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	12/21/2015

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00186990. Complaint IN00186990 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F282. Survey dates: December 15, 16, 17, 18, and 21, 2015. Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census bed type: SNF: 13 SNF/NF: 96 Total: 109 Census payor type: Medicare: 19 Medicaid: 71 Other: 19 Total: 109 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 26143, on December 30, 2015.			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to provide services in accordance with a resident's written plan of care related to transfer assistance for toileting for 1 of 18 residents whose care plans were reviewed. (Resident #C) Finding includes: On 12/18/15 at 10:12 a.m., Resident #C was observed sitting in a wheelchair in her room. The resident was observed to have a personal alarm clipped onto the back of her shirt. On 12/21/15 at 11:10 a.m., Resident #C was observed sitting in a wheelchair in the therapy gym participating in therapy. Record review for Resident #C was completed on 12/18/15 at 8:54 a.m. The	F 0282	**F282 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.* **1) Immediate actions taken for those residents identified:** Resident #C is supervised while using the bathroom. Nursing Staff in-serviced on following care plan for all areas including level of assistance. **2) How the facility identified other residents:** All resident's care plans will be reviewed for all areas including level of	01/20/2016

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	resident's diagnoses included, but were not limited to, heart failure, hypertension, atrial fibrillation, difficulty walking, and muscle weakness. A Nursing Care Plan dated 8/24/15 indicated the resident had an ADL (Activity of daily Living) self care deficit or potential for as evidenced by needing assistance or was dependent in: oral/dental care, bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene, bathing and was at risk for developing complications associated with decreased ADL self-performance related to weakness and a pelvic fracture. A Nursing Care Plan dated 8/20/15 indicated the resident had a history of falls and the potential for falls. The resident required assistance with transfers. A Skilled Medicare Assessment completed on 9/27/15 indicated the resident was oriented to person and had a STM (short term memory) impairment. The resident had weakness and unsteady gait requiring supervision with ADLs. A Nurse's Note completed on 11/14/15 at 10:30 a.m., indicated the resident was found lying on the bathroom floor in her room. The resident was assessed and		assistance required. Nursing Staff in-serviced on following care plan for all areas including for level of assistance. **3) Measures put into place/ System changes:** Nursing Staff in-serviced on following care plan for all areas including level of assistance. Supervision audit to determine if care plan was followed for all areas and ADL care was provided according to plan of care will be completed 5x/week on various shifts with oversight by DON or designee. **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: January 20, 2016**	

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	assisted into her wheelchair. The resident had indicated she was trying to adjust herself on the toilet. A Nurses's Noted completed on 11/5/15 at 4:53 p.m., indicated the Fall IDT (Interdisciplinary Team) Note: summary of fall was the resident was on the toilet and attempted to get up unassisted and fell. The resident had indicated she should have used the call button for the nurse. The root cause of the fall was the resident stood and went to turn and fell to the floor. The resident had an unassisted transfer. The intervention was staff education completed. A Fall Investigation Worksheet completed by the facility on 11/4/15 indicated the resident had a fall in the bathroom. Activity at the time of the fall: resident adjusting self on toilet. The CNA statement indicated she had helped the resident onto the toilet and stepped out for her to use the bathroom. She indicated she then heard a noise and saw the resident on the floor. The resident had complained of knee pain. The recommended intervention was staff education. The conclusion/root cause analysis indicated: the resident was assisted onto the toilet and required assistance off the toilet. She indicated she did not use her call light because she			

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	thought she could do it without assistance. An interview completed on 12/18/15 at 10:12 a.m., with Resident #C indicated the CNAs usually stood by the door when she used the restroom but that time the CNA was not there so she thought she could get up on her own. She indicated when she had fallen the CNA was not able to get to her in time before she fell. She further indicated she believed it was an accident. An interview with the Assistant Director of Health Services 2 (ADHS2) on 12/18/15 at 10:31 a.m., indicated the CNA was supervising the resident to use the restroom. She indicated the resident was a 1 assist with transfers but sometimes she was able to transfer herself from the wheelchair to the toilet independently by using the grab bars. She indicated the CNAs were there to provide supervision in case she needed assistance because the resident had a weak knee that would sometimes give out on her. She indicated the CNA had gone out to the hallway while the resident was using the restroom and instructed her to use her call light when she was finished. She indicated the CNA was in the hall less than a minute when she had went back into the bathroom and found the			

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	resident on the floor. She indicated it was the expectation of the CNAs that if a resident needs assistance with toileting they were to stay close by while the resident was on the toilet. She indicated the CNA should have stayed with the resident while she was in the restroom instead of going to the hallway. She indicated the CNA could have given the resident privacy by slightly closing the bathroom door and standing there instead of being out in the hallway. She further indicated the resident had her days when she would be slightly confused and may not remember to use the call light for assistance. She indicated a whole house Nursing Inservice had been completed after the residents fall on staying with residents when assisting them to the restroom. An interview with CRCA #3 was completed on 12/18/15 at 1:45 p.m., indicated she took care of the resident before she had fallen. She indicated the resident was able to transfer herself on and off the toilet but she always stood close by to see if the resident needed assistance. She indicated she would not have left the resident alone in the bathroom and gone out into the hallway. This Federal Tag relates to Complaint IN00186990.			

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	3.1-35(g)(2)			
F 0314 SS=D Bldg. 00	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 provide the necessary treatments and services to promote healing and to prevent infection of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers of the 4 who met the criteria for pressure ulcers. (Resident #149) Finding includes: An wound treatment for a pressure ulcer on Resident #149's left buttock was observed on 12/16/15 beginning at 2:30 p.m., with the Wound Nurse. At that time, the following was observed:	F 0314	**F314** **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*	01/20/2016

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	The Wound Nurse gathered her supplies, spoke with the resident and explained what she needed to do, washed her hands and donned clean gloves. She had the resident stand at the bedside leaning on the bed per the resident's request, pulled down her pants and brief, removed the old dressing and her gloves, washed her hands, and donned new gloves. She then cleaned the wound with Normal Saline and patted it dry with gauze. At this time, the Wound Nurse realized she forgot the treatment medicine in the cart, removed her gloves, and then had the resident sit back down in her wheelchair at the bedside with her bare bottom and wound uncovered. The wheelchair had a previously used bath blanket already on top of the wheelchair seat, but no clean covering was placed prior to the resident sitting down. The Wound Nurse returned with the medication Santyl, washed her hands, donned clean gloves, had the resident stand back up leaning on the bed, and was preparing to apply the Santyl. She was stopped at this point in the process and asked if she would normally clean the wound again since the resident sat down with her wound uncovered on an unclean surface. The Wound Nurse indicated, yes, she should clean the wound again, set the Santyl down, cleaned the wound again with Normal		*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 #149 dressing was changed following proper procedures. Wound nurse educated on the proper procedure for wound care. **2) How the facility identified other residents:** Any resident receiving dressing changes have the potential to be affected. Nursing staff educated on the proper procedure for wound care. **3) Measures put into place/ System changes:** Reeducated nursing staff on the proper procedure for wound care.	

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	Saline, removed her gloves, washed her hands, donned clean gloves, applied the Santyl with a sterile Q tip, placed a 4 x 4 gauze on the wound and applied a dated bordered gauze dressing. She then pulled up the resident's briefs and pants and had the resident sit back down in her wheelchair. The Wound Nurse proceeded to complete wound treatments on both heels. Interview with the Wound Nurse after all treatments were completed on 12/16/15 at 3:11 p.m., indicated she should not have had the resident sit down in her wheelchair with her wound uncovered and normally would not have done so. Resident #149's record was reviewed on 12/17/15 at 8:27 a.m. Diagnoses included, but were not limited to, pressure ulcer sacral region unstageable, pressure ulcer right heel stage ll, pressure ulcer left heel stage ll. Review of current Physician's Orders indicated a treatment order for "Santyl ointment apply to coccyx topically every day shift for wound. Cleanse NS (Normal Saline) fold 4 x 4 gauze transparent dressing daily & PRN (as needed). Apply to coccyx as needed for wound." A policy titled "General Wound and Skin		Two dressing changes and/or treatments will be observed/audited per week for proper procedure under the supervision of the DON or designee. **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:** **January 20, 2016**	

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	Care Guidelines" was provided by the DHS (Director of Health Services) on 12/17/15 at 9:15 AM and deemed as current. The policy indicated, "Purpose: To provide measures that will promote and maintain good skin integrity. Procedure: ... 9. Dress chronic wounds using clean technique ...." 3.1-40(a)(2)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to provide adequate supervision while toileting two residents resulting in a resident falling and obtaining a kneecap fracture, and a resident falling with no injury for 2 of 4 residents reviewed for accidents of the 5 who met the criteria for accidents. (Resident's #C and #B) Findings include: 1. On 12/18/15 at 10:12 a.m., Resident	F 0323	**F323** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	01/20/2016

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	#C was observed sitting in a wheelchair in her room. The resident was observed to have a personal alarm clipped onto the back of her shirt. On 12/21/15 at 11:10 a.m., Resident #C was observed sitting in a wheelchair in the therapy gym participating in therapy. Record review for Resident #C was completed on 12/18/15 at 8:54 a.m. The resident's diagnoses included, but were not limited to, heart failure, hypertension, atrial fibrillation, difficulty walking, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment completed on 9/25/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 12 which indicated the resident's cognition was moderately impaired. The assessment indicated the resident required extensive assistance of 1 person for transfers and toileting. The assessment indicated the resident was not steady and only able to stabilize with staff assistance for moving on and off the toilet. A Nursing Care Plan dated 8/24/15 indicated the resident had an ADL (Activity of daily Living) self care deficit or potential for as evidenced by needing		*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 #C is supervised while using the bathroom. Nursing Staff in-serviced on following care plan for level of assistance. Resident #B is no longer in the facility. **2) How the facility identified other residents:** All residents will be reviewed to determine level of assistance required. Nursing Staff in-serviced on following care plan for level of assistance.	

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	assistance or was dependent in: oral/dental care, bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene, bathing and was at risk for developing complications associated with decreased ADL self-performance related to weakness and a pelvic fracture. A Nursing Care Plan dated 8/20/15 indicated the resident had a history of falls and the potential for falls. The resident required assistance with transfers. A Social Service Care Plan dated 8/21/15 and revised on 9/11/15 indicated the resident had impaired cognition as evidenced by expressive problems, receptive problems and hearing problems related to hard of hearing, and dementia. A Social Service Care Plan dated 8/21/15 indicated the resident had impaired cognition as evidence by Short Term Memory (STM) impairment related to dementia. A nursing intervention included to maintain and establish consistency in the resident's daily routine when able. A Fall Risk Assessment completed on 8/15/15 indicated the resident had intermittent confusion, had a history of falls and was chair bound. The		**3) Measures put into place/ System changes:** Nursing Staff in-serviced on following care plan for level of assistance. Supervision audit to determine if ADL care was provided according to plan of care will be completed 5x/week on various shifts with oversight by DON or designee. **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:** **January 20, 2016**	

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	assessment indicated the resident was at risk for falls. A Skilled Medicare Assessment completed on 9/27/15 indicated the resident was oriented to person and had a STM impairment. The resident had weakness and unsteady gait requiring supervision with ADLs. A Nurse's Note completed on 11/14/15 at 10:30 a.m., indicated the resident was found lying on the bathroom floor in her room. The resident was assessed and assisted into her wheelchair. The resident had indicated she was trying to adjust herself on the toilet. A Nurse's Note completed on 11/4/15 at 11:16 a.m., indicated the physician had been notified and the resident had been sent to the ER to be evaluated. A Nurses's Noted completed on 11/5/15 at 4:53 p.m., indicated the Fall IDT (Interdisciplinary Team) Note: summary of fall was the resident was on the toilet and attempted to get up unassisted and fell. The resident had indicated she should have used the call button for the nurse. The root cause of the fall was the resident stood and went to turn and fell to the floor. The resident had an unassisted transfer. The intervention was staff			

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	education completed. An ER visit summary completed on 11/4/15 indicated the resident was evaluated for a fall from standing and a Right Patellar Fracture (kneecap fracture). A state reportable dated 11/4/15 indicated, ..."Resident was assisted by the staff into the restroom and instructed to use the call light when done. Resident attempted to self stand and fell forward. Was sent to ER for evaluation. Noted to have a fractured right patella". Follow up added on 11/6/15 indicated, "Resident was scored not at risk for falls on the assessment done in August. Resident requires assist of one to transfer. CNA assisted resident into the bathroom and instructed her to use the call light when she was ready to get up. CNA exited the restroom to grab a new incontinent brief for resident. Resident attempted to adjust her position on the toilet by standing and fell (per resident). Resident stated she should have used the call button when asked about the incident. Resident has a BIMS of 12 on most recent MDS...." A Fall Investigation Worksheet completed by the facility on 11/4/15 indicated the resident had a fall in the bathroom. Activity at the time of the fall:			

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	resident adjusting self on toilet. The CNA statement indicated she had helped the resident onto the toilet and stepped out for her to use the bathroom. She indicated she then heard a noise and saw the resident on the floor. The resident had complained of knee pain. The recommended intervention was staff education. The conclusion/root cause analysis indicated: the resident was assisted onto the toilet and required assistance off the toilet. She indicated she did not use her call light because she thought she could do it without assistance. A Fall Assessment completed after the fall on 11/4/15 indicated the resident had intermittent confusion and was at risk for falls. An Inservice completed with the CNAs and Nurses on 11/4/15 indicated, ..."A rule to follow if you assist a resident onto the toilet, into a shower chair you must stay with them and assist them out of the chair or off the toilet. If a resident requires assistance it's because they are not physically able to do so by themselves and or they are not cognitively able to be safe or both. Failure to stay with a resident that requires assistance on or off a surface will result in disciplinary action...."			

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	155156	A. BUILDING 00 B. WING	12/21/2015

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An interview completed on 12/18/15 at 10:12 a.m., with Resident #C indicated the CNAs usually stood by the door when she used the restroom but that time the CNA was not there so she thought she could get up on her own. She indicated when she had fallen the CNA was not able to get to her in time before she fell. She further indicated she believed it was an accident.

An interview with the Assistant Director of Health Services 2 (ADHS2) on 12/18/15 at 10:31 a.m., indicated the CNA was supervising the resident to use the restroom. She indicated the resident was a 1 assist with transfers but sometimes she was able to transfer herself from the wheelchair to the toilet independently by using the grab bars. She indicated the CNAs were there to provide supervision in case she needed assistance because the resident had a weak knee that would sometimes give out on her. She indicated the CNA had gone out to the hallway while the resident was using the restroom and instructed her to use her call light when she was finished. She indicated the CNA was in the hall less than a minute when she had went back into the bathroom and found the resident on the floor. She indicated it was the expectation of the CNAs that if a

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	resident needs assistance with toileting they were to stay close by while the resident was on the toilet. She indicated the CNA should have stayed with the resident while she was in the restroom instead of going to the hallway. She indicated the CNA could have given the resident privacy by slightly closing the bathroom door and standing there instead of being out in the hallway. She further indicated the resident had her days when she would be slightly confused and may not remember to use the call light for assistance. She indicated a whole house Nursing Inservice had been completed after the residents fall on staying with residents when assisting them to the restroom. An interview with CRCA #3 was completed on 12/18/15 at 1:45 p.m., indicated she took care of the resident before she had fallen. She indicated the resident was able to transfer herself on and off the toilet but she always stood close by to see if the resident needed assistance. She indicated she would not have left the resident alone in the bathroom and gone out into the hallway. Interview with the Social Service Director (SSD) #1 on 12/18/15 at 1:56 p.m., indicated the resident's cognition could fluctuate on a daily basis. She			

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	indicated on some days the resident may not remember to use a call light for assistance. Interview with LPN #1 on 12/18/15 at 2:02 p.m., indicated she did not take care of the resident before her fall and was unaware of how she was supposed to transfer prior to her fall. 2. The closed record for Resident #B was reviewed on 12/17/2015 at 11:42 a.m. The resident's diagnoses included, but were not limited to, pneumonia, surgical aftercare, hypertension, dysphagia, muscle weakness, difficulty walking, Parkinson's disease, Alzheimer's, lung cancer, thyrotoxicosis, metabolic encephalopathy, and dementia. The 11/4/15 30-Day Minimum Data Set (MDS) assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5, indicating the resident was severely impaired for decision making and had severe cognitive impairment. The resident was an extensive assist with a physical assist of two people for transfers and toilet use. The resident had one fall since admission or prior assessment. The current and updated plan of care dated 9/2015 indicated the resident was at risk for falls related to weakness, recent			

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	abdominal surgery, and requiring assistance with transfers. The Fall Investigation Worksheet dated 10/25/15 provided by the Director of Health Services (DHS) on 12/16/15 at 3:00 p.m., was reviewed. The activity at the time of the fall indicated the resident was on the toilet attempting to get paper towels off a table that she thought was toilet paper and fell. The intervention at the time was to replace the call button with a touch pad calling device. Interview with the Director of Health Services, Assistant Director of Health Services #2, and the Care Plan Coordinator #1 on 12/17/15 at 12:53 p.m., indicated the resident was confused, she was oriented to self and knew she was not at home. On 10/25/15 the resident was placed on her bedside commode by two nursing staff, they exited the room, leaving the resident unattended, and informed the resident's CNA she would need to be assisted off the commode. When the CNA entered the room the resident was observed on the floor. Continued interview indicated the resident had a bed side stand next to the commode and there were paper towels on the stand, the resident reached for the towels thinking it was toilet paper and she fell to the floor which resulted in			

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	no injury. The DHS further indicated the resident's call light was within reach, however, she does not know if the resident was cognitively able to use the call light, "she should not have been left alone". This Federal Tag relates to Complaint IN00186990. 3.1-45(a)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to touching food, lack of beard guards in use, uncovered food in the servery for 2 of 4 units throughout the facility and 1 room tray observation. The facility also failed to ensure the high temperature dishwasher was maintained in safe operating condition in 1 of 1 kitchens. This had the potential to affect 107 of the 109 residents who ate in the	F 0371	**F371 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*	01/20/2016

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	dining room. (The 100 Unit and The 400 Unit) Findings include: 1. On 12/15/2015 at 12:04 p.m., in the 400 Unit dining room Dietary Cook #1 was observed preparing for the lunch meal. The cook was observed with facial hair above his lip and on his chin. The cook was not observed wearing a beard guard at the time. Nor was he observed wearing a beard guard while preparing the resident's meal trays. 2. At 12:17 p.m., Dietary Cook #1 was observed donning gloves, at this time he touched a plate, a tray card and other items on and around the steam table. He was then observed picking up a grilled cheese sandwich from the steam table with his gloved hand and placing the sandwich on a plate. Interview with the Dietary Cook at 12:25 p.m., indicated he was not aware he should have worn a beard guard while preparing meal trays and at the time there were no tongs available to retrieve the grilled cheese sandwich from the steam table. 3. On 12/16/2015 at 8:37 a.m., CNA #1 was observed delivering breakfast trays.		*federal and state law.* **1) Immediate actions taken for those residents identified:** The dish machine was repaired. The sticker on the side of the machine was changed to reflect the correct type of machine. Dietary Cook #1 was in-serviced on the proper use of a beard guard and gloves. CNA #1 was in-serviced on the proper method for serving food. Dietary staff was in-serviced on the need to keep food covered when delivering from the kitchen. **2) How the facility identified other residents:** Residents who receive food from the kitchen have the potential to be affected. Staff was in-serviced on the proper used of beard guards, gloves and how to serve food. **3) Measures put into place/ System changes:** Staff in-serviced on the proper use of beard guards, gloves and how to serve food. An audit will be done 3 times per week to include all meals with oversight by the dietary manager or designee to monitor for compliance. **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: January 20, 2016**	

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	The CNA entered the resident's room, placed the tray on the resident's bedside table and uncovered it. She then asked the resident if she would like jelly on her toast. She then proceeded to touch the resident's toast with her ungloved hand as she spread the jelly on the bread. Interview with the Administrator on 12/18/15 at 3:30 p.m., indicated the Dietary Cook should have worn a beard guard while preparing meal trays and the facility staff's unsanitized gloved or ungloved hands should not touch the resident's food. The current facility policy Glove Use-Dietary provided by the Administrator on 12/21/15 at 2:33 p.m., indicated "Gloves should be used for only one task such as working with ready-to-eat foods or with raw animal food, used for no other purpose, and discarded when damaged, soiled or when interruptions occur in the operation." 4. On 12/15/15 at 11:44 a.m., food trays arrived to the 100 unit for lunch. At that time the turkey was observed uncovered and left open to air. Interview at that time with LPN #3, indicated the turkey had not been covered when she approached the area to serve lunch. She further indicated the turkey			

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	should have been covered and not open to air. On 12/21/15 at 3:30 p.m., interview with the Food Service Manager indicated, food should be covered prior to serving. 5. On 12/15/15 at 8:35 a.m., the Food Service Manager ran the dishwasher, the wash temperature registered 130 degrees Fahrenheit. At that time, the Food Service Manager indicated, the temperature should have registered 140 degrees or higher and would notify Plant Operations to look at it. On 12/18/15 at 1:05 p.m., interview with the Director of Plant Operations indicated, the dishwasher was a chemical dishwasher but had a booster added to it to make it a high temperature dishwasher. He further indicated no chemicals were used. On 12/18/2015 at 1:10 p.m., the Food Service Manager ran the dishwasher, the wash temperature registered 142 degrees. Review of Eco Dishwasher Book on 12/18/15 at 1:15 p.m., CE Series Conveyors, Install & Operations Manual 2010 Ecolab Inc, Section 2: Installation/Operation Instructions, Page 31....the hot water sanitizing mode, the			

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	temperature gauge must specify 160 degree minimum wash, and a minimum rinse at 180 degrees, and the dishwasher should have a Orange Sticker on the side of the machine to indicate the Hot Water Sanitizing mode. On 12/18/2015 1:57 p.m.., interview with Ecolab Employee #1 indicated, the dishwasher machine at the facility is a Hot Water Sanitizing Model, high temperature dishwasher, and the yellow sticker on the side of the machine which indicates it is a chemical dishwasher is incorrect. He further indicated the machine should have been washing at 160 degrees. Review of the Dish Machine Temperature Log Sheet on 12/18/15 at 3:20 p.m., indicated dinner wash temperatures on 12/14/15 were 140 degrees, on 12/15/15 160 degrees, 12/16/15 145 degrees, and 12/17/15 146 degrees. On 12/18/2015 at 3:30 p.m., interview with the Food Service Manager indicated, the dishwasher should have been washing at 160 degrees according to the manual. 3.1-19 (bb) 3.1-21(i)(3)			

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F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and	F 0431	**F431 The facility requests paper compliance for this**	01/20/2016

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	record review, the facility failed to ensure narcotic medications were stored properly and safely in 2 of 4 medication rooms. (300 Unit Medication Room, 400 Unit Medication Room) Findings include: 1. On 12/21/15 at 2:30 p.m., the 300 Unit Medication Room was observed with LPN #2. The refrigerator contained an Emergency Drug Kit (EDK) that contained 1 vial of IM (intramuscularly) lorazepam (anxiety medication) which was a controlled substance. The refrigerator did not have a lock. Interview at the time of the observation with LPN #2 indicated the medication room door was locked but the refrigerator should have a lock if it contained narcotics. 2. On 12/21/15 at 2:39 p.m., the 400 Unit Medication Room was observed with QMA #1. The refrigerator contained an EDK that contained 1 vial of IM lorazepam. The refrigerator did not have a lock. Interview at the time of the observation with QMA #1 indicated she believed the refrigerator should have a lock if it contained narcotics. Interview with the Assistant Director of Health Services 1 (ADHS1) on 12/21/15		**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.* **1) Immediate actions taken for those residents identified:** The refrigerators in the 300 med room and the 400 medication room were locked. **2) How the facility identified other residents:** Residents having narcotics that require refrigeration could be affected. All refrigerators containing narcotics were locked. **3) Measures put into place/ System changes:** Nurses and QMAs were in-serviced on the need to maintain the locks on the refrigerators in the medication rooms which contain narcotics. An audit of all 4 medication rooms will be completed 3x/ week on all shifts with oversight by the DON or designee to determine if refrigerators containing narcotics are properly locked. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting	

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	at 2:40 p.m., indicated the refrigerator should have a lock on it because it contained a narcotic. She indicated she was going to inform maintenance right away to put a lock on the refrigerator and to check the rest of the refrigerators in the medication rooms of the other units. A policy titled Pharmore Drugs LLC and received from the Director of Health Services (DHS) on 12/21/15 3:40 p.m., indicated, ..."Storage of Medications 1. Medications and biologicals must be stored safely, securely, and properly...." 3.1-25(m) 3.1-25(n)		monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance: January 20, 2016**	
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents			

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	infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview the facility failed to ensure the infection control practices and standards were maintained related to the improper disposal of a lancet. Finding includes: On 12/21/2015 at 8:09 a.m., during a medication administration observation LPN #4 was observed exiting a resident's room after completing blood glucose monitoring. The LPN was observed	F 0441	**F441** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.*	01/20/2016

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	throwing a disposable lancet into the trash container on the side of her medication cart. Interview at the time indicated the lancet used during the blood glucose monitoring should have been disposed of into the sharps container located on the side of the medication cart. The current Needle Sharps-Handling and Disposal policy provided by the Director of Health Services on 12/21/15 at 1:19 p.m., indicated "Used needless and other sharp objects, must be placed in a puncture-resistant biohazard container." 3.1-18(b)(1)		*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 sharp was disposed of correctly. LPN #4 was re-educated on the proper disposal of sharps. **2) How the facility identified other residents:** Rounds were completed to identify any other sharps not disposed of correctly. No other improperly disposed of sharps were identified. **3) Measures put into place/ System changes:**	

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	155156	A. BUILDING 00 B. WING	12/21/2015

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

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			Staff in-serviced on the proper disposal of sharps in a puncture resistant container. Audit to be completed 5x/week for proper disposal of sharps under the oversight of the DON or designee. **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:** **January 20, 2016**	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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 maintain a functional	F 0465	**F465**	01/20/2016

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	and safe environment related to dirty bathroom call light pull cords, dirty and rusted fixtures on 4 of 4 units throughout the facility. (The 100, 200, 300, and 400 Units) Findings include: An Environmental Tour was conducted on 12/21/15 beginning at 2:35 p.m., with the Administrator, Director of Plant Operations, and Director of Environmental Services. During the tour, the following was Observed: 1. 400 Unit a. Room 403: A dirty call light pull cord was observed in the bathroom. One resident resided in this room. b. Room 413: A dirty call light pull cord was observed in the bathroom. One resident resided in this room. 2. 300 Unit a. Room 309: A dirty call light pull cord was observed in the bathroom, the toilet chair was rusted, and the bottom of the bathroom closet doors were dirty. Two residents shared this bathroom. b. Room 312: A dirty call light pull cord		**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.* **1) Immediate actions taken for those residents identified:** Bathroom call light pull cords were replaced in rooms: 403,413,309,312,313,318,319,323,214/216, and room 103. The cane in room 103 was replaced with another device.	

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	was observed in the bathroom. One resident resided in this room. c. Room 313: A dirty call light pull cord was observed in the bathroom and there was a substance on the floor behind the toilet. Two residents shared this bathroom. d. Room 318: A dirty call light pull cord was observed in the bathroom and a substance was on the floor behind the toilet. Two residents shared this bathroom. e. Room 319: A dirty call light pull cord was observed in the bathroom. Two residents shared this bathroom. f. Room 323: A dirty call light pull cord was observed in the bathroom. Two residents shared this bathroom. 3. 200 Unit a. Rooms 214/216: A dirty call light pull cord was observed in the bathroom and the toilet chair was rusted. Three residents shared this bathroom. 4. 100 Unit: a. Room 103: The base of the cane next to bed A was rusted. (Resident #76)		**2) How the facility identified other residents:** Any bathroom call light cords with the nylon string have the potential to become soiled. All bathroom call light cords were replaced with a washable vinyl cording. An audit will be completed for assistive devices to determine if any additional devices have rust. Items with rust will be repaired or replaced. **3) Measures put into place/ System changes:** Facility will no longer use the nylon cording on the bathroom call light pull stations. An audit will be done 5x/week by maintenance with oversight by the administrator or designee to determine if call light cords are clean, and assistive devices are rust free. **4) How the corrective actions will be monitored:** The results of these audits will be	

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	At the time of the tour, the above facility staff indicated all areas were in need of cleaning and/or repair. 3.1-19(f)		reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. **5) Date of compliance:** **January 20, 2016**	