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 02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaints IN00141558, IN00142653, IN00144903, and IN00145143. Complaint IN00141558-Substantiated. No deficiencies related to the allegation are cited. Complaint IN00142653-Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F312. Complaint IN00144903-Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F312. Complaint IN00145143-Substantiated. Federal/State deficiency related to the allegation is cited at F465. Survey dates: February 25, 26, & 27, 2014 Facility number: 000076 Provider number: 155156 AIM number: 100271060	F000000	Please accept the following plans of correction as the facility's credible allegation of compliance. The plans of correction do not constitute an admission of guilt or liability by the facility and are submitted only in response to the regulatory requirements. We are requesting a desk review for this survey.	

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

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

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	Survey team: Janet Adams, RN-TC Census bed type: SNF: 23 SNF/NF: 117 Total: 140 Census payor type: Medicare: 26 Medicaid: 93 Other: 21 Total: 140 Sample: 10 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on March 1, 2014, by Janelyn Kulik, RN.			
F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. Based on observation, record review, and interview, the facility failed to ensure staff provided	F000312	Please accept the following plan of correction as the facility's credible allegation of compliance. The plan of correction does not	02/28/2014

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	incontinence care to dependent residents in a timely manner for 1 of 3 residents reviewed for incontinence in the sample of 10. (Resident #E) Findings include: During Orientation Tour on 2/25/14 at 3:45 p.m., Resident #E was observed in a gerichair in the TV area. The resident had a blanket over her lap. The resident was not receiving care from any staff member at the above time. On 2/25/14 at 6:00 p.m. 6:55 p.m., 7:20 p.m., and 7:45 a.m., the resident was observed in a gerichair in the TV area. The resident had a blanket over her lap. The resident was not receiving care from any staff member at the above times. On 2/25/14 at 8:05 p.m., the resident was observed in bed in her room. CNA #1 and CNA #2 were in the room with the resident . The CNA's indicated they had just transferred the resident from the gerichair into bed. The CNA's them began to remove the resident's pants to provide incontinence care. CNA #1 felt the resident pants and indicated they were wet. The two		constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice Resident E was provided incontinence care at 8:05 PM as indicated on the CMS 2567How other residents that have the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken All residents who are incontinent have the potential to be affected by the same alleged deficient practice. During the survey process nursing management did rounds on all residents and all residents had received incontinence care. All nursing staff was in serviced on 2/28/14 on providing incontinence care as indicated in the resident's care plans (see attachment 1). Nursing staff unable to attend the inservice on 2/28 have been inserviced or will be inserviced prior to working the floor. Steps the facility will take to ensure that the same alleged deficient practice does not recur All nursing staff was in serviced on 2/28/14 on providing incontinence care as indicated in the residents care plans. Nursing staff unable to attend the 2/28 inservice have been or will be inserviced prior to working the floor. How the facility	

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	CNA's then removed the resident's disposable brief. There was a strong urine odor noted at this time. The resident's brief was wet with urine covering the entire brief from side to side and front to back. The CNA's then continued to turn the resident and cleansed the resident's perineal area with a wash cloth and towel. The clinical record for Resident #E was reviewed on 2/26/14 at 8:10 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, anemia, high blood pressure, degenerative joint disease, and glaucoma. The 12/6/13 MDS (Minimum Data Set) Quarterly Assessment indicated resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight -bearing support) of two plus staff members for bed mobility and toilet use. The assessment also indicated the resident required total dependence(full staff performance) of two plus staff members for transfers and total dependence of one staff member for personal		will monitor for compliance The DON or designee will use the attached QA tool to randomly observe 5 incontinent residents a week for 6 months to ensure compliance. Results of these audits and any trends noted will be presented to the QA committee at the QA meetings which are held monthly at the facility. Date of compliance: 2/28/14 _____IDR-F312 In response to the deficiency cited under F312, the facility feels that this deficiency is unwarranted. The facility acknowledges that the resident was wet at 8:05 PM, but feels that this does not in and of itself warrant a deficiency. As indicated on the CMS 2567, the resident is incontinent. 2 nurses (Aimee Santa, RN and Come sha Wright, LPN) stated that at approximately 5:30PM they repositioned resident E and that she was not wet (see attached statements from both nurses- see attachment 2). This information was presented to the surveyor during the survey process and disregarded. Based on these statements and the information indicated in the CMS 2567 the resident was changed at 3:30 PM, was checked for incontinence at 5:30 PM and was found to be dry, and was again provided with incontinence care at approximately 8 PM. The facility requests that the	

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	hygiene. Review of the resident's current care plans indicated there was a care plan initiated on 9/26/13 which indicated the resident had the potential for alteration in skin integrity. The care plan was last reviewed on 12/30/13 and had a goal date of 3/31/14. Care plan interventions included for staff to provide incontinence care after each episode. A second care plan indicated the resident had or had the potential for an ADL (Activities of Daily Living) Deficit. The care plan was initiated on 9/26/13 and was last reviewed on 12/30/13 with a goal date of 3/31/14. Care plan interventions included for staff to assist the resident with personal hygiene. The care plan also indicated the resident was to be turned and repositioned by staff. When interviewed on 2/25/14 at 8:25 p.m., CNA #1 indicated Resident #E was up in the gerichair at the start of her shift at 2:00 p.m. today. The CNA indicated she last provided incontinence care for the resident at around 3:30 p.m. CNA #1 indicated she and CNA #3 transferred the resident in bed using the Hoyer lift (a mechanical lift		deficiency cited under F312 be removed from the record.	

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	device) and provided incontinence care at that time. The CNA indicated the resident was then transferred back into the gerichair after they completed incontinence care. When interviewed on 2/25/14 at 8:30 p.m., Unit Manager #2 indicated the resident was to be checked and changed for incontinence every 2 hours. This Federal tag relates to Complaints IN00142653 and IN00144903. 3.1-38(a)(3)			

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F000314 SS=D	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 necessary treatment and services were provided related to failure to notify Licensed Nursing Staff of the development of an alteration in skin integrity(shearing) observed during incontinence care for 1 of 3 residents reviewed for skin integrity during incontinence care in the sample of 10. (Resident #E) (CNA #1) Findings include: During Orientation Tour on 2/25/14 at 3:45 p.m., Resident #E was observed in a gerichair in the TV area. The resident had a blanket over her lap. The resident was not receiving care from any staff member the above time.	F000314	Please accept the following plan of correction as the facility's credible allegation of compliance. The plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice:As indicated on the CMS 2567, the licensed nurse was informed of the shearing to resident E during the survey process, and treatment orders were received that day as well. How other residents that have the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:All residents at risk for skin impairments have the potential to be affected by the same alleged deficient practice. Nursing management reviewed the skin sheets for all residents	02/28/2014

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	On 2/25/14 at 6:00 p.m. 6:55 p.m., 7:20 p.m., and 7:45 p.m., the resident was observed in a gerichair in the TV area. The resident had a blanket over her lap. The resident was not receiving care from any staff member at the above times. On 2/25/14 at 8:05 p.m., the resident was observed in bed in her room. CNA #1 and CNA #2 were in the room with the resident . The CNA's indicated they had just transferred the resident from the gerichair into bed. The CNA's them began to remove the resident's pants to provide incontinence care. CNA #1 felt the resident pants and indicated they were wet. The two CNA's then removed the resident's disposable brief. There was a strong urine odor noted at this time. The resident's brief was wet with urine covering the entire brief from side to side and front to back. The CNA's then continued to turn the resident and cleansed the resident's perineal area with a wash cloth and towel. Two small open areas directly next to each other were observed. The areas were approximately .5 cm in diameter. The wound beds of the areas were red. The clinical record for Resident #E		between 2/28 and 3/6 and there were no new unkown areas. All nursing staff was inserviced on 2/28/14 on reporting skin impairments to the nurse in a timely manner. Nursing staff unable to attend the 2/28 inservice have been or will be inserviced prior to working the floor. Steps the facility will take to ensure that the same alleged deficient practice does not recur:All nursing staff was inserviced on 2/28/14 on reporting skin impairments to the nurse in a timely manner. Nursing staff unable to attend the 2/28 inservice have been or will be inserviced prior to working the floor. How the facility will monitor for compliance:The DON or designee will use the attached QA tool to monitor 3 new skin impairments a week for 6 months (if applicable) to ensure that licensed nurses were notified in a timely manner. Results of these audits and any trends noted will be presented to the QA committee at the QA meetings which are held monthly at the facility.Date of compliance: 2/28/14	

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	was reviewed on 2/26/14 at 8:10 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, anemia, high blood pressure, degenerative joint disease, and glaucoma. The 12/6/13 MDS (Minimum Data Set) Quarterly Assessment indicated resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of two plus staff members for bed mobility and toilet use. The assessment also indicated the resident required total dependence(full staff performance) of two plus staff members for transfers and total dependence of one staff member for personal hygiene. Review of the resident's current care plans indicated there was a care plan initiated on 9/26/13 which indicated the resident had the potential for alteration in skin integrity. The care plan was last reviewed on 12/30/13 and had a goal date of 3/31/14. Care plan interventions included for staff to provide incontinence care after each			

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	episode and to provide a pressure reducing mattress and a chair cushion. A second care plan indicated the resident had or had the potential for an ADL (Activities of Daily Living) Deficit. The care plan was initiated on 9/26/13 and was last reviewed on 12/30/13 with a goal date of 3/31/14. Care plan interventions included for staff to assist the resident with personal hygiene. The care plan also indicated the resident was to be turned and repositioned by staff. A Braden Scale for predicting pressure sore risk was completed on 2/21/14. The resident's score was (9). A score of (9) indicated the resident was at high risk for the development of sores. The 2/2014 Nurses' Notes were reviewed. An entry made on 2/25/14 at 9:45 p.m., indicated an area to the coccyx was observed during pericare. A Skin Impairment Circumstance Investigation form was initiated on 2/25/14. The form indicated the resident had a shearing (interaction of gravity and friction against the surface of the skin) wound to the coccyx area. The assessment			

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	indicated the resident was not independently mobile, was incontinent, and had no recent medical decline. A Skin Impairment Assessment was initiated on 2/25/14. The Assessment indicated a "shearing" type wound was first observed on 2/25/14. The Assessment indicated the area was red in color. The 2/25/14 Physician orders were reviewed. There was an order written to apply Calazyme cream to the coccyx area every shift and as needed for shearing. When interviewed on 2/25/14 at 8:25 p.m., CNA #1 indicated Resident #E was up in the gerichair at the start of her shift at 2:00 p.m. today. The CNA indicated she last provided incontinence care for the resident at around 3:30 p.m. CNA #1 indicated she and CNA #3 transferred the resident in bed using the Hoyer lift (a mechanical lift device) and provided incontinence care at that time. The CNA indicated the resident was then transferred back into the gerichair after they completed incontinence care. CNA #1 indicated the open area to the resident's buttock area			

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	was present at this time. The CNA indicated she had forgotten to tell the Nurse about the area at that time. When interviewed 2/25/14 at 8:30 p.m., LPN #2 indicated she was assigned to care for Resident #E at this time. The LPN indicated she had not been informed of the new open area prior to this time. When interviewed on 2/25/14 at 8:30 p.m., Unit Manager #2 indicated the resident was to be checked and changed for incontinence every 2 hours. When interviewed on 2/24/14 at 11:45 p.m., the Director of Nursing indicated CNA #1 should have informed the Nurse of the new skin area when it was first observed. This Federal tag relates to Complaints IN00142653 and IN00144903. 3.1-40(a)(1)			

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F000465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE 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 provide a clean and sanitary environment related to dried spillage, dirt, debris on walls, counters, register vents, window blinds, chairs, and ceilings in the common areas on 1 of 4 Units. (The 300 Unit) Findings include: During Environmental Tour on 2/25/14 at 10:30 a.m., with the Housekeeping Manager, the following was observed on the 300 Unit. a. There was dried spillage under the electrical outlet on the wall between the two entrance doors to the unit Dining Room. b. There was a peeled banana, a store type Styrofoam coffee cup, empty jelly packets, cracker package wrappers, and an uncovered plastic spoon on the counter under the telephone in the Dining Room. There was also dried coffee spillage on the counter around the coffee	F000465	Please accept the following plan of correction as the facility's credible allegation of compliance. The plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.What corrective action will be accomplished for those residents found to be affected by the alleged deficient practice: There were no residents directly affected by the alleged deficient practiceThe dried spillage under the electrical outlet on the wall between the 2 entrance doors to the 300 unit dining room was cleaned during the survey process on 2/25/14. See photos AThe trash on the counter under the telephone in the 300 unit dining room was thrown away during the survey process on 2/25. The counter (near the telephone area and near the coffee machine area) was cleaned and the salt shaker was removed. See photos BThe 3 tiered cart near the window in the 300 unit dining room, the 4 tiered cart near the steam table and the trash can connected to the cart were cleaned during the survey process on 2/25/14. See photos CThe counter behind the steam	03/06/2014

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	machine on the counter. There were crumbs on the counter against the wall. There was a white plastic salt shaker on the counter. There was dried red spillage on the salt shaker. c. There was spillage on the sides and shelves of a plastic three tiered cart near the window in the Dining Room. There were crumbs on the bottom shelf. d. There was spillage on a 4 tiered cart next to the steam table in the Dining Room. There was a black plastic trash can connected to the cart. There were lines of whitish substance down the sides of the trash can. There were crumbs and debris in the corners of the this cart. e. There were crumbs on the counter behind the steam table in the Dining Room. There was dried spillage along the sides of the counter. There were crumbs on the ledge next to the steam table. There were crumbs on the top of the toaster on the counter. There was dried spillage on the ceiling above the steam table area. f. There were multiple reddish spots of spillage on the ceiling in the		table, the ledge next to the steam table, the toaster on the counter and the ceiling above the steam table in the 300 unit dining room were cleaned during the survey process on 2/25/14, as well as the rest of the ceiling in the 300 unit dining room. See photos DThe vents under the windows in the 300 unit dining room were cleaned during the survey process on 2/25/14. See photo EThe cove base under the coffee machine area in the 300 unit dining room was cleaned during the survey process on 2/25/14. See photo FThe wall and the wall guard strip under the rack of hanging aprons in the 300 unit dining room were cleaned during the survey process on 2/25/14. See photo GThe wall guards along the wall between the 2 entrances to the 300 unit dining room was cleaned during the survey process on 2/25/14. See photo HThe beverage cart and the wall in the alcove near the 300 dining room were cleaned during the survey process on 2/25/14. See photo IThe wall behind the counter in the activity room, the window sill in the activity room and the vents under the windows in the activity room were cleaned during the survey process on 2/25/14. See photos JThe blinds in the lounge area near the aviary and the Broda chair that was in the TV lounge at the time of the survey were cleaned during the survey	

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 02/27/2014
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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	Dining Room. g. There were areas of tan spillage along areas on the register vents under the windows in the Dining Room. h. There were areas of dried spillage on the cove base under the coffee machine area in the Dining Room. i. There was dried spillage on the wall and the wall guard strip under the rack of hanging aprons in the Dining Room. j. There was a build up of dust along the wall guards along the wall between the two entrance doors to the Dining Room. k. There was red spillage on the beverage cart and the wall in the area next to the Dining Room. l. There was dried spillage on the wall behind the counter in the Activity Room. m. There was dust on the window sills in the Activity Room and dried spillage on the register vents under the windows in the Activity Room. n. There was dried spillage on the		process on 2/25/14. See photos KHow other residents that have the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:All residents in the facility have the potential to be affected by the same alleged deficient practiceSteps the facility will take to ensure that the same alleged deficient practice does not recur:Staff was inserviced on 3/6 to report spills and other areas in need of cleaning to the housekeeping staff (see attachment 4)Housekeeping staff was inserviced on 2/28 on proper cleaning of common areas in the facility such as dining rooms, activity rooms and lounges (see attachment 5).How the facility will monitor for compliance: The Housekeeping director or designee will use the attached QA tool to inspect 5 common areas a week for 6 months to ensure compliance. Results of these audits and any trends noted will be presented to the QA committee at the QA meetings which are held monthly at the facility.Date of compliance: 3/7/14	

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	blinds in the TV lounge area with the bird Avery. o. There were crumbs along the sides of the seat of a Broda chair the TV lounge areas on the first hall. There was also a dried brownish substance to the cushion in the seat of the Broda. There were three residents in the lounge at this time. When interviewed at this time, the Environmental Manager indicated the above areas were in need of cleaning. This Federal tag relates to Complaint IN00145143. 3.1-19(f)			