

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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F000000	<p>This visit was for the Investigation of Complaint IN00136138.</p> <p>Complaint IN00136138-Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F323.</p> <p>Survey date: September 12, 2013</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Survey team: Janet Adams, RN, TC Heather Hite, RN</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 7 Medicaid: 43 Other: 7 Total: 57</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandate submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully</p>	
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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 that other safeguards 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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	Quality review completed on September 17, 2013, by Janelyn Kulik, RN.		request consideration of paper compliance for the cited deficiencies.		

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review, and interview, the facility failed to ensure the resident's family/responsible party was notified of a sexual occurrence between the two residents for 1 of 4</p>	F000157	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility notified resident D's POA of the occurrence that happened on	10/08/2013			

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	<p>residents in the sample of 5 reviewed for family/responsible party notification. (Residents #D and #E)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 9/12/13 at 9:10 a.m. The resident's diagnoses included, but were not limited to, senile dementia, delusional disorder, insomnia, anxiety disorder, and high blood pressure. A POA (Power of Attorney) document in the resident's record indicated the resident's daughter was his POA. The face sheet in the front of the resident's record indicated his daughter was also the resident's responsible party.</p> <p>The 7/12/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (4). A score of (4) indicated the resident's cognitive patterns were impaired.</p> <p>Review of the 8/2013 and 9/2013 Nursing Progress Notes indicated there was no documentation of the resident's daughter being informed of any occurrence between the resident and his roommate on 8/31/13 or on</p>		<p>08/31/2013 and room mates allegations on 09/04/2013. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A full facility audit orders and IDA reports for the past 30 days was conducted to ensure all families have been notified change in condition or status. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur :Nursing Staff were educated by SDC regarding the policy and procedure for physician and family notification. Education was initiated 09/25/2013 and will be complete by 10/08/2013. Unusual occurrence education was initiated 09/16/2013 and will be on going to include all departments. This will be complete by 10/08/2013. Investigations will be conducted by Nursing Administration and discussed with the interdisciplinary team during the daily clinical meeting (Monday-Friday). On weekends unusual occurrences will be reported to nurse manager on duty And she will notify the DON and the Administrator per protocol. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Director of Nursing or designee will conduct an audit of the Physicians orders and IDA</p>				

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	<p>9/4/13 of any allegations made indicating the resident had touched another residents perineal area.</p> <p>When interviewed on 9/12/13 at 10:30 a.m., the Social Worker indicated there was a recent incident reported to her indicating a Nurse had entered the resident's room and observed the resident next to his roommate's bed and consensual sexual contact was occurring between the two residents. The Social worker indicated the Director of Nursing informed her of the occurrence.</p> <p>When interviewed on 9/12/13 at 10:55 a.m., the Director of Nursing indicated on 8/31/13 at approximately 6:30 p.m., she received a call from the Nurse assigned to care for Resident #D. The Nurse reported she had witnessed an occurrence of consensual contact between Resident #D and his roommate (Resident #E). The Director of Nursing indicated Resident #E spoke with her on 9/4/13 and indicated Resident #D had touched him and the resident pointed to the front of his perineal area. The Director of Nursing indicated Resident #D's daughter was his POA and responsible party and the daughter had not informed of the 8/31/13 occurrence or the event Resident #E</p>		<p>reporting system on a weekly basis for 12 weeks and then bi weekly for 8 weeks and then monthly for 2 months to insure physicians and families have been notified of any condition or status change. Staff education to be provided as necessary. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain is: 10/08/2013</p>				

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	<p>reported to her on 9/4/13.</p> <p>The facility policy titled "Changes in Resident's Condition or Status" was reviewed on 9/12/13 at 9:20 a.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current.</p> <p>The policy indicated the resident, attending Physician, and representative were to be notified of changes in the resident's condition and/or status. The policy also indicated notifications were to be made as soon as practical, not exceeding (24) hours.</p> <p>This federal tag relates to Complaint IN00136138.</p> <p>3.1- 5(a)(2)</p>				

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F000323 SS=D	<p>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 ensure adequate supervision was provided to protect other residents in the facility after accusations were made related to unwanted touching by the resident. (Resident #D) The facility also failed to ensure adequate supervision plans were in place to protect a resident after another resident verbalized intent to hit the resident. (Residents #D and #E)</p> <p>Findings include:</p> <p>1. On 9/12/13 at 9:00 a.m., Resident #D was observed sitting in a chair in the lounge area near the front entrance to the facility. Several other residents were present in the lounge area. The resident was watching a television program.</p> <p>The record for Resident #D was reviewed on 9/12/13 at 9:10 a.m. The resident's diagnoses included, but were not limited to, senile dementia, delusional disorder, insomnia, anxiety</p>	F000323	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility initiated behavior monitoring for residents D and E on 09/12/2013 for engaging in unwanted touching contact with others. Resident E was moved on 09/04/2013 to the west unit to a private room. Behavior tracking for physical aggression was already in place and will continue for resident E. Behavior tracking for verbal aggression was put in place for resident E. Both care plans were updated regarding unwanted touching for resident D and E. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All residents have the potential to be affected by the deficient practice. The behavior monitor tracking tool will be reviewed by DON or designee and Social Services for resident E 1 time weekly. SDC Educated nursing staff on reporting unusual occurrences initiated on 09/16/2013 to be completed by 10/08/2013. All staff to be educated on abuse and</p>	10/08/2013			

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	<p>disorder, and high blood pressure. A POA (Power of Attorney) document in the resident's record indicated the resident's daughter was his POA. The face sheet in the front of the resident's record indicated his daughter was also the resident's responsible party.</p> <p>The 7/12/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (4). A score of (4) indicated the resident's cognitive patterns were impaired.</p> <p>When interviewed on 9/12/13 at 10:30 a.m., the Social Worker indicated there was a recent incident reported to her indicating a Nurse had entered the room of Residents #D and #E and observed one of the residents standing next to the other residents bed and consensual sexual contact between the two residents was observed. The Social worker indicated the Director of Nursing informed her of the occurrence.</p> <p>When interviewed on 9/12/13 at 10:55 a.m., the Director of Nursing indicated on 8/31/13 at approximately 6:30 p.m., she received a call from the Nurse assigned to care for</p>		<p>neglect and resident rights to be initiated 09/30/2013 and complete by 10/08/2013. Resident E was moved to the West side of facility in a private room and Resident D and E do not eat meals in the same dining room. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur :Staff was in serviced on 09/16/2013 and is ongoing regarding the policy and procedure for reporting unusual occurrences. This education will be completed by 10/08/2013. Staff to be educated on abuse and neglect and resident rights to be initiated 09/30/2013 and complete by 10/08/2013. Unusual occurrences investigations will be conducted by Nursing Administration and discussed with the interdisciplinary team during the daily clinical meeting (Monday through Friday). Weekend manager will initiate any investigations that occur Saturday and Sunday and will notify DON and Administrator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Director of Nursing or designee will conduct an audit on 5 random residents on the completed "Behavior Monitoring Tracking Log" once a week for 12 weeks then bi-weekly times 8 weeks, then monthly times 2 months any issues will be addressed immediately. Audit results and system components</p>		

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	<p>Resident #D. The Nurse reported to her she had witnessed an occurrence of consensual contact which involved masturbation between Resident #D and Resident #E (his roommate). The Director of Nursing indicated Resident #E spoke with her on 9/4/13 and indicated Resident #D had touched him and the resident pointed to the front of his perineal area. The Director of Nursing indicated Resident #E requested a room change and said to her "if he comes to my bed I'm goin' to hit him." The Director of Nursing indicated Resident #E was moved to another room after the above interview with the resident.</p> <p>The Resident #D's current care plans were reviewed on 9/12/13 at 1:00 p.m. A care plan initiated on 11/20/12 indicated the resident had cognitive impairment skills. The care plan was last updated with a target goal of 10/31/13. The 9/2013 Behavior Monthly Flow Record indicated the only two behaviors being monitored were "delusions expressed" and "refusing care." There was no documentation in the resident's record related to protecting resident #D related to any threats of his roommate hitting him. There was no documentation of plans to supervise Resident #D's behaviors related to</p>		will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain is: 10/08/2013		

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	<p>accusations made that the resident had touched another resident in the perineal area.</p> <p>When interviewed on 9/12/13 at 2:20 p.m., the Social Worker indicated there were no behavioral monitoring plan in place to monitor Resident #D to ensure he did not touch other residents in the facility without consent after the allegations made by Resident #E on 9/4/13.</p> <p>When interviewed on 9/12/13 at 2:20 p.m. the Director of Nursing indicated no Behavior Plan was in place to ensure Resident #D was supervised to attempt to prevent the resident from unwanted touching of any other residents or protecting the resident from harm by Resident #E. The Director of Nursing indicated resident's roommate (Resident #E) was moved to another unit.</p> <p>This federal tag relates to Complaint IN00136138.</p> <p>3.1-45(a)(2)</p>			

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