

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2011
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN46975
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F0000	<p>This visit was for the Investigation of Complaint #IN00100377.</p> <p>Complaint #IN00100377 Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, and F309.</p> <p>Survey dates: December 6-8, 2011</p> <p>Facility number: 000325 Provider number: 155379 Aim number: 100274300</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Census payor type: Medicare: 10 Medicaid: 70 Other: 25 Total: 105</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/8/11</p>	F0000	<p><u>Allegation of Compliance</u> <u>Please accept the following plan of correction for the complaint survey on December 8, 2011. Life Care Center of Rochester respectfully requests consideration for a desk review of the following plan of corrections. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community.</u></p>	

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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F0225 SS=D	<p>Cathy Emswiller RN</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interviews, the facility failed to thoroughly investigate</p>	F0225	1.The bruise on resident "D" had previously resolved.	12/22/2011	

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	<p>a fall which resulted in a 16 cm (centimeter) X 4 cm and a 6 cm X 6 cm bruise for 1 of 1 residents in a sample of 3 reviewed for falls and bruises. (Resident "D")</p> <p>Findings include:</p> <p>During the initial tour, on 12/06/11 between 2:00 and 3:00 p.m., while accompanied by Unit Manager #2, Resident "D" was identified as having a recent fall and resulting in a bruise across his back. The record for Resident "D" was reviewed on 12/07/11 at 9:20 a.m. and indicated diagnoses including, but not limited to, emphysema, personality disorder, depression, esophageal reflux, and hypertension.</p> <p>Review of nurses notes indicated: "11/20/11 0 (no) AE (adverse effects) R T (related to) Flu Vaccine." The next entry in the nurses notes indicated: "11/28/11 9:45 p (p.m.) Received information that resident had been found sitting on bathroom floor on 11/22/28 (sic). He has two fading bruises to back. Areas greenish in color at this time. Measurements (1) 16 cm (centimeters) X 4 cm, (2) 6 cm X 6 cm...physician notified along c (with) (name), legal gardian (sic)."</p>		<p>2.Residents that have fallen since December 8, 2011 were reviewed to ensure fall investigations were thoroughly completed and head to toe assessments were audited for accuracy.</p> <p>3.Licensed nurses will be re-educated by the Director of Nursing and Staff Development Coordinator by December 20, 2011, education will include review of Incident Data Archive process and completion of witness statements. DON or designee will audit to ensure the facility thoroughly investigates a fall resulting in a bruise at least three (3) times weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4.The results of these audits will be presented to the monthly Performance Improvement committee. The Performance Improvement committee will reevaluate the continued need of auditing; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>		

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	<p>Review of the computer generated "Daily Care" forms, for 11/2011 and 12/2011, indicated the Resident "D" received a shower on 11/21/11 and 12/5/11. Resident "D" received "Sponge Bath" (for freshening up and/or peri-care) a minimum of 1 time a day every day of November through December 7, 2011.</p> <p>Review of the "Weekly Skin Integrity Data Collection" form, from 11/18/11 through 12/06/11, indicated "Skin Intact/Dry" on 11/22/11 and 11/25/11. The entries were signed by LPN #3. The entry for 11/29/11 indicated "Bruises", and was signed by LPN #4.</p> <p>Review of the fall investigation, initiated on 11/28/11, indicated: "11/22/11 8:00 p.m...Summary of Investigative Facts: .Res found on floor. When asked what happened he stated he slipped & fell. Bruise noted to back. Recommendations/Actions Taken: Maint (maintenance) check of environment, therapy screen. Med review sent to pharmacy; nonskid strips placed in front of toilet.... Follow-up: 12/02/11: 0 (no) further issues. Non-skid strips placed in front of toilet. Therapy screen, 0 recommendations. Education provided to staff (11/30/11)." Review of a signed education form indicated LPN #7 was not</p>				

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	<p>notified of the fall by CNA #5.</p> <p>Unit Manager #2 was interviewed on 12/07/11 at 1:05 p.m. and indicated the fall investigation was initiated on 11/28/11. The Unit Manager indicated CNA #5 reported the unwitnessed fall to the evening nurse, LPN #7, on 11/22/11. CNA #5, when caring for Resident "D" on 11/28/11, noted the bruising and reported it to Unit Manager #2. Unit Manager #2 did not know why direct care staff did not note or report bruising to the back during the 6 days between care provided by CNA #5. The Unit Manager indicated staff who provided sponge baths and/or showers were not queried as to skin observations which occurred between 11/22/11 and 11/28/11.</p> <p>Review of a policy and procedure, titled, "INDIANA STATE DEPARTMENT OF HEALTH: Division of Long Term Care: REPORTABLE UNUSUAL OCCURRENCES", provided by the Regional Nurse on 12/07/11 at 9:30 a.m., indicated:</p> <p>I. Occurrences to be Reported... (6) SIGNIFICANT INJURIES A) Examples, but not inclusive of all:... 2) large areas of contusions or large lacerations as defied in facility policy;..."</p>				

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	<p>Interview with the Administrator, on 12/07/11 at 10:00 a.m., indicated the facility did not have a policy to define what areas of contusions or lacerations were to be reported.</p> <p>The DNS (Director Nursing Services) was interviewed on 11/08/11 at 9:20 a.m. The DNS indicated the fall was investigated following the Unit Director's knowledge of the incident on 11/28/11. The DNS indicated the investigation concluded the bruise was from the unwitnessed fall reported by CNA #5 and therefore, did not fall in the facility's policy and procedure of reporting.</p> <p>This federal tag relates to Complaint #IN00100377.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>				

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F0226 SS=D	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interviews, the facility failed to follow their Policy and Procedure in regards to reporting a significant injury thoroughly following a fall which resulted in a 16 cm (centimeter) X 4 cm and a 6 cm X 6 cm bruise for 1 of 1 residents in a sample of 3 reviewed for falls and bruises. (Resident "D")</p> <p>Findings include:</p> <p>During the initial tour, on 12/06/11 between 2:00 and 3:00 p.m., while accompanied by Unit Manager #2, Resident "D" was identified as having a recent fall and resulting in a bruise across his back. The record for Resident "D" was reviewed on 12/07/11 at 9:20 a.m. and indicated diagnoses including, but not limited to, emphysema, personality disorder, depression, esophageal reflux, and hypertension.</p> <p>Review of nurses notes indicated: "11/20/11 0 (no) AE (adverse effects) R T (related to) Flu Vaccine." The next entry in the nurses notes indicated:</p>	F0226	<p>1.The facility followed its policy and procedure for reporting bruises of unknown origin.</p> <p>2.Residents that have fallen since December 8, 2011 were reviewed to ensure fall investigations were thoroughly completed and head to toe assessments were audited for accuracy.</p> <p>3.The facility developed a policy and procedure to define what areas of contusions or lacerations were to be reported (attachment A). Facility staff will be re-educated by the Executive Director and Staff Development Coordinator by December 20, 2011, on reporting guidelines of alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, misappropriation of resident property and contusions and lacerations greater than ten centimeters. The ED or designee will review the "Weekly Skin Integrity Data Collection" forms to ensure appropriate reporting is followed at least two (2) times weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4.The results of these audits will be presented to the monthly Performance Improvement</p>	12/22/2011	

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	<p>"11/28/11 9:45 p (p.m.) Received information that resident had been found sitting on bathroom floor on 11/22/28 (sic). He has two fading bruises to back. Areas greenish in color at this time. Measurements (1) 16 cm (centimeters) X 4 cm, (2) 6 cm X 6 cm...physician notified along c (with) (name), legal gardian (sic)."</p> <p>Review of the computer generated "Daily Care" forms, for 11/2011 and 12/2011, indicated the Resident "D" received a shower on 11/21/11 and 12/5/11. Resident "D" received "Sponge Bath" (for freshening up and/or peri-care) a minimum of 1 time a day every day of November through December 7, 2011.</p> <p>Review of the "Weekly Skin Integrity Data Collection" form, from 11/18/11 through 12/06/11, indicated"Skin Intact/Dry" on 11/22/11 and 11/25/11. The entries were signed by LPN #3. The entry for 11/29/11 indicated "Bruises", and was signed by LPN #4.</p> <p>Review of the fall investigation, initiated on 11/28/11, indicated: "11/22/11 8:00 p.m...Summary of Investigative Facts: .Res found on floor. When asked what happened he stated he slipped & fell. Bruise noted to back. Recommendations/Actions Taken: Maint (maintenance) check of environment,</p>		<p>committee. The Performance Improvement committee will reevaluate the continued need of auditing; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated</p>		

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	<p>therapy screen. Med review sent to pharmacy; nonskid strips placed in front of toilet...</p> <p>Follow-up: 12/02/11: 0 (no) further issues. Non-skid strips placed in front of toilet. Therapy screen, 0 recommendations. Education provided to staff (11/30/11)." Review of a signed education form indicated LPN #7 was not notified of the fall by CNA #5.</p> <p>Unit Manager #2 was interviewed on 12/07/11 at 1:05 p.m. and indicated the fall investigation was initiated on 11/28/11. The Unit Manager indicated CNA #5 reported the unwitnessed fall to the evening nurse, LPN #7, on 11/22/11. CNA #5, when caring for Resident "D" on 11/28/11, noted the bruising and reported it to Unit Manager #2. Unit Manager #2 did not know why direct care staff did not note or report bruising to the back during the 6 days between care provided by CNA #5. The Unit Manager indicated staff who provided sponge baths and/or showers were not queried as to skin observations which occurred between 11/22/11 and 11/28/11.</p> <p>Review of a policy and procedure, titled, "INDIANA STATE DEPARTMENT OF HEALTH: Division of Long Term Care: REPORTABLE UNUSUAL OCCURRENCES", provided by the</p>			

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	<p>Regional Nurse on 12/07/11 at 9:30 a.m., indicated:</p> <p>I. Occurrences to be Reported... (6) SIGNIFICANT INJURIES A) Examples, but not inclusive of all:... 2) large areas of contusions or large lacerations as defied in facility policy;..."</p> <p>Interview with the Administrator, on 12/07/11 at 10:00 a.m., indicated the facility did not have a policy to define the size of contusions or lacerations to be reported.</p> <p>The DNS (Director Nursing Services) was interviewed on 11/08/11 at 9:20 a.m. The DNS indicated the fall was investigated following the Unit Director's knowledge of the incident on 11/28/11. The DNS indicated the investigation concluded the bruise was from the unwitnessed fall reported by CNA #5 and therefore, did not fall in the facility's policy and procedure of reporting.</p> <p>This federal tag relates to Complaint #IN00100377.</p> <p>3.1-28(a)</p>				

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F0309 SS=D	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to accurately assess and monitor a bruise for 1 of 1 residents in a sample of 3 reviewed for bruises. (Resident "D")</p> <p>Finding includes:</p> <p>During the initial tour, on 12/06/11 between 2:00 and 3:00 p.m., while accompanied by Unit Manager #2, Resident "D" was identified as having a recent fall and resulting in a bruise across his back. The record for Resident "D" was reviewed on 12/07/11 at 9:20 a.m. and indicated diagnoses including, but not limited to, emphysema, personality disorder, depression, esophageal reflux, and hypertension.</p> <p>Review of nurses notes indicated: "11/20/11 0 (no) AE (adverse effects) R T (related to) Flu Vaccine." The next entry in the nurses notes indicated: "11/28/11 9:45 p (p.m.) Received information that resident had been found sitting on bathroom floor on 11/22/28 (sic). He has two fading bruises to back.</p>	F0309	<p>1.A skin assessment was completed on resident "D" on December 14, 2011 with no bruises noted.</p> <p>2.Resident skin assessments will be completed by December 19, 2011 to ensure all bruises were documented on nurse's notes and monitored as needed.</p> <p>3.Licensed nurses will be re-educated by the Director of Nursing and Staff Development Coordinator by December 20, 2011; education will include review of policy and procedure for completing weekly skin assessments and required documentation. The DON or designee will review the "Weekly Skin Integrity Data Collection" forms to ensure documentation is completed as appropriate at least two (2) times weekly for four (4) weeks and continue weekly for no less than two (2) additional months.</p> <p>4.The results of these audits will be presented to the monthly Performance Improvement committee. The Performance Improvement committee will reevaluate the continued need of auditing; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>	12/22/2011	

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	<p>Areas greenish in color at this time. Measurements (1) 16 cm (centimeters) X 4 cm, (2) 6 cm X 6 cm...physician notified along c (with) (name), legal gardian (sic)."</p> <p>Review of the computer generated "Daily Care" forms, for 11/2011 and 12/2011, indicated the Resident "D" received a shower on 11/21/11 and 12/5/11. Resident "D" received "Sponge Bath" (for freshening up and/or peri-care) a minimum of 1 time a day every day of November through December 7, 2011.</p> <p>Review of the "Weekly Skin Integrity Data Collection" form, from 11/18/11 through 12/06/11, indicated"Skin Intact/Dry" on 11/22/11 and 11/25/11. The entries were signed by LPN #3. The entry for 11/29/11 indicated "Bruises", and was signed by LPN #4.</p> <p>The back area of Resident "D" was observed, accompanied by LPN #6, on 12/07/11 at 9:50 a.m. A minimally yellow shadowy area, approximately 5 cm X 6 cm, was visible on the right lower back of Resident "D".</p> <p>Unit Manager #2 was interviewed on 12/07/11 at 1:05 p.m. and indicated the fall investigation was initiated on 11/28/11. The Unit Manager indicated CNA #5 reported the unwitnessed fall to</p>				

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	<p>the evening nurse on 11/22/11. CNA #5, when caring for Resident "D" on 11/28/11, noted the bruising and reported it to Unit Manager #2. Unit Manager #2 did not know why direct care staff did not note or report bruising to the back during the 6 days between care provided by CNA #5.</p> <p>Review of an undated policy and procedure, titled, "Post-admission Weekly Skin Assessment", provided by the DNS (Director Nursing Services) on 11/08/11 at 9: 20 a.m., indicated: "...On a weekly basis, a licensed professional searches for area of skin that differ form surrounding tissue. These areas may be painful, firm, boggy, soft, warmed, or cooler in temperature compared to adjacent tissue,..."</p> <p>The results of skin assessment are documented on the 'Weekly Skin Integrity Data Collection' form...."</p> <p>This federal tag relates to Complaint #IN00100377.</p> <p>3.1-37(a)</p>						