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 _____	**08/26/2020**

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was free from physical restraints for 1 of 1 abuse allegations reviewed. (Resident B) Finding includes: The record for resident B was reviewed on 8/26/20 at 8:50 a.m. The resident was admitted to the facility on [DATE] with hospice care. [DIAGNOSES REDACTED]. An Admission Note, dated 8/19/20 at 10:54 p.m., indicated, .Resident is unable to verbalize needs. Resident is not eating or drinking. Resident have {sic} involuntary body movements The policy titled, Abuse Prevention and Reporting-Indiana, revised 1/22/19, was received from the Administrator on 8/26/20 at 10:00 a.m. The policy indicated, The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint During an interview with LPN 1 on 8/26/20 at 11:00 a.m., she indicated on 8/20/20 around 8:30 a.m., the hospice nurse arrived to visit with the resident. Shortly after, the hospice nurse came to get her and brought her into the resident's room. There was a sheet folded, laid across the resident's legs and tied on each side of the bed. They untied the sheet and assessed him for injury. The LPN then notified the Administrator. During an interview with the Administrator on 8/26/20 at 9:00 a.m., she indicated she had been informed of the incident by LPN 1 on 8/20/20. She started an investigation immediately. After interviewing staff, a Qualified Medication Aide (QMA) had admitted to tying the sheet across the resident's legs because he was agitated. The QMA indicated the midnight nurse was aware of it. This Federal tag relates to Complaint IN 753. 3.1-3(w)

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.