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	11/27/2016

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 Complaint IN00215091. Complaint IN00215091 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, F425, and F505. Survey date: November 27, 2016 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census bed type: SNF: 21 SNF/NF: 96 Total: 117 Census payor type: Medicare: 19 Medicaid: 78 Other: 20 Total: 117 Sample: 6 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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	Quality review completed by 32883 on 11/28/16.			
F 0157 SS=D Bldg. 00	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is			

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	available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			
	Based on observation, record review, and interview, the facility failed to notify the Physician of a wound vac not in place as ordered for 1 of 3 residents reviewed for pressure ulcers in a sample of 6. (Resident C) Finding includes: 1. On 11/27/16 at 12:10 p.m., the Wound Nurse was observed completing wound care for Resident C. The resident was in bed. No wound vacs (a suction device placed over wounds) were in place. Dressings were in place to the coccyx/ buttock areas and the right hip area. The Wound Nurse removed the dressings. No wound vac was in place to any of the wounds.	F 0157	**F157** **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*	12/19/2016

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	The record for Resident C was reviewed on 11/27/16 at 1:50 p.m. The resident's diagnoses included, but were not limited to, Multiple Sclerosis, diabetes mellitus, chronic kidney disease, and osteomyelitis (an infection of the bone). A Physician order was initiated on 11/17/16 for a wound vac to the left buttock and the right hip and to change the wound vac on Tuesdays, Thursdays, and Saturdays. The wound vac was to be set at 125 mmHg (millimeters of Mercury) of negative pressure. The 11/2016 Treatment Administration Record was reviewed. The above treatments were signed out as completed last on 11/22/16 (Tuesday). Nursing staff signed the treatment as not completed on 11/24/16 (Thursday) and 11/26/16 (Saturday). There was no documentation of Physician notification of the ordered wound vac not in place 11/23/16 through 11/26/16 in the Nursing records. When interviewed on 11/27/16 at 2:40 p.m., the Director of Nursing indicated the Physician should have been notified of the wound vac not in place for the above dates.		*and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The physician was notified that wound VAC supplies were not available for resident C and a temporary alternate treatment order was received and applied. Wound VAC supplies were received for Resident #C and treatment applied as ordered. **2) How the facility identified other residents:** Treatment orders were reviewed for all residents and no other treatment supplies were unavailable. **3) Measures put into place/ System changes:** The staff was educated on requirements to notify physician and request alternate treatment when treatment is unable to be followed as ordered. An audit of 5 residents per week receiving wound treatment will be completed to ensure treatment supplies are available and	

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	This Federal tag relates to Complaint IN00215091. 3.1-5(a)(3)		physician orders are followed. . **4) How the corrective actions will be monitored:** An audit of 5 residents per week receiving wound treatment will be completed to ensure treatment supplies are available and physician orders are followed. This will be completed under the direction of the DON or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **December 19, 2016**	
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's			

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	comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on record review and interview, the facility failed to ensure the necessary care and services were provided related to the failure to identify the antibiotic that was given was resistant to the infection requiring treatment for 1 of 3 residents reviewed for wounds in a sample of 6. (Resident B) Finding includes: The closed record for Resident B was reviewed on 11/27/16 at 10:05 a.m. The resident's diagnoses included, but were not limited to, left ankle pressure ulcer, peripheral vascular disease, osteoarthritis, and congestive heart failure. The 9/2/16 Minimum Data Set (MDS)	F 0309	**F309** **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*	12/19/2016

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	quarterly assessment indicated the resident required extensive assistance from staff for bed mobility, dressing, and personal hygiene. The resident was totally dependent on staff for transfers and had limited range of motion in both of her lower extremities. The resident had one Unstageable ulcer measuring 7.0 cm x 4.0 cm x 0.2 cm. Slough tissue was present. The 9/15/16 Physician Progress Notes indicated the resident was seen due to arterial insufficiency of her left ankle on the lateral side. The wound had more drainage with edema and redness in the surrounding skin area. The full thickness ulcer measured 7 cm x 4 cm (centimeters) with foul smelling drainage from the ulcer. A Physician's order was written on 9/15/16 for the resident to receive Doxy (an antibiotic) 100 milligrams orally every 12 hours from 9/15/16 through 9/22/16. A wound culture and sensitivity laboratory test was ordered for 9/13/16. The laboratory picked up the specimen on 9/13/16. The final results were faxed to the facility on 9/17/16 at 1:34 p.m. The final report indicated the culture and sensitivity was positive. Proteus Mirabilis		*is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B has been discharged. **2) How the facility identified other residents:** All cultures within the last 30 days were reviewed to determine if the organisms were sensitive to the antibiotic ordered and that physician was notified timely. **3) Measures put into place/ System changes:** Nurses educated to notify physician of lab results at the time they are received and to compare antibiotic orders to the sensitivity listing. **4) How the corrective actions will be monitored:** An audit tool was devised to monitor physician notification of all lab results and review sensitivity for any antibiotics ordered. This will be completed	

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	and Pseudomonas Aeruginosa organisms (bacteria) were present. The Sensitivity indicated neither of the above two organisms were sensitive to the Doxy antibiotic which the resident was receiving since 9/15/16. The Proteus Mirabilis was "Resistant" to Tetracycline. "Faxed to Dr (attending Physician's name)" was written on the report. No date or time the fax was sent was noted. The Nursing 2014 Drug Handbook indicated Doxycycline was an antibiotic. The pharmacological class of Doxy was "Tetracycline." The 9/2016 Nursing Progress Notes were reviewed and noted as follows: - 9/17/16 at 2:47 p.m.- The resident noted with an infection to the left outer ankle. Foul odor and purulent (yellow, gray, or green drainage from a wound when an infection is present) drainage present. Swelling noted at site. - 9/18/16 at 9:08 p.m.- The resident noted with an infection to the left ankle wound. Foul odor and purulent drainage present. Pain and tenderness at the site. - 9/19/16 at 10:08 a.m.- The resident noted with an infection to the left outer ankle. Swelling note at the sight. Foul		5x weekly under the supervision of the DON or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **December 19, 2016**	

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	odor and purulent drainage present. - 9/20/16 at 10:12 p.m.- The wound infection was not improving as evidenced by larger measurement and odor. The resident was receiving Doxycycline every 12 hours. Awaiting call from the Physician. - 9/20/16 at 11:52 a.m. - Return call from the Doctor. Orders given to send the resident to the hospital Emergency Room for IV antibiotics, Surgical Debridement, and a Vascular work up. An entry in Nursing Progress Notes on 9/24/16 at 5:30 p.m. indicated the resident returned to the facility with a PICC (Peripherally Inserted Central Catheter) Intravenous line in place. The resident was to receive intravenous Unasyn (an antibiotic) every (6) hours to treat a left leg ulcer infection. When interviewed on 11/27/16 at 2:30 p.m., the Director of Nursing indicated the final Culture and Sensitivity results were faxed to the facility on 9/17/16. The results noted the organisms were not sensitive to the current antibiotic the resident had been receiving for the wound infection. This Federal tag relates to Complaint			

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	IN00215091. 3.1-37(a)			
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure wound care was provided as ordered related to wound vac supplies not available for 1 of 3 residents reviewed with wounds in a sample of 6. (Resident C Finding includes:	F 0314	**F314** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of*	12/19/2016

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	On 11/27/16 at 12:10 p.m., the Wound Nurse was observed completing wound care for Resident C. The resident was in bed. No wound vac (a suction device placed over wounds). Dressings were in place to the coccyx/ buttock areas and the right hip area. The Wound Nurse removed the dressings. No wound vac was in place to any of the wounds. The record for Resident C was reviewed on 11/27/16 at 1:50 p.m. Diagnoses included, but were not limited to, Multiple Sclerosis, diabetes mellitus, chronic kidney disease, and osteomyelitis (an infection of the bone). Review of the 11/21/16 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance from staff for bed mobility, dressing, and personal hygiene. The resident was identified to be at risk for the development of pressure ulcers. The resident had (2) Stage I pressure ulcers, (1) stage III pressure ulcer, and (2) stage IV pressure ulcers. Review of the 11/22/16 Wound Assessment Detail reports indicated the resident had an Unstageable (full thickness tissue loss with the base of the wound covered by slough or necrotic		*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) Immediate actions taken for those residents identified:** The physician was notified that wound VAC supplies were not available for resident C and a temporary alternate treatment order was received and applied. Wound VAC supplies were received for Resident #C and treatment applied as ordered. **2) How the facility identified other residents:** Treatment orders were reviewed for all residents and no other treatment supplies were unavailable.	

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	unviable tissue) pressure ulcer to the right trochanter (hip) area. The wound tissue was 75% prink or red and 25% necrotic tissue. A scant amount of bloody drainage was noted. The wound measured 7.0 cm (centimeters) x 10.0 cm with the depth unknown. The resident also had a Stage IV pressure ulcer(full thickness tissue loss with exposed bone or tendon) to the left buttock. The wound tissue was 100% bright pink. A moderate amount of serous (bloody) drainage was noted. The wound measured 1.5 cm x 2.0 cm x .20 cm. A Physician order was initiated on 11/17/16 to a wound vac to the left buttock and the right hip and to change the wound vac on Tuesdays, Thursdays, and Saturdays. The wound vac was to be set at 125 mmHg (millimeters of Mercury) of negative pressure. The 11/2016 Treatment Administration Record was reviewed. The above treatments were signed out as completed last on 11/22/16 (Tuesday). Nursing staff signed the treatment as not completed on 11/24/16 (Thursday) and 11/26/16 (Saturday). November 2016 Nursing Progress Notes were reviewed as follows: 11/23/16 at 4:36 p.m.- wound vac not on,		**3) Measures put into place/ System changes:** The staff was educated on requirements to notify physician and request alternate treatment when treatment is unable to be followed as ordered. An audit of 5 residents per week receiving wound treatment will be completed to ensure treatment supplies are available and physician orders are followed. **4) How the corrective actions will be monitored:** An audit of 5 residents per week receiving wound treatment will be completed under the direction of the DON or designee to ensure treatment supplies are available and physician orders are followed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **December 19, 2016**	

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	awaiting supplies 11/25/16 at 3:40 p.m.- awaiting supplies for wound vac treatment 11/26/16 at 11:39 a.m.- maintaining wet to dry dressing due to wound vac supplies not available. 11/27/16 at 10:30 a.m.- Doctor made aware of wound vac leaking, staff unable to reinforce, treatment order changed per Doctor approval. When interviewed on 11/27/16 at 2:40 p.m., the Wound Nurse indicated she worked last on 11/22/16 and the wound vac was in place. The Central Supply Nurse was responsible for maintaining and ordering wound vac supplies. The Wound Nurse indicated she spoke with the Central Supply Nurse who stated there were supplies before she also left on vacation. This Federal tag relates to Complaint IN00215091. 3.1-40(a)(2)			
F 0425 SS=D Bldg. 00	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide			

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	pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; Based on record review and interview, the facility failed to ensure arrangements were in place to ensure IV (Intravenous) antibiotics were received by the facility in a timely manner for 1 of 3 residents reviewed for wound infections in a sample of 6. (Resident B) Finding includes: The closed record for Resident B was reviewed on 11/27/16 at 10:05 a.m. Diagnoses included, but were not limited to, left ankle pressure ulcer, peripheral vascular disease, osteoarthritis, and congestive heart failure. The 9/15/16 Physician Progress Notes indicated the resident was seen due arterial insufficiency of her left ankle on the lateral side. The wound had more drainage with edema and redness in the surrounding skin area. The full thickness	F 0425	**F425** **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.*	12/19/2016

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	ulcer measured 7 cm x 4 cm (centimeters) with foul smelling drainage from the ulcer. The resident was sent to the hospital on 9/20/16 and returned to the facility on 9/24/16. An entry in Nursing Progress Notes on 9/24/16 at 5:30 p.m. indicated the resident returned to the facility with a PICC (Peripherally Inserted Central Catheter) Intravenous line in place. The resident was to receive intravenous Unasyn (an antibiotic) every (6) hours to treat a left leg ulcer infection. The Nursing Progress Notes from 9/25/16 to 9/26/16 were reviewed. 9/25/16 at 6:00 p.m.- Pharmacy did not deliver the IV antibiotic 9/25/16 at 7:48 p.m.- Left a message with the Physician related to the IV antibiotic not delivered- No return call from the Physician. 9/26/16 at 12:22 a.m.- IV antibiotic in route from the Pharmacy. The 9/2016 Medication Administration Record indicated the initial dose of the IV Unasyn was administered on 9/26/16 at 6:00 a.m. When interviewed on 11/27/16 at 2:30		**1) Immediate actions taken for those residents identified:** Resident #B has been discharged. **2) How the facility identified other residents:** Medication orders were reviewed for all new admission and re-admission to determine if all medications have been received. **3) Measures put into place/ System changes:** The staff was educated to call pharmacy if medication is not received on next delivery and request stat delivery. In addition, they were educated to notify physician of possible delay in treatment. **4) How the corrective actions will be monitored:** An audit tool was devised to monitor new medication orders for timely delivery and proper staff follow-up. This audit will be completed 5x weekly under the supervision of the DON or designee. The results of these	

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	155156	A. BUILDING 00 B. WING	11/27/2016

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	p.m., the Director of Nursing indicated the Pharmacy delivers medication twice a day every day of the week. The above antibiotics should have been delivered in a more timely manner. This Federal tag relates to Complaint IN00215091. 3.1-25(a)		audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **December 19, 2016**	
F 0505 SS=D Bldg. 00	483.50(a)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS (a) Laboratory Services (2) The facility must- (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on record review and interview, the facility failed to ensure the Physician was notified of a wound Culture and Sensitivity laboratory test result for 1 of 3 residents reviewed for infections in a sample of 6. Findings include: The closed record for Resident B was reviewed on 11/27/16 at 10:05 a.m.	F 0505	**F505** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	12/19/2016

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	Diagnoses included, but were not limited to, left ankle pressure ulcer, peripheral vascular disease, osteoarthritis, and congestive heart failure. The 9/15/16 Physician Progress Notes indicated the resident was seen due arterial insufficiency of her left ankle on the lateral side. The wound had more drainage with edema and redness in the surrounding skin area. The full thickness ulcer measured 7 cm x 4 cm (centimeters) with foul smelling drainage from the ulcer. A Physician's order was written on 9/15/16 for the resident to receive Doxycycline (an antibiotic) 100 milligrams orally every 12 hours from 9/15/16 through 9/22/16. A wound culture and sensitivity laboratory test was ordered for 9/13/16. The laboratory picked up the specimen on 9/13/16. The final results were faxed to the facility on 9/17/16 at 1:34 p.m. The final report indicated the culture and sensitivity was positive. Proteus Mirabilis and Pseudomonas Aeruginosa organisms (bacteria) were present. The Sensitivity indicated neither of the above two organisms were sensitive to the Doxycycline antibiotic which the resident was receiving since 9/15/16. The Proteus		*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) Immediate actions taken for those residents identified:** Resident B has been discharged. **2) How the facility identified other residents:** All cultures within the last 30 days were reviewed to determine if the organisms were sensitive to the antibiotic ordered and that physician was notified timely. **3) Measures put into place/ System changes:** Nurses educated to notify physician of lab results at the time they are received and to document that notification.	

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	Mirabilis was "Resistant" to Tetracycline. "Faxed to Dr (attending Physician's name). No date or time the fax was sent was noted. Review of the 9/2016 Nursing Progress Notes indicated there was no documentation of any attempts to notify the Physician of the above final culture results between 9/17/16 and 9/20/16. When interviewed on 11/27/16 at 2:30 p.m., the Director of Nursing indicated the Culture and Sensitivity results were faxed to the facility on 9/17/16 and noted the organisms were not sensitive to the current antibiotic the resident had been receiving. The Director of Nursing indicated the Physician should have been notified for the Sensitivity results. This Federal tag relates to Complaint IN00215091. 3.1-49(f)(2)		**4) How the corrective actions will be monitored:** An audit tool was devised to monitor physician notification of all lab results. This audit will be completed 5x weekly under the supervision of the DON or designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **December 19, 2016**	