

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  07/10/2013
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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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F000000	<p>This visit was for the Investigation of Complaint IN00132218.</p> <p>Complaint IN00132218-Substantiated. Federal/state deficiency related to the allegation is cited at F309.</p> <p>Survey date: July 10, 2013</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF: 21 SNF/NF: 119 Total: 140</p> <p>Census payor type: Medicare: 26 Medicaid: 93 Other: 21 Total: 140</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2</p>	F000000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. We are also requesting paper compliance for this citation.	

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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	Quality review completed on July 13, 2013, by Janelyn Kulik, RN.			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the necessary treatment and services were provided related to the lack of assessing a resident after a change in responsiveness for 1 of 3 residents reviewed for change in condition in the sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>The closed record for Resident #C was reviewed on 7/10/13 at 9:10 a.m. The resident's diagnoses included, but were not limited to, fibromyalgia, systemic lupus erythematosus, hypothyroidism, chronic renal failure, chronic obstructive pulmonary disease, seizures, spinal stenosis, congestive heart failure, pneumonia, lung infiltrate related to lupus, coronary artery bypass graft surgery, and high blood pressure.</p> <p>Review of the 7/2013 Physician Order Statement (POS) indicated there was</p>	F000309	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p><b>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice:</b> Resident C was discharged from the facility on 7/7/13 due to expiration</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice:</b> All residents in the facility that have a change of condition have the potential to be affected by the same practice.</p> <p><b>Measures the facility will take to ensure that the problem will</b></p>	07/17/2013	

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	<p>an order for "No CPR (cardio pulmonary resuscitation)."</p> <p>The 7/7/13 Nurses' Notes were reviewed. The first entry was made at 1:45 p.m. This entry indicated the Physician was called and informed of the resident complaining of dizziness and the resident was clammy. The resident's blood pressure was 108/78, respirations 22, and heart rate 72. The entry also indicated the Physician stated for staff to monitor the resident for an hour and to send her to the hospital if not any better. There was no Change in Condition form that was initiated on 7/7/13 available.</p> <p>The next entry in the Nurses' Notes was made on 7/7/13 at 2:15 p.m. This entry indicated the LPN went to check the resident and the resident was unresponsive. The entry also indicated the LPN called another Nurse into the room and called 911 to transport the resident to the Emergency Room. The entry indicated the resident's blood sugar level was 64 (within normal levels). There was no documentation of any vital signs or any other physical assessment of the resident in this entry.</p>		<p><b>be corrected and will not recur:</b> All licensed nursing staff will be re-in serviced by DHS or designee by 7/17/13 regarding completion of change of condition forms and assessment documentation. DHS or designee will audit all change of condition forms 5 days a week. The DHS or Designee will use audit tool A and will report findings to QA&amp;A monthly for 6 months or 100% compliance is met.</p> <p><b>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:</b> QA&amp;A will monitor monthly for trends and make recommendations to the plan of correction as needed. QA&amp;A will monitor for 6 months or until 100% compliance is met.</p>				

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	<p>The next entry in the Nurses' Notes was made on 7/7/13 at 2:25 p.m. This entry indicated the EMS (Emergency Medical Service) had arrived and the resident had no vital signs. The entry also indicated the EMS staff did not do CPR as the resident had DNR (Do Not Resuscitate) paperwork.</p> <p>A 7/7/13 EMS "Out of Hospital Care Report" was reviewed. The report indicated the EMS ambulance was dispatched to the facility on 7/7/13 at 2:17 p.m. and arrived at the facility at 2:20 p.m. The narrative documentation on the report indicated the unit was dispatched for an unresponsive female resident. The report indicated when the EMS first arrived at the resident's room the resident was found "not breathing and pulseless." The report also indicated the resident had cyanosis (bluish color of the skin due to lack of oxygen in the blood) to her lips and nail beds. The report indicated then "(facility's name) staff came in the room and stated the resident was a DNR." The report indicated the EMS staff informed the facility staff it "appeared that the patient had died prior to them calling 911."</p> <p>When interviewed on 7/10/13 at 10:15</p>						

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	<p>a.m., the Director of Nursing indicated the weekend manager notified her of the resident's expiration on 7/7/13. The Director of Nursing indicated the next day she talked with Nurse who was assigned to care for the resident on 7/7/13. The Director of Nursing indicated the Nurse caring for the resident on 7/7/13 was LPN #1. The Director of Nursing indicated she spoke with LPN #1 the next day. The Director of Nursing indicated the LPN informed her the resident had no vital signs present when the ambulance arrived.</p> <p>When interviewed on 7/10/13 at 10:35 a.m., LPN #1 indicated she was assigned to care for Resident #C for the day shift on 7/7/13. The LPN indicated at 1:45 p.m., Resident #C's sister came to her and asked if she was the Nurse for Resident #C. The LPN indicated she was and went to the resident's room and asked the resident what was wrong. Resident#C indicated she felt "dizzy." The LPN indicated the resident appeared clammy. The LPN then left the room to obtain equipment to take the resident's vital signs, returned to the room with the equipment, and took the resident's vital signs at this time. The LPN indicated she then paged the Physician and the</p>			

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	<p>Physician called back on the telephone in approximately 5 minutes. The LPN informed the Physician of the resident's complaints of dizziness, the residents vital signs, and that the resident was clammy. The Physician indicated to her to check the resident's blood sugar level, monitor the resident for an hour, and to send the resident to the hospital if not any better. The LPN indicated she then went back to the resident's room at approximately 2:00 p.m. and checked the resident's blood sugar level and the blood sugar was 64 at this time. LPN #1 then indicated she asked the resident if she wanted some Ensure (a liquid nutritional supplement) and gave the resident some strawberry Ensure to drink. The LPN indicated she went back to check on the resident at approximately 2:15 p.m. and the resident was unresponsive and still breathing at that time. The LPN then went to the doorway of the room and another Nurse was walking down the hall and this Nurse also came into the room. The LPN indicated this Nurse also indicated the resident was breathing and they decided to call 911. LPN #1 indicated both she and the other Nurse walked out of the room to the Nurses' Station and prepared the paperwork and called 911.</p>						

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	Continued interview with LPN #1 at this time indicated as she and the other staff members were completing the paperwork to send with the resident when the ambulance arrived and the ambulance staff went down to Resident #C's room. LPN #1 indicated she saw them go down into the resident's room and then she and RN #2 went down to the resident's room. When they arrived in the room the 911 staff indicated to them the resident was not breathing and they had placed the machine on the resident and it was flat line (indicating the resident had no heartbeats). The LPN indicated they showed the 911 staff the paper which indicated the resident was a DNR and no CPR was initiated. The LPN indicated she had only obtained one set of vital signs and that was when the resident first complained of dizziness and no other vital signs were obtained until the paramedics arrived. The LPN indicated no vital signs were taken when the resident was observed to be unresponsive. LPN #1 indicated the resident was breathing at that time, the resident was not clammy, and the resident's breathing was not labored. The LPN indicated the resident did not respond when her name was called and did not respond when she			

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	<p>did a sternal rub (rubbing on the resident chest) on the resident's chest. The LPN indicated the resident was still breathing at this time. The LPN indicated no other physical assessment of the resident was done at that time and no vital signs were taken. The LPN indicated she had not checked the resident oxygen saturation level since approximately 8:00 a.m. LPN #1 indicated she walked past the resident's room earlier at approximately 1:30 p.m. and the resident was laying in bed watching television.</p> <p>When interviewed on 7/10/13 at 11:05 a.m., RN #2 indicated she had worked the day shift on 7/7/13 on another unit and was walking down to Resident's C's unit where she was going to work the evening shift at approximately 2:20 p.m. The RN indicated LPN #1 called her from Resident C's room and asked her to come into the room. RN#2 indicated she entered the resident's room, the resident's breathing was rapid and the resident was unresponsive. The RN indicated she did not observe any obvious cyanosis or mottling at this time. RN #1 indicated she was in the resident's room for just a few minutes and then left to get the paperwork</p>			

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	<p>ready to send the resident out. The RN indicated she was on the unit when the paramedics arrived and she and LPN #1 then went back into Resident #C's room when the paramedics were in there and they were not performing CPR.</p> <p>When interviewed on 7/10/13 at 12:20 p.m., LPN #1 indicated she and RN #2 had left the resident's room and were at the Nurses' Station when the paramedics arrived. The LPN indicated to her knowledge no other staff members were in the room with the resident from the time they left the room to call the paramedics until the time the paramedics arrived and found the resident without vital signs.</p> <p>When interviewed on 7/10/13 at 12:35 p.m., the Director of Nursing indicated LPN #1 documented she had called the Physician when the resident complained of dizziness and she did not write orders for instructions the Physician gave her to check the resident's blood sugar level, monitor her for an hour, and to send her to the hospital if her condition did not improve. The Director of Nursing indicated there was no other physical assessment of the resident or vital signs when the resident's condition changed as she</p>				

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	<p>was responsive.</p> <p>The facility policy titled "Change in Condition Form Guidelines" was reviewed on 7/10/13 at 9:05 a.m. The policy date was last updated on 1/08. The facility Administrator provided the policy and indicated the policy was current. The policy indicated the Nurse was to assess the resident's change in status and initiate the Change in Condition Form to document the nursing process.</p> <p>The facility policy titled "Physician Notification of Diagnostic Testing and Change in Condition" was reviewed on 7/10/13 at 9:05 a.m. The policy was dated 12/06/2007. The facility Administrator provided the policy and indicated the policy was current. The policy indicated "Resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or diagnostic tests should be completed in a timely manner."</p> <p>This federal tag relates to Complaint IN00132218.</p> <p>3.1-37(a)</p>				