

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2013
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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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F0000	<p>This visit was for the Investigation of Complaints IN00120905 and IN00121834.</p> <p>Complaint IN00120905-Substantiated. Federal/state deficiencies related to the allegations are cited at F514.</p> <p>Complaint IN00121834-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: January 22, 23, 24, 2013</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type SNF: 34 SNF/NF: 120 Total: 154</p> <p>Census payor type: Medicare: 42 Medicaid: 95 Other: 17</p>	F0000	We ask that you accept this plan of correction and do a desk review in lieu of a return visit. Please accept this plan of correction as The Arobors at Nichigan City's credible allegation of compliance. This plan of correction does not constitute any admission or guilt or liability by the facility and is only submitted in response to regulatory requirement	

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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	<p>Total: 154</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on January 25, 2013 by Randy Fry RN.</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interviews and record review, the facility failed to ensure transfer records were complete. This deficiency affected 2 of 3 residents, whose transfer records were reviewed, in a sample of 4. (Resident #B and #C)</p> <p>Findings include</p> <p>1. On 1/22/13 at 12:15 p.m., during the orientation tour, LPN #12 indicated Resident #B had been hospitalized recently.</p> <p>The clinical record of Resident #B was reviewed on 1/22/13 at 2:00 p.m. and indicated the resident was transferred to the hospital on 12/30/12 and returned to</p>	F0514	<p>F-514</p> <p>1. Medical Records department of hospital that Resident #B recently had an admission stay at was called per the DHS on 2/1/13 and offered to send information missing off of transfer form and declined at this time. Offered to send date and signature of nurse who sent resident #C hospital due to missing off of transfer form and medical records department declined at this time.</p> <p>2. All transfer forms were reviewed on 2/5/13 for the last 30 days, any deficiencies noted were corrected at this time.</p> <p>3. Licensed nurses will be re-inserviced by DHS or designee</p>	02/21/2013			

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	<p>the facility on 1/4/13.</p> <p>Sections of the Transfer Record, sent with the resident on 12/30/12, were blank, including but not limited to; information regarding the resident's functional status, behavior, communication ability, mental status, assistance devices, suggestions for care, and immunization history. The information, not completed on the transfer record, was not included in other documents sent with the resident to the hospital.</p> <p>On 1/23/12 at 9:00 a.m., the Director of Nursing was interviewed and indicated information on Resident #B's transfer record was not completed and was not included in other documentation sent with the resident.</p> <p>2. The clinical record of Resident #C was reviewed on 1/23/13 at 10:00 a.m. and indicated the resident was transferred to the hospital 12/6/12 and returned to the facility on 12/10/12.</p> <p>The Transfer Record, sent with the resident to the hospital on 12/6/12, was not signed by the person completing the record and was not dated.</p> <p>This Federal tag relates to Complaint</p>		<p>related to correctly filling out of transfer forms on 2/11/13. DHS or designee will audit all transfer forms 5 days a week to include all shifts. The DHS or designee will use audit tool A and will report findings to QA&A monthly for 6 months.</p> <p>4. QA&A will monitor monthly for trends and make recommendations to the plan of correction as needed. QA&A will monitor for 6 months or until compliance is met.</p> <p>5. Completion date: 2/21/13</p>		

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	IN00120905. 3.1-50(a)(1)			