

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  08/12/2014
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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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F000000	<p>This visit was for the Investigation of Complaints IN00152714 and IN00153806.</p> <p>Complaint IN00152714- Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Complaint IN00153806- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 11 &amp; 12, 2014</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 10027260</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF: 24 SNF/NF: 121 Total: 145</p> <p>Census payor type: Medicare: 24 Medicaid: 101 Other: 20 Total: 145</p>	F000000		
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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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F000323 SS=G	<p>Sample: 7</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 14, 2014, by Janelyn Kulik, RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was transferred correctly and was not moved before being assessed by a Licensed Nurse after a fall for 1 of 3 residents reviewed for falls in the sample of 7 resulting in a hip fracture. (Resident # E), (RN #1), (CNA #2)</p> <p>Findings include:</p> <p>On 8/11/14 at 10:45 a.m., Resident #E was observed sitting in a wheelchair. An alarm was in place to the wheelchair.</p> <p>The record for Resident #E was reviewed on 8/11/14 at 10:15 a.m. The resident's</p>	F000323	<p>F323</p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>The facility requests paper</b></p>	09/05/2014

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	<p>diagnoses included, but were not limited to, healing traumatic hip fracture, anxiety state, bi-polar disorder, osteoporosis, and difficulty walking. The resident was admitted to the hospital on 7/8/14 and returned to the facility on 7/13/14.</p> <p>Review of the current Physician orders indicated there were orders for the resident to have alarms in place to the bed and the wheelchair. These orders were obtained on 6/5/14. There were also Physician orders for the resident's bed to be in the lowest position and floor mats to be in place. These orders were also obtained on 6/5/14.</p> <p>A Physician's order was written on 7/7/14 at 9:45 p.m. for an X-ray of the resident's left hip to be done. The order also indicated the resident was to be given a one time dose of Norco (a narcotic pain medication) 5/325 milligrams.</p> <p>A Physician's order written on 7/8/14 at 2:10 a.m., indicated the resident was to be transferred to the hospital Emergency Room for an evaluation and treatment.</p> <p>Review of the 5/5/14 Minimum Data Set (MDS) Quarterly Assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). A score of (6) indicated the resident's cognitive</p>		<p><b>compliance for this citation.</b></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #E: As stated in 2567, resident was transferred to hospital for evaluation on 7/8/14 and returned to facility 7/13/14. Plan of care was reviewed upon return and updated to reflect current transfer status.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents at risk for falls have the potential to be affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Licensed nurses and CNA's will be re-educated regarding following plan of care for transfers and not moving residents after a fall until after</p>	

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	<p>patterns were severely impaired. The MDS Assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two or more staff for transfers and was totally dependent on staff for bathing. The assessment also indicated the resident had one fall with injury since admission or the last prior assessment. The assessment indicated the resident had impairment of range of motion in one upper extremity and was not steady moving on and off the toilet, not steady moving from a seated to a standing position, and not steady transferring surface to surface such as between bed and chair.</p> <p>A Fall Risk Assessment completed on 2/28/14 indicated the score was (21). A score of 10 or above indicated the resident was at high risk for falls. A Fall Risk completed on 7/5/14 indicated the resident's score was (11).</p> <p>The resident's Care Plans were reviewed. A Care Plan initiated on 3/5/14 indicated the resident was at risk for falls/injury as evidenced by a history of falls and the potential for falls related to depression and high blood pressure. The Care Plan had a goal date of 10/30/14. Care plan interventions included for the resident's</p>		<p>licensed nurse completes an assessment.</p> <p>The Director of Health Services or designee will observe at least 5 resident transfers per week on varied shifts to ensure proper procedure is followed for transfers according to plan of care.</p> <p>The Director of Health Services or designee will interview licensed nurses after each fall incident to ensure that resident was not moved until after licensed nurse assessment.</p> <p>The Executive Director will be responsible for oversight of these audits.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be</p>	

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	<p>bed to be in the lowest position, floor mats to be in place, call light to be left in reach, and to lock brakes on the chair and bed when transferring the resident.</p> <p>A Care Plan initiated on 3/5/14 indicated the resident had an ADL (Activities of Daily Living) Self- Care deficit or potential for as evidenced by need for supervision assistance with transfers, toilet use, personal hygiene and locomotion. The Care Plan also indicated the resident had weakness, depression, pain, and a total knee replacement. The Care Plan was last updated with a goal date of 10/30/14. Care Plan interventions included for the resident to be transferred with (2) assists.</p> <p>The resident's Care Card (card with care interventions for each resident) for Resident #E was reviewed on 8/11/14 at 3:55 p.m. The Care Card was received from the ADON (Assistant Director of Nursing) at this time. The ADON indicated the interventions in this Care Card were in be in place at the time of the 7/5/14 fall. Interventions included to encourage the resident to stay in a common area, to be transferred by two staff members using a gait belt ( a belt used to assist residents to a standing position and with transfers), and the resident was not to be left in the</p>		<p>reviewed in monthly Quality Assurance meetings x3 months, then quarterly thereafter if no trends are identified for a total of 6 months.</p> <p><b>5) Date of compliance:</b> 9/5/14</p>				

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	<p>bathroom unattended, and not to be left in room in her wheelchair unattended.</p> <p>The July 2014 electronic Progress Notes were reviewed. An entry made on 7/5/14 at 1:13 p.m. indicated the entry was made related to to fall. The entry indicated the time of the fall was 9:10 a.m. and the fall occurred in the Shower Room bathroom when the resident "began to slide to floor and CNA assisted by lowering to floor and res (resident) sat down." The entry also indicated the resident complained of discomfort with movement to the left leg and was alert and orientated. The resident was returned to bed, given Tylenol as ordered, and alarms were in place. The Physician and POA (Power of Attorney) were called. This entry was completed by RN #1.</p> <p>A hand written "Nurse's Note" dated 7/5/14 at 9:10 a.m. indicated a CNA notified the writer (RN #1) that the resident slid to the floor while in the shower bathroom and sat on her buttock, and was "assisted per CNA to W/C (wheelchair)..." The Nurse's Note also indicated the resident was "returned to bed" with an evaluation done with the resident complaining of discomfort to the left leg and no redness or rotation noted.</p> <p>Review of Radiology Report of the</p>						

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	<p>7/7/14 left hip X-Ray indicated there was a" left subcapital fracture with moderate displacement." The results also indicated mild degenerative changes were seen. Diffuse osseous demineralization was also noted. The report indicated the X-Ray was read by the Radiologist on 7/8/14 at 12:27 a.m.</p> <p>Resident #E's July 2014 hospital records were reviewed. A History and Physician report indicated the resident was transferred to the Emergency Room because of complaints of left hip pain. The report indicated the resident had fallen on Saturday (7/5/14) and had vague complaints of aches and pain and no specific X-rays were done at that time. The report also indicated the night Nurse (7/7/14) noted there was leg length discrepancy and when the Nurse tried to move the resident's leg the resident complained of pain and therefore an X-ray of the left hip was then done in the night and showed a fracture of the of the left hip. The resident was transferred to the Emergency Room. A subcapital fracture was confirmed and the resident was then admitted to the hospital for further treatment. The "Review of Systems" section of the History and Physical noted the resident recognized the Physician by knowing his name and complained of pain in the left hip from a</p>						

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	<p>fall on Saturday. The "Impression" section of the History and Physical indicated the resident had an "accidental fall resulting in left subcapital femur fracture." This section also noted the resident had a history of a fracture of the lateral and medial tibial plateau of the left tibia in December 2013 and had osteoarthritis of multiple joints.</p> <p>A hospital Operative Report was reviewed. The report indicated a "Cemented bipolar hemiarthroplasty, left hip" was performed on 7/10/2014. The report indicated the resident had a completely displaced femoral neck fracture.</p> <p>A 7/18/14 Physicians Progress Note indicated the resident had been admitted to the hospital on 7/8/14 for a subcapital left hip fracture secondary to fall. The Progress Note also indicated the resident had left hip surgery for a subcapital fracture and had osteoporosis.</p> <p>The ADON (Assistant Director of Nursing) and the DON (Director of Nursing) were interviewed on 8/11/14 at 2:19 p.m. related to Resident #E's fall on 7/5/14. The ADON indicated the fall was investigated and staff members were interviewed. The ADON indicated the staff Nurse working at the time of the fall</p>			

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	interviewed the CNA who was with the resident at the time of the fall and she (the staff Nurse) was told the CNA was in the bathroom with the resident and the resident stood up to pull her pants up and the resident's knees began to buckle and she was lowered to the floor. The ADON indicated the on-call manager was called and at that time it was being viewed as an assisted fall based on the above information. The ADON indicated she worked on 7/7/14 and started a complete investigation of the fall. The ADON indicated she did talk to the resident and staff members on 7/7/14. The ADON indicated when the resident was asked about the fall the resident told her she stood up to pull up her pants and was alone in the bathroom at the time. The ADON indicated she then started re-interviewing the staff CNA and staff Nurse who were taking care of the resident at the time of the fall. The ADON indicated CNA #2 was the CNA who took the resident to the toilet in the Shower Room on 7/5/14 and the during this interview the CNA indicated she lowered the resident to the floor. The ADON indicated the CNA did confirm in an interview that no one else was present when she transferred the resident to toilet and she transferred the resident to the toilet and then back up from the floor onto to the chair after the resident was			

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	<p>lowered to the floor and took the resident to the Nurses Station and met the Nurse. The ADON indicated the CNA confirmed the resident's Care Card noted the resident was to be a two person transfer and was to be transferred with a gait belt and this was not done.</p> <p>Continued interview with the ADON indicated she interviewed RN #1 (the Nurse caring for the resident at the time of the fall on 7/5/14) on 7/8/14. The RN indicated she did not assess the resident in the Bathroom. The ADON indicated the resident was to be a two person transfer with the use of gait belt and staff should have transferred the resident with two staff members using a gait belt.</p> <p>The ADON also indicated CNA #2 was suspended and no longer was employed by the facility. RN #1 was also suspended and returned to work after being educated as she did not immediately inform management of CNA #2 moving the resident back into a chair without calling for the Nurse to assess the resident before moving her.</p> <p>This Federal tag relates to Complaint IN00152714.</p> <p>3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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