STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155156	A. BUILDING 00 B. WING	01/26/2016

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00189924, IN00191307, and IN00191820. Complaint IN00189924- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00191307- Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, and F226. Complaint IN00191820- Substantiated. No deficiencies related to the allegations are cited. Survey date: January 21, 2106 Extended survey date: January 22 & 26, 2016 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census bed type: SNF: 24 SNF/NF: 89 Total: 113 Census payor type:	F 0000		

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

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	Medicare: 24 Medicaid: 75 Other: 14 Total: 113 Sample: 13 Extended sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on February 2, 2015.			
F 0223 SS=K Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview the facility failed to ensure residents remained free of physical, verbal, and emotional abuse related to a CNA	F 0223	*This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute*	01/28/2016

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	spraying water on a and using profanity towards a cognitively impaired dependent resident who was undressed in the shower. The CNA recorded a video of the resident in the resident being sprayed with water and the profanity used. The video was posted on social media for 1 of 3 residents reviewed for allegations of abuse. This resulted in an Immediate Jeopardy. (Resident #E) The Immediate Jeopardy began on 1/18/16 when CNA #1 posted a video of Resident #E on social media (Snap Chat). The video revealed the resident in the shower with no clothing on and CNA # 1 spraying water on the resident and using profanity. Two other staff members saw the video and reported the above to Administration. The Administrator, Director of Nursing, and Nurse Consultant were notified of the Immediate Jeopardy on 1/21/16 at 12:49 p.m. The Immediate Jeopardy was removed on 1/22/16, but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: On 1/21/16 at 9:32 a.m., Resident #E was observed sitting in a wheel chair in the		*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.* The facility disputes that this incident meets the criteria for Immediate Jeopardy outlined in appendix Q and that it should have been cited as past noncompliance. The facility requests an IDR review. **1) Actions taken for those residents identified: <u>On 01/18/16:</u>** CNA immediately suspended and escorted from the building, and has not returned. Witness statements of those who saw the video were obtained following the removal of accused CNA. ADON and Social Services evaluated resident with no signs of distress or trauma. Initiated in-servicing on cell phones, elder justice act, HIPPA, abuse/reporting for all employees currently in the building. (Annual in-services are typically schedule as online education. These in-services were done in person and 1:1 or in small groups. The cell phone policy was clarified that the phone will be confiscated, and the employees had the opportunity to ask questions if they did not understand.) Notified ISDH and local police. Notified family. Initiated review of surveillance footage outside the shower room. Interviewed	

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	hallway in front of a lounge/TV room. The resident was awake, alert, and calm. The resident was dressed in clean clothes. A staff member was talking with the resident and explaining the exercises she was going to assist them with. The clinical record for Resident #E was reviewed on 1/19/16 at 9:40 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, brief psychotic disorder, high blood pressure, and diabetes mellitus. Review of the 12/8/15 Minimum Data set (MDS) annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment indicated the resident had physical behaviors 1-3 days during the reference periods. The assessment indicated the resident required extensive assistance of two staff members for transfers and extensive assist of one staff member for bed mobility and personal hygiene. Resident #E's Care Plans were reviewed. A Care Plan initiated on 4/13/14 indicated the resident was non compliant and resistive to care with ADL's, showers, eating, and medication		several additional residents on the unit if anyone had taken pictures of them. Met with police officer to file a report. **On 01/19/16:** Continued review of surveillance footage outside shower room. Identified other employees who entered the shower room during the time frame of the shower. Interviewed the QMA who entered at the beginning of the shower. She did not witness anything, and assisted with transfer. Interviewed the Nurse who entered at the end of the shower. She assisted with transfer and did not witness anything. A CNA received a screenshot of the photo from someone who had viewed it. She provided it to us. Spoke with the detective handling the police investigation and notified him of the receipt of a screenshot. Met with resident's son and social services. Explained what had occurred and notified him that the police would be contacting him. **On 01/20/16:** Spoke with the nurse who assisted with the transfer at the end of the shower. She identified that the third person who entered the shower room reported that she did not see or hear anything. **On 01/21/16:** Received official statement from third person who reports that she was in the shower the same time as the QMA who helped transfer and that she exited immediately. She did not witness anything unusual.	

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	administration. Care plan intervention included to encourage the resident to be compliant, explain all procedures before initiating them and leave resistant resident alone and reapproach as needed. The Care Plan was last revised on 12/29/15. A Care Plan initiated on 3/3/2014 indicated the resident had a behavior problem. Behaviors included: Verbally Abusive- yelling and swearing at others and threatening to kill self. Physically Abusive - biting scratching, pinching staff during ADL's (Activities of Daily living, attempts to bite staff. Socially inappropriate- throws items, fecal smearing, and throws soap on aides during showers. A Social Service note completed on 12/8/15 at 10:10 a.m., indicated on 12/3/15 the resident was very combative kicking, biting, and punching in the shower. The resident also attempted to hit a CNA while she was getting her dressed. A Social Service note completed on 1/5/16 at 9:29 a.m., indicated the resident was pinching, scratching, kicking, and biting during care and the behavior ended when care was completed.		Spoke again with the nurse who assisted with transfer at end of shower. She was able to view resident's skin from just above the waist to the knees and did not note any issues. She also reports that resident had no concerns and did not exhibit any signs of emotional upset. Follow up skin assessment completed with no findings. **2) How the facility identified other residents: On 01/18/16:** Initiated Staff and resident interviews. All resident's interviewed and no other residents were identified. **On 01/22/16** Reviewed again mood and behavior charting on all residents (including cognitively impaired residents) for the past 30 days to determine if there were any new or increased mood issues Reviewed again any injuries of unknown origin for the past 30 days to determine if they are of a suspicious nature. **3) Measures put into place/ System changes: 01/18/16-present: Continued in-servicing on cell phones, elder justice act, HIPPA, abuse/reporting, dignity and privacy with additional staff including all departments. 01/18/16-present: Department heads to do observation rounds to monitor for compliance. 01/19/16: Notified ISDH via an elder justice act report. Ongoing: Will interview at least 5 residents**	

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	A Social Service note completed on 1/7/16 at 9:24 p.m., The note indicated the resident was verbally and physically aggressive in her room. The resident became combative while the Nurse was administering her insulin. The resident was flailing her hands and broke a nail on her thumb. A Social Service note completed on 1/18/16 at 4:12 p.m. The note indicated the Social Service Director spoke with the resident related to an incident that had occurred earlier in the day. The resident stated she thought she may have had a shower but was not sure. The resident displayed no signs of distress and was cheerful during the conversation. A Physician's Progress note dated 11/10/2015 indicated the resident did not want to be examined or touched. The note also indicated the resident seemed a little agitated. Review of the 11/25/15 Behavioral Health Follow up Progress note indicated the resident's mood was calm. The note indicated staff had reported the resident did have episodes of aggression during care. Review of a report and investigation of an allegation of Abuse for Resident #E		**and 5 employees per week for concerns related to cell phone use, video/ pictures, privacy, abuse with oversight by administrator or designee. Observation rounds (including observation of staff and resident interactions, residents displaying s/s of distress or emotional upset, cell phone presence) and staff interviews for compliance with above policies will occur on varying shifts and days unannounced. Rounds will be documented and given to the administrator. Administrator will be verbally notified immediately of any concerns. Ongoing: Social services will review all mood and behavior charting 5x/wk to identify changes/ concerns. Ongoing: New Injures and Injuries of unknown origin will be reviewed as they occur to identify any suspicious injuries. Administrator or designee will be responsible for the oversight of all audits related to F223. 4) How the corrective actions will be monitored:** The results of these audits/ reviews will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. Any non-compliance with these policies will be reported immediately to the administrator and addressed. 5) Date of Compliance 01/28/16	

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	indicated on 1/18/16 at approximately 11:45 a.m., CNA#2 was on her way back from her lunch break and and was looking at Snap Chat on her phone. She opened a video sent by CNA #1. CNA #3 was with CNA #2 at the time, the video was played and heard by both of the CNA's. The video was of Resident #E naked in the shower room with CNA #1. Both CNA #2 and CNA#3 reported the event to a manager immediately after viewing the video. CNA #1 was escorted to the Administrator's office and was immediately suspended. The local Police were called. A written statement from CNA #3 on 1/18/16 was reviewed. The statement indicated the CNA was coming from lunch and looking at her Snap Chat and observed CNA #1 had a Snap Chat showing Resident #E in the shower room. The resident was naked while the staff member was spraying the resident with water. The statement indicated the video was sent to her personally but it was for public viewing. A written statement from CNA #2 on 1/18/16 was reviewed. The statement indicated CNA #1 had a video on Snap Chat and Resident #E was naked in a			

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	shower chair and CNA #1 said" look at his crazy b---h she doesn't like taking showers." A written statement from CNA #1 on 1/18/16 was reviewed. The statement indicated the CNA she took a picture of Resident #E's face while she was in the shower room. When interviewed on 1/21/16 at 10:20 a.m., the facility Administrator indicated an incident of possible abuse was reported. CNA #1 took a picture of Resident #E with her cell phone and posted it on Snap Chat. CNA #1 sent the video to CNA#3. CNA #3 was coming back from break with CNA #2. The two CNA's watched the video. They immediately looked for someone to report it to. CNA #1 was located and escorted out of the facility at this time. Statements were then obtained from both CNA #2 and CNA #3 and the facility security cameras were reviewed. The security video did show CNA #4 had walked into the shower when CNA #1 was in the room with the resident. This CNA stepped in the room with a bag of trash and exited in approximately 2-3 minutes. They other person seen on the video going in or out of the shower room at this time was CNA #5 who was seen stepping in for approximately a minute			

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	and walking out. The Nurse went in to help transfer the resident and perform a skin check at the end of the shower. The Administrator indicated they noted a 10 minute gap of time that CNA #1 was in the shower room alone with Resident #E. Continued interview with the Administrator indicated CNA#1 was asked to write a statement and was then escorted out of the building. CNA #1 admitted to posting a picture of Resident #E on Snap Chat and stated she meant to post it privately, not publicly. CNA #1 also first stated it was just a picture and not a video. The Administrator indicated CNA #3 was interviewed and stated she received a message that CNA#1 had sent to her on Snap Chat and she clicked on it and it was a video of CNA #1 talking and spraying water on Resident #E who was naked in the shower room. The Administer indicated she also spoke with CNA #2 who stated she saw the video and heard CNA #1 saying "Look at this crazy b----h she doesn't like taking showers." The Administrator indicated the Social Service Director then assessed the resident and asked the resident if she had			

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	taken a shower and the resident answered yes to her. Continued interview with the Administrator indicated the facility policy was for staff not to have any cell phones on the unit when they were working on the floor. The Administrator indicated the local Police were called and came to the facility that evening. CNA #1 was not in the facility when the Police arrived as they had escorted her out of the building as soon as the other two CNA's reported the incident. The Administrator indicated CNA #3 and CNA #2 were interviewed separately and they both stated the occurrence was seen as a video and not a picture even though CNA #1 stated she had taken a picture of the resident in the shower and not a video. The Administrator indicated CNA #1 stated she had deleted the photo. CNA #2 was interviewed on 1/21/16 at 11:20 a.m. The CNA indicated she and CNA #3 were coming back from their break and CNA # 3 received a Snap Chat message from CNA #1. CNA #2 indicated it was a video and it started with seeing CNA #1 and ended with Resident #E. CNA #2 saw Resident #E completely naked in the shower and trying to splash water on CNA#1. CNA #1 was waving the hose over the resident			

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	and it seemed like CNA#1 was "trying to get a reaction from (Resident #E's name)." CNA #2 indicated she did not hear the resident say anything. Continued interview with CNA #2 indicated she had taken care of Resident #E before and the resident tended to get physical and would tell you "I'm gonna hit you" and she sometime made clawing like gestures, yelled and screamed. The CNA indicated the resident required one person assistance for showers but she herself always made sure she had someone else in the room when she took care of the resident. CNA #3 was interviewed on 1/21/16 at 12:00 p.m. The CNA indicated she and CNA #2 were coming back from their breaks and she noted a video from CNA #1 was on her phone. The CNA said it was a video of Resident #E in the shower naked an CNA #1 was spraying water on the resident and the resident was doing a "fanning" motion with her hands. CNA #3 indicated there was a caption that read like I thought we were friends and CNA #1 saying look and this "crazy b----h". CNA #3 states both she and CNA #2 were "shocked " to see that. CNA #3 indicated she had never seen anything like that before.			

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	When interviewed on 1/21/16 at 12:25 p.m., the facility Administrator indicated she had received a screen shot that another CNA (CNA #7) provided her. A friend of CNA#7 had seen the video and took a screen shot of it and sent it to the CNA. This CNA showed the Administrator the shot. The picture was of Resident #E naked on a shower chair and the caption on the photo read "she F-----G hates showers." The facility protocols for the Use of Recording Devices and Personal Telephone Calls were reviewed on 1/21/16 at 1:00 p.m. The facility Administrator provided the protocols from the Employee Handbook. The protocol for Personal Telephone Calls indicated cell phone usage was not permitted during working hours. The protocol for Recording Devices indicated each facility resident "should be free of any fear that he or she will be photographed or video taped, or have his or her voice recorded, copied or transmitted improperly." The protocol also indicated employees were prohibited from possessing or using, or assisting any other persons to use or process any recording devices while on the facility premises. The protocol also indicated the term "recording device" meant any camera, videotape recorder, tape			

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	recorder, computer disc or tape drive, cellular telephone, or any other recording device to record or transmit visual images, sound, or electronic information. The facility Abuse policy was reviewed on 1/21/16 at 11:00 a.m. The policy indicated residents had the right to be free from verbal, sexual, physical, and mental abuse. The policy indicated residents were not to be subjected to abuse by anyone. The policy indicated resident rights were to be protected by providing a method to investigate and report allegations of abuse, neglect, and mistreatment. The Immediate Jeopardy that began on 1/18/16 was removed on 1/22/16 when. statements made by staff present at the time were obtained and reviewed. The involved staff member had been removed from the facility and the resident's physical and psychosocial well being was assessed. Inservicing began on 1/18/16 and were done in person and 1:1 or in small groups. The Inservicing covered cell phone usage, the elder justice act, HIPPA (Health Insurance portability and Accountability Act), and Abuse/reporting for all employees who were currently in the building. All employees were given the chance to ask questions related to the information. On			

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	1/18/16 the facility notified ISDH (Indiana State Department of Health), the local Police Authority, and the resident's family. Surveillance footage outside the involved shower room was reviewed. Several additional residents were interviewed for concerns. A Police Offer arrived at the facility on 1/18/16. Further interviews with several other staff members were completed on 1/20/16 and 1/21/16. Staff assessed the resident's skin and emotional status again on 1/21/6. Staff completed resident interviews to assure no other resident concerns were identified. The facility again reviewed all injuries of unknown occurring in the past 30 days. On 1/18/16 continued inservicing continued and Department Heads were assigned to do observation rounds on varying shifts and days to monitor for compliance and observed staff /resident interactions. The Immediate Jeopardy was removed but the noncompliance remained at a lower scope and severity level of "No actual harm with potential for more than minimal harm" that is not Immediate Jeopardy as continued monitoring of the interventions was to be continued to evaluate the effectiveness of the removal plan to ensure abuse does not occur. The survey team completed various round throughout the facility on 1/22/16 and observed Department Heads present			

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	155156	A. BUILDING 00 B. WING	01/26/2016

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ARBORS AT MICHIGAN CITY	1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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	on the units. Staff members from different departments were interviewed related to the the facility policy for cell phone use, social media use, and reporting allegations immediately and response were as in the facility polices and procedures. This Federal tag relates to Complaint IN00191307. 3.1-27(a)(1) 3.1-27(b)			
F 0225 SS=E Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would			

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	indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure allegations of abuse were reported to the Administrator immediately for 1 of 3 allegation of Abuse reviewed. (Resident #L). Finding includes: The record for Resident #L was reviewed. The resident's diagnoses included, high blood pressure, glaucoma,	F 0225	*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*	01/28/2016

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	colostomy and anxiety episodes. Review of the 12/15/15 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (13). A score of (13) indicted the resident's cognitive patterns were intact. A facility report of the Investigation of an allegation of abuse for Resident #L was reviewed on 1/21/16. The report indicated the resident's daughter turned in a Grievance Form to the Nurse on duty as the daughter was leaving the facility at approximately 6:45 p.m. on 1/1/16. The Nurse read the grievance and noticed the daughter reported a concern regarding a male CNA. The Nurse notified the facility Administrator and the daughter was then called by the Administrator. The daughter reported she had called her Mother in the evening of 12/31/15 after she left the facility around 8:00 p.m. The daughter reported her Mother answered the phone and said "hang on, hang on" and "He's being mean to me." The daughter reported she heard a male voice state "we're not going to play this game again tonight." The daughter also reported she then heard a female enter the room and say "You should leave the room. I'll do this."		*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) Immediate actions taken for those residents identified:** CNA#6 was suspended pending investigation. Abuse investigation was initiated and completed on the allegation for resident #L. **2) How the facility identified other residents:** Reviewed other abuse allegations in the past thirty days to determine if there was a delay in reporting. **3) Measures put into place/ System changes:** Staff in all departments were	

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	The male Employee (CNA #6) was suspended on 1/1/16. The CNA was interviewed and stated he did not say anything along the lines of "we're not going to play this game." The CNA indicated he may have been louder then intended as he had just left the room of another resident who was heard of hearing. CNA #6 denied speaking to the resident in a mean manner. A female Employee (CNA #5) was also working the evening shift on 12/31/15. The CNA was interviewed on 1/1/16 and stated she was working with CNA #6 on 12/31/15 and heard a loud voice saying something about playing games and being up and down and she then walked into Resident #L's room. CNA #6 was in the room and she (CNA #5) told the other CNA to go out of the room and she would take care of the resident in his place. CNA #5 indicated the other CNA appeared frustrated. The resident never complained to CNA #5. When interviewed on 1/22/16 at 11:39 a.m., the Director of Nursing indicated CNA #5 did not report what she heard from Resident #L's room on 12/31/15. The Director of Nursing indicated CNA #5 should have reported the conversation she heard on 12/31/15 to the DON (Director of Nursing) and the		in-serviced on abuse policy and abuse reporting. Audits were initiated with oversight by the Administrator or designee for five employees per week. Audits are to occur on all shifts and within all departments. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** **01/28/16**	

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	Administrator on 12/31/15 when it occurred. This Federal tag relates to Complaint IN00191307. 3.1-27(a)(1) 3.1-27(b)			
F 0226 SS=E Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview ,the facility failed to follow the Abuse policy related staff not reporting an allegation of verbal abuse for 1 of 3 allegations reviewed. This resulted in a delay in the initiation of an investigation of allegations. (Resident #L) Findings include: 1. The record for Resident #L was	F 0226	*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*	01/28/2016

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	she heard on 12/31/15 to the DON (Director of Nursing) and the Administrator on 12/31/15 when it occurred. This Federal tag relates to Complaint IN00191307. 3.1-28(c) 3.1-28(d)			