STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MICHIGAN CITY	802 US HWY 20 E MICHIGAN CITY, IN 46360

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00156354. Complaint IN00156354-Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 29, 30, October 1, 2, and 3, 2014 Facility number: 000236 Provider number: 155344 Aim number: 100287700 Survey Team: Lara Richards, RN-TC Heather Tuttle, RN Janet Adams, RN Julie Ferguson, RN (9/29, 9/30, 10/2 & 10/3/14) Census bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 24 Medicaid: 52 Other: 3 Total: 83	F000000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exsists or that this statement of deficiency was correctly cited, and it also not to not to be construed as of an admission of interest against the facility, the Administrator or any employee or agents, or any other individuals who draft or may be discussed in the Plan of Correction. In addition preparation and submission of the Plan of Correction does not consitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirement under State and federal law that mandates submission of the Plan of Correction a condition to participate in the Title 18 and Title 19 programs. The submission of this plan of correction within this timeframe should in no way be of non-compliance or admission by the facility.This provider is respectfully requesting paper compliance. If accepted all paperwork will be uploaded and/or faxed.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 7, 2014, by Janelyn Kulik, RN.			
F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by			

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	transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and interview, the facility failed to ensure a resident's privacy was respected while being transferred from a gurney to her bed for 1 of 1 residents reviewed for privacy. (Resident #155) Findings include: On 9/30/14 at 1:03 p.m., Resident #155 was observed in her room. Two members of the ambulance transport team as well as the Admissions Director were observed in the resident's room. The door to the resident's room was open at this time. The resident was standing next to the gurney wearing a hospital gown. The resident's entire backside was visible and she was not wearing under garments at this time. Interview with LPN #3 on 9/30/14 at 1:10 p.m., indicated the door to the resident's room should have been closed while being transferred from the gurney to the bed. Interview with the Administrator on 10/1/14 at 9:30 a.m., indicated the door to the resident's room should have been closed and she would call the ambulance transport company and talk to them as	F000164	1. Resident's #155's privacy will be respected when care is provided.2. Facility residents were checked for privacy (doors/curtains closed) during resident care on 10/3/14. Any privacy concerns were corrected immediately and staff involved received education.3. The admissions director and ambulance transport company were provided education relating to providing privacy with resident transfers on 10/3/14 by the DON and ED. The staff development coordinator inserviced staff on 10/3/14 and again on 10/14/14 regarding the provision of resident privacy.4. ED/designee will conduct 20 random audits three times weekly to ensure resident privacy for three consecutive months and 10 resident rooms for the following three months. Audit results and system components will be reviewed by the performance improvement committee with subsequenet plans of correction developed and implemented as deemed necessary.5. Date certain is 10/31/14	10/31/2014

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	well. 3.1-3(p)(2)			
F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically related social services for each resident related to monitoring a resident's behaviors towards a specific staff member for 1 of 2 residents reviewed for abuse of the 2 residents who met the criteria for abuse. (Resident #116) Findings include: On 9/29/14 at 2:10 p.m., Resident #116 was interviewed. At that time, the resident expressed a concern that he had been harassed by a dietary employee for the last three months. The resident further indicated he had told the Social Service Director his concerns. The record for Resident #116 was reviewed on 9/30/14 at 1:25 p.m. The resident's diagnoses included, but were	F000250	1. On 10/1/14 during resident interviews conducted by the Indiana State Department of Health (ISDH), resident 116 stated he had been harassed by a dietary staff member. Upon receiving the report from ISDH, the Executive Director immediately initiated an investigation. The investigation included an interview with resident 116, other residents, and staff members. Based upon the investigation, the allegation could not be substantiated. Resident 116 does present with increased anxiety and confusion related to his terminal diagnosis of cancer and subsequent decline. Resident 116 has a history of behaviors including false allegations. His care plan was reviewed and updated to include his behaviors. Resident 116 will be monitored for signs and symptoms of distress. The Executive Director has provided	10/31/2014

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	not limited to, stroke, pancreatic mass, and reactive depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/11/14, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 13. The resident did display verbal behaviors, and had the feeling of being tired and had little energy. Review of a Social Service Quarterly assessment dated 9/11/14, indicated the resident reported feeling tired. The resident had cursed and screamed at staff on 9/7 and 9/8/14. The resident's actions interfered with his care when staff wanted to give/assist with shower. Review of the current plan of care updated on 9/2014, indicated there was no care plan regarding the resident's behaviors such as verbal aggression, arguing or cursing at staff. Interview with LPN #3 on 9/30/14 at 1:15 p.m., indicated the resident had told staff about his concerns with a particular dietary aide. She indicated he talked to the Social Service Director all the time about his concerns. LPN #3 further indicated all staff were aware of his concerns with the dietary department.		education for the Social Service Director and Dietary Manager related to documenting and addressing resident concerns. 2. Full facility resident interviews will be completed by Social Services, by 10/22/14, to determine if any other resident may have unresolved issues, concerns or grievances. Any other issues identified will be addressed immediately by appropriate discipline. Residents care plans will be amended as necessary. 3. Staff to be educated on facility policy and procedure for documentation and follow through of grievances by Executive Director and/or designee. Social Services Director and/or designee to conduct random (5 X per week for 6 months) resident interviews to ensure residents do not have any unresolved issues, concerns and/or grievances. Grievances and concerns will be reviewed by management team on a weekly basis to validate resolution. 4. Social Service Director will report results of random interviews to the PI Committee on a monthly basis. Audit results and system components will be reviewed and subsequent plans of correction will be developed and implemented as deemed necessary.	

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	She further indicated the latest was the other day, when the resident did not have any silverware and he took some off of another table. She indicated he had told her the dietary aide yelled at him. Interview with the Social Service Director on 9/30/14 at 1:46 p.m., indicated there was one girl in the dietary department that the resident did not like. She further indicated the resident would come to her and tell her the Dietary Aide wanted to "write him up." She further indicated she had asked the resident what the dietary aide does and all the resident had ever indicated was she wanted to "write me up." The Social Service Director indicated the resident had not spoken to her in about two weeks regarding the issue. She indicated she had discussed with the Dietary Aide not to have any interaction with the resident including speaking to him and serving him his meals. The Social Service Director had indicated this problem had been going on at least five months. Interview with the Administrator on 9/30/14 at 2:00 p.m., indicated the resident had not ever used the word "harassed" about the Dietary Aide. She indicated the resident had these thoughts in his head the dietary staff person was "out to get him." The Administrator			

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	indicated we had just told the Dietary Aide not to serve him and just to stay away from him. Interview with the Dietary Food Manager on 10/1/14 at 9:45 a.m., indicated she recalled about 5 months ago, her dietary employee came up to her and indicated Resident #116 and another resident got into a verbal altercation and she told them both to go back to their tables and stop arguing. She further indicated the dietary employee told both resident's nurses about the argument. The Dietary Food Manager then indicated about one week later, the resident had said to her the same dietary employee was trying to poison him and kill him. She indicated she had reported the incident to the resident's nurse. She further indicated she had instructed the dietary employee to stay away from the resident and not to pass his tray anymore. She indicated since then the dietary employee does not serve the resident or even talk to him, however on occasion she had heard the resident make snide remarks about the dietary employee. Review of the Nursing Progress Notes for the months of May, June, July, August, and September 2014, indicated there was no evidence of any ongoing monitoring of the resident's continued behaviors with			

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	the Dietary Aide. There was no documentation regarding the resident's concerns about being poisoned or that dietary staff wanted to kill him. Interview with the Social Service Director on 10/1/14 at 10:48 a.m., indicated she had not written any of the resident's concerns down about the Dietary Aide and how he thinks she was going to write him up. She further indicated there was no behavior log or concern written about his complaints of the Dietary Aide. She indicated there was no evidence of any ongoing documentation of the resident's concerns and behaviors regarding the Dietary Aide. Interview with the Administrator on 10/1/14 at 12:45 p.m., indicated, there had been no written documentation of the resident's concerns regarding the Dietary Aide. She indicated there should have been some sort of documentation regarding this ongoing problem he had with the dietary aide. 3.1-34(a)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified			

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	persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure Physician's orders as well as the plan of care were followed related to monitoring bruises and scratches for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 4 residents who met the criteria for skin conditions (non-pressure related). The facility also failed to ensured dialysis shunts were monitored for 1 of 1 residents reviewed for dialysis and orthostatic blood pressures were monitored correctly for 1 of 5 residents reviewed for unnecessary medications. (Residents #31, #64, and #77) Findings include: 1. On 9/30/14 at 8:58 a.m. and 1:35 p.m., Resident #77 was observed with a fading purple bruise to the top of her left hand near her thumb. The resident also had red scabbed areas to her upper chest. On 10/1/14 at 8:45 a.m., 10:44 a.m., and 1:45 p.m., the resident was observed with red scabs to her upper chest area. She also had a fading bruise to the top of her left hand near her thumb. There was no additional padding to the resident's wheelchair arms at this time.	F000282	1. Resident #31's dialysis shunt is being monitored every shift. Resident#64's orthostatic blood pressures have been discontinued. Resident #77's bruises and scratches are being monitored until healed. 2. Full facility audits were completed for residents with dialysis shunts; physican orders for orthostatic blood pressures, and any residents with bruises or scratches. Physican orders were obtained and resident care plans were amended as indicated following this audit. Residents with dialysis shunts will be monitored every shift; residents with orthostatic blood pressure orders were assessed for proper blood pressure monitoring; residents with non presssure skin conditions will be monitored with weekly documentation reflected on the "non-pressure skin condition record". 3. The Staff develpoment coordinator conducted inservices for nurses on 10/3/14 and again on 10/14/14 regarding monitoring of shunt sites, transcribing orthostatic blood pressures and the completion of the resident weekly skin checks. A shunt monitoring order has been placed on each residents's medication adminstration record (MAR). New colored dialysis books (with dialysis monitoring form) were created on 10/08/14 for each	10/31/2014

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	The record for Resident #77 was reviewed on 9/30/14 at 1:37 p.m. A Physician's order dated 6/28/13 and listed on the October 2014 Physician's order summary (POS), indicated padding was to be applied to bilateral wheelchair arm rests. The plan of care dated 4/25/14, indicated the resident was at risk for developing skin tears and bruises due to the diagnosis of dementia, gets up unassisted and wanders in wheelchair around the facility. The interventions included, but were not limited to, notify Nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bathing or daily care and chair cushion padding to wheelchair armrests. Review of the weekly non-pressure skin sheets for the month of 9/2014 on 10/1/14 at 8:45 a.m., indicated there were sheets for self inflicted scratches to the left and right upper arms. There were no non-pressure skin sheets for the scabs to the chest area and the bruise to the left hand. There was no documentation in the Nursing progress notes from 8/2014 thru		resident to transpsort to and from the dialysis center. Residents with current physican orders for orthostatic blood pressures will have their medication adminstration records audited for completion. Upon new orders, a new orthostatic blood pressure form will be placed in the resident's MAR. The resident treatment record (TAR) will be monitored weekly by the DON/designee for the completion of resident skin assessments. 4. The DON/designee will audit the dialysis books, orthostatic blood pressures, MARs and TARS weekly for accuracy and completion per the above outlined areas. Audit results and system components will be reviewed by the performance review committee with subsequent plans of correction developed and implemented as deemed neccessary. 5. Date certain is October 31, 2014.	

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	9/2014 related to bruising or scratches. Observation with RN #2 on 10/1/14 at 1:45 p.m., indicated the resident had a fading bruise to the top of her left hand between her thumb and her index finger. She also indicated the resident had two red scabbed areas to the upper chest area. Interview with the RN at the time, indicated the resident had a history of scratching and picking at her arms, chest and face. She was not aware of the fading bruise to the left hand. She indicated when a bruise was found, it was to be reported to Nursing so a non-pressure skin sheet could be initiated. Continued interview with the RN at the time, indicated if a resident was to have padded wheelchair arms there was usually fleece added or a towel. 2. The record for Resident #31 was reviewed on 10/1/14 at 9:59 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease. Review of the current plan of care plan dated 4/23/14, indicated the potential for complication related to hemodialysis. The Nursing approaches were to check shunt site for signs and symptoms of infection, pain or bleeding daily and as needed. Communicate with dialysis center regarding medication, diet and lab			

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	results. Review of the dialysis communication book that was sent to the dialysis center with the resident every Monday, Wednesday and Friday, indicated many of the pre/post dialysis checklist forms were missing, blank and incomplete. Review of the pre/post dialysis checklist forms, indicated there were none completed for the month of October, 2014. The last checklist completed for 9/2014 was dated 9/24/14. The 9/24/14 checklist form was incomplete with only the resident's vital signs documented. The information regarding the resident's shunt was blank and incomplete. There were completed forms checking the resident's shunt on 9/17, 9/10, and 9/3/14. The only completed pre/post checklists completed for 8/2014 were on 8/11 and 8/27/14. There were forms completed on 8/4 and 8/20/14 however, information regarding the resident's shunt was blank and incomplete. There were no checklists completed with documentation of assessing the resident's shunt for the month of July, 2014. There were checklist forms completed on 7/18 and 7/25/14 with only documentation of the resident's vital signs. Review of the Treatment Administration			

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	Record (TAR) for 10/2014 and 9/2014, indicated there was no evidence the resident's shunt was monitored on a daily basis. Interview with LPN #2 on 10/1/14 at 9:25 a.m., indicated Nursing staff were to complete the pre/post dialysis form before she left for dialysis. 3. The record for Resident #64 was reviewed on 9/30/14 at 12:47 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, anxiety and chronic obstructive pulmonary disease (respiratory disease). Review of Physician's orders dated 9/16/14 indicated, check blood pressure three times a week, check orthostatics (checking for low blood pressure). Review of the Medication Administration Record (MAR) for the month of 9/2014, indicated orthostatic blood pressures had not been monitored. Interview with LPN #1 on 9/30/14 at 2:24 p.m., indicated on the MAR there lacked documentation of the orthostatic blood pressures. Interview with the ADON (Assistant Director of Nursing) on 9/30/14 at 2:28 p.m., indicated the September 2014			

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	MAR lacked documentation of the orthostatic blood pressure which was taken when sitting, standing or lying. The policy titled "Orthostatic Blood Pressure," was provided by the DON (Director of Nursing) on 10/1/14 at 9:00 a.m. The DON indicated this policy was current. The policy indicated: "...Procedure...3. Count the pulses (P) and take the blood pressure in baseline position (supine-laying on back-or sitting). 4. Move resident to next most upright position that can be maintained: a. supine to trunk up with or without dangling. b. Gerichair (speciality wheelchair) to sitting up or dangling. c. Sitting to standing...6. Wait one minute if possible. 7. Recheck the pulse and blood pressure.. 8. Restore to prior position. 9. If symptoms are present but no change is noted at one minute, consider repeating at three (3), five (5), or ten (10) minutes...." 3.1-35(g)(2)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/03/2014
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	the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure Physician's orders as well as the plan of care were followed related to monitoring bruises and scratches for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 4 residents who met the criteria for skin conditions (non-pressure related). The facility also failed to ensured dialysis shunts were monitored for 1 of 1 residents reviewed for dialysis. (Residents #31 and #77) Findings include: 1. On 9/30/14 at 8:58 a.m. and 1:35 p.m., Resident #77 was observed with a fading purple bruise to the top of her left hand near her thumb. The resident also had red scabbed areas to her upper chest. On 10/1/14 at 8:45 a.m., 10:44 a.m., and 1:45 p.m., the resident was observed with red scabs to her upper chest area. She also had a fading bruise to the top of her left hand near her thumb. There was no additional padding to the resident's wheelchair arms at this time. The record for Resident #77 was reviewed on 9/30/14 at 1:37 p.m.	F000309	1.Resident #31's dialysis shunt is being monitored every shift. Resident #77's bruises and scratches will be monitored until healed. 2.Full facility audits were completed for any residents with dialysis shunts and non-pressure related skin conditions. Residents with dialysis shunts will have dialysis shunt sites monitored every shift. Residents will be monitored weekly for any non-pressure related skin conditions. 3.The SDC provided inservice education to Nurses on 10/03/14 and again on 10/14/14 regarding the monitoring of dialysis shunt sites, and the completion of weekly skin checks. A shunt monitoring order has been placed on each dialysis residents Medication Administration Record (MAR). New colored dialysis books (with dialysis monitoring/communication forms) were created on 10/08/14 for each resident to transport to and from the dialysis center. The resident Treatment record (TAR) will be monitored weekly by the DON/designee for completion of resident skin assessments. 4.The DON/designee will audit the dialysis books and Treatment Administration Records on a weekly basis to validate accuracy and completion. Audit results and system components will be reviewed by the Performance Improvement	10/31/2014

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	A Physician's order dated 6/28/13 and listed on the October 2014 Physician's order summary (POS), indicated padding was to be applied to bilateral wheelchair arm rests. The plan of care dated 4/25/14, indicated the resident was at risk for developing skin tears and bruises due to the diagnosis of dementia, gets up unassisted and wanders in wheelchair around the facility. The interventions included, but were not limited to, notify Nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bathing or daily care and chair cushion padding to wheelchair armrests. Review of the weekly non-pressure skin sheets for the month of 9/2014 on 10/1/14 at 8:45 a.m., indicated there were sheets for self inflicted scratches to the left and right upper arms. There were no non-pressure skin sheets for the scabs to the chest area and the bruise to the left hand. There was no documentation in the Nursing progress notes from 8/2014 thru 9/2014 related to bruising or scratches. Observation with RN #2 on 10/1/14 at		Committee with subsequent plans of correction developed and implemented as deemed necessary. 5.Date certain: 10/31/14	

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	1:45 p.m., indicated the resident had a fading bruise to the top of her left hand between her thumb and her index finger. She also indicated the resident had two red scabbed areas to the upper chest area. Interview with the RN at the time, indicated the resident had a history of scratching and picking at her arms, chest and face. She was not aware of the fading bruise to the left hand. She indicated when a bruise was found, it was to be reported to Nursing so a non-pressure skin sheet could be initiated. Continued interview with the RN at the time, indicated if a resident was to have padded wheelchair arms there was usually fleece added or a towel. The RN proceeded to measure the areas and initiate a non-pressure skin sheet. Documentation in the Nursing progress notes on 10/2/14, indicated the resident had a faded purple bruise noted to the left hand which measured 1 centimeter (cm) x 0.6 cm. Dry small scabs times three to the right upper chest 0.3 cm x 0.2 cm, mid upper chest 0.1 cm x 0.3 cm, right breast 0.1 cm x 0.1 cm. Nurse practitioner and daughter notified. Resident scratches self, nails cut no new orders. 2. The record for Resident #31 was reviewed on 10/1/14 at 9:59 a.m. The			

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	resident's diagnoses included, but were not limited to, end stage renal disease. Review of Physician Progress notes dated 4/17/14, indicated the resident received Hemodialysis three times weekly. Review of the Minimum Data Set (MDS) Significant Change assessment dated 7/22/14. indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 11. The resident also received dialysis. Review of the current plan of care plan dated 4/23/14, indicated the potential for complication related to hemodialysis. The Nursing approaches were to check shunt site for signs and symptoms of infection, pain or bleeding daily and as needed. Communicate with dialysis center regarding medication, diet and lab results. Review of the dialysis communication book that was sent to the dialysis center with the resident every Monday, Wednesday and Friday, indicated many of the pre/post dialysis checklist forms were missing, blank and incomplete. Review of the pre/post dialysis checklist forms, indicated there were none completed for the month of October,			

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	2014. The last checklist completed for 9/2014 was dated 9/24/14. The 9/24/14 checklist form was incomplete with only the resident's vital signs documented. The information regarding the resident's shunt was blank and incomplete. There were completed forms checking the resident's shunt on 9/17, 9/10, and 9/3/14. The only completed pre/post checklists completed for 8/2014 were on 8/11 and 8/27/14. There were forms completed on 8/4 and 8/20/14 however, information regarding the resident's shunt was blank and incomplete. There were no checklists completed with documentation of assessing the resident's shunt for the month of July, 2014. There were checklist forms completed on 7/18 and 7/25/14 with only documentation of the resident's vital signs. Review of the Treatment Administration Record (TAR) for 10/2014 and 9/2014 indicated there was no evidence the resident's shunt was monitored on a daily basis. Interview with LPN #2 on 10/1/14 at 9:25 a.m., indicated Nursing staff were to complete the pre/post dialysis form before the resident left for dialysis. 3.1-37(a)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure each residents' drug regimen was free from unnecessary drugs related to lack of documentation why a gradual dose reduction could not be completed for a resident receiving antipsychotic medications and the lack of monitoring for side effects from heparin (a blood thinner) for 2 of 5 residents reviewed for unnecessary medications. (Residents #29 and #148) Findings include:	F000329	1.Resident #29 was seen by the Psychiatric Nurse Practitioner on 10/06/14 and supporting documentation was provided to contraindicate reducing the residents' medication. Resident #148 heparin was discontinued. 2.Full facility audit was conducted by the DON on 10/14/14 related to residents requiring use psychotropic medications. The purpose of the audit was to ensure each psychotropic medication had an appropriate diagnosis to support use of the prescribed medication. Issues	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/03/2014
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	1. The record for Resident #29 was reviewed on 10/1/14 at 11:03 a.m. The resident's diagnoses included, but were not limited to, schizophrenia and vascular dementia with depressive disorder. A Physician's order dated 9/17/13 and listed on the October 2014 Physician's order summary(POS), indicated the resident was to receive Zyprexa (an antipsychotic medication) 5 milligrams (mg) daily. A Physician's order dated 8/19/12 and listed on the October 2014 POS, indicated the resident was to receive Navane (an antipsychotic) 5 mg at 6:00 p.m. The Psychiatric progress note dated 6/17/14, indicated the resident was calm and cooperative. Social Services reports no behavior disturbances. The resident was socializing with peers, no signs of depression nor anxiety noted today. Resident presently taking Aricept (a medication used to treat dementia) 5 mg at night, Lorazepam (an anti-anxiety medication) 0.25 mg every 8 hours, Zyprexa 5 mg daily, Navane 5 mg daily at 6:00 p.m. and Ambien (a hypnotic) 5 mg every night. Resident's condition was stable and a reduction in medications		identified via this audit will be discussed with the attending physician. All other residents on anticoagulants are being monitored for adverse reactions. 3.The clinical records of new residents with psychotropic medications will be audited upon admission for appropriate diagnosis by the DON/designee. Any resident on psychotropic medications without a corresponding diagnosis will be assessed by the physician/designee for an appropriate diagnosis or discontinuation of the medication. Staff were educated on 10/3/14 and 10/14/14 regarding pychotropic documentation and anticoagulant monitoring. 4.New admission charts will be audited by the DON/designee utilizing the admission checklist. Any issues identified will be addressed immediately and this audit will be ongoing. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary 5.Date certain: 10/31/14	

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	may impair her daily functioning. It was clinically contraindicated to reduce Lorazepam, Zyprexa, Ambien, and Navane. Will continue to monitor behavior, condition, and manage medications as clinically indicated. Review of the 6/17/14 Antipsychotic Gradual Dose Reduction (GDR) consideration form completed by the Psychiatric Nurse Practitioner, indicated Zyprexa 5 mg daily, Navane 5 mg daily at 6:00 p.m. for the diagnosis of Schizo-affective disorder. No target behaviors. On the form, the box was checked "no", a GDR was contraindicated for the following reason: box checked. "the resident has a specific non-dementia related psychiatric diagnosis as defined above. I feel any type of dose reduction for this resident would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder for the following reason: it is clinically contraindicated to reduce the medication at this time." There was no documentation on the form to indicate what the resident's function or psychiatric instability had been during previous dose reduction attempts.			

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	Review of the April, May and June 2014 Behavior/intervention flow sheets, indicated the resident had no behaviors or delusions for the month. Interview with the Assistant Director of Nursing on 10/2/14 at 9:15 a.m., indicated the Psychiatric Nurse Practitioner should have provided additional documentation as to why the GDR was contraindicated and she would notify Social Services. 2. The record for Resident #148 was reviewed on 10/1/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, edema, dehydration, muscle weakness, and high blood pressure. The October 2014 Physician Order Sheet was reviewed. An order was written on 9/23/14 for the resident to receive Heparin (a medication to thin the blood) 5,000 units subcutaneous (injected into the skin) units every 12 hours for 14 days. Review of the 9/2014 Medication Administration Record (MAR), indicated the initial dose of the Heparin was given on 9/24/14 at 7:00 p.m. The MAR also indicated the resident received the Heparin injections at 7:00 a.m. and 7:00			

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	p.m. from 9/25/14 through 9/30/14. A "Side Effect Flow Sheet and Anticoagulant Therapy Signs and Symptoms" form was reviewed on 10/2/14 at 8:45 a.m. The Director of Nursing (DON) provided the form and indicated the form was current. The form indicated Nursing staff were to indicate "yes" or "no" on the form every shift for the following: unusual bleeding, any noted bruising, rapid heart rate, nausea, vomiting, bleeding of the gums, or none. When interviewed on 10/2/14 at 8:45 a.m., the DON indicated, the resident was receiving Heparin injections. The DON also indicated a Side Effect Flow Sheet should have been completed every shift while the resident was receiving the Heparin injection to monitor for side effects of the anticoagulant medication. The DON indicated the Side Effect Flow Sheet had not been in place for the resident. 3.1-48(a)(3) 3.1-48(b)(2)			
F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or			

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	greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 8 residents observed during medication pass. Two medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 8%. The errors involved one resident. (Resident #105) Findings include: On 10/2/14 at 6:17 a.m., RN #1 was observed preparing and pouring medications for Resident #105. The RN removed two bottles of eye drop medication. The first was Dorzolamide/timolol (an eye drop used to treat glaucoma) and the second was Brimonidine 0.2% (an eye drop used to treat glaucoma) from the containers. The RN also prepared the inhaler of Spirivia by placing the capsule into the inhaler. The RN then placed clean gloves on both of her hands and walked into the resident's room. She administered the Dorzolamide/timolol eye drops first by placing one drop into each eye. The time was 6:20 a.m. The RN then rolled up the resident's bed and administered the Spiriva inhaler by placing it in the resident's mouth as the resident inhaled	F000332	1.Resident # 105 had no adverse reaction from the administration of the eye drops. 2.The Medication Administration Records (MARS) of residents with multiple eye drop orders were assessed for proper administration times. New orders were written on the residents Medication Administration Records (MARS to "wait 5 minutes " in between the administration of 2 different eye drops. 3.Nurses were inserviced on 10/03/14 and again on 10/14/14 related to proper eye drop administration. The SDC conducted nurse competencies of eye drop administration on 10/14/14 which includes waiting 5 minutes between multiple eye drops and hand washing. 4.The SDC will continue to audit 6 nurses on proper eye drop administration weekly on all shifts for 3 months and then 3 nurses for the next 3 months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary. 5.Date certain: 10/31/14	10/31/2014

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	the contents of the capsule. She then instructed the resident to hold his breath. The nurse then gave him water to rinse his mouth. The nurse then rolled the head of the bed back down and then administered the second eye drop of Brimonidine 0.2% at 6:22 a.m. The nurse waited approximately two minutes in between the multiple eye drops. Interview with RN #1 at that time, indicated she was aware she was to wait 3 to 5 minutes in between two different eye drop medication administrations. The record for Resident #105 was reviewed on 10/2/14 at 7:30 a.m. The resident's diagnoses included, but were not limited to, glaucoma. Review of Physician Orders on the current 10/2014 recap, indicated Brimonidine 0.2% 1 drop each eye twice a day at 6:00 a.m. and Dorzolamide/timolol 1 drop each eye twice a day at 6:15 a.m. Review of the current 2005 policy for eye drop administration provided by the Staff Development Supervisor indicated "When two or more different eye solutions must be administered at the same pass time, allow a five minute period between them...."			

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NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF MICHIGAN CITY

STREET ADDRESS, CITY, STATE, ZIP CODE: 802 US HWY 20 E, MICHIGAN CITY, IN 46360

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	Interview with the Staff Development Supervisor on 10/2/14 at 9:00 a.m., indicated the nurse should have waited at least five minutes in between the two different eye drop medications. 3.1-48(c)(1)			
F000371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was stored under sanitary conditions related to spillage noted on refrigerator doors, shelves, drawers and refrigerated food and nutritional supplements not dated and stored past expirations dates in 1 of 2 Unit Kitchen Pantry areas. (The West Unit Pantry) Findings include: On 10/3/14 at 9:30 a.m. the following observations were made in the refrigerator/freezer in the Pantry on the	F000371	FTag371 Food storage 1.The pantry on the West unit has been cleaned and expired food was immediately discarded. 2.The remaining refrigerators were assessed for expired food on 10/03/14 by the DON/designee. Any expired food was discarded. 3.Facility Staff received education by the Staff Development Coordinator on 10/03/14 and again on 10/14/14 regarding proper storage of food/snacks. 4.The pantry will be audited 3 times weekly for proper food storage by Audit results and system components will be reviewed by the	10/31/2014

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	West Unit: a. There was a plastic 1/2 gallon container of chocolate milk in the refrigerator. The container was open and 1/4 full. The milk container had a sell by date of 9/26/14. b. There were four individual containers of yogurt in the refrigerator. Two of the containers were dated 8/27/14 and the other two were dated 9/27/14. There were no resident names on the four yogurt containers. c. There was a Styrofoam container of food on one of the shelves. The date of 9/12/14 and a resident's name was written on the container. d. There were three unopened Strawberry Shake containers in the freezer. All three were labeled with the same resident's name. Two of the containers were dated as sent from the Dietary department on 9/25/14 and the other was dated as sent on 9/22/14. There were no sell by or expiration dates on the three containers. e. There was dried spillage and crumbs on the shelves, sides on the cabinets, and the inside of the refrigerator door.		Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary. 5.Date certain: 10/31/14	

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	When interviewed on 10/3/14 at 9:57 p.m., the Director of Nursing indicated the CNA's were responsible for cleaning the unit kitchen refrigerators. When interviewed on 10/3/14 at 10:30 a.m., the Dietary Manager indicated Dietary Staff deliver the supplements/shakes to the units daily. The Dietary Manager indicated they were labeled by dietary staff with the the resident's name, date, and time they were delivered. The Dietary Manager indicated there were no expiration dates when the individual shakes were taken out of the original cases when they were delivered to the facility. The Dietary Manager indicated the Nursing staff should have thrown the containers away if the resident did not take them the day they were sent as the staff would have no knowledge of the expiration dates. The Dietary Manager indicated she was not aware the Nursing staff were storing them in the unit refrigerator. 3.1-21(i)(3)			
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the			

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	development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure staff washed their hands promptly after glove removal during medication pass for 2 of 8 residents observed during medication pass. The facility also failed to store reusable resident equipment such	F000441	1.Residents # 33 and 48 had no adverse effects from the deficient practice. 2.Full facility room audit was completed to ensure proper storage of reusable resident equipment. Nursing staff were inserviced on proper hand washing and on the storage of	10/31/2014

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	as wash basins and urine collection containers properly for 1 of 2 units. (Resident #33 and #48) (The West Unit) Findings include: 1. On 9/30/14 at 8:41 a.m., there was a white urine collection container and a pink wash basin on the floor in the bathroom of room 506. Both pieces of equipment were not stored in a plastic bag. On 10/2/14 at 11:00 a.m., the white urine collection container was still observed on the floor beside the toilet in the bathroom of room 506. At that time, it was not contained in a bag. The wash basin was stored in a three drawer plastic container. The wash basin was not contained in a bag. There were two residents who resided in this room. Interview with the Housekeeping Supervisor on 10/2/14 at 11:00 a.m., indicated the white urine collection container and the wash basin were to be stored in plastic bags and not on the floor. Review of the current undated policy of commode chair care and cleaning of provided by the Assistant Director of Nursing indicated after use, the		reusable resident equipment. Those not in compliance were corrected. 3.Facility staff was educated on hand washing after glove removal, on 10/03/14 and storage of reusable resident equipment on 10/13/14 by the Staff Development Coordinator and both topics were again inserviced on 10/14/14. 4.The DON/SDC will audit hand washing and storage of reusable resident equipment 3 times a week for 3 months and then 2 times a week for the following 3 months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary. 5.Date certain: 10/31/14	

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	equipment should be cleaned and stored. The equipment should not be left in the bathroom or on the floor. 2. On 10/2/14 at 6:03 a.m., RN #1 was observed pouring and preparing medication for Resident #33. At that time, the RN placed clean gloves to both of her hands and walked into the resident's room. She then administered eye drops, removed the gloves and walked out of the room. She placed the soiled gloves in the garbage can on the side of the medication cart. She then signed the medications out after the pass, closed the book, and pushed the cart down the hall to the next room. Continued observation, indicated the RN still had not washed her hands with soap and water or used alcohol gel after the removal of the gloves. At that time, Resident #48 had requested help from the RN immediately to untangle her oxygen tubing. The RN walked into her room and helped her with the oxygen tubing. At that time, the RN was observed touching Resident #48 as well as moving her wheelchair and oxygen tubing. Continued observation indicated the RN still had not washed her hands with soap and water or used alcohol gel to either one of her hands during that time.			

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	Interview with RN #1 at that time, indicated she was aware she did not wash her hands with soap and water or use alcohol gel immediately after removing her gloves. 3.1-18(b)(1)			