

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  12/05/2014
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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 a Recertification and State Licensure Survey.</p> <p>Survey Dates: December 1, 2, 3, 4, &amp; 5, 2014</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey Team: Heather Tuttle, RN-TC Lara Richards, RN Yolanda Love, RN Cynthia Stramel, RN 12/1-12/4/14 Janet Adams, RN 12/4-12/5/14 Janelyn Kulik, RN 12/1/14</p> <p>Census bed type: SNF: 28 SNF/NF: 113 Total: 141</p> <p>Census payor type: Medicare: 28 Medicaid: 102 Other: 11 Total: 141</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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F000241 SS=E	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 12, 2014, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to not knocking on doors prior to entering resident rooms and personal care signs posted above the bed for 2 of 3 residents reviewed for dignity of the 3 who met the criteria for dignity. The facility also failed to ensure 6 of 27 residents, who ate in the 300 Unit dining room, were not labeled as "feeders." (Residents #14, #18, #57, #106, #107, #111, #155 and #157)</p> <p>Findings include:</p> <p>1. On 12/2/14 at 12:27 p.m. at 3:05 p.m., a personal care sign was posted above the</p>	F000241	<p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.</p> <p>1. Resident # 107 had sign removed. In service on all staff knocking on doors. In service all staff on not using pet names or</p>	01/04/2015

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	<p>head of Resident #107's bed. The sign indicated the following, "Attention Nurses' and CNA's oral care is to be done on (room and bed number) every shift."</p> <p>On 12/3/14 at 8:40 a.m., 1:20 p.m., and 2:45 p.m., the sign remained on the resident's wall above the head of her bed.</p> <p>On 12/4/14 at 7:10 a.m., 10:30 a.m., and 2:30 p.m., the sign remained on the resident's wall above the head of her bed.</p> <p>The record for Resident #107 was reviewed on 12/3/14 at 2:53 p.m. The resident's diagnoses included, but were not limited to, paralysis and pervasive developmental disorder.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/30/14, indicated the resident was severely impaired for daily decision making.</p> <p>Interview with the Director of Nursing (DON) on 12/5/14 at 9:45 a.m., indicated the resident should not have had a sign posted above her bed related to oral care. The DON indicated this was a dignity issue.</p> <p>2. On 12/2/14 at 9:53 a.m., LPN #1 entered Resident #157's room. The LPN did not knock on the door prior to</p>		<p>referring to residents as "feeders."</p> <p>2. All residents have the potential to be impacted.</p> <p>A. Facility sweep to identify residents with signage</p> <p>B. In service on all staff knocking on doors, copies of in service attached. In service on all staff not using pet names or referring to residents as "feeders," copies of in service attached.</p> <p>3. Management to observe resident rooms 2 x week for signage, also to observe for knocking on doors; during meals, managers to observe for no use of term "feeders." Copies of audit tool attached.</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will be reviewed quarterly for 6 months.</p>	

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F000242 SS=D	<p>entering the room. At 9:55 a.m., CNA #1 entered the resident's room. The CNA did not knock on the door prior to entering the room.</p> <p>Interview with the Director of Nursing on 12/5/14 at 10:20 a.m., indicated staff should have knocked on the door prior to coming into the resident's room.</p> <p>3. On 12/01/2014 at 12:21 p.m., in the 300 Unit dining room, Dietary Aide #2 was overheard calling Resident #18, Resident #57, Resident #106, Resident #111, Resident #14, and Resident #155 "Feeders" while preparing their serving trays.</p> <p>Interview at the time with the Dietary Aide, indicated the residents should be called by their first names and not nick names such as "Feeders."</p> <p>Interview with the Director of Nursing (DON) on 12/5/14 at 9:45 a.m., indicated the residents should be called by their first names and not nick names.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact</p>		5. 1-04-15				

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	<p>with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, record review and interview, the facility failed to honor resident choices related to shower preferences and when to get out of bed in the morning for 1 of 4 residents reviewed for choices of the 7 residents who met the criteria for choices. (Resident #1)</p> <p>Findings include:</p> <p>Family interview on 12/4/14 at 2:28 p.m. with Resident #1's sister and legal guardian indicated she visits her sister almost everyday and she comes in at all times of the day. She indicated her sister resided on the 100 Unit which was the memory care unit and a locked unit. The resident's legal guardian indicated she would like her sister to have a shower at least three times a week, because she was still very young and does have body odor more often. She further indicated the resident gets up very early in the morning around 5:30 a.m., and there was no reason for it. She indicated when she visits now, she finds her sleeping because she was so tired. She indicated the resident attends workshop two times a week on Mondays and Wednesday and leaves the facility around 8:30 a.m. She used to attend five times a week, but now</p>	F000242	<p><b>The facility requests paper compliance for this citation.</b></p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of federal and state law.</p> <ol style="list-style-type: none"> <li>Resident # 1 has updated shower preference for 3 x week. In service on shower/bathing preferences being honored (copies attached) .</li> <li>All residents had care plans reviewed for shower/bathing preferences, any corrections needed were completed and schedules updated.</li> <li>On admission and quarterly thereafter, Activities to complete preferences and then will notify unit managers of any need to</li> </ol>	01/04/2015	

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	<p>with the reduction she does not know why they continue to get her up so early.</p> <p>On 12/4/14 at 5:27 a.m. on the 100 Unit there were seven residents dressed and sitting up in chairs or wheelchairs in front of and across from the Nurse's station. One of the residents observed was Resident #1 who was sitting in a regular chair in the hallway to the left of the Nurse's Station. The resident was dressed in black pants, a light purple top, and tennis shoes. The resident was observed with her head down and her eyes closed.</p> <p>Interview with LPN #3 on 12/5/14 at 5:37 a.m., indicated there were six residents who were on night shift "get up" list.</p> <p>Interview on 12/5/14 at 5:41 a.m. with CNA #4 indicated Resident #1 was on her list to get up early. She indicated she was always gotten out of bed early. The CNA indicated there were no special days the resident gets up earlier, it was everyday. The CNA indicated the resident was usually asleep when she awakened her. She indicated she started getting the resident up at 5:00 a.m.</p> <p>Continued observation on 12/5/14 at 6:05 a.m., indicated Resident #1 was observed</p>		<p>update shower/bathing schedules based on resident preferences. ADON's (or designee) will review shower documentation 3 time per week to ensure that showers/baths are occurring as care planned and are documented appropriately. Audit tool attached.</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified ( 3 deficient practices per month is considered a trend) then results will reviewed quarterly for six months.</p> <p>5. 1-04-15</p>		

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	<p>sitting in the same chair with her head down and eyes closed.</p> <p>Observation on 12/5/14 at 6:55 a.m. indicated the resident was still seated in the chair with her head down and her eyes closed.</p> <p>Interview on 12/5/14 at 6:11 a.m., with LPN #2 indicated breakfast was served to the residents around 7:30 a.m. for both Dining Areas on the unit. The LPN indicated Resident #1 goes to workshop every Monday and Wednesday and usually leaves after breakfast around 8:30 a.m. or 9:00 a.m.</p> <p>The record for Resident #1 was reviewed on 12/5/14 at 8:32 a.m. The resident's diagnoses included, but not limited to, cerebral palsy, dementia without behavioral disturbance, convulsions, intellectual disabilities, bipolar disorder, chronic kidney disease, and anxiety.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 11/12/14 indicated the resident had no memory recall and was severely impaired for decision making. The resident displayed other behavioral symptoms not directed toward others which occurred 1 to 3 days. The resident's family member completed the preference and activity section which</p>						

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	<p>indicated it was very important on what clothes for her to wear, very important on whether to choose between a bath or shower, and very important on when to choose her own bedtime. The family member indicated it was very important to listen to music she likes, very important to be around animals, very important to do things in groups, and very important to go outside when weather was good. The resident needed extensive assist with one person physical assist for bed mobility, transfers, walking in corridor, dressing, eating, personal hygiene, and toilet use. She was total dependence on staff for bathing.</p> <p>The Activity assessment dated 11/15/14 indicated the resident was an early riser.</p> <p>The current 11/12/14 care plan indicated the resident had an Activities of Daily Living (ADL) self care deficit or potential for as evidenced by needs assistance or was dependent with bathing. The Nursing approaches were to shower three times a week per family request. This approach had a start date of 9/24/14. Another Nursing approach was to honor the resident preferences.</p> <p>The shower book indicated the resident was to be bathed on Mondays, Wednesdays, and Fridays.</p>			

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	<p>The shower sheets for December 2014 indicated the resident had only received a shower on 12/1 and 12/5/14</p> <p>The shower sheets for the month of November 2014 indicated the resident had only received a shower on 11/3, 11/7, 11/10, 11/14, 11/17, 11/19, 11/21, and 11/27/14.</p> <p>The shower sheets for the month of October 2014 indicated the resident had only received a shower on 10/6, 10/8, 10/13, 10/17, 10/20, 10/22/14.</p> <p>The resident did not receive a shower three times a week as per her Legal Guardian's preference.</p> <p>Review of the CNA assignment worksheet indicated the resident was an early riser and was supposed to receive a shower on Monday, Wednesday, and Friday.</p> <p>Interview with LPN #2 on 12/5/14 at 9:51 a.m., indicated the resident had been getting up early for a very long time due to going to workshop five days a week. She indicated it had been that way forever and she did not know why they still continued to get her up early now because she no longer goes to workshop</p>			

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F000246 SS=D	<p>five days a week.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's call light was within reach at all times for 1 of 40 residents observed for call lights. (Resident #136)</p> <p>Findings include:</p> <p>On 12/1/14 at 11:02 a.m., Resident #136 was observed seated in her wheelchair in her room between the closet and the bed facing the television set. At that time, her call light was observed laying in the middle of the bed. Further observation indicated the resident was wearing a splint to her left hand and the resident's bed was on the left side of her. She indicated she could not reach her call light. She further indicated she used the call light when it was in reach.</p>	F000246	<p><b>The facility requests paper compliance for this citation.</b></p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of federal and state law.</p> <p>1. Call light immediately put into place for resident # 136.</p>	01/04/2015	

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	<p>On 12/1/14 at 11:38 a.m., the resident was still observed in the same position in her room and the call light was still lying on the bed and out of reach.</p> <p>On 12/2/14 at 9:07 a.m., the resident was observed in bed and the call light was laying on the floor. Interview with the resident at that time, indicated she did not know where the call light was.</p> <p>On 12/3/14 at 2:30 p.m., the resident was observed in bed. The call light was on the floor and completely out of reach for the resident. Interview with the resident at that time, indicated she was unaware where her call light was at.</p> <p>On 12/5/14 at 9:50 a.m., until 10:15 a.m., the resident was observed in bed. At those times, the call light was located on the floor and completely out of reach for the resident.</p> <p>Interview with CNA #2 on 12/5/14 at 10:17 a.m. indicated the resident's call light should be in reach for her to use at all times.</p> <p>Interview with LPN # 5 on 12/5/14 at 10:18 a.m., indicated the resident should have her call light in reach at all times while in her room.</p>		<p>2. All residents have the potential to be impacted. Nursing management conducted a sweep of the building to ensure that call lights were accessible.</p> <p>3. In service of all departments on placing call lights appropriately for each resident's needs. (copy attached) Nursing management to observe call lights in place for 5 random residents 5 x weekly (audit tool attached).</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified ( 3 deficient practices per month is considered a trend) then results will reviewed quarterly for six months.</p> <p>5. 1-04-15</p>				

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F000247 SS=D	<p>The record for Resident #136 was reviewed on 12/3/14 at 9:42 a.m. The resident's diagnoses included, but were not limited to, urinary retention, high blood pressure, congestive heart failure affect due to at stroke, left hemiplegia, and dysphagia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/16/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 14. The resident was total dependence on staff for transfers with a 2 person physical assist.</p> <p>3.1-3(v)(1)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to ensure each resident received prior notice before a room or roommate change, for 1 of 3 residents reviewed for admission, transfer, and discharge of the 3 who met the criteria for admission, transfer, discharge. (Resident #102)</p> <p>Findings include:</p>	F000247	<p><b>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it</b></p>	01/04/2015

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F000248 SS=D	<p>Interview with Resident #102 on 12/2/14 at 10:33 a.m., indicated he was not notified prior to receiving a new roommate.</p> <p>The record for Resident #102 was reviewed on 12/3/14 at 10:50 a.m. Review of the Social Service progress notes indicated no evidence of documentation indicating the resident received notice prior to getting a new roommate.</p> <p>Interview with the Social Service Director on 12/3/14 at 11:00 a.m., indicated there was no evidence of documentation indicating Resident #102 received notice prior to getting a new roommate.</p> <p>3.1-3(v)(2)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p>		<p><i>is required by the provisions of federal and state law. 1) The resident (102) was subsequently notified of the change in roommates. 2) All residents had the potential to be affected.No negative resident impact was noted. New admissions and room changes within the last 30 days were reviewed to ensure that there was timely roommate notification (where applicable.). 3) Social Services will in-service relevant staff related to room changes, no later than 1.4.15. An audit of admission and room changes will be completed at least three time per week to ensure roommate was notified prior to change and notification was documented. 4) Results of these audits will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for a total of 6 months. 5. 1.4.15</i></p>	

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  12/05/2014
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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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	<p>Based on observation, record review and interview, the facility failed to ensure activity preferences were honored as well as one to one visits completed for 1 of 1 residents reviewed for hospice services. The facility also failed to ensure structured activities were offered for 1 of 4 residents reviewed for activities of the 7 residents who met the criteria for activities as well as the residents who resided on the 100 unit. (Residents #1 and #107)</p> <p>Findings include:</p> <p>1. On 12/2/14 at 3:05 p.m., Resident #107 was observed in her room in bed. The resident's room was dark and her television was turned on. There was no radio in the resident's room.</p> <p>On 12/3/14 at 8:40 a.m., 10:40 a.m., 1:20 p.m., and 2:45 p.m., the resident was in her room in bed. Her eyes were closed and her television was turned on. There was no radio in the resident's room.</p> <p>On 12/4/14 at 2:30 p.m., the resident was in her room in bed. The television was turned on but the volume was turned down. There was no radio in the resident's room.</p> <p>The record for Resident #107 was</p>	F000248	<p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1. The activity schedule for Residents 107 and 1 were revised by the Activity Director (see attached). Documentation of said activities are being monitored by the Activities Director and her assistant. A radio was placed in the resident's room. One-on-one visits were immediately reinstated.</p> <p>2. All residents had the potential</p>	01/04/2015

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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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	<p>reviewed on 12/3/14 at 2:53 p.m. The resident's diagnoses included, but were not limited to, paralysis and pervasive developmental disorder.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 7/17/14, indicated the resident was severely impaired for daily decision making. The resident's past activity preferences included listening to music, reading books, newspapers or magazines, and being around animals such as pets.</p> <p>The plan of care dated 7/31/14, and reviewed October 2014, indicated the resident no longer responded to external stimulus. No longer capable of complex social interactions. Interest include: unable to assess. History of enjoying music and being read to. The interventions included, but were not limited to, assess most enjoyable stimuli based on history and past preferences and keep sensory items available in room or bring into room for one to one time.</p> <p>Interview with the Activity Director on 12/5/14 at 8:55 a.m., indicated the resident was bed bound and received one to one visits.</p> <p>The 11/2014 Activity log indicated the resident's last one to one visit was on</p>		<p>to be affected. The Activities Director reviewed the activities schedule to update as needed.</p> <p>3. The Activities calendars (there is a separate calendar for the 100 unit) are undergoing revision (January calendars attached). All activity preferences are being reviewed and updated. Work assignments for activity aides are also being revised to include specific activities to be completed with specific time frames. Staff will be required to document all activities. If an activity cannot be completed, documentation as to why must be completed. The Activity Director (or designee) will do random observations of activities (see attached form) on various days and times. (no less than 5 times per week) and documentation will be reviewed on a daily basis. (see attached example) Activities staff were inserviced on the need to provide meaningful activities and document same.</p> <p>4. The Executive Director (or designee) will monitor compliance through review of the observation forms and documentation checks. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns</p>				

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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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	<p>11/18/14. There was no documentation related to music.</p> <p>The 12/2014 Activity log indicated the resident received a hand massage and friendly visit on 12/2/14.</p> <p>Interview with the Activity Director on 12/5/14 at 9:45 a.m., indicated based on the documentation on the one to one sheet, it looked like the resident had not received a one to one visit since 11/18/14. She also indicated that she would get a radio and place it in the resident's room. The Activity Director indicated the resident used to get out of bed and they would bring her down to music activities. She indicated the resident no longer gets out of bed due to pain issues.</p> <p>2. Family interview on 12/4/14 at 2:28 p.m. with Resident #1's sister and Legal Guardian indicated she visits her sister almost everyday and she comes in at all times of the day. She indicated her sister resided on the 100 Unit which was the memory care unit and a locked unit. She further indicated she does not see activities on the unit anymore. She indicated there used to be activities all the time, but now they have significantly decreased. The Legal Guardian indicated her sister used to attend workshops in the community based on her mental</p>		<p>are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for six months.</p> <p>5. 1.4.15</p>				

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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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	<p>disabilities five times a week, however, now she attends only two times a week, due to her advanced stage in her medical condition. She indicated the facility offered activities for the resident and that was why they chose to keep her at the facility more often instead of having go out everyday, however, "activities have slowed down a great deal."</p> <p>Observation on 12/4/14 from 4:00 p.m., until 5:00 p.m., on the 100 unit there were approximately 22 residents seated in their wheelchairs near or at the Nurse's station. There were no structured activities going on during this time. The residents were observed to become restless, some starting yelling out loud and some started to try and stand by themselves. Other residents were then observed ambulating around the unit. Continued observation at 4:50 p.m. a CNA was observed to start singing Rudolph the Red Nose Reindeer and then Frosty the Snowman in which she did not know all the words to either song. There was no Activity Aide on the unit during this time.</p> <p>Continued observation on 12/4/14 at 4:33 p.m., indicated Resident #1 was observed sitting in a chair by herself near one of the dining rooms. No staff were interacting with her or asking her and</p>			

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	<p>encouraging her to participate in the singing of those songs.</p> <p>Interview with LPN #8 on 12/4/14 at 4:37 p.m., indicated she primarily works the day shift until 6 or 6:30 p.m. She indicated there was not enough staff to interact with the residents and keep them busy and there was no full time activity aide on the unit. She further indicated they must rely on the CNAs to do the activities and they also have to take care of the residents, therefore activities get missed most of the time. She indicated during the day shift they staff 2 and 1/2 CNAs from 10 a.m., until 2 p.m. and then another CNA comes in at 5 p.m., to 9 or 10 p.m. to help with dinner and putting the residents to bed.</p> <p>Interview with CNA #3 on 12/4/14 at 4:40 p.m., indicated she has worked on the unit since September 2014. She was new to the facility and usually worked the 2-10 shift on the 100 Unit. She indicated the CNAs do the activities on the 100 Unit in the evenings. She indicated they usually will get the residents to do exercise or sing with them. She indicated since she was new, she just follows the other CNAs. CNA #3 indicated activities usually go on at least 3 times a week during the evenings but not everyday, "It really all depends on the residents and</p>			

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	<p>their behaviors and needs if they can do activities with the them or not."</p> <p>The record for Resident #1 was reviewed on 12/5/14 at 8:32 a.m. The resident's diagnoses included, but not limited to, cerebral palsy, dementia without behavioral disturbance, convulsions, intellectual disabilities, bipolar disorder, chronic kidney disease, and anxiety.</p> <p>Annual Minimum Data Set (MDS) assessment dated 11/12/14 indicated the resident had no memory recall and was severely impaired for decision making. The resident displayed other behavioral symptoms not directed toward others which occurred 1 to 3 days. The resident's family member completed the preference and activity section which indicated it was very important to listen to music she likes, very important to be around animals, very important to do things in groups, and very important to go outside when weather was good. The resident needed extensive assist with one person physical assist for bed mobility, transfers, walking in corridor, dressing, eating, personal hygiene, and toilet use. She was total dependence on staff for bathing.</p> <p>The current care plan dated 11/12/14 indicated the resident had low cognitive</p>			

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	<p>functioning and had a need for low functioning activities. The goal indicated the resident will actively participate in 2-3 lower functioning activities each week to maintain current functionality and enhance quality of life. The Nursing approaches were to assess resident interests, abilities, and limitations, invite encourage family or friends to participate in programs with the resident. Evaluate plan and adjust as needed. Invite and encourage to lower functioning programs of interest as they occur.</p> <p>The resident's Activity participation record for November 2014 was reviewed. The resident participated in the following: friendly visits 11/1-11/26 and 11/29/14 TV/radio 11/1-11/26 and 11/29 facility outing on 11/1 current events 11/4 music sing a long 11/4 and 11/9 special programs 11/17 snack 11/3, 11/17 popcorn 11/4 volunteer visits 11/5 and 11/17</p> <p>Review of the December 2014 100 Unit Activity Calendar indicated Monday, Wednesday, and Friday at 9:00 a.m., current events was to take place. At 9:30 a.m., on those days some sort of physical activity was to begin. Everyday at 11:00</p>			

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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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	<p>a.m. Lunch Preparation was the activity.</p> <p>Interview with the Unit Director on 12/5/14 at 9:10 a.m., indicated she does not do anything with activities on the unit, that was the responsibility of the Activity Director.</p> <p>Interview with Activity Director of 12/5/14 at 9:45 a.m., she indicated there were all different levels of residents with dementia on the unit. She further indicated she staffed an Activity Aide on the unit from 9:00 a.m. until 12:00 p.m., who helps with activities and the lunch meal. There was also an Activity Aide from 4 p.m., until 7 p.m., who helps with the evening meal as well. She also indicated the Activity Aide was a CNA, so that person could help feed the residents at lunch and dinner time. She indicated sometimes her staff would tell her the Nursing staff want them to do 1 on 1 with a resident due to behaviors or take residents to the bathroom and do CNA duties and not activities. The Activity Director indicated there were about 5 or 6 residents on the unit who very high functioning and the rest of the residents were lower functioning. She indicated the Administrator had just informed her the approval to hire a full time activity person for the unit.</p>			
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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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F000278 SS=E	<p>Interview with Activity Aide #1 on 12/5/14 at 11:00 a.m., indicated she works on the 100 unit about 3 times a week. She indicated she works from 9-12 and helps feed the residents at lunch time. Activity Aide #1 indicated she was also a CNA so there were many times she performs CNA duties on the unit as well as trying to do the scheduled activities.</p> <p>Interview with the Administrator on 12/5/14 at 1:30 p.m., indicated she was aware the 100 unit was in need of a full time Activity Aide and they were currently looking for someone.</p> <p>3.1-33(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual</p>			

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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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	<p>who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was coded correctly related to anticoagulant and antidepressant medications for 2 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure dialysis was coded for 1 of 1 residents reviewed for dialysis and accurate dental status was coded for 1 of 2 residents reviewed for dental services of the 2 residents who met the criteria for dental services. (Residents #64, #154, #163, and #175)</p> <p>Findings include:</p> <p>1. The record for Resident #163 was reviewed on 12/2/14 at 3:21 p.m. The resident's diagnoses included, but were not limited to, depressive disorder, anxiety state, and episodic mood disorder.</p>	F000278	<p><b>F278 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</b></p> <p>1. R#163- MDS with ARD of 10/28/14 was corrected to reflect antidepressant use in section N. R#175- MDS with ARD of 7/9/14 was corrected to reflect dental carries in section L R#64- MDS with ARD of 11/15/14 was corrected to reflect Dialysis in section O. R#154- MDS with ARD of 10/28/14 was corrected to reflect anticoagulant in section N.</p> <p>2. All current residents with ARD of 12/1/14 to present</p>	01/04/2015

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  12/05/2014	
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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	<p>The 12/2014 Physician's order summary (POS), indicated the resident was receiving Trazodone HCl (an antidepressant) 50 milligrams (mg) at night and Zoloft (an antidepressant) 50 mg daily.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 10/28/14, indicated antidepressants were not coded as being received in the last 7 days under Section N Medications.</p> <p>The October 2014 Medication Administration Record, indicated the resident was receiving the Trazodone and Zoloft as ordered.</p> <p>Interview with MDS Coordinator #1 on 12/5/14 at 1:00 p.m., indicated that she was not aware the resident was receiving antidepressant medications.</p> <p>2. The record for Resident #175 was reviewed on 12/2/14 at 3:33 p.m. The resident was admitted to the facility on 9/20/13. The resident's diagnoses included but were not limited to, high blood pressure, stroke, and diabetes type two.</p> <p>Review of the Nursing Admission assessment dated 9/20/13 indicated the oral assessment regarding the resident's</p>		<p>receiving Antidepressants, Anticoagulants, and Dialysis were reviewed to confirm they were marked correctly on most recent OBRA MDS. All current residents with ARD of 12/1/14 to present were reviewed for accuracy in coding section L for cavities, broken teeth. 3. MDS Coordinator was in serviced on correct coding of section N for medications, section O for Dialysis as a special service and section L for assessing oral cavity. MDS Coordinator and/or designee will audit 5 records weekly for accuracy in coding antidepressants, anticoagulants, dialysis, and oral cavity assessment. 4. The Executive Director will monitor compliance through review of the inspection forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for 6 months. 5 1.4.15</p>				

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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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	<p>teeth was incomplete and blank.</p> <p>Review of the Minimum Data Set (MDS) Quarterly assessment 9/23/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status of 15. He had no broken or loosely fitting dentures or mouth pain.</p> <p>Review of the Annual MDS assessment dated 7/9/14 indicated the resident had no problems with his teeth. The section obvious or likely cavity or broken natural teeth was checked "No."</p> <p>The last dental exam in the resident's record was dated 12/16/13. The tooth notes indicated the resident had multiple areas of large decay throughout. The Dentist recommended extractions, but the resident declined at that time. The treatment plan was to schedule in 3 months a Prophy visit and schedule in 6 months a periodic visit.</p> <p>Interview with MDS Coordinator #1 on 12/4/14 at 10:29 a.m., indicated she does not complete the dental section for residents, the Registered Dietitian does that, however, she was the person signing the overall completion and accuracy of the MDS.</p> <p>3. The record for Resident #64 was</p>			

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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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	<p>reviewed on 12/4/14 at 8:44 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, peripheral vascular disease, stroke, anemia, depression, and chronic renal failure.</p> <p>Physician Orders dated 10/22/14 indicated to check bruit and thrill left arm shunt every shift. Continued review of Physician Orders dated 10/22/14 indicated dialysis every Monday, Wednesday, and Friday.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/15/14 indicated the resident was not alert and oriented and dialysis was coded as "No" while a resident at the facility.</p> <p>Interview with MDS Coordinator #1 on 12/4/14 at 10:32 a.m., indicated dialysis while a resident at the facility should have been coded as a "Yes" on the MDS.</p> <p>4. The record for Resident #154 was reviewed on 12/4/14 at 12:00 p.m. The resident's diagnoses included, but were not limited to dementia, psychosis, high blood pressure, cardiac pacemaker, and altered mental status.</p> <p>Physician Orders dated 10/10/14 indicated Eliquis (an anticoagulant</p>				

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  12/05/2014
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F000282 SS=E	<p>medication used to thin the blood) 2.5 milligrams (mg) twice a day.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 10/28/14 indicated the resident was not alert and oriented. Under the section of medication use anticoagulant medications was coded with a "0" indicating the resident did not receive the medication in the last 7 days.</p> <p>The 10/2014 Medication Administration Record was reviewed and indicated the Eliquis medication was administered to the resident 10/10-10/31/14.</p> <p>Interview with MDS Coordinator #1 on 12/5/14 at 1:30 p.m., indicated she was unaware Eliquis was an anticoagulant medication.</p> <p>3.1-31(i)</p> <p>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 persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to activities for 1 of 1 residents reviewed for</p>	F000282	<p>The facility requests paper compliance for this citation. This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and / or execution of</p>	01/04/2015

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	<p>hospice, activities of daily living (ADL's) related to assistance with grooming for 1 of 3 residents reviewed for ADL's of the 11 who met the criteria for ADL's, pressure ulcer treatments for 1 of 1 residents reviewed for pressure sores, skin monitoring for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 3 who met the criteria for skin conditions (non-pressure related) and not inserting a voice valve for 1 of 1 residents reviewed for tracheostomy care. (Residents #7, #64, #107, #157, and #183)</p> <p>Findings include:</p> <p>1. On 12/2/14 at 3:05 p.m., Resident #107 was observed in her room in bed. The resident's room was dark and her television was turned on. There was no radio in the resident's room.</p> <p>On 12/3/14 at 8:40 a.m., 10:40 a.m., 1:20 p.m., and 2:45 p.m., the resident was in her room in bed. Her eyes were closed and her television was turned on. There was no radio in the resident's room.</p> <p>On 12/4/14 at 2:30 p.m., the resident was in her room in bed. The television was turned on but the volume was turned down. There was no radio in the resident's room.</p>		<p>the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.</p> <p>1. Resident # 107 received a radio immediately. In service to be completed (copies attached)</p> <p>Resident # 157 was provided a shower and shave immediately. In service to be completed. (copies attached).</p> <p>Resident # 64 had incorrect treatments replaced with correct treatments immediately. In service to be completed. (copies attached)</p> <p>Resident # 7 had area measured, MD and family notified. Order to monitor until resolved implemented. Geri sleeves applied immediately. In services to be completed. (copies attached).</p> <p>Resident # 183 had valve placed. New order to provide the valve as resident requests. In service to be completed. (copies attached).</p> <p>2. Facility wide audit was conducted per the ADHS, DHS</p>	

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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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	<p>The record for Resident #107 was reviewed on 12/3/14 at 2:53 p.m. The resident's diagnoses included, but were not limited to, paralysis and pervasive developmental disorder.</p> <p>The plan of care dated 7/31/14, and reviewed October 2014, indicated the resident no longer responded to external stimulus. No longer capable of complex social interactions. Interest include: unable to assess. History of enjoying music and being read to. The interventions included, but were not limited to, assess most enjoyable stimuli based on history and past preferences and keep sensory items available in room or bring into room for one to one time.</p> <p>Interview with the Activity Director on 12/5/14 at 8:55 a.m., indicated the resident was bed bound and received one to one visits.</p> <p>The 11/2014 Activity log indicated the resident's last one to one visit was on 11/18/14. There was no documentation related to music.</p> <p>The 12/2014 Activity log indicated the resident received a hand massage and friendly visit on 12/2/14.</p>		<p>and MDSC to identify any other residents with skin issues not previously identified or monitored with no other issues noted.</p> <p>3. Licensed Nursing staff to be re-inserviced related to skin assessment procedures, completion of occurrence report, and continued monitoring of areas identified. Providing correct treatments per physician order and per care plan. All nursing staff in serviced on providing shower/bathing preferences and ADL care daily. C.N.As to be re-inserviced related to observing daily for changes in skin integrity and reporting to the nurses and changes noted. Nursing managers to monitor 5 x week for showers completed timely and ADL care provided. Managers to monitor the treatment orders of five residents per week to ensure that care is being completed per physician order. Managers to monitor 1 week that valve being placed as per resident requests.</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will be reviewed quarterly for six</p>	

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	<p>Interview with the Activity Director on 12/5/14 at 9:45 a.m., indicated based on the documentation on the one to one sheet, it looked like the resident had not received a one to one visit since 11/18/14. She also indicated that she would get a radio and place it in the resident's room. The Activity Director indicated the resident used to get out of bed and they would bring her down to music activities. She indicated the resident no longer gets out of bed due to pain issues.</p> <p>2. On 12/2/14 at 10:50 a.m., Resident #157 was observed with a growth of facial hair. The resident's hair was also greasy in appearance. The resident indicated at this time that "he would love to have a shave." At 3:06 p.m., the resident's facial hair had not been removed.</p> <p>On 12/3/14 at 10:45 a.m. and 1:20 p.m., the resident's facial hair remained. The resident's hair was also greasy in appearance.</p> <p>On 12/4/14 at 7:58 a.m., the resident's facial hair remained and his hair was also greasy in appearance.</p> <p>The record for Resident #157 was reviewed on 12/3/14 at 11:12 a.m. The</p>		<p>months.</p> <p>5. 1-04-15</p>				

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	<p>resident's diagnoses included, but were not limited to, rehabilitation and healing traumatic fracture of upper arm.</p> <p>The plan of care dated 7/30/14, and reviewed October 2014, indicated the resident had an ADL (activities of daily living) self care deficit or potential for as evidenced by needing assist or was dependent in personal hygiene and bathing and was at risk for developing complications associated with decreased ADL self-performance related to pain and weakness. The interventions included, but were not limited to, assist with personal hygiene as needed.</p> <p>Interview with the resident on 12/4/14 at 12:00 p.m., indicated the last shower he had was about a week ago.</p> <p>Interview with the Director of Nursing on 12/4/14 at 12:06 p.m., indicated the resident should have been provided assistance with shaving and showering.</p> <p>3. On 12/4/14 at 12:50 p.m. Resident #64 was observed lying in bed. At that time, RN #1 was preparing to complete the pressure ulcer treatment to the coccyx and right buttock. RN #1 was observed to wash her hands with soap and water and she donned a pair of clean gloves to both of her hands. She then cleaned both areas with wound wash and patted them</p>			

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	<p>dry. The RN then opened the tubes Santyl and Bactroban ointments (a debriding and antibiotic ointment) and mixed them into a medicine cup. She then used the q-tip applicator and applied the mixed ointment to the coccyx and right buttock ulcers. The RN then cut two small pieces of Calcium Alginaid (a medicated gauze sponge) into circles and placed them on top of each open area. She then covered both open areas with an Octofoam (a protective dressing).</p> <p>Interview with RN #1 at that time indicated she had thought both open areas were to have the Santyl and Bactroban ointment mixture applied to them. She also indicated she had thought the treatment called for Calcium Alginaid to be placed over the top of the pressure ulcers</p> <p>The record for Resident #64 was reviewed on 12/4/14 at 8:44 a.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus, high blood pressure, peripheral vascular disease, stroke, anemia, depression, and chronic renal failure.</p> <p>Physician Orders dated 11/21/14, indicated the treatment to the right buttock as follows: Cleanse right buttock wound with wound wash pat dry, apply</p>			

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	<p>hydrogel foam dressing daily and as needed.</p> <p>Physician Orders dated 11/21/14 indicated the treatment to the coccyx as follows: Cleanse coccyx wound with wound wash pat dry apply Bactroban and Santyl mix to wound cover with dry dressing daily and as needed.</p> <p>Interview with the 300 Unit Manager as well as the Wound Nurse on 12/4/14 at 1:10 p.m., indicated the Santyl and Bactroban was only to be used on the coccyx wound and there was no Physician Order for the Calcium Alginaid to be applied over the open areas.</p> <p>4. On 12/2/14 at 9:49 a.m., Resident #7 was observed sitting in a chair. At that time there was a blue bruise noted to the left outer hand near her thumb. There were no geri sleeves noted to the resident's arms.</p> <p>On 12/2/14 at 3:21 p.m., the resident was observed in bed. At that time, there was a blue bruise noted to her left outer hand near her thumb. There were no geri sleeves noted on either arm.</p> <p>On 12/3/14 at 9:06 a.m., and 11:00 a.m., the resident was observed sitting in a chair. At those times there was a blue</p>			

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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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	<p>bruise noted to the left outer hand near her thumb. There were no geri sleeves noted to the resident's arms.</p> <p>On 12/3/14 at 2:35 p.m., the resident was observed in bed. At that time, there was a blue bruise noted to her left outer hand near her thumb. There were no geri sleeves noted on either arm. RN #1 was asked to perform a skin assessment. She noted a blue/purple bruise to the left outer hand, near her thumb area. She indicated she was aware she had the bruise and thought it was from a lab draw that happened the previous week. She then measured the bruise which was 3.5 centimeters (cm) by 4 cm.</p> <p>The record for Resident #7 was reviewed on 12/3/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to dementia with agitation, high blood pressure, hypothyroidism, seizures, deep vein thrombosis, and dehydration.</p> <p>Review of Physician Orders dated 6/21/14 and on the current 12/2014 recap indicated geri sleeves to bilateral upper extremities.</p> <p>Interview with RN #1 on 12/4/14 at 9:10 a.m., indicated the resident was to wear geri sleeves at all times as per the Physician's Order.</p>			

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	<p>5. On 12/2/14 at 10:07 a.m., Resident #183 was observed in bed resting with her eyes closed, there was no speaking valve noted.</p> <p>On 12/3/14 at 8:41 a.m., Resident #183 was observed in bed eating breakfast, there was no speaking valve noted.</p> <p>The record for Resident #183 was reviewed on 12/3/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, tracheostomy, dysphagia oropharyngeal phase, and hypertension.</p> <p>Review of the Physician's Orders indicated, Passy Muir Valve (a speaking valve) to be placed daily and removed at night per resident tolerance.</p> <p>The care plan dated 9/9/14 indicated, change trach inner cannula and trach ties as ordered. Insert Passy Muir Valve as ordered.</p> <p>On 12/4/14 at 10:39 a.m., trach care observation with LPN # 7 indicated, after completing trach care for Resident #183, she failed to insert the resident's speaking valve.</p> <p>Interview at the time with LPN #7 indicated she failed to insert the resident's speaking valve after completing the</p>			

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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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F000309 SS=D	<p>resident's trach care.</p> <p>Interview with the Director of Nursing (DON) on 12/5/14 at 9:45 a.m., indicated upon completion of the resident's trach care the speaking valve should have been put in place.</p> <p>3.1.35.(g)(2)</p> <p>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 the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessing of bruises and for monitoring a resident pre and post dialysis for 2 of 3 residents reviewed for non pressure related skin conditions of the 3 residents who met the criteria for non pressure related skin conditions and for 1 resident reviewed for dialysis. (Residents #7, #64, &amp; #224)</p> <p>Findings include:</p>	F000309	<p>The facility requests paper compliance for this citation. This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	01/04/2015

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  12/05/2014
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	<p>1. The record for Resident #64 was reviewed on 12/4/14 at 8:44 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, peripheral vascular disease, stroke, anemia, depression, and chronic renal failure.</p> <p>Physician Orders dated 10/22/14 indicated to check bruit and thrill left arm shunt every shift. Continued review of Physician Orders dated 10/22/14 indicated dialysis every Monday, Wednesday, and Friday.</p> <p>Review of the current 11/14/14 care plan indicated resident receives hemodialysis three times a week on Monday, Wednesday, and Friday. The Nursing approaches were to encourage compliance with dialysis communication tools.</p> <p>Review of the red dialysis folder located on the 300 unit where the resident resided indicated there were communication sheets to be completed by the facility and the dialysis center each time the resident goes to dialysis. Further review of the folder indicated there was only one facility report sheet in the folder. The date on the sheet was 6/9/14. There were no other communication forms available for review.</p>		<p>1. Resident #64 proper paperwork put into place.</p> <p>Resident #7 had assessment completed, occurrence/skin/feet, area measured and documented. MD and family made aware. Order implemented to monitor until resolved.</p> <p>Resident #224 assessment completed, occurrence report and skin/feet assessment completed. Area measured and order to monitor until resolved. MD and family notified.</p> <p>2. All residents, receiving dialysis, have the potential to be impacted. A facility wide audit was conducted per ADHS and DHS, MDSC, to identify any other residents with skin issues not previously identified or monitored. Any areas identified had assessments and notifications completed.</p> <p>3. In service nursing staff on completing thorough skin assessments weekly, PRN and on admission (copies attached). In service nursing staff on proper procedure for dialysis communication and assessment (copies attached). Licensed Nursing staff to be re-inserviced related to skin assessment procedures, completion of</p>	

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	<p>The current and undated Post Dialysis Policy provided by the Director on Nursing indicated, "Documentation: At least a daily check of blood pressure and vital signs. Clinical information notes from observation and monitoring."</p> <p>Interview with the Medical Records Employee on 12/4/14 at 9:49 a.m., indicated there were no completed dialysis communication sheets in the resident's overflow chart. She further indicated there were no completed communication sheets on the entire unit.</p> <p>Interview with RN #1 on 12/4/14 at 10:31 a.m., indicated the dialysis communication sheets were to be completed prior to the resident going to dialysis.</p> <p>2. On 12/2/14 at 9:49 a.m., Resident #7 was observed sitting in a chair. At that time there was a blue bruise noted to the left outer hand near her thumb. There were no geri sleeves noted to the resident's arms.</p> <p>On 12/2/14 at 3:21 p.m., the resident was observed in bed. At that time, there was a blue bruise noted to her left outer hand near her thumb. There were no geri sleeves noted on either arm.</p>		<p>occurrence report, and continued monitoring of areas identified. In service to be completed for procedure for proper communication with dialysis facility and resident assessment. C.N.As to be re-inserviced related to observing daily for changes in skin integrity and reporting to the nurses any changes noted. ADHS or designee to do skin assessments on 3 residents weekly. ADHS or designee to audit dialysis communication sheets completed per policy 5 x week. (audit tool attached).</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will be reviewed quarterly for 6 months.</p> <p>5. 5. 1-04-15</p>	

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  12/05/2014
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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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	<p>On 12/3/14 at 9:06 a.m., and 11:00 a.m., the resident was observed sitting in a chair. At those times there was a blue bruise noted to the left outer hand near her thumb. There were no geri sleeves noted to the resident's arms.</p> <p>On 12/3/14 at 2:35 p.m., the resident was observed in bed. At that time, there was a blue bruise noted to her left outer hand near her thumb. There were no geri sleeves noted on either arm. RN #1 was asked to perform a skin assessment. She noted a blue/purple bruise to the left outer hand, near her thumb area. She indicated she was aware she had the bruise and thought it was from a lab draw that happened the previous week. She then measured the bruise which was 3.5 centimeters (cm) by 4 cm. She indicated when bruises were first observed, they were to measure it, complete a skin assessment sheet with measurements and notify the Doctor.</p> <p>The record for Resident #7 was reviewed on 12/3/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to dementia with agitation, high blood pressure, hypothyroidism, seizures, deep vein thrombosis, and dehydration.</p> <p>Review of Physician Orders dated</p>			

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	<p>6/21/14 and on the current 12/2014 recap indicated geri sleeves to bilateral upper extremities.</p> <p>Review of the monthly charting form dated 11/20/14 indicated no new changes in skin integrity noted.</p> <p>Review of Nursing Progress noted indicated the last progress note was dated 11/21/14 and there was no information or assessment regarding a bruise to the left outer hand.</p> <p>There was no non pressure sore related sheet completed for the bruise.</p> <p>Interview with RN #1 12/3/14 at 2:45 p.m., indicated she had not taken a measurement of the bruise when she first observed it on her left hand. She indicated there was no skin integrity sheet or non pressure sore related sheet completed for the bruise.</p> <p>Interview with the 300 Unit Manager on 12/3/14 at 3:00 p.m., indicated when bruises were observed by Nursing staff they were supposed to initiate and complete a skin integrity sheet.</p> <p>3. On 12/2/14 at 10:03 a.m. Resident #224 was observed with a round bruise on his right forearm.</p>			

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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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	<p>On 12/4/14 at 8:14 a.m., the resident was observed sitting in a wheel chair in the unit Dining Room. The resident was wearing a shirt with short sleeves. A round dark ruddy colored bruise was noted to his right upper forearm.</p> <p>On 12/4/14 at 11:05 a.m., the resident was observed in bed. The Director of Nursing was present in the room. The round bruise remained present to the resident's right upper forearm. The resident indicated he believed the area was from the hospital and denied any injury or accident to the area.</p> <p>The record for Resident #224 was reviewed on 12/4/14 at 8:17 a.m. The resident was admitted to the facility from the hospital on 11/26/14. The resident's diagnoses included, but were not limited to, obstructive sleep apnea, atrial fibrillation (an irregular hear rate), prostate cancer, high blood pressure, and anemia.</p> <p>An Admission/Admit assessment was completed on 11/26/14 at 6:15 p.m. The assessment indicated the resident was orientated to person, place, time, and situation. The assessment indicated the resident's skin color was normal and his skin was warm. No open area or bruises were noted on the assessment.</p>				

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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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	<p>A Skin/Feet assessment was completed on 11/26/14 at 8:56 p.m. This assessment indicated the resident's skin was warm and dry. No bruising was noted on the assessment. An assessment completed on 12/3/14 at 1:25 p.m. indicated the resident's skin was warm, dry, and flushed. No skin problems or bruises were noted in this assessment either. There were no further assessment or documentation of any bruising to the resident's right forearm in the resident's record. There were no Skin Occurrence forms noted in the resident's record.</p> <p>The 11/2014 Physician orders were reviewed. There was an order written on 11/17/14 for the resident to receive Coumadin (a medication to thin the blood) 5 milligrams every evening. An order was written on 11/29/14 for the resident to have a Weekly Skin Assessment.</p> <p>When interviewed on 12/4/14 at 3:42 p.m., the Director of Nursing indicated the resident stated he had the bruise in the hospital and this should have been documented. The Director of Nursing indicated there were no records of any monitoring or assessment of the bruise to the forearm.</p>			

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F000311 SS=D	<p>When interviewed on 12/5/14 at 12:57 p.m., the Director of Nursing indicated there was an assessment completed on 12/3/14 and that assessment should have included a full body assessment. The Director of Nursing also indicated if the bruise was present on 12/3/14 Nursing staff should have completed a Skin Occurrence Form and Skin Feet Assessment and the bruise to the resident's right forearm should have been assessed it was observed on 12/2/14.</p> <p>3.1-37(a)(1)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, record review and interview, the facility failed to ensure assistance was provided with activities of daily living (ADL's) related to showers and shaving for 1 of 3 residents reviewed for ADL's of the 11 residents who met the criteria for ADL's. (Resident #157)</p> <p>Findings include:</p> <p>On 12/2/14 at 10:50 a.m., Resident #157 was observed with a growth of facial hair. The resident's hair was also greasy</p>	F000311	<p>The facility requests paper compliance for this citation.</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the</p>	01/04/2015			

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	<p>in appearance. The resident indicated at this time that "he would love to have a shave." At 3:06 p.m., the resident's facial hair had not been removed.</p> <p>On 12/3/14 at 10:45 a.m. and 1:20 p.m., the resident's facial hair remained. The resident's hair was also greasy in appearance.</p> <p>On 12/4/14 at 7:58 a.m., the resident's facial hair remained and his hair was also greasy in appearance.</p> <p>The record for Resident #157 was reviewed on 12/3/14 at 11:12 a.m. The resident's diagnoses included, but were not limited to, rehabilitation and healing traumatic fracture of upper arm.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/5/14, indicated the resident's Brief Interview for Mental Status (BIMS) score was a 13 indicating he was cognitively intact. The resident needed extensive assist for personal hygiene. For bathing, the resident needed physical help limited to transfers only.</p> <p>The plan of care dated 7/30/14, and reviewed October 2014, indicated the resident had an ADL (activities of daily living) self care deficit or potential for as evidenced by needing assist or was</p>		<p>statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.</p> <ol style="list-style-type: none"> <li>Resident #157 was showered and shaved immediately.</li> <li>All residents have the potential to be impacted. Nursing management completed rounds and any residents identified as needing personal hygiene had care provided.</li> <li>In services to be completed on completion of shower sheets per shower schedule (copies attached). ADHS or designee will audit for completion of showers and ADL care provided 5 x week (audit tool attached).</li> <li>DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend)</li> </ol>		

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F000312 SS=D	<p>dependent in personal hygiene and bathing and was at risk for developing complications associated with decreased ADL self-performance related to pain and weakness. The interventions included, but were not limited to, assist with personal hygiene as needed.</p> <p>The Shower book indicated the resident's shower days were scheduled on Wednesday and Saturday on the evening shift. A shower sheet had not been completed for 12/3/14.</p> <p>Interview with the resident on 12/4/14 at 12:00 p.m., indicated the last shower he had was about a week ago. The resident indicated he was supposed to receive a shower yesterday evening but no one came and got him.</p> <p>Interview with the Director of Nursing on 12/4/14 at 12:06 p.m., indicated the resident should have been offered a shower yesterday evening. She also indicated the resident should have been provided assistance with shaving and showering.</p> <p>3.1-38(a)(2)(A)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p>		<p>then results will be reviewed quarterly for six months.</p> <p>5. 1-04-15</p>				

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	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on record review and interview, the facility failed to ensure each resident who was dependent on staff for Activities of Daily Living (ADL) received at least two showers a week for 1 of 3 residents reviewed for choices of the 7 residents who met the criteria for choices. (Resident #136)</p> <p>Findings include:</p> <p>Interview with Resident #136 on 12/1/14 at 10:51 a.m., indicated she only received a shower once a week and she would like at least two.</p> <p>The record for Resident #136 was review on 12/3/14 at 9:42 a.m. The resident's diagnoses included, but not limited to, urinary retention, high blood pressure, congestive heart failure, stroke, left hemiplegia, and degenerative joint disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 9/16/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) of 14. The resident was total dependence on staff for</p>	F000312	<p>The facility requests paper compliance for this citation.</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and / or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.</p> <ol style="list-style-type: none"> <li>1. Resident #136 was provided a shower immediately.</li> <li>2. Nursing management audited showers for the week prior to survey to ensure residents received showers as scheduled and as they preferred. If any resident was identified as not having showers completed, showers were provided.</li> <li>3. All nursing staff to be in</li> </ol>	01/04/2015	

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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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	<p>transfers with a two person physical assist and total dependent on staff with one person physical assist with bathing.</p> <p>Review of the current plan of care updated on 9/2014 indicated the resident had and ADL self care deficit. The Nursing approaches were to honor residents preferences regarding ADL'S and to provide a bath/shower twice weekly and as necessary.</p> <p>The shower sheets for the month of October indicated the resident received shower on 10/10 and 10/28/14</p> <p>The shower sheets for the month of November indicated the resident received a bed bath on 11/18 and 11/25/14 and a shower on 11/21/14.</p> <p>There were no shower sheets available for review for the month of December 2014.</p> <p>Interview with the Director of Nursing on 12/3/14 at 11:00 a.m., indicated there was no way to tell if the resident received a shower with the computer charting. The ADL computer charting only indicated the physical support for her bathing. She further indicated that some of the hand written shower sheets were not available for review.</p>		<p>serviced on providing shower/bathing preferences and ADL care daily and completing shower sheets to have documentation in place (copies attached). ADHS or designee to monitor showers by review of shower sheets 5 x week (audit tool attached).</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will be reviewed quarterly for six months..</p> <p>5. 1-04-15</p>				

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F000314 SS=D	<p>3.1-38(a)(2)(A)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to ensure the resident received the necessary treatment and services to promote wound healing related providing the correct treatment to an unstageable pressure sore for 1 of 1 resident reviewed for pressure ulcers of the 1 resident who met the criteria for pressure ulcers. (Resident #64)</p> <p>Findings include:</p> <p>On 12/4/14 at 12:50 p.m. Resident #64 was observed lying in bed. At that time, RN #1 was preparing to complete the pressure ulcer treatment to the coccyx and right buttock. RN #1 was observed to wash her hands with soap and water and she donned a pair of clean gloves to</p>	F000314	<p>The facility requests paper compliance for this citation.</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and / or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.</p> <p>1. Resident # 64 had correct treatments applied immediately.</p>	01/04/2015

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  12/05/2014
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	<p>both of her hands. She then cleaned both areas with wound wash and patted them dry. The RN then opened the tubes Santyl and Bactroban ointments (a debriding and antibiotic ointment) and mixed them into a medicine cup. She then used the q-tip applicator and applied the mixed ointment to the coccyx and right buttock ulcers. The RN then cut two small pieces of Calcium Alginaid (a medicated gauze sponge) into circles and placed them on top of each open area. She then covered both open areas with an Octofoam (a protective dressing).</p> <p>Interview with RN #1 at that time indicated she had thought both open areas were to have the Santyl and Bactroban ointment mixture applied to them. She also indicated she had thought the treatment called for Calcium Alginaid to be placed over the top of the pressure ulcers</p> <p>The record for Resident #64 was reviewed on 12/4/14 at 8:44 a.m. The resident's diagnoses included, but were not limited to, Diabetes Mellitus, high blood pressure, peripheral vascular disease, stroke, anemia, depression, and chronic renal failure.</p> <p>Physician Orders dated 11/21/14, indicated the treatment to the right</p>		<p>2. Facility wide audit was conducted to identify any residents with skin issues, if any issues were identified follow up was completed. In service to be completed for licensed nurses to complete treatments as per physician orders (copies attached).</p> <p>3. Licensed nursing staff to be re-in serviced on completing treatments as per physician orders. ADHS or designee to do random audit of treatments completed as per physician orders for 3 residents weekly (audit tool attached).</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will be reviewed quarterly for six months.</p> <p>5. 1-04-15</p>	

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	<p>buttock as follows: Cleanse right buttock wound with wound wash pat dry, apply hydrogel foam dressing daily and as needed.</p> <p>Physician Orders dated 11/21/14 indicated the treatment to the coccyx as follows: Cleanse coccyx wound with wound wash pat dry apply Bactroban and Santyl mix to wound cover with dry dressing daily and as needed.</p> <p>The Braden skin assessment dated 11/2014 indicated the resident was a moderate risk for pressure ulcers.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/15/14 indicated the resident was not alert and oriented. She needed extensive assist with one to two person physical assist with her activities of daily living. The resident was readmitted from the hospital with one Stage III and 1 Stage IV pressure ulcers.</p> <p>The 12/3/14 measurements to both areas were as follows: Coccyx 1.6 centimeters (cm) by 1.8 cm by .6 cm and was staged as unstageable. The right buttock measured 1 cm by 1.2 cm and was classified as Stage III.</p> <p>Further review of the pressure ulcer measurements indicated the coccyx has</p>			

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F000364 SS=E	<p>depth but the wound bed noted with slough. The right buttock was clean and pink with scattered slough but the wound bed visual.</p> <p>Interview with the 300 Unit Manager as well as the Wound Nurse on 12/4/14 at 1:10 p.m., indicated the Santyl and Bactroban was only to be used on the coccyx wound and there was no Physician Order for the Calcium Alginaid to be applied over the open areas.</p> <p>3.1-40(a)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview the facility failed to ensure each resident received food served at the proper temperature for 4 of the 20 residents interviewed for food served at the proper temperature. The facility also failed to maintain proper documentation of temperature logs for 3 of the 4 units in the facility. (Residents # 51, #116, #157, #224 and Unit 200, Unit 300, and Unit 400)</p>	F000364	<p><b>The facility requests paper compliance for this citation.</b> <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of</i></p>	01/04/2015			

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  12/05/2014
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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	<p>Findings include:</p> <p>1. Interview with Resident #116 on 12/01/2014 at 3:22 p.m., indicated the food was often served cold.</p> <p>Interview with Resident #224 on 12/02/2014 at 9:59 a.m., indicated the food was sometimes served too cold.</p> <p>Interview with Resident #157 on 12/02/2014 at 10:08 a.m., indicated the breakfast was served cold.</p> <p>Interview with Resident #51 at 12/02/2014 at 1:02 p.m., indicated the food was served cold.</p> <p>2. Review of the 200, 300, and 400 Unit temperature logs on 12/4/14 at 11:50 a.m., indicated lack of documentation on several dates and times.</p> <p>Interview with the Kitchen Manager on 12/4/14 at 12:00 p.m., indicated the 200, 300, and 400 Unit temperature logs contained lack of documentation on several dates and times. Further interview indicated each unit's steam table should behave temperatures taken before each meal and documented in the temperature logs.</p> <p>The current and undated Food Handling,</p>		<p><i>federal and state law.</i> 1) The Food Service Manager interviewed residents 51, 116, 157, and 224 to gain more information on issues related to food temperatures (copies attached). She also in-serviced staff on the importance of maintaining temp logs. (copies attached) 2) All residents had the potential to be affected by the alleged practice.No negative resident impact was noted. 3) The Food Service Manager (or designee) is reviewing temp logs for random meals and random dining rooms times six meals per week (will include at least one breakfast, one lunch and one dinner). Monitoring tool attached. 4). The Executive Director will monitor compliance through review of the inspection forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for 6 months. 5. 1.4.15</p>		

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F000371 SS=F	<p>Cooking , Cooling, and Holding of Raw Animal Foods policy provided by the Dietary Food Manager indicated, "Hot holding temperatures for potentially potential hazardous foods shall be at (140 degrees Fahrenheit) for hot foods, expect roasts which will be at temperature as listed in the Food Code Section 161(b)."</p> <p>3.1-21(a)(2)</p> <p>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</p> <p>Based on observation and interview, the facility failed to serve and distribute food under sanitary conditions related to serving ice to a resident from a plastic gray tray containing milk and serving desserts uncovered and below waist level for 1 of 4 dining rooms. There were 37 residents who dined in the 300 Unit dining room. The facility also failed to store kitchenware and food under sanitary conditions for 1 of 1 kitchens. This had the potential to affect 140 of 141 residents who resided in the facility. (The 300 Unit and the Kitchen)</p>	F000371	<p><b>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. The Food Service Manager in-serviced staff immediately on the proper way to maintain</b></p>	01/04/2015			

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	<p>Findings include:</p> <p>1. On 12/1/14 at 9:00 a.m., during an initial tour of the Kitchen with the Kitchen Manager, the following was observed:</p> <p>a. There were serving pans of various sizes stacked in the storage area. Eleven of the pans had moisture inside. On another rack, there were full size serving pans, 6 of the pans had moisture inside. There were 3 cooking pots of various sizes that had a white residue inside, the residue flaked off when rubbed.</p> <p>Interview with the Kitchen Manager at that time indicated the pots and pans should be completely cleaned and dried.</p> <p>b. In the walk-in refrigerator there was a large pot of chicken soup dated 11/23/14, and a pot of chicken and mushrooms soup dated 11/24/14.</p> <p>Interview at the time with the Kitchen Manager, indicated leftovers were to be thrown out after 3 days.</p> <p>The current and undated Equipment Storage policy provided by the Dietary Food Manager indicated, "Cleaned and sanitized portable equipment and utensils shall be stored above the floor in a clean,</p>		<p>kitchenware so that it is clean and dry, (sign-in sheet attached). A drying rack for pots and pans was also installed. All refrigerators were checked to ensure that outdated products were removed. Staff were in-serviced on proper food storage and disposal. (see attached) Rolling dessert carts have been permanently removed from service. 2. All residents had the potential to be affected by the alleged practice. No negative resident impact was noted. 3. The Food Service Manager (or designee) will complete a weekly Kitchen Sanitation Checklist (copy attached) at least one time per week. 4. The Executive Director will monitor compliance through review of the inspection forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for 6 months. 5. 1.4.15</p>	

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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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	<p>dry location so that food contact surfaces are protected from splash, dust and other contamination. Utensils shall be air dried before being stored or shall be stored in self draining position on suitable located hooks or racks constructed of corrosion resistant materials."</p> <p>The current and undated Food Storage policy provided by the Dietary Food Manager indicated, "All stored food products will be covered, identified and dated. Dating of potentially hazardous foods shall indicated the last day the item can be consumed."</p> <p>2. On 12/01/2014 at 12:02 p.m., during an observation of the 300 Unit dining room, CNA #5 was observed scooping ice from a plastic gray tray containing milk cartons into a resident's empty glass. She then proceeded to assist the resident with pouring his tomato juice over the ice.</p> <p>Interview at the time with CNA #5 indicated the resident should have been served ice from the ice machine and not from the gray plastic tray on her serving cart containing milk cartons.</p> <p>3. On 12/01/2014 at 12:37 p.m., during an observation of the 300 Unit dining room QMA #1 was observed serving</p>			

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F000412 SS=D	<p>desserts on a three tier rolling cart. The cart was wheeled through the dining room and the desserts were uncovered.</p> <p>Interview at the time with QMA #1 indicated she was unaware the desserts should have been covered and/or served above waist level.</p> <p>Interview with Dietary Aide #2 on 12/01/2014 at 12:41 p.m., indicated the desserts should have been covered and/or served above waist level.</p> <p>3.1-21(i)(3)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received dental services provided by the dentist as needed for 1 of 2 residents reviewed for dental services of the 2 residents who met the criteria for</p>	F000412	<p><b>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute</b></p>	01/04/2015			

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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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	<p>dental services. (Resident #175)</p> <p>Findings include:</p> <p>On 12/2/14 at 9:33 a.m., Resident #175 was observed with carried and decayed teeth. Interview with the resident at that time indicated his teeth were decayed and he wanted to see the dentist for extractions. He indicated the last time he saw the dentist was in 2013 but was not sure of the month.</p> <p>The record for Resident # 175 was reviewed on 12/2/14 at 3:33 p.m. The resident was admitted to the facility on 9/20/13. The resident's diagnoses included but were not limited to, high blood pressure, stroke, and diabetes type two.</p> <p>Review of the Nursing Admission assessment dated 9/20/13 indicated the oral assessment regarding the resident's teeth was incomplete and blank.</p> <p>Review of the Minimum Data Set (MDS) Quarterly assessment 9/23/14 indicated the resident was alert and oriented with a Brief Interview for Mental Status of 15. He had no broken or loosely fitting dentures or mouth pain.</p> <p>Review of the Annual MDS assessment</p>		<p><i>admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1.</b> Resident 175 was seen by the oral surgeon on 12.15.14. The oral surgeon scheduled a follow-up appointment on 2.3.15.</p> <p><b>2.</b> The schedule of dental visits was reviewed by Social Services to ensure that residents are receiving needed dental services.</p> <p><b>3.</b> Discussed scheduling issues with Prime Source (dental services provider) and developed a scheduling calendar for tracking visits. (copy attached) Social Services will monitor monthly.</p> <p><b>4.</b> Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for a total of 6 months. <b>5)</b> Date of compliance: 1.4.15</p>	

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  12/05/2014
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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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	<p>dated 7/9/14 indicated the resident had no problems with his teeth. The section obvious or likely cavity or broken natural teeth was checked "No."</p> <p>There was no care plan for the resident regarding his carried and/or decayed teeth.</p> <p>The last dental exam in the resident's record was dated 12/16/13. The tooth notes indicated the resident had multiple areas of large decay throughout. The Dentist recommended extractions, but the resident declined at that time. The treatment plan was to schedule in 3 months a Prophy visit and schedule in 6 months a periodic visit.</p> <p>The Dentist had visited the facility on 2/3, 2/24, 4/18, 5/30, 7/8, 8/7, 10/14, 10/30, and 11/11/14. The resident was on the list to be seen but refused to see the Dentist on 5/30, 7/8, and 8/7/14. The resident had not been placed on the list since the 8/7/14 visit.</p> <p>Interview with Social Service Employee #1 on 12/3/14 at 11:44 a.m., indicated she was unaware the resident wanted his teeth extracted. She further indicated they were looking at their system and the communication with the Dentist regarding resident refusals and when and</p>			

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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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F000441 SS=E	<p>how often the Dentist should try to see a resident again after repeated refusals.</p> <p>3.1-24(a)(1)</p> <p>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 development and transmission of disease and infection.</p> <p>(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.</p> <p>(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.</p>			

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  12/05/2014
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	<p>(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 wash basins and urinals were stored correctly on 2 of 4 units throughout the facility. The facility also failed to ensure gloves were worn while administering insulin for 1 of 1 insulin injections observed, hands were washed after glove removal for 1 of 1 treatments observed, and ensuring isolation precautions were implemented for a resident with a multi-drug resistant organism. (Residents #64, #71, and #128, the 200 and 300 units)  Findings include:</p> <p>1. On 12/3/14 at 7:15 a.m., LPN #8 was observed administering insulin to Resident #71. The LPN washed her hands prior to giving the insulin, however, she did not wear gloves when she gave the injection. After administering the insulin, she washed her hands again.</p> <p>Interview with the LPN and the Care Plan Coordinator immediately afterward, indicated the LPN should have been</p>	F000441	<p>The facility requests paper compliance for this citation.</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and / or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.</p> <p>1. Resident #64 had no harm noted related to nurse not washing hands after removal of gloves.  Resident #71 had no harm noted r/t gloves not worn during insulin injection.  Resident #128 completed antibiotic therapy and order received to remove from isolation during survey.</p> <p>2. All residents have the</p>	01/04/2015

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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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	<p>wearing gloves.</p> <p>The current policy titled How To Administer: Subcutaneous Medications was received from the Care Plan Coordinator on 12/3/14 at 7:25 a.m. The policy indicated, "3. Wash hands and apply disposable examination gloves."</p> <p>2. Interview with the 100 Unit Manager on 12/1/14 at 9:30 a.m. and on 12/3/14 at 10:00 a.m., indicated Resident #128 was in contact isolation for ESBL (Extended-Spectrum Beta-lactamase) of the urine. The room was observed at that time, there was no isolation cart inside or outside of the room, and no biohazard bins were observed in the room.</p> <p>The record for Resident #128 was reviewed on 12/3/14 at 10:30 a.m. A Physician's order dated 11/17/14, indicated the resident was to have a urine culture with sensitivity. The final results of the urine culture dated 11/19/14, indicated the resident had a multi-drug resistant organism and to refer to infection control policies for isolation precautions. A Physician order dated 11/20/14, indicated the resident was to receive Augmentin (an antibiotic) 875/125 milligrams for ten days.</p> <p>At 10:30 a.m., on 12/3/14, there was a</p>		<p>potential to be impacted.</p> <p>QMA was provided 1:1 education on wearing gloves during insulin injections.</p> <p>Nurse provided 1:1 education on washing her hands after removing gloves.</p> <p>No resident currently in isolation precautions. Facility wide cleaning and storage of wash basins, urinals completed.</p> <p>3. Nursing staff to be in serviced on hand washing, gloves to be worn during insulin injections, proper cleaning and storage of wash basins and urinals (copies attached). All staff to be in serviced on isolation guidelines (copies attached). ADHS or designee to monitor 5 x week for maintaining proper procedure for residents in isolation. ADHA or designee to do 3 random checks per week to ensure nurses washing hands after glove removal and ensuring gloves worn for insulin injections. DHS to monitor 5 x week, checks completed for proper storage of wash basins and urinals (audit tool attached).</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented</p>	

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	<p>resident laying in Resident #128's bed. QMA #2 indicated that it was not Resident #128. There was no isolation cart outside of or inside the room, or in the bathroom. There was no sign on the door indicating the resident was on isolation precautions.</p> <p>Interview with the Unit Manager at the time, indicated there should be an isolation cart in the room for gloves and gowns and signage on the door to indicate the resident was on isolation precautions.</p> <p>The current Isolation and Standard Precaution policies were received from the Care Plan Coordinator on 12/3/14 at 11:20 a.m. The policy indicated Standard Precautions should be used for most Isolations. "Standard Precautions requires the use of appropriate barriers (personal protective equipment) when healthcare giver's hands are likely to contact mucous membranes, non-intact skin, or moist body substances (...urine). Eyes, nose, mouth, or clothing are likely to be splattered or soiled by moist body fluids."</p> <p>3. On 12/2/14 at 10:52 a.m. and 3:06 p.m., a urinal containing urine was observed hanging from the left side rail in Room 210-D. There was no lid on the</p>		<p>monthly at QAPI meeting x 90 days. If, after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will be reviewed quarterly for six months.</p> <p>5. 1-04-15</p>	

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  12/05/2014
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	<p>urinal.</p> <p>On 12/4/14 at 7:10 a.m., a urinal containing urine was again observed hanging from the left side rail. There was no lid on the urinal. Two residents resided in this room.</p> <p>4. On 12/2/14 at 9:16 a.m. and on 12/4/14 at 3:15 p.m., a pink wash basin was observed behind the toilet in the bathroom of Room 201. The washbasin was on the floor and there was a toilet plunger inside of the wash basin. The wash basin was uncovered. Two residents resided in this room.</p> <p>5. On 12/2/14 at 10:23 a.m., a pink wash basin was observed on the floor behind the toilet in the bathroom of Room 209. The wash basin was uncovered. One resident resided in this room.</p> <p>6. On 12/2 at 10:01 a.m. and on 12/4/14 at 3:15 p.m., a urine collection container was observed on the back of the toilet in Room 225. The urine collection container was uncovered. Three residents used this bathroom.</p> <p>7. On 12/2 at 1:57 p.m. and on 12/4/14 at 3:15 p.m., a wash basin was observed on top of the refrigerator in Room 303. The wash basin was uncovered. Two</p>			

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	<p>residents resided in this room.</p> <p>Interview with the Director of Nursing on 12/4/14 at 3:30 p.m., indicated she did not know how the urinals and wash basins were to be stored and she would pull up the policy.</p> <p>The current "Care of Resident Devices, Equipment" policy was provided by the Director of Nursing on 12/4/14 at 3:37 p.m. The policy indicated "bedpans, urinals, wash basins and other resident care equipment will be cleaned after use and stored in a plastic disposable bag in the resident's bedside table or closet."</p> <p>8. On 12/4/14 at 12:50 p.m. Resident #64 was observed lying in bed. At that time, RN #1 was preparing to complete the pressure ulcer treatment to the coccyx and right buttock. RN #1 was observed to wash her hands with soap and water and she donned a pair of clean gloves to both of her hands. She then was observed to spray wound wash to a gauze sponge and wiped around the pressure areas. The RN removed her gloves and donned clean gloves. She did not wash hands or use alcohol gel after the glove removal. She then used the wound wash to clean the actual areas with a gauze sponge. The RN removed the gloves and did not wash her hands. She then opened the tubes Santyl and Bactroban ointments</p>			
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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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	<p>and mixed them into a medicine cup. The RN donned clean gloves to both of her hands and used the q-tip applicator and applied the ointment to the coccyx wound. She then removed her gloves and did not wash her hands. She donned a clean pair of gloves and used the q-tip and applied the ointment solution to the right buttock. She removed her gloves and did not wash her hands. She donned a clean pair of gloves to her hands and cut two small pieces of Calcium Alginaid (a medicated gauze sponge) into circles and placed them on top of each open area. She then removed her gloves and donned a clean pair without washing her hands with soap and water. The RN then covered both open areas with an Octofoam (a protective dressing). At that time, she removed her gloves and washed her hands with soap and water.</p> <p>Interview with RN #1 at that time indicated she was supposed to wash her hands with soap and water or use alcohol gel after removing her gloves.</p> <p>Review of the current and undated Hand washing Policy provided by the Director of Nursing indicated Health Care Workers shall wash hands after removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes,</p>			

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F000463 SS=D	<p>specimens, resident equipment, grossly soiled linen, etc.</p> <p>Interview with the 300 Unit Manager on 12/4/14 at 1:45 p.m., indicated the Nurse should have washed her hands after removing the gloves or used an alcohol base gel.</p> <p>3.1-18(b)(1)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure the emergency call system in the resident's bathroom was functioning for 2 of 4 units. (The 100 and 300 Units)</p> <p>Findings include:</p> <p>1. On 12/1/14 at 11:35 a.m., the emergency call light was pulled in the bathroom in room 107. At that time when the switch was pressed no alarm sounded. There was one resident who resided in the room.</p> <p>Interview with the 100 Unit Manager on</p>	F000463	<p><b>F463 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) The calls lights in rooms 107 and 307 were repaired immediately. 2) A call light inspection was</b></p>	01/04/2015

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F000465 SS=E	<p>12/1/14 at 11:30 a.m., indicated he would notify maintenance to repair the switch immediately.</p> <p>2. On 12/2/14 at 8:52 a.m., the emergency call light in the bathroom of room 307 was not functioning when the switch was pulled. There were two residents who resided in the room.</p> <p>Interview with Maintenance Employee #1 at that time, indicated the call light was not functioning in the bathroom and he was going to replace the entire switch plate.</p> <p>3.1-19(u)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the environment was clean and in good repair related to large gouges in walls, marred doors, marred walls, holes in doors, chipped paint, stained privacy curtains, and rusty toilets for 3 of 4 units observed. (The 100 Unit, 200 Unit, and 300 Unit)</p> <p>Findings include:</p>	F000465	<p>completed by the Maintenance Director using the attached form to ensure that all call lights were in working order. <b>3)</b> Call light inspections are completed once each month and will continue. Additional random audits will be completed, by the Maintenance Department, on five rooms, across all units, each week. (copy attached) <b>4)</b> The Executive Director will monitor compliance through review of the inspection forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for 6 months. <b>5)</b> 1.4.15</p> <p><b>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it</b></p>	01/04/2015	

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	<p>The Environmental tour was completed on 12/4/14 at 1:15 p.m., with the Maintenance Director, the Housekeeping Supervisor and the Administrator.</p> <p>1. The following was observed on the 100 Unit:</p> <p>a. Room 111- There were three large gouges in the wall next to the bed. There were rust stains in the toilet. One resident resided in the room.</p> <p>b. Room 121- The bathroom door frame and walls were marred. The closet doors had numerous small holes where hardware had been removed. Two residents shared the bathroom.</p> <p>2. The following was observed on the 200 Unit:</p> <p>a. Room 201- The closet doors were marred and had chipped paint. Two residents shared the room.</p> <p>b. Room 206- The closet door was chipped and marred. The footboard on the bed was marred, as well as the arm chair and legs. The over bed table was stained with a sticky substance. Two residents shared the room.</p> <p>c. Room 208- There were red stains on the privacy curtain. Two residents resided in the room.</p>		<p><i>is required by the provisions of federal and state law. 1) Repairs were made to all items noted. (see attached) The privacy curtain was replaced immediately and the sticky over bed table was cleaned the same day. 2) A room inspection was completed by the Maintenance Director using the attached form to ensure that all call lights were in working order. (see attached) All rooms were checked to ensure privacy curtains and over bed tables were clean. 3) Room inspections are completed once each month by both the Maintenance and Housekeeping Departments and will continue. Additional random audits will be completed, by the Maintenance Department and the Housekeeping Department, on five rooms, across all units, each week. (see attached) 4) The Executive Director will monitor compliance through review of the inspection forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for a total of 6 months. 5) 1.4.15</i></p>	

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	<p>d. Room 209- The closet doors were marred and chipped. The edge of the wall by the closet was marred. Two residents resided in the room.</p> <p>e. Room 210- The bathroom wall was chipped and marred. The bathroom door was scratched and marred. Three residents shared the bathroom.</p> <p>f. Room 212- The closet door was chipped and marred. The bathroom walls were chipped and marred, and the door was scratched and marred. The privacy curtain was stained and missing hooks from the track. Two residents resided in the room.</p> <p>g. Room 225- The door was marred and chipped. The closet door was marred. The caulking around the toilet was cracked and worn. There was chipped ceiling paint. Three residents shared the bathroom.</p> <p>h. Room 232- The closet door was marred. There was chipped paint and gouges on the bathroom wall. There was chipped wood on the door. Four residents shared the bathroom.</p> <p>i. Room 230- The bathroom door frame and the walls were marred. There was chipped paint on the door. Two residents</p>			

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	<p>shared the bathroom.</p> <p>3. The following was observed on the 300 unit:</p> <p>a. Room 303- The bathroom door and walls were marred. Two residents shared the bathroom.</p> <p>b. Room 307- There were rust stains in the toilet. Two residents shared the bathroom.</p> <p>c. Room 310- The raised toilet seat was rusty. Two residents shared the bathroom.</p> <p>d. Room 314- There were rust stains in the toilet. One resident resided in the room.</p> <p>Interview at the time with the Administrator, Housekeeping Supervisor and the Maintenance Director indicated the above items were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>				