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| 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 02/26/2015 |
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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 visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00162446 completed on 1/13/15.</p> <p>This visit was done in conjunction with the PSR to the Recertification and State Licensure Survey completed on 12/5/14.</p> <p>This visit was done in conjunction with the PSR to the Investigation of Complaints IN00160464 and IN00161191 completed on 12/18/14.</p> <p>This visit was done in conjunction with the Investigation of Complaints IN00163785, IN00164923, and IN00164979.</p> <p>Complaint IN00162446-Not Corrected.</p> <p>Survey Dates: February 23, 24, 25, and 26, 2015</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey Team: Heather Tuttle, RN-TC Lara Richards, RN</p> | F000000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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| F000323 SS=D | <p>Census bed type: SNF: 31 SNF/NF: 105 Total: 136</p> <p>Census payor type: Medicare: 31 Medicaid: 89 Other: 16 Total: 136</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 3, 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.</p> <p>Based on record review and interview, the facility failed to ensure a resident was</p> | F000323 | F323 | 03/04/2015 | | | |

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| | <p>adequately supervised during a meal to prevent choking or gagging on food for 1 of 2 residents reviewed for choking. (Resident #B)</p> <p>Finding includes:</p> <p>The record for Resident #B was reviewed on 2/24/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, bipolar disorder, dementia, chronic airway obstruction, antisocial personality disorder, anemia, Alzheimer disease, muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 10/6/14 indicated the resident was rarely/never understood and was severely impaired for daily decision making. The resident required extensive assist with two person physical assist with eating.</p> <p>Physician Orders on the 11/2014 recap indicated the resident required CPR (Cardiopulmonary Resuscitation) with an original date of 6/5/14. The resident was to receive a mechanical soft diet with nectar thick liquids.</p> <p>The current 9/24/14 care plan indicated the resident was at risk for aspiration related to dysphagia. The Nursing approaches were to monitor signs and</p> | | <p>The facility requests paper compliance for this citation.</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) Immediate actions taken for those residents identified:</p> <p>Resident #B is no longer in the facility.</p> <p>2) How the facility identified other residents:</p> <p>A care plan review was completed</p> | | |

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| | <p>symptoms of aspiration (coughing, wheezing, etc). Notify Physician if symptoms of aspiration were present. Consult speech therapy as indicated. Utilize individualized interventions as outlined by speech therapy (chin tucks, no straws, small bites/sips, ensure food was swallowed before giving another bite, liquid between bites). Provide plenty of time for food and liquid consumption. Provide assistance with food/liquid consumption as needed. Provide diet as ordered and thickened liquids as ordered. Required cueing both physical and verbal during meals.</p> <p>Another plan of care dated 9/24/14 indicated Activities of Daily Living (ADL) self care deficit or potential for related to eating. The Nursing approaches were to escort to and from dining room before and after meals to sit back in chair and chair to be against table for meals. Special utensils for meals and serve food in bowls as needed.</p> <p>The last documented Dietary Progress note by the Registered Dietitian was dated 10/7/14 which indicated the resident eats 76-100% of meals on mechanical soft diet with nectar thick liquids. He needs assist with most meals. Food to be served in bowls to aid in self feeding.</p> | | <p>and no other residents were identified as requiring that level of supervision.</p> <p>3) Measures put into place/ System changes:</p> <p>Reeducated staff on how and when to do the Heimlich (see attached). Meals will not be served without a Heimlich trained employee present. Supervision audit will be completed at least 5 meals per week with oversight by Executive Director (see attached).</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>Months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> | |

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| | <p>The incident report form follow up dated 12/3/14 was reviewed. The report indicated "Resident #B was in dining room being assisted by staff to eat. CNA #5 who was assisting him, called to nurse who was near by. Nurse noted that resident appeared to be spitting food out, Nurse thought resident may vomit and so removed him from dining room. Nurse states no change in skin color noted until resident went limp and became unresponsive. Resident was placed on floor to initiate CPR. 911 was called, resident treated until EMTs (Emergency Medical Transportation) arrived and took over. Resident transferred to nearest hospital. Family and Physician notified."</p> <p>The findings of investigation were as follows: "On 11/27/14 at 1 p.m., this resident (Resident #B) was observed with productive cough with no shortness of breath. Physician made aware orders received for breathing treatment. Oxygen saturations remains between 92-95% on room air. No distress noted. Was sitting near nurses station without discomfort. Vital signs remain stable. Resident assisted to dining room just before 6 p.m. with staff member as per care plan to prevent resident grabbing at objects near him. He was placed at table but meal not</p> | | <p>March 4, 2015</p> | |
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| | <p>within reach. CNA confirmed correct diet of mechanical soft was provided to resident. At 6:15 p.m. CNA #5 called to nurse to check on (Resident name) since he was observed having difficulty swallowing his food. The nurse assessed the resident and instructed him to spit food out. Resident removed from dining room and placed by nurses station where nurse assessed and remained with resident. Resident was noted to have color change and breathing difficulties. Staff proceeded to do Heimlich maneuver, but resident eventually became unresponsive, resident placed on floor and CPR initiated, as food in mouth visualized staff did mouth sweep to remove visible food. 911 called. All staff that was interviewed confirmed that (Resident name) was not observed reaching or grabbing anything while at the dining room. Review of medical records from the Emergency Room showed that it was not certain if resident choked on food. Stroke could be a factor. Conclusion: chest X-ray did not show any airway obstructions and neither any resistance nor obstructions when e-tube (endotracheal) was inserted."</p> <p>The investigation with staff interviews were reviewed. RN #1 indicated the following: the resident was sitting between two tables. There was one nurse</p> | | | |

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| | <p>and one CNA in the dining room. CNA #4 called the nurse over to check Resident #B out. The resident was spitting food out of his mouth, his color was fine. The nurse removed food from his mouth which was a piece of bread/bun. RN #1 took the resident out of the dining room and to his room, the resident was gagging. RN #1 went to get a suction machine. The RN placed the resident at the nurse's station and his color was turning. RN #1 and CNA #7 laid the resident on the floor. CNA #6 and CNA#7 began CPR. and 911 was called.</p> <p>CNA #6's interview indicated she had seen Resident #B at the nurses's station. CNA #7 and LPN #3 performed the Heimlich on the resident. The resident started to turn blue. The resident was placed on the floor in the hallway and her and CNA #7 began CPR. A finger sweep was performed and a packet of butter was removed from his mouth.</p> <p>Interview with the Director of Nursing on 2/24/15 at 1:58 p.m., indicated she was not on duty when the incident happened. She further indicated it was unclear how the resident had a packet of butter in his mouth when he was supposed to be supervised during meals.</p> | | | |

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| | This deficiency was cited on 1/13/15. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-45(a)(2) | | | | |