STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident was free from misappropriation of property related to a missing Playstation gaming controller for 1 of 3 residents reviewed for misappropriation. (Resident B) Finding includes: The record for Resident B was reviewed on 8/3/20 at 12:00 p.m. [DIAGNOSES REDACTED]. A Concern/Compliment Form, dated 1/24/20, indicated the resident was missing a blue Playstation controller. The facility searched for the missing item, it was not located, and the family replaced it. The corrective action taken by the notifying staff included, but was not limited to, informed the family to label the item and reminded them to keep it secure. The Admission Minimum Data Set (MDS) assessment, dated 1/17/20, indicated the resident was severely cognitively impaired for decision making, and required an extensive one person physical assist with transfers and walking in the room. A Care Plan, dated 1/10/20, indicated the resident had limited physical mobility related to weakness. The interventions included, but were not limited to, Physical Therapy (PT) and Occupational Therapy (OT) referrals as needed. Interview with the Administrator on 8/4/20 at 1:30 p.m., indicated the blue Playstation gaming controller should have been safely secured by the facility staff and when the item was reported missing the facility should have reimbursed the family after they replaced it. This Federal tag refers to Complaint IN 510. 3.1-28(a)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided for dependent residents related to incontinence care and showers for 2 of 6 residents reviewed for activities of daily living (ADL's). (Residents C and H) Findings include: 1. On 8/4/20 at 9:00 a.m., Resident C was observed in bed lying on her back. The resident was awake and watching television. On 8/4/20 at 10:30 a.m., CNA 2 and CNA 4 entered the resident's room to provide incontinence care. They donned clean gloves to both hands, removed the front of her brief and there was a large amount of bowel movement noted between her legs. CNA 2 cleaned the front of the resident first and then rolled her over onto the left side and provided incontinence care. At that time, there was an uncovered open area observed on her buttocks. CNA 2 indicated at that time, the resident was a cares in pairs and no males were allowed to provide care per the resident's choice. The CNA indicated she last checked the resident for incontinence at 7:00 a.m. and the resident refused to be checked and/or changed. The CNA had not gone back into check or change the resident since that time. The record for Resident C was reviewed on 8/3/20 at 1:45 p.m. The resident was admitted on [DATE]. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/20, indicated the resident was cognitively intact. She was an extensive assist with a 2 person physical assist for bed mobility, transfers, dressing and personal hygiene. The resident was totally dependent on staff with a 2 person physical assist for toilet use, eating, and locomotion off unit. The resident had pressure ulcers. A Care Plan, revised on 1/9/20, indicated the resident had bowel incontinence related to immobility and gastrostomy tube. The approaches were, but not limited to, check the resident every two hours and assist with toileting as needed. The shower schedule indicated when the resident was first admitted she preferred showers on Mondays and Thursdays. In April 2020 the resident was changed to bed baths on Tuesdays and Fridays. The resident's shower schedule from 1/2020 to current 8/4/2020 indicated the following: Coded Not Applicable on 1/13, 2/6, 2/20, 4/6, 4/9, and 4/13 and missing showers on 1/16 and 4/21/20. Interview with CNA 2 on 8/4/20 at 10:45 a.m., indicated she was aware the residents were to be checked and/or changed every 2 hours. Interview with the LPN 2 on 8/4/20 at 3:30 p.m., indicated the CNAs were to check and change the residents every 2 hours. Interview with the Administrator on 8/5/20 at 2:30 p.m., indicated she had instructed the CNAs not to put Not Applicable for a response on the showers. She indicated the above documented missing showers or Not Applicable were not completed. 2. On 8/4/20 at 9:00 a.m., Resident H was observed in bed laying on her back. There were 2 pillows noted on each side of her propping up both arms. The resident had an enteral feeding infusing and she was ventilator dependent. Her eyes were closed at that time. On 8/4/20 at 11:30 a.m., CNA 2 and CNA 3 entered the room and asked the resident if they could provide incontinence care. The resident agreed and CNA 3 removed the bed linens. There was a large amount of dark brown liquid bowel movement observed between her legs and overflowing from the incontinent brief she was wearing. The CNAS cleaned the resident and turned her onto her left side. The incontinent brief was saturated with bowel movement that had leaked onto the pad underneath the resident. There was a white bandage observed on the resident's coccyx area that was identified as a pressure ulcer. Interview with CNA 3 at that time, indicated he had asked the resident if she wanted to be changed at 7:30 a.m., right before breakfast and she refused. This was the first time since then he had asked her again to be changed. He was aware the resident was to be checked and/or changed at least every 2 hours. The record for Resident H was reviewed on 8/4/20 at 10:05 a.m. The resident was admitted on [DATE]. [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) assessment, dated 6/22/20, indicated the resident was cognitively intact and was totally dependent on staff with a 2 person physical assist for bed mobility, transfers, dressing, bathing, toilet use, and personal hygiene. She was admitted with 1 Stage 3 pressure ulcer. The Care Plan, dated 6/18/20, indicated the resident was incontinent of bowel. The approaches were to check and change every 2 hours and as needed and to notify nursing if the resident refused incontinent care. Interview with the LPN 2 on 8/4/20 at 3:30 p.m., indicated the CNAs were to check and change the residents every 2 hours. This Federal tag refers to Complaints IN 346, IN 734, IN 715, and IN 883. 3.1-38(a)(2)(A) 3.1-38(a)(2)(C)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure treatments were completed as ordered as well as not initiating treatments for existing and new onset pressure ulcers for 3 of 4 residents reviewed for pressure ulcers. (Residents J, C, and K) Findings include: 1. On 8/3/20 at 9:38 a.m., Resident J was observed in his room in bed. LPN 2 indicated at that time, the resident had pressure ulcers to his back and bottom. The LPN proceeded to roll the resident to his right side. The resident had a white gauze dressing to his left scapula (shoulder blade) that was not dated and a dressing to the right scapula that was dated 7/31/20. Light greenish drainage was observed on the right scapula dressing and a slight odor was noted. There was a foam dressing to the resident's sacral area (tail bone) dated 7/31/20. Interview with LPN 2 at the time, indicated the left scapula dressing was not dated and the dressings to the right scapula and sacrum were dated 7/31/20. The LPN indicated she had not completed her treatments yet. The record for Resident J was reviewed on 8/3/20 at 11:51 a.m. [DIAGNOSES REDACTED]. physician's orders [REDACTED]. Cleanse all 3 areas to the right scapula with [MEDICATION NAME], lateral scapula area apply santyl and calcium alginate, inferior lateral area apply calcium alginate only and cover entire area with foam dressing daily et prn every day shift. Cleanse area to the left scapula with

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

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) [MEDICATION NAME], pat dry, cover with silver alginate and foam dressing daily and prn every day shift. The August 2020 Treatment Administration Record was reviewed. The treatments to the resident's left and right scapula as well as the sacrum were signed out as being completed on 8/1 and 8/2/20. The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/20, indicated the resident's short and long term memory were not assessed. The resident was extensive two person assist with bed mobility and transfers. The resident was also identified as having two Stage 2 pressure ulcers, one Stage 3 pressure ulcer, two Stage 4 pressure ulcers and one Unstageable pressure ulcer. The Care Plan, dated 4/3/20, indicated the resident had a pressure ulcer to the left and right buttocks and sacrum. Interventions included, but were not limited to, administer treatments as ordered and assess for effectiveness. Interview with the Wound Nurse on 8/4/20 at 3:34 p.m., indicated the resident's treatments to his left and right scapula as well as his sacrum were to be completed daily. She indicated she has talked with the Unit Manager before as this has been a problem in the past, staff will sign out the treatment as being completed but will not do the treatment. She indicated she would talk to the Unit Manager again. 2. On 8/3/20 at 1:10 p.m., Resident C was observed in bed lying on her back. At that time, LPN 2 was administering a bolus enteral feeding through the resident's gastrostomy tube (a tube placed directly into the stomach for nutrition). The resident had written on her dry erase board that she needed her catheter looked out because she was peeing around it. After the bolus was completed, CNA 5 and LPN 2 turned the resident over onto her left side and removed the incontinent brief. The brief was saturated with urine. At that time, there was an uncovered open area on the resident's buttocks. The area was red with white edges. Interview with the LPN 2 at that time, indicated she was only taking care of Resident C on the vent unit and was unaware if the area had a treatment or not. On 8/4/20 at 10:30 a.m., CNA 2 and CNA 4 entered the resident's room to provide incontinence care. They donned clean gloves to both hands, removed the front of her brief and there was a large amount of bowel movement noted between her legs. CNA 2 cleaned the front of the resident first and then rolled her over onto the left side and provided incontinence care. At that time, there was an uncovered open area observed on her buttocks. The area was red with white edges and had bowel movement all over it. CNA 2 indicated she was going to tell LPN 2 there was no bandage covering her pressure ulcer on her buttock. On 8/5/20 at 1:15 p.m., the Wound Nurse and a CNA attempted to do the treatment for [REDACTED]. The record for Resident C was reviewed on 8/3/20 at 1:45 p.m. The resident was admitted on [DATE]. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/20, indicated the resident was cognitively intact. She was an extensive assist with a 2 person physical assist for bed mobility, transfers, dressing and personal hygiene. The resident was totally dependent on staff with 2 person physical assist for toilet use, eating, and locomotion off unit. The resident had pressure ulcers. A Care Plan, dated 1/2/20, indicated the resident had a potential for impairment to skin integrity. The approaches were to keep skin clean and dry and provide the treatment as ordered. Nurses' Notes, dated 7/22/20 at 5:01 p.m., indicated staff reported an open area to the buttocks. Noted right buttocks has an open area. Treatment changed to [MEDICATION NAME] Zinc ointment and cover with foam dressing daily and as needed. physician's orders [REDACTED]. Cleanse with normal saline, pat dry, and apply ointment and cover with foam dressing. A Wound Assessment Details Report, dated 7/22/20, indicated the resident had a Stage 2 pressure ulcer to the right buttock. The sore measured 1.5 centimeters (cm) by 1.5 cm by 0.10 depth and had 100% [MEDICATION NAME] tissue. A wound measurement on 7/29/20 indicated the pressure ulcer had advanced to a Stage 3 and measured 2 cm by 2 cm by .10 depth. The area was 100% bright red or pink, however now had maceration (when skin was in contact with moisture for too long) around the periwound. Interview with the Wound Nurse on 8/5/20 at 1:15 p.m., indicated the resident refused treatments, turning and repositioning and incontinence care all the time. She was aware the pressure ulcer had maceration and indicated she does not allow the staff to change her. The Wound Nurse indicated there should have been a bandage over the pressure ulcer at all times and the nurses were to change it when it becomes soiled. 3. On 8/3/20 at 9:35 a.m., during a random wound observation with RN 1 and CNA 1, Resident K was observed with a small pink/reddish open area to her left buttock, the area was open to air. The resident's coccyx area and right buttock was covered with a white cream. Interview at the time with the RN indicated the open area to her left buttock was new. The record for Resident K was reviewed on 8/4/20 at 10:54 a.m. [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 5/22/10, indicated the resident was rarely/never understood, she required 1 person physical assistance with bed mobility, and had no pressure ulcers. An updated Care Plan, dated 8/3/20, indicated the resident had the potential for further skin alterations related to decreased mobility, incontinence, [MEDICAL CONDITION], chronic excoriation to abdominal folds, and a history of pressure ulcers. The interventions included, but were not limited to, assess/record changes in skin status, and notify the Physician of skin alterations. physician's orders [REDACTED]. The Skin-Pressure/Diabetic/Venous/Arterial Wound Report, dated 8/3/20 at 9:59 a.m., indicated new wound development, house acquired: - wound 1, to left coccyx, stage 2 measuring 0.5 cm (centimeters) x 0.5 cm - wound 2, to left coccyx, stage 2 measuring 0.5 x 0.5 cm. There was no documentation to indicate the resident had any skin impairments to her buttocks prior to 8/3/20. Interview with the Wound Nurse on 8/3/20 at 3:15 p.m., indicated last week, on 7/29/20, during her wound rounds the resident had red areas to her right and left buttocks which were not open. She also had an order for [REDACTED]. She further indicated the resident had two small open areas to her buttocks which were treated with Zinc Oxide and left open to air. The areas were not new and were unchanged. Interview with the Director of Nursing on 8/4/20 at 3:00 p.m., indicated the resident's areas should have been properly assessed, documented, and treated when first noted. This Federal tag refers to Complaints IN 346, IN 734, IN 715, and IN 883. 3.1-40(a)(2)
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident was free from accidents and hazards related to not following physician's orders [REDACTED]. (Resident B) Finding includes: The record for Resident B was reviewed on 8/3/20 at 12:00 p.m. [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) assessment, dated 1/17/20, indicated the resident was severely cognitively impaired for decision making and had a feeding tube. A Care Plan, dated 1/13/20, indicated the resident received all nutrition via feeding tube related to recent [MEDICAL CONDITION] perforation with surgical repair. The interventions included, but were not limited to, administer nutritional support as ordered via tube feeding and flushes. A physician's orders [REDACTED]. The 1/2020 Fluid Intake CNA Flow Chart indicated the resident received fluids on the following days: - 1/14, 610 ounces - 1/15, 560 ounces - 1/16, 240 ounces - 1/18, 560 ounces - 1/19, 300 ounces - 1/22, 300 ounces - 1/25, 240 ounces - 1/29, 560 ounces Interview with the Director of Nursing on 8/4/20 at 3:00 p.m., indicated the physician's orders [REDACTED]. This Federal tag refers to Complaint IN 510. 3.1-45(a)(2)
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred walls, dark discoloration with white frothy areas along the base of the wall radiator and wall, malodorous rooms, food and debris on the floor, dirty carpet, dirty floor mats, and an unsecured wall radiator for 1 of 4 units observed. (200 unit) Findings include: 1. During the Environmental tour on 8/5/20 at 1:30 p.m. with the Maintenance Director, the following was observed: 200 unit a. room [ROOM NUMBER] - There were marred walls under the window seal, and dark discolorations with white frothy areas along the base of the wall radiator and wall. There was a mildew odor in the room. There was food and debris on the floor, and the carpet as well as the floor mats were dirty. Interview with the resident in the room indicated there was a black substance along the base of her radiator in her room. She indicated she had reported it multiple times to staff and the housekeeper cleaned the area every once in a while. b. The wall radiator outside of room [ROOM NUMBER] was unsecured to the base. There was debris inside the top and bottom of the radiator. Interview with the Administrator, on 8/6/20 at 10:44 a.m., indicated she cleaned the room last week. The housekeeper was supposed to clean the room daily. She indicated she planned to have all of the carpet removed from the residents' rooms. Interview with the Maintenance Supervisor, on 8/5/20 at 1:53 p.m., indicated all of the above was in need cleaning and/or

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) repair. 2. On 8/3/20 at 1:30 p.m., the entire 200 unit in the hallway smelled like mildew. There were fans blowing on the carpet outside of room [ROOM NUMBER] and there was a fan blowing on the carpet inside room [ROOM NUMBER]. Interview with the Maintenance Director at that time, indicated there was condensation from the pipes that caused the carpet to get wet on very humid days. This Federal tag relates to Complaint IN 466. 3.1-19(f)