PRINTED: 02/21/2018
FORM APPROVED

CENTERS FOR	R MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039				
	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/30/2018				
	PROVIDER OR SUPPLIER N CARE ARBORS MICHIGAN CITY	1101 E	STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360					
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	COMPLETION DATE				
F 0000								
Bldg. 00	This visit was for the Investigation of Complaint IN00251670. Complaint IN00251670 - Substantiated.	F 0000						
	Federal/State deficiencies related to the allegations are cited at F689.							
	Survey date: January 30, 2018							
	Facility number: 000076 Provider number: 155156 AIM number: 200064830							
	Census Bed Type: SNF/NF: 93 SNF: 26 Total: 119							
	Census Payor Type: Medicare: 35 Medicaid: 69 Other: 15 Total: 119							
	This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.							
	Quality review completed on 1/31/18.							
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9TEC11 Facility ID: 000076 If continuation sheet Page 1 of 4

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155156		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/30/2018		
NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360 ID (X5)				
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
	adequate supervito prevent accided Based on observation interview, the facility supervision related during a transfer resutures for 1 of 3 results (Resident E) Finding includes: The closed record for 1/30/17 at 9:23 a.m. not limited to, Partifalling, anxiety dischemiplegia (weakn mental status. The Admission MI assessment, complex Resident E required staff members for the and toileting. The decision making weak A Fall Risk Assess indicated the resident was at A Care Plan, initiated resident had an AD self-care deficit reliparkinson's, requirit transfers, bed mobil Interventions included in lowest positions.	on, record review, and ity failed to provide adequate to not providing care in pairs sulting in a laceration requiring esidents reviewed for accidents. For Resident E was reviewed on a Diagnoses included, but were kinson's disease, history of order, high blood pressure, ess in extremities), and altered OS (Minimum Data Set) eted on 12/13/17, indicated di extensive assistance of two bed mobility, transfer, dressing, resident's cognitive skills for ere moderately impaired. In the side of the provide adequate to not provide adeq	F 00	589	F 689 Free of accidents hazards/supervision/devices. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s 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 take for those residents identified Resident E was discharged. 2) How the facility identification of the residents:	of ot ment the et	

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Event ID:

9TEC11

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If continuation sheet

Page 2 of 4

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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rnysician for suture removal. x3 consecutive months. The QA		2.2			l '			
		Physician for suture removal.						
Committee will identify any trends		D	1/20/10 - / 11/24 FI *			-	nds	
During an interview on 1/30/18 at 11:34 a.m., Unit or patterns and make		-				-		
Manager 3 indicated the CNA transferred the recommendations to revise the		_						
resident with one assist. The CNA got the plan of correction as indicated.			C			plan of correction as indicated.		
resident on the bed and he was not sitting far								
enough and the CNA went to pick the resident up								
and sit him back further and he sustained a skin 5) Date of compliance:								
tear to the leg. An investigation was initiated the February 26, 2018						February 26, 2018		
next day. The Nurses were interviewed. It was		next day. The Nurs	ses were interviewed. It was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9TEC11 Facility ID: 000076

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2018			
NAME OF PROVIDER OR SUPPLIER APERION CARE ARBORS MICHIGAN CITY			STREET ADDRESS, CITY, STATE, ZIP COD 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX					CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG		ULATORY OR LSC IDENTIFYING INFORMATION TAG		DEFICIENCY)		DATE		
	room. Disciplinary was terminated. During an interview Director of Nursing initiated due to the rappy indicated the transfer.	A was the only staff in the action was taken and the CNA on 1/30/18 at 2:50 p.m., the indicated Care in Pairs was resident's behaviors with staff, the resident was a 1-2 person ates to Complaint IN00251670.						

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