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 _____	**10/13/2020**

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 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain Physician's Orders related to COVID-19 resident testing due to a facility outbreak for 1 of 3 residents reviewed for Infection Control. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 10/13/20 at 12:00 p.m. [DIAGNOSES REDACTED]. There was no documentation indicating the facility obtained a Physician's Order to obtain a PCR COVID-19 test for the resident in September 2020. Interview with the Administrator on 10/13/20 at 1:15 p.m., indicated all the residents and staff were tested on ,[DATE] and 9/4/20 due to a positive employee. The residents were again tested on ,[DATE] and 9/16/20 and they were all negative. Interview with the Administrator on 10/13/20 at 1:50 p.m., indicated there was no Physician's Order to perform a COVID-19 test for the resident. The CMS Memorandum, dated 8/26/20, indicated the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing . 3.1-49(f)(1)
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** Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and/or contain COVID-19 related to personal protective equipment (PPE) not worn properly with resident and staff interaction, hand hygiene not completed after glove removal, transmission based precautions not initiated for new admissions or readmissions, and improper linen handling for random observations for infection control, as well as lack of monitoring residents for COVID-19 signs and symptoms for 8 of 8 residents and on 2 of 4 Units. (The Special Care and 400 Units and Residents 2,3,5,6,7,8, 9, and 10) Findings include: 1. During a random observation, on 10/13/20 at 9:31 a.m. in the therapy office, the Therapy Director had his mask pulled down around his chin and was talking to Certified Occupational Therapist Aide (COTA) 1. The COTA was not wearing a mask and they were not standing six feet apart from each other. Another therapy staff member seated on the side of the room had her mask pulled down around her chin and another staff member seated in the back of the room was not wearing a mask. Interview with the Administrator on 10/13/20 at 11:00 a.m., indicated the therapy staff members should have been wearing their masks while they were in the office. 2. Observation of the 400 Unit on 10/13/20 at 9:35 a.m., indicated an isolation set up was outside of room [ROOM NUMBER]. There was a stop sign on the door which indicated to check with the nurse prior to entering. There was no sign on the door indicating what type of isolation the resident was in. Interview with the 400 Unit Manager at the time, indicated the resident in room [ROOM NUMBER] was in contact isolation and a sign should have been on the door. 3. During a random observation, on 10/13/20 at 9:35 a.m., Resident 2 was seated in her wheelchair in the 400 Unit hallway. The resident was wearing a surgical mask at the time. Interview with the 400 Unit Manager at the time, indicated they have had five new admissions within the past 14 days, Residents 2, 3, 7, 8 and 10. When asked what was done when the facility had a new admission or readmission, the Unit Manager indicated the residents were quarantined for 14 days and not allowed to come out of their rooms. Personal protective equipment (PPE) was to be worn when entering the room. The rooms for the new residents were observed. There were no isolation set ups outside of their rooms and no signs on the doors to indicate they were in droplet/contact precautions. At 9:40 a.m., the Physician was observed entering Resident 7's room. The Physician was wearing a surgical mask. No other PPE was used. A list of new admissions was provided by the Administrator, there had been a total of 8 new admissions within the past 14 days. Resident 2 was readmitted on [DATE]. Resident 3 was admitted on [DATE]. Resident 5 was admitted on [DATE]. Resident 6 was admitted on [DATE]. Resident 7 was admitted on [DATE]. Resident 8 was admitted on [DATE]. Resident 9 was admitted on [DATE]. Resident 10 was admitted on [DATE]. None of the above residents had signs on their doors or isolation set ups outside of their rooms. Interview with the Administrator on 10/13/20 at 10:30 a.m., indicated the new admissions and readmissions were to be quarantined for 14 days. She confirmed the residents should be in transmission based precautions with signs on the door and isolation set ups outside of the rooms. The interim facility policy addressing the healthcare crisis related to the human [MEDICAL CONDITION], dated 10/6/20, was provided by the Director of Nursing on 10/13/20 at 1:45 p.m. The policy indicated, new admissions or re-admissions required a 14 day quarantine under transmission based precautions. All recommended COVID-19 PPE was to be worn during care of residents under 14 day quarantine observation, which included eye protection, N95 mask, gloves and gown. 4. During a random observation on the Special Care Unit on 10/13/20 at 9:22 a.m., Activity Aide 1 was observed walking down the hallway with her facemask below her nose. She walked over to a room and grabbed a plastic ball and walked back down the hallway towards the dining room. There were multiple residents observed in that hallway seated in straight chairs and wheelchairs. The residents were not wearing any masks. Interview with Activity Aide 1 at that time, indicated she was aware the facemask was supposed to be over her nose, but it was loose and would not stay up. After the interview, she continued to walk to a small lounge area and situated 2 residents in a circle and started a game of ball toss. The mask continued to fall below her nose, however, she did not stop and get a new one and continued to play the game with the facemask below her nose. At 9:30 a.m., a nurse that was seated behind the desk, got up from her seat and started to position the residents further apart and observed the activity aide playing the game with her facemask below her nose, however, she said nothing to her about pulling it up. 5. During a random observation on 10/13/20 at 9:40 a.m., CNA 1 was observed walking down the hallway toward the clean utility room. The CNA was wearing her facemask below her nose. She stepped out of the room carrying clean linen consisting of sheets, incontinent pads, towels and wash cloths against her body. She proceeded to walk down the hallway carrying the clean linen, with her facemask below her nose. The DON observed this and followed her down the hallway and shortly thereafter, the CNA walked back down the hallway still holding the linen and threw all of that linen into a laundry bin in the soiled room. The CNA was still observed with her facemask below her nose. Interview with CNA 1 at 9:46 a.m., indicated she was very new to the job and only had been a CNA for 3 weeks. She indicated the facemask was not fitting her face. 6. On 10/13/20 at 10:25 a.m., Medical Assistant 1 (working for the outsourced laboratory) was observed performing COVID-19 PCR nasopharyngeal swabs to all of the employees as part of their weekly staff testing according to the county rate. The Medical Assistant was observed seated in the dining room at a 4 foot square table. She was wearing a N95 facemask, however, she had no other personal protective equipment (PPE) on like a face shield or an isolation gown. At 10:35 a.m., an employee entered the dining room to be swabbed. The Medical Assistant told the employee to sit in the chair next to the table. She obtained a label and filled it out and placed it on the specimen tube. She donned clean gloves to both hands, obtained the nasal swab sample and placed it in the tube and then in a biohazard plastic bag. She removed her gloves and threw them away in a brown paper bag next to the table. She did not perform hand hygiene

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) before or after removing the gloves. She also had no other PPE on other than a N95 facemask. The Medical Assistant was observed touching her face and hair and straightening her glasses after glove removal. She did not clean the table or wipe it down with any antiseptic cleaner after she had obtained the nasal swab. Another employee entered the room, sat down in same chair, and the Medical Assistant completed another label. She donned clean gloves to both hands, without performing hand hygiene, obtained the specimen, while her left gloved hand was touching and leaning on the table. She placed it in the tube and then in the plastic bag. She removed the gloves, threw everything away in the brown paper bag and did not perform hand hygiene. The table was not cleaned after the swab was obtained. The third employee was standing in line waiting for her test. She was seated in the same chair next to the table. The Medical Assistant donned clean gloves, obtained a label and placed it on the specimen container. She did not perform hand hygiene before donning the gloves. The swab was obtained and placed in the tube. She then picked up the pen with her gloved hands and wrote something else on the label and placed it in the plastic bag. She removed her gloves and threw them away in the brown paper bag. She did not perform hand hygiene after glove removal. Interview with Medical Assistant 1 at that time, indicated she had protective eyewear, however, she did not think she needed to wear it. She also indicated she had no isolation gown and was not provided one when she first arrived. The facility also gave her the brown paper bag to dispose all of her garbage in including specimen sticks and used gloves. When asked if she ever performed hand hygiene after each swab, the Medical Assistant stated, But I changed my gloves after every one. Interview with the Administrator on 10/13/20 at 1:45 p.m., indicated the lab technicians were to bring in their own PPE to perform testing. This was the first time this lab had been in their building. The lab tech should have performed hand hygiene before and after donning gloves and wiped down the table in between employee testing. The current and updated 10/6/20 Infection Control-Interim policy addressing healthcare crisis related to Human Coronavirus policy, provided by the Interim Director of Nursing on 10/13/20 at 1:45 p.m., indicated the health care professional should perform hand hygiene before and after glove removal. 7. The record for Resident 2 was reviewed on 10/13/20 at 12:00 p.m. [DIAGNOSES REDACTED]. The resident was readmitted from the hospital on [DATE]. physician's orders [REDACTED]. There were no other physician's orders [REDACTED]. Nurses' Notes, dated 10/8/20, at 12:26 a.m., indicated a 72 hour assessment was completed. The resident's pulse oximetry was 95% on room air and was last taken on 9/8/2018. The information was old data. A 72 hour assessment, completed on 10/9/20 at 10:52 a.m., indicated the resident's pulse oximetry was 95% on room air and was last taken on 9/8/2018. A 72 hour assessment, completed on 10/10/20 at 3:52 a.m., indicated the same information as above. A 72 hours assessment, completed on 10/11/20 at 2:10 a.m., was the first time a new pulse oximetry level was obtained and it was 95% on room air. The vital signs documentation indicated a pulse oximetry was obtained on 10/12/20 at 7:37 a.m., no other oxygen saturations had been obtained. The Medication Administration Record [REDACTED]. Interview with the Administrator on 10/13/20 at 2:15 p.m., indicated there should have been a COVID-19 assessment for the resident at least every shift while in transmission based precautions. The current and updated 10/6/20 Infection Control-Interim policy addressing healthcare crisis related to Human Coronavirus policy, provided by the Interim Director of Nursing on 10/13/20 at 1:45 p.m., indicated all residents were to be screened for elevated body temperature, pulse oxygen level, and symptoms of COVID-19 as listed by CDC at least daily. Residents with known or suspected COVID-19 should have a respiratory assessment, monitored vital signs, and oxygen saturation assessment every shift. 3.1-18(b)(1)
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on record review and interview, the facility failed to ensure the Infection Preventionist had completed a specialized training course necessary for the COVID-19 survey protocol. Finding includes: During a visit on 10/13/20, the Director of Nursing (DON), who was deemed the facility's Infection Preventionist, lacked a certificate which indicated she had completed a training course related to infection prevention and control. During an interview with the Administrator on 10/13/20 at 2:00 p.m., she indicated the previous DON was the Infection Preventionist and her last day of work was 10/9/20. An Agency Interim DON started at the facility on 10/12/20. The Administrator indicated it was facility policy to have the DON serve as the Infection Preventionist.