

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 04/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
---	---

(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 000 Bldg. 00	<p>This visit was the Investigation of Complaint #IN00170818.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00169306</p> <p>Complaint #IN00170818 - Substantiated. Federal/State deficiency related to the allegations is cited at F157.</p> <p>Survey dates: March 30, 31, April 1, 2, 6 and 7, 2015</p> <p>Facility number: 000325 Provider number: 155379 AIM number: 100274300</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census payor type: Medicare: 12 Medicaid: 50 Other: 13 Total: 75</p> <p>Sample: 3</p>	F 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
---	---

(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 157 SS=D Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
---	---

(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
	<p>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 interviews, the facility failed to ensure an injury was reported to the family timely for 1 of 3 residents reviewed. (Resident C)</p> <p>Finding includes:</p> <p>The clinical record for Resident C was reviewed on 04/06/15 at 11:00 A.M. Resident C was originally admitted to the facility on 07/02/13, and most recently readmitted to the facility on 04/02/15, with diagnosis, including but not limited to edema, right below the knee amputation, diabetes mellitus, osteomyelitis, morbid obesity and recent amputation of the left third toe.</p> <p>A podiatrist exam note, dated 12/15/14, indicated the podiatrist had drained an abscess located on the distal tip of the resident's third toe on her left foot. The podiatrist ordered betadine ointment [antiseptic ointment] and bandaid to the area until it was healed.</p> <p>The facility non pressure wound documentation, from 12/15/14 to</p>	F 157	<p>F Tag 157 Notification of Family</p> <p><i>What Corrective action will be accomplished for those residents found to be affected by the deficient practice?</i></p> <p>Facility will follow it's policy to ensure any changes of condition for resident C will be reported to the family timely</p> <p>.</p> <p><i>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>Full facility audit of incidents and significant changes for the past 30 days was conducted to ensure timely reporting of incidents and significant changes to families/responsible parties.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>Staff Development Coordinator will educate new staff upon hire on the importance of notification and</p>	05/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
---	---

(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
	<p>01/19/15, indicated the resident's third toe area was assessed and treated until the area resolved on 01/19/15.</p> <p>A nursing progress note, dated 03/19/15 at 11:25 P.M., indicated the following: "Res [Resident] left foot third toe old area re-opened. res foot/toe was laying up against the foot of bed. [physician's name] notified for tx [treatment], staff given instructions to raise foot of bed and boost res up so toe does not lay against footboard cont [continue] to monitor."</p> <p>Nursing progress notes, from 03/19/15 through 03/23/15 at 12:44 P.M., indicated although the physician and the nursing unit manager were contacted regarding the resident's toe injury and the continued deteriorating condition of the resident's toe, there was no documentation the resident's family was notified of the toe injury.</p> <p>A nursing progress note, dated 03/23/15 at 1:13 P.M., indicated the resident's responsible party, her son was telephoned regarding the issue with the resident's toe and the conversation with her physician, and the physician's order to send the resident to the acute care facility for treatment.</p> <p>The face sheet for Resident C and</p>		<p>review policy and procedure.</p> <p>Director of Nursing will re-educate nursing staff on notifying POA/Family of any change of condition or incidents. Director of Nursing will institute audit tool</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>Director of Nursing or designee to audit 10 random charts 3x a week for 2 weeks; then 2x a week for 2 weeks; then 1x a week for 2 months; then 1x a month for 6 months. Audit results and system components will be reviewed during monthly PI/QA committee meeting with subsequent plans of correction developed and implemented as deemed necessary</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155379	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
---	---

(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
	<p>admission documentation indicated although the name and phone number of her spouse were listed as "Next of kin," the resident's son's name and phone number was listed as "Call 1st" and the durable Power of Attorney forms, located on the chart, indicated the resident's son as her power of attorney.</p> <p>During an interview on 04/07/2015 at 3:56 P.M., the Director of Nursing indicated the nurse involved had been contacted and said she left a message for the son but he did not call back and she did not chart the notification.</p> <p>This Federal tag relates to Complaint #IN00170818.</p> <p>3.1-5(a)(1)</p>			