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	02/07/2017

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 IN00220704. Complaint IN00220704 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F505. Survey dates: February 6 & 7, 2017 Facility number: 000076 Provider number: 155156 AIM number: 100271060 Census bed type: SNF/NF: 88 SNF: 16 Total: 104 Census payor type: Medicare: 15 Medicaid: 64 Other: 25 Total: 104 Sample: 9 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/9/17.	F 0000		

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

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

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F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails			

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	with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.			
	Based on observation, record review, and interview the facility failed to ensure fall risk interventions were in place related to a Dycem (anti skid) pad not in place for 1 of 3 residents reviewed for falls in a sample of 9. (Resident G) Finding includes: On 2/7/17 at 3:20 p.m., Resident #G was observed in a wheel chair in the lounge area in front of the Nursing Station. LPN #1 and QMA/CNA #1 returned the resident to his room. The two staff members assisted the resident to a standing position. A cushion was in place on the seat. No Dycem pads were in place on top of or underneath the cushion. LPN #1 confirmed the resident was to have a Dycem in place. The record for Resident #G was reviewed on 2/7/17 at 2:24 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, altered mental status, and high blood pressure. A Fall Risk Assessment was completed	F 0323	**F323** **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:** The Dycem was replaced in the wheelchair for Resident #G.	03/06/2017

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	on 2/2/17. The resident was assessed to be at risk for falls. Admission Care Plans were initiated on 2/2/17. The resident had a history of falls, demonstrated poor safety awareness, a history of wandering and exit seeking, and was confused. Care Plan Interventions included, but were not limited to, anti roll backs to the wheel chair and a Dycem to the wheel chair. The placement of the Dycem was to be checked every shift. A Fall Investigation Worksheet was completed on 2/5/17. A fall occurred at 9:30 a.m. The resident was going to the Dining Room Door and stood up from the wheel chair. The resident fell to the ground on his buttock. No injuries were observed. A Fall Investigation Worksheet was completed on 2/6/17. A fall occurred at 10:30 a.m. The resident was sitting in the common area and the Nurse heard a bump and observed the resident sitting on the floor next to his wheel chair. Recommended interventions initiated at the time were for anti roll backs to be placed on the resident's wheel chair. A Fall Investigation Worksheet was completed on 2/6/17. A fall occurred at		**2) How the facility identified other residents:** All fall care plans were reviewed. Assessed fall interventions for continued appropriateness and verified they were in place. **3) Measures put into place/ System changes:** In-serviced staff on need to follow plan of care and the importance of fall interventions. An audit tool was developed to monitor the correct usage of fall interventions **4) How the corrective actions will be monitored:** DON or designee to audit three residents three times per week on a variety of units and on different shifts to verify that fall interventions are in place as per the plan of care. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is	

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	6:00 p.m. The resident was observed sitting on the floor in front of his wheel chair. No injuries were noted. The fall was not witnessed. Recommended interventions initiated at the time were for a Dycem to be applied to the wheel chair. The Director of Nursing was interviewed on 2/7/17 at 3:40 p.m. The resident should have had a Dycem in place to his wheel chair. The Dycem was placed yesterday after a fall occurred. This Federal tag relates to Complaint IN00220704. 3.1-45(a)(2)		achieved x3 consecutive months. **5) Date of compliance:** **03/06/2017**	
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			

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	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 and Responsible Party were notified of abnormal laboratory test results in a timely manner for 1 of 2 residents reviewed with Alert laboratory levels in a sample of 9. (Resident C) Finding includes: The closed record for Resident C was reviewed on 2/6/17 at 7:58 p.m. The diagnoses included, but were not limited to, heart failure, high blood pressure, right femur fracture, pulmonary fibrosis, and Alzheimer's disease. A Physician order was written on 12/26/16 for the resident to receive Apixoban (a blood thinner) 2.5 milligrams twice a day. The medication was not discontinued until the resident was discharged on 1/25/17. Laboratory test results indicated a CBC (Complete Blood Count) was completed on 1/12/17. The resident's Hemoglobin level was 8.4 (norm 14-18). The Physician signed the result notification and requested a CBC be repeated in 10 days.	F 0505	**F505** **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 has discharged from the facility.	03/06/2017

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	Another CBC was completed on 1/23/17. The Hemoglobin level was 7.0. The level was flagged as an Alert level. The results were reported to the facility on 1/23/17 at 2:44 p.m. The results page was not signed by the Physician until 1/24/17. Progress Notes related to the above 1/23/17 tests results were completed by Nursing on 1/24/17 at 9:49 a.m. The Physician was made aware of the resident's Hemoglobin level of 7.0. New laboratory orders were received and noted for Vitamin B12, Ferritin, and Folate levels to be completed. The Resident/POA was made aware. The Director of Nursing was interviewed on 2/7/17 at 9:30 a.m. The Director of Nursing confirmed the Physician was not notified of the Alert level until 1/24/17. All Alert laboratory results were to be called to the Physician at the time they were received from the laboratory. The facility policy titled "Physician/Family/Responsible Party Notification" indicated the facility was required to notify the resident, consult the Physician, and notify the resident's legal representative or an interested family member of any significant change in the resident's condition and any need to alter		**2) How the facility identified other residents:** All lab results were reviewed to determine if there were any lab results awaiting physician notification. **3) Measures put into place/ System changes:** All nurses educated on the necessity to notify physician of alert and critical lab results immediately upon receipt, and that all other labs will have physician notification within 24 hours. An audit was developed to monitor physician notification within a timely manner, and nurse on call will check in to each unit by 6PM to ask if any alert or critical results were received. **4) How the corrective actions will be monitored:** DON or designee will audit all labs five times a week for timely	

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	treatment. This Federal tag relates to Complaint IN00220704. 3.1-49(f)(2)		notification. Nurse on call will audit for the presence of critical or alert labs and confirm physician notification daily by 6PM. 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:** **03/06/2017**	