

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2015
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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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F000000	<p>This survey was for the Investigation of Complaint IN00162415 and Complaint IN00162446.</p> <p>Complaint IN00162415 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00162446 - Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey dates: January 12 - 13, 2015</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Honey Kuhn, RN, TC</p> <p>Census bed type: SNF: 27 SNF/NF: 117 Total: 144</p> <p>Census payor type: Medicare: 27 Medicaid: 103 Other: 14 Total: 144</p> <p>Sample: 3</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000323 SS=G	<p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 14, 2015, by Janelyn Kulik, RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, record review, and interview, the facility failed to ensure a resident's seatbelt was secured during transport in the facility van which resulted in a fall from a wheelchair and a leg fracture for 1 of 3 residents in a sample of 3 reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B was identified during the Entrance Conference, on 01/12/15 at 9:00 a.m. with the Administrator and the DNS (Director Nursing Services), as incurring a fall with fracture while being transported in the facility van, on</p>	F000323	<p>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. All Activity staff were retrained on safety practices with special emphasis on the use of seat belts. (see attached sign-in sheet) 2. All residents who use our vans have the potential to be impacted by the alleged practice. The employee who was driving</p>	02/12/2015

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	<p>12/31/14.</p> <p>Interview with the Administrator, at the time, indicated Resident #B was a passenger in the facility van when it came to an abrupt stop and the resident slid from her wheel chair to her knees onto the van floor. The Administrator indicated the resident's seat belt had not been secured by the facility transport driver. The resident was not moved. The van driver notified the facility and the local EMS. The EMS assessed the resident and assisted the resident to the wheelchair, secured the seatbelt and the resident was returned to the facility.</p> <p>The record of Resident "B" was reviewed on 01/12/15 at 10:45 a.m. Resident #B's diagnoses including, but were not limited to, dementia, intellectual disability, aphasia [inability to speak], and hypertension.</p> <p>Review of the most recent Annual MDS (Minimum Data Set: a tool to assess and assist the facility to plan care need), dated 10/30/14, indicated Resident #B was cognitively impaired, was non-ambulatory, required extensive assist of 2 for transfers and was unable to stabilize self when seated or transferring from a chair or wheelchair.</p>		<p>the bus, was suspended, pending investigation and subsequently terminated. Safety policies and procedures were reviewed with the Activities staff. (see attached training materials) 3. Activities Director (or designee) will conduct random van inspections, a minimum of three times per week, to ensure that all safety devices are being used properly. Said inspections will be documented on the attached audit tool. 4. Executive Director 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. 5. 2-12-15</p>				

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	<p>A Progress Note indicated: "Nurses Note: 12/31/14 16:00 [4:00 p.m.] Nurse rendered head to toe assessment on resident d/t [due/to] incident on bus, no visible injuries noted at this time, pain noted on assessment to both knee's, resident unable to rate pain on pain scale d/t mental disability, [name of POA] at bedside with resident and is aware of incident, nurse notified physician to obtain order for X-ray to both knee's. Resident received her scheduled Tramadol to help with the pain, will continue to observe...."</p> <p>"01/01/15 01:50 [1:50 a.m.] [X-ray provider] here and took X-rays bilat [bilateral: both] knees. Awaiting results."</p> <p>"01/01/15 04:40 [4:10 a.m.] X-ray results back, left knee impression transverse undisplaced fracture of the upper tibial shaft noted. Effusion with bulging of the suprapatellar [above kneecap] fat pad noted....Spoke to [Physician's name] and gave the order to send to the ER [Emergency Room] to eval [evaluate] and treat...."</p> <p>"Nurses Note: 01/01/15 08:03 [8:03 a.m.] Resident returned from [ACF: Acute Care Facility: Hospital] ER with a soft mold cast in place to left leg..."</p>			

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	<p>Review of the ACF: ER summary, dated 01/01/15, indicated: "Diagnosis:...Fracture of tibia, proximal, left."</p> <p>Resident #B was observed on 01/12/15, at 9:30 a.m., seated in a wheelchair with both legs elevated and on 01/13/15 at 11:00 a.m. in her bed sleeping.</p> <p>A confidential interview, during the survey, with RN#5 indicated Resident #B was totally dependent since the fall and now required transfer with a Hoyer lift (mechanical lift requiring a minimum of 2 staff.)</p> <p>A confidential interview, during the survey, with RN#7 indicated Resident #B was no longer able to be able to be up for the time periods she had prior to the fall.</p> <p>Interview with the Administrator and the DNS, on 01/12/14, at 2:00 p.m., indicated the facility's van driver, DOH (Date of Hire) 12/10/14, was terminated from employment on 12/31/14 following the incident. Review of an undated "Driver Policy", provided at the time of interview, indicated: "Facility Van Protocol...Van Operation...Driver and all passengers to wear seat belt at all time...". The Administrator further indicated the policy</p>						

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	was part of the driver orientation packet. This Federal tag relates to complaint IN00162446. 3.1-45(a)(2)				