an open area.</p> <p>(continued on next page)</p>		

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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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3.1-40(a)(2)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident with a limited range of motion had a physician-ordered splint in place for 2 of 2 residents reviewed for range of motion. (Residents 21 and 5)</p> <p>Findings include:</p> <p>1. During random observations on 5/28/25 at 10:33 a.m. and 11:35 a.m., Resident 21 was observed with his left hand closed in a fist. There was no palm protector (an anti-contracture device) and/or rolled wash cloth in use to the left hand.</p> <p>On 5/29/25 at 3:30 p.m., the resident was observed in his room in bed. The resident was awake and his left hand remained closed in a fist. There was no palm protector and/or rolled wash cloth in use.</p> <p>The record for Resident 21 was reviewed on 5/28/25 at 4:02 p.m. Diagnoses included, but were not limited to, contracture (a structural change in the body's soft tissues that cause them to stiffen and shorten) of the left hand and wrist, hemiplegia/hemiparesis (muscle weakness/paralysis) following a stroke, and vascular dementia with behavior disturbance.</p> <p>A Care Plan, reviewed on 5/1/25, indicated the resident had a contracture to the left wrist and hand related to left hemiplegia. The resident would refuse the splint at times but would accept a rolled wash cloth. Interventions included, but were not limited to, if splint was not available, use a rolled wash cloth in the hand to prevent skin impairment and palm protector to the left hand.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 5/7/25, indicated the resident had moderate cognitive impairment for daily decision making and he had no impairment in range of motion (ROM) to his upper and lower extremities. The resident was not receiving physical, occupational, or restorative services.</p> <p>A Physician's Order, dated 6/18/24 and listed as current on the May 2025 Physician's Order Summary (POS), indicated the resident was to wear a palm protector to the left hand as tolerated. Inspect the skin when donning and doffing every shift.</p> <p>The May 2025 Treatment Administration Record (TAR), indicated the palm protector was signed out as being applied all three shifts on 5/28/25 and the day and evening shift on 5/29/25.</p> <p>During an interview on 6/3/25 at 12:09 p.m., the Director of Nursing indicated if the resident could not tolerate the hand splint, he was to have a rolled wash cloth in place. She also indicated if the resident could not tolerate the splint, staff should not have signed it out as being applied.</p> <p>2. During random observations on 5/27/25 at 10:01 a.m. and 11:17 a.m., on 5/28/25 at 10:48 a.m., on 5/29/25 at 9:30 a.m. and 1:52 p.m., and on 5/30/25 at 9:48 a.m. and 11:15 a.m., Resident 5 was observed sitting up in a wheelchair. At those times, her left hand was tightly closed in the shape of a fist. There was no anti-contracture device in her left hand.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/2/25 at 11:08 a.m., the resident's left hand was again closed in the shape of a fist with no anti-contracture device. CNA 3 was in the resident's room and a black [NAME] guard was observed on the nightstand. The CNA indicated the resident would refuse to wear the device and they were to tell the nurse when she did. She tried placing the [NAME] guard in the resident's hand, however, the resident began to grimace so she stopped.</p> <p>The record for Resident 5 was reviewed on 5/29/25 at 9:30 a.m. Diagnoses included, but were not limited to, dementia, osteoarthritis, high blood pressure, and stroke.</p> <p>The 3/19/25 Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had resident had no impairment to the upper extremities.</p> <p>There was no care plan for the contracted left hand.</p> <p>A Physician's Order, dated 6/17/24, indicated to don the [NAME] guard to the left upper extremity as tolerated throughout the day/night with nursing to monitor for signs of redness/skin break down to the left palm.</p> <p>There was no documentation on the Medication or Treatment Administration Records for the months of 3/2025, 4/2025 and 5/2025 of the [NAME] guard being donned or doffed. There was no documentation of any refusals in nursing notes for the above dates.</p> <p>During an interview on 6/2/25 at 11:25 a.m., LPN 2 indicated they were made aware the resident refused to wear the [NAME] guard, however, there was no place to document the information.</p> <p>During an interview on 6/2/25 2:00 p.m., the Director of Nursing indicated they had tried using a carrot in her hand in the past, but there was no documentation of it being donned or doffed.</p> <p>3.1-42(a)(2)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents in the memory care unit were supervised during meals for 1 of 1 resident reviewed for supervision. (Resident B)</p> <p>Finding includes:</p> <p>During the lunch meal observation on the memory care unit on 5/27/25 at 11:54 a.m., there were eight residents, including Resident B in dining room [ROOM NUMBER]. CNA 3 plated the food for the residents and CNA 2 and CNA 4 served them. At 11:59 a.m., they were finished serving dining room [ROOM NUMBER], and they all left, leaving the residents with no supervision while eating.</p> <p>At 12:01 p.m., LPN 1 entered the room and left at 12:02 p.m., leaving all the resident unsupervised while eating. At 12:03 p.m., QMA 2 entered the dining room and left at 12:05 p.m.</p> <p>During the lunch meal observation on the memory care unit on 5/28/25 at 11:49 a.m., dietary staff brought the food into dining room [ROOM NUMBER].</p> <p>At 11:51 a.m., there were 9 residents observed in dining room [ROOM NUMBER]. There were seated at tables with beverages in front of them. There was no staff observed with those residents as they drank their beverages.</p> <p>At 11:58 a.m., the CNAs were finished serving the food in dining room [ROOM NUMBER] and pushed the cart of food into the hallway and served the residents who were seated at the tables in front of the nursing station. There were 10 residents including Resident B eating their food in dining room [ROOM NUMBER] without any staff supervision. QMA 2 was observed pushing a resident to her room for the Agency Nurse to administer insulin. While she waited for the nurse, she stood outside of dining room [ROOM NUMBER], however, she did not enter the room to supervise the residents while they were eating. At 12:06 p.m., QMA 2 continued to stand outside of the dining room and was not supervising the residents while they were eating.</p> <p>During a confidential interview on 5/28/25 at 10:00 a.m., a family member of a loved one on the memory care unit indicated after the staff served the food to the residents they would leave and there was no one to supervise the residents. She was afraid someone would choke during the meals.</p> <p>The record for Resident B was reviewed on 5/29/25 at 2:10 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing) and dementia.</p> <p>The 5/23/25 admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident needed supervision or touching assistance with eating.</p> <p>During an interview on 6/2/25 at 11:15 a.m., CNA 3 indicated last week on 5/27/25 and 5/28/25, QMA 2 was instructed to stay in the dining areas where the residents were eating after they had finished serving the food.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/2/25 at 2:00 p.m., the Director of Nursing indicated a staff member should have been in the dining rooms while the residents were eating.</p> <p>During an interview on 6/2/25 at 2:05 p.m. the Administrator indicated nursing staff needed to be present while the residents were eating.</p> <p>This citation relates to Complaint IN00460204.</p> <p>3.1-45(a)(2)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, record review, and interview, the facility failed to ensure oxygen and flow rate was documented per titration and oxygen was on at the correct flow rate for 2 of 2 residents reviewed for oxygen. (Residents 23 and 322)</p> <p>Findings include:</p> <p>1. On 5/27/25 at 10:28 a.m., Resident 23 was observed walking from the bathroom, she was wearing oxygen via nasal cannula at four liters.</p> <p>On 5/28/25 at 9:44 a.m., the resident was observed sitting on the side of her bed, she was having difficulty breathing. Her oxygen flow rate was set at just below the four liter line.</p> <p>The record for Resident 23 was reviewed on 5/28/25 at 9:44 a.m. Diagnoses included, but were not limited to, psychotic disorder with delusions, dementia, COPD, depression, and hypertension (high blood pressure).</p> <p>The 4/16/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident required oxygen therapy.</p> <p>A Physician's Order, dated 3/6/25, indicated to administer oxygen at three liters continuously every shift.</p> <p>A Care Plan, revised on 4/15/25, indicated the resident required oxygen therapy. Interventions were to monitor signs and symptoms of respiratory distress, and to use oxygen as ordered.</p> <p>A Care Plan, revised on 4/15/25, indicated the resident had Emphysema/COPD and acute chronic respiratory failure. Interventions were to administer oxygen as ordered and monitor for difficulty breathing on exertion.</p> <p>The Medication Administration Records (MAR), from January 2025 through May 2025, indicated oxygen was not signed out on the MAR.</p> <p>During an interview on 5/28/25 at 10:09 a.m., the Director of Nursing (DON) indicated she turned down Resident 23's oxygen to three liters per minute. The unit manager would put in a care plan because the resident changed her own oxygen levels and that was not documented.</p> <p>2. On 5/27/25 at 4:04 p.m., Resident 322 was observed lying in bed, she was extremely short of breath and requested the nurse. The resident was wearing oxygen via nasal cannula at three liters.</p> <p>On 5/28/25 at 9:33 a.m., the resident was observed lying in bed asleep. She was wearing oxygen at three liters via nasal cannula.</p> <p>On 5/29/25 at 8:07 a.m., the resident was observed lying in bed asleep. She was wearing oxygen at three liters via nasal cannula.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The record for Resident 322 was reviewed on 5/29/25 at 10:59 a.m. Diagnoses included, but were not limited to, diabetes, asthma, dementia, dysphagia (difficulty swallowing), depression, and bipolar disorder.</p> <p>The 5/21/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely impaired for daily decision making and required oxygen therapy.</p> <p>A Physician's Order, dated 5/10/25, indicated to administer oxygen at three liters per nasal cannula as needed (PRN). Titrate oxygen to four liters to maintain oxygen saturation above 90%.</p> <p>A Care Plan, revised on 5/21/25, indicated the resident required oxygen therapy. Interventions were to monitor signs and symptoms of respiratory distress, and to use oxygen as ordered.</p> <p>The Medication Administration Record (MAR) indicated the PRN oxygen was signed out for May 27, 28 & 29, 2025. There was no flow rate documented in the oxygen titrate order.</p> <p>During an interview on 5/29/25 at 1:30 p.m., the Nurse Consultant indicated the oxygen order on the MAR was changed and now included a place to document the oxygen flow rate.</p> <p>3.1-47(a)(6)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were stored properly and not expired for 2 of 5 medication carts observed. (100 Unit Cart 1 and 400 Unit Odd Cart)</p> <p>Findings include:</p> <p>1. On [DATE] at 2:51 p.m., the following was observed on the 100 Unit Cart 1 with LPN 1:</p> <ul style="list-style-type: none"> - An Admelog SoloStar Pen (insulin) with an open date on [DATE]. The expiration date was written for [DATE]. - An Admelog SoloStar Pen with an open date on [DATE]. The expiration date was written for [DATE]. <p>During an interview at the time of the observation, LPN 1 indicated the insulins were only supposed to be kept for 28 days and both were expired and should have been discarded.</p> <p>2. On [DATE] at 3:35 p.m., the following was observed on the 400 Unit Odd Cart with RN 1.</p> <ul style="list-style-type: none"> - A Lantus SoloStar Pen (insulin) with an open date on [DATE]. The expiration date was written for [DATE]. <p>During an interview at the time of the observation, RN 1 indicated the insulin was expired and should have been discarded.</p> <p>No policy related to the storage of insulins was provided by the facility.</p> <p>3.1-25(o)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to touching toast with bare hands and transporting uncovered food down the hallway for 1 of 4 units. (The Memory Care Unit). This had the potential to affect 27 of 27 residents residing on the unit.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During the lunch meal observation on 5/27/25 at 11:54 a.m. on the memory care unit, residents were observed in both dining rooms as well at the tables in front of the nursing station. CNA 3 was observed plating the food for the residents in Dining room [ROOM NUMBER] and CNAs 3 and 4 were observed passing the food to them. After they were finished in Dining room [ROOM NUMBER], CNA 1 pushed the cart with uncovered food out into the hallway and plated for 3 more residents. She then pushed the cart with uncovered food to Dining room [ROOM NUMBER] and plated and served the food to those residents. 2. During a lunch meal observation on 5/28/25 at 11:49 a.m. on the memory care unit, the residents were seated in both dining rooms as well as the tables in front of the nursing station. CNA 1 was observed plating the food for the residents and CNA 4 was observed passing the plates to them. After they finished in Dining room [ROOM NUMBER], CNA 1 pushed the uncovered food out into the hallway and plated food for the residents sitting at the tables by the nursing station. She then pushed the uncovered food to Dining room [ROOM NUMBER] and finished plating and serving the food to the rest of the residents. 3. During a breakfast meal observation on 5/29/25 at 7:34 a.m., the food arrived to the Memory Care Dining room [ROOM NUMBER] from the kitchen. At 7:43 a.m., QMA 1 entered the room and washed her hands with soap and water. Using her bare hands, the QMA proceeded to open jelly packets, picked up the toast and put jelly on them using a spoon. She jellied four pieces of toast and then it was time to plate and serve those residents who were seated in Dining room [ROOM NUMBER]. The QMA started to plate the food and instead of using tongs to pick the jellied toast, she used her bare hands and placed the toast on the residents plates. She proceeded to this with all four pieces of toast. At 8:03 a.m., the QMA pushed the uncovered food out of the dining room and out into the hallway, where she served a few residents who were seated at the tables in front of nursing station. She then pushed the uncovered food to Dining room [ROOM NUMBER], plated and served the food to those residents. <p>During an interview on 5/29/25 at 9:18 a.m., the Dietary Food Manager (DFM) indicated the memory care was the only unit where the staff plated and served the food on the unit. Staff were instructed not to touch food with their bare hands and the food should have been covered while transporting it from one dining room to the next.</p> <p>The current and undated Handling, Serving, and Transporting Foods policy, provided by the DFM on 5/29/25 at 9:24 a.m., indicated if food was transported from the main kitchen to another kitchenette, all food must be covered during transport. When serving room trays, every item must be covered until it reached the resident.</p> <p>3.1-21(i)(3)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were in place and implemented related to the disposal of used lancets into the garbage can for 1 of 1 glucometer (machine used to test blood sugar levels) testing observed and the placement of clean treatment materials on dirty tables for 2 of 5 treatments observed. (Residents 18, 48 and 317)</p> <p>Findings include:</p> <p>1. On 5/27/25 at 3:43 p.m., LPN 2 indicated he was going to check Resident 18's blood sugar. The nurse washed his hands, applied gloves, and wiped the resident's fourth right finger with an alcohol wipe. He then poked the resident's finger with the lancet. Blood was observed on the resident's finger. The nurse then proceeded to check the blood sugar with the glucometer. He discarded the lancet into the garbage can next to the resident's bed. He was unable to get a reading on the glucometer and indicated he would have to poke the resident's finger again to check the blood sugar. He proceeded to wipe the resident's third right finger with an alcohol wipe. He then poked the resident's finger with the lancet. Blood was observed on the resident's finger. He checked the blood sugar again with the glucometer. Again, he discarded the lancet into the garbage can next to the resident's bed. The blood sugar reading was complete on the glucometer. The nurse discarded his gloves into the garbage can, used hand sanitizer, and then left the resident's room.</p> <p>During an interview after the observation, LPN 2 indicated he should not have discarded the lancets into the garbage can. He should have discarded them into the sharps container.</p> <p>A facility policy titled, Medical Waste Disposal and received as current from the facility, indicated, .Standards: . 3. Type I waste, SHARPS ONLY, shall be placed in a non-porous hazardous waste container marked with the universal biohazard symbol .</p> <p>2. On 5/30/25 at 10:22 a.m., Wound Nurse 1 was observed during a dressing change for Resident 48. The wound nurse was prepping supplies from the wound treatment cart when she had run out of Normal Saline Solution (NSS). She excused herself to search for more solution. When she returned she did not perform hand hygiene or put on gloves. She then retrieved a handful of 4 x 4 gauze out of the treatment cart and placed it into a plastic cup with her bare hands. The 4 x 4 gauze was then sprayed with NSS. Once that was completed, the wound nurse brought her supplies, which consisted of 3 cups that contained saturated 4 x 4 gauze, a clean drape unopened, and 3 opened gauze rolls, into the resident's room. The betadine solution was left on the treatment cart and was later obtained by CNA 7. The supplies were placed on the resident's bedside table which was littered with crumbs and the resident's belongings. The clean drape was opened and placed on the resident's dining table and the other supplies were then moved to the clean drape. Both heels were cleaned with the saturated 4 x 4 gauze and wrapped with the gauze rolls.</p> <p>The record for Resident 48 was reviewed on 5/30/24 at 10:01 a.m. Diagnoses included, but were not limited to, after care following a joint replacement, COPD, seizures, and obstructive sleep apnea.</p> <p>The 5/20/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately intact for daily decision making and needed substantial to maximum assistance for bed mobility and transfers. The resident had two unstageable pressure ulcers on admission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Aperion Care Arbors Michigan City		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E Coolspring Ave Michigan City, IN 46360	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physician's Order, dated 5/9/25, indicated to clean the right heel with NSS, pat dry, paint the area with Betadine and wrap with kerlix dressing daily and as needed.</p> <p>A Physician's Order, dated 5/9/25, indicated to clean the left heel with NSS, pat dry, paint the area with Betadine and wrap with kerlix dressing daily and as needed.</p> <p>During an interview on 5/30/25 at 11:14 a.m., the Nurse Consultant indicated she understood the concern and had no additional information to provide.</p> <p>3. On 5/30/25 at 10:49 a.m., Wound Nurse 1 was observed during a wound treatment. The wound nurse set down her supplies, which included two open foam dressings, and 1 unopened clean drape. The supplies were set down on top of Resident 317's table which had crumbs and her belongings on it. The clean drape was opened and then the two open dressings were placed on top.</p> <p>The record for Resident 317 was reviewed on 5/30/25 at 10:05 a.m. Diagnoses included, but were not limited to, Alzheimer's, anxiety, chronic kidney disease, and hypertension (high blood pressure).</p> <p>The 5/22/25 admission Minimum Data Set (MDS) assessment indicated the resident was moderately intact for daily decision making. She had no pressure ulcers.</p> <p>A Physician's Order, dated 4/27/25, indicated to cleanse bilateral heels with NSS, pat dry and apply a foam dressing to each heel one time a day every Monday, Wednesday, Friday, and as needed.</p> <p>During an interview on 5/30/25 at 11:14 a.m., the Nurse Consultant indicated she understood the concern and had no additional information to provide.</p> <p>3.1-18(b)</p>		