

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155156	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2018
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 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	<p>This visit was for the Investigation of Complaints IN00274176 and IN00275205.</p> <p>Complaint IN00274176 - Substantiated. Federal/State deficiencies related to the allegations are cited at F659.</p> <p>Complaint IN00275205 - Substantiated. Federal/State deficiencies related to the allegations are cited at F659.</p> <p>Survey dates: October 10 & 11, 2018</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 200064830</p> <p>Census Bed Type: SNF/NF: 115 SNF: 20 Total: 135</p> <p>Census Payor Type: Medicare: 25 Medicaid: 81 Other: 29 Total: 135</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on 10/15/18.</p>	F 0000		
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>facility, as outlined by the comprehensive care plan, must-</p> <p>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, facility failed to ensure care was provided by qualified staff related to the CNAs turning off a tube feeding pump for 1 of 3 residents observed with tube feedings infusing. (Resident F) (CNA 1 and CNA 2)</p> <p>Finding includes:</p> <p>On 10/10/18 at 9:50 a.m., Resident F was positioned on her back in bed. Tube feeding was infusing via an infusion pump. CNA 1 and CNA 2 entered the room to provide incontinence care. The CNAs removed the resident's brief. CNA 2 turned toward the tube feeding pump and asked CNA 1 if she could turn off the tube feeding pump. CNA 1 told CNA 2 to turn the pump on hold. CNA 2 then turned the tube feeding pump off. Both CNAs then started to turn the resident on her side.</p> <p>When asked if it was acceptable for CNAs to turn tube feeding pumps on or off, CNA 1 stated "No, I guess it's really not in our scope of practice." CNA 2 left the room at this time and returned with Unit Manager 3. The Unit Manager returned to the room with CNA 2. Unit Manager 3 indicated CNAs were not allowed to turn tube feeding infusion pumps on or off.</p> <p>The record for Resident F was reviewed on 10/10/18 at 1:41 p.m. Diagnoses included, but were not limited to, tracheostomy, gastrostomy tube, history of pneumonia, multiple contractures, and dependence on a ventilator.</p>	F 0659	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>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.</i></p> <p>1.) Immediate actions taken for those residents identified: Unit Manager 3 (Nurse) immediately responded to the room of Resident F and attended to the tube feeding pump. The pump was returned to on as prescribed by the attending physician. Resident F was assessed by the Unit manager 3 (Nurse).</p> <p>2.) How the facility identified other residents: Six other infusion therapy residents could have been affected by this practice however this was an isolated incidence.</p> <p>3.) Measures put into place/System changes:</p>	10/20/2018

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	<p>An Admission MDS (Minimum Data Set) assessment was completed on 7/24/18. The resident was rarely or never understood and displayed no behaviors or rejection of care. Extensive assistance of (2) staff members was needed for bed mobility, transfers, dressing, and personal hygiene.</p> <p>When interviewed on 10/10/18 at 10:10 a.m., the Director of Nursing indicated CNAs were not allowed to turn off tube feeding pumps. This was to be performed only by Nurses. The CNAs had been educated to call for a Nurse to turn off or start any tube feeding pumps.</p> <p>The facility Certified Nursing Assistant Job Description was reviewed. Turning tube feeding pumps on or off was not included in the Job Description.</p> <p>This Federal tag relates to Complaints IN00274176 and IN00275205.</p> <p>3.1-35(g)(2)</p>		<p>C.N.As were immediately educated on the correct practice and the limited scope of their duty while the State Surveyor was in the building. Housewide inservices for C.N.As were completed on the same information within twenty-four hours.</p> <p>4.) How the correction actions will be monitored: Each of the four units of the community has a Unit Manager. Nurse supervisors report to the unit managers and each nurse station has a nurse. The staff nurse will manage the pumps for nutritional support. The nurse supervisor will monitor for best practice in this area making sure that C.N.As remain within their scope of duty and do not manipulate feeding pumps. Unit Managers will audit along with nursing supervisors five days a week at various times for three weeks, then once a shift per month for three months for continued compliance. Any deviation from this practice will be reported to the unit manager and on to the Director of Health Services and the QAPI team.</p>	