

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2011
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HWY 20 E MICHIGAN CITY, IN46360
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F0000	<p>This visit was for the Investigation of Complaint IN00100394.</p> <p>Complaint IN00100394- Substantiated. Federal/State deficiencies related to the allegation are cited at F225, F226, F282, and F323.</p> <p>Survey dates: November 30, 2011 December 1 & 2, 2011</p> <p>Facility number: 000236 Provider number: 155344 AIM number: 100287700</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 21 Medicaid: 55 Other: 12 Total: 88</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings</p>	F0000	<p>Note: This provider wishes this Plan of Corrections to be considered as our credible allegation of compliance. Preparation and or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of Deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provision of the Federal and State laws.</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>cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/05/11 by Suzanne Williams, 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 observation, record review, and</p>	F0225	Resident B bruises healed from	01/01/2012

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	<p>interview, the facility failed to ensure 1 of 1 allegation of sexual abuse and 2 of 3 allegations of injuries of unknown origin were thoroughly investigated for 2 of 5 residents reviewed for allegations of abuse and injuries of unknown origin in the sample of 10. (Residents #D and #G)</p> <p>Findings include:</p> <p>1. On 12/1/11 at 8:25 a.m., Resident #G was observed sitting in high back wheelchair in the dining room. There was an alarm in place to the wheelchair.</p> <p>The record for Resident #G was reviewed on 12/1/11 at 11:15 a.m. The resident's diagnoses included, but were not limited to, dementia, arthritis, depression, vertigo, difficulty walking, and osteoarthritis.</p> <p>The 8/31/11 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (7). A score of (7) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance of one staff member for bed mobility, transfers, dressing, personal hygiene, and toilet use.</p> <p>Review of the October 2011 Nurses'</p>		<p>10/7/2011. Bruises noted on Resident G on 10/14/2011 were determined to be from a previous fall per resident interview. Causes for current bruises have been identified and documented per facility policy. Resident D bruise from 9/25/2011 healed. The 3-11pm nurse's statement was obtained and contained no information of value to the investigation. Causes for current bruises have been identified and documented per facility policy. Alert and oriented residents were interviewed for possible abuse by the social service department on 12/9/2011 and 12/12/2011, and all other resident's skin was assessed for injuries of unknown origin and abuse on 12/8/2011. Those with injuries of unknown origin were investigated immediately by the DON/Designee and documented per facility policy. Allegation of abuse and injuries of unknown origin will be investigated completely and immediately by ED/designee per facility policy. A new investigation check-off sheet and call log was initiated with the current abuse procedures. Staff were Inservice on 12/2/2011 and 12/5/2011 on the policy and procedure of abuse and investigations by Administration. Nurses were In-serviced by the Staff Development Coordinator (SDC) on proper documentation and follow up with resident</p>		

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	<p>Notes indicated an entry was made on 10/7/11 at 8:00 p.m. This entry indicated the CNA found a bruise on the resident's left lower arm. The bruise measured 5.5 cm (centimeters) x 6 cm. The entry also indicated the resident did not know how it got there. The next entry was made on 10/8/11 at 1:00 a.m. This entry indicated the bruise remained to the resident's left lower arm and the resident had no complaints. An entry made 10/12/11 at 10:00 a.m. indicated the entry was made as a PIA (pressure/accident/incident) entry. The entry indicated a bruise was noted to the resident's left arm on 10/7/11. There was no documentation of any investigation to determine the cause of the bruise in this entry.</p> <p>An entry made in the Nurses' Notes on 10/14/11 at 10:30 p.m., indicated a CNA found a bruise to the resident's left arm measuring 15.2 cm x 8 cm. When the resident was asked what happened, the resident's roommate stated the resident fell in the morning and the roommate went and got help. The next entry was made on 10/15/11 at 2:00 a.m. This entry indicated the resident had a bruise to the left arm measuring 15.2 cm x 8 cm and the resident denied pain. The next entry was made on 10/15/11 at 11:00 a.m. This entry indicated the writer spoke to the resident regarding the bruise on her arm</p>		<p>changes in condition on 12/5/2011. Staff will be in-serviced on abuse and reporting and investigation of abuse and injuries of unknown origin monthly X3 and quarterly thereafter by the SDC. The ED/designee will audit the 24 hour report sheets, Incidents and Accidents, resident, family and staff complaints on working business days Monday –Friday for potential abuse. The weekend manager is available for immediate notification of potential abuse. All new staff will continue to be educated on abuse polices in orientation and in ongoing education by the SDC. Allegations of abuse and injuries of unknown origin will be reported to the Performance Improvement Committee monthly. The ED is responsible for ensure on-going compliance. Compliance date is January 1, 2012.</p>		

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	<p>and the resident denied abuse or mistreatment. The resident also stated she fell in the bathroom, and when asked if she had gotten up on her own, the resident stated "no, the girls helped me." The entry also indicated the resident was unable to identify who helped her.</p> <p>When interviewed on 12/2/11 at 1:05 p.m., the Director of Nursing indicated there was no investigation of the 5.5 cm x 6 cm bruise observed to the resident's left lower arm on 10/7/11.</p> <p>When interviewed on 12/1/11 at 3:15 p.m., the Director of Nursing indicated all injuries of unknown origin, including bruises, required an investigation.</p> <p>When interviewed on 12/2/11 at 12:00 p.m., the Assistant Director of Nursing indicated she was informed of the 10/14/11 bruise. The Assistant Director of Nursing indicated the Nurse called her the evening it occurred. The Assistant Director of Nursing indicated she came into facility the next day and talked with the resident and the resident's roommate. The Assistant Director of Nursing indicated the roommate was legally blind and the roommate told her the resident was on the floor in the bathroom, and she went to the hallway and yelled for help. The Assistant Director of Nursing</p>				

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	<p>indicated she interviewed the two midnight CNAs and the midnight Nurse and also the Nurse and the two CNAs who worked the day shift that day related to the bruise and if the resident had a fall. The staff members stated they did not observe the resident have any fall or any other occurrence related to the bruise or hearing the resident or roommate yelling for help. The Assistant Director of Nursing indicated she did not interview the CNA who was working the evening shift on the day the bruise was observed. The Assistant Director of Nursing indicated she did not document any of the staff interviews she completed. The Assistant Director of Nursing also indicated the facility policy indicates all staff involved with the resident over the past 24 hours were to be interviewed, and she should have interviewed the evening shift CNA that was working to complete the investigation of the cause of the resident's bruise. The Assistant Director of Nursing also indicated she did not complete an investigation of the bruise observed on 10/7/11.</p> <p>2. The record for Resident #D was reviewed on 11/30/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, convulsions, iron deficiency anemia, encephalopathy, and osteoarthritis.</p>				

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	<p>Review of the September 2011 Nurses' Notes indicated an entry was made on 9/25/11 at 1:30 a.m. The entry indicated a new bruise was observed to the resident's left outer buttock measuring 10 cm (centimeters) x 4 cm. The entry indicated the bruise was "possibly from seizure in sleep." The resident was unaware of the bruise. Review of the Nurses' Notes from 9/16/11 through 9/25/11 indicated there was no documentation of the resident having a fall or any injury. Review of the Nurses' Notes from 9/25/11 through 10/4/11 indicated there was no documentation related to an investigation of how the resident's bruise occurred.</p> <p>Review of the November 2011 Nurses' Notes of an entry made on 11/22/11 at 5:45 a.m. indicated the resident was found on the floor in the bathroom and was having a seizure. A cut was observed on the right side of the resident's forehead. An ambulance was called and arrived at 6:00 a.m. The next entry at 6:15 a.m. indicated the resident was transferred by ambulance to the hospital. There was no documentation in the Nurses' Notes from 11/14/11 through 11/22/11 at 5:45 a.m. of the resident having any accident, injury, or leg or pelvic bruising.</p>			

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	<p>An entry made in the Nurses' Notes on 11/22/11 at 12:00 p.m. indicated a phone call was received from the hospital stating the resident was being admitted with seizures, a urinary tract infection, and possible sexual abuse.</p> <p>Records of the resident's hospitalization on 11/22/11 were reviewed on 12/1/11. The Emergency Physician Record indicated the bruising was observed to the resident's left inner thigh, left labia majora and minora. The record also indicated impressions noted by the physician were seizure, urinary tract infection, and suspected sexual abuse. The 11/22/11 ED (Emergency Department) Supplemental Flow Sheet was reviewed. An entry made at 9:35 a.m. indicated the resident was to be admitted to the hospital and the case was referred to APS (Adult Protective Services) and the case manager.</p> <p>When interviewed on 11/30/11 at 11:20 a.m., the Director of Nursing indicated she was notified by the hospital case manager the afternoon of 11/22/11 informing her the resident was being admitted to the hospital for seizures, urinary tract infection, and possible sexual abuse. The Director of Nursing indicated she called the Emergency Room and was informed the resident had bruises on her legs and pelvic area. The Director of</p>				

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	<p>Nursing indicated she initiated her investigation at this time, notified the Indiana State Department of Health, Adult Protective Services, and the local Police. The Director of Nursing indicated she then called the nursing staff members who had worked on 11/21/11 and 11/22/11 and interviewed them related to the allegation and bruising. The Director of Nursing indicated she was able to talk to the CNAs and Nurses on the 11/21/11 and 11/22/11 shifts except for the Nurse who worked the 3:00 p.m. to 11:00 p.m. shift on 11/21/11. The Director of Nursing also indicated she had not obtained a statement from that Nurse as of this date. The Director of Nursing indicated the Nurse should have been interviewed as the facility policy indicates all staff caring for the resident in the past 24 hours were to be interviewed.</p> <p>Review of the facility investigation of the allegation of sexual abuse indicated staff interviews were completed. A "Witness Statement Form" was completed and signed by CNA #1 on 11/24/11. The form indicated the CNA wrote that she answered the resident's light and took the resident to the bathroom. The CNA left the bathroom and heard a sound and then saw the resident on the floor in a fetal position. The statement form also indicated CNA #1 and another CNA</p>				

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	<p>stood the resident up and put her in the wheelchair and then put her back in the bed. The statement also indicated one of the EMTs (Emergency Medical Technician) saw a dark purple/plum colored bruise about the size of a tangerine on the resident's right inner thigh and the EMT asked the CNA "where did this come from?" The statement indicated CNA #1 then told the EMT "I don't know, you can ask the nurse, she got a book that will tell you."</p> <p>When interviewed on 11/30/11 at 12:30 p.m., the Director of Nursing indicated CNA #1 did not tell her about the bruise the EMT asked about when she first interviewed her on 11/22/11. The Director of Nursing indicated she did the 11/22/11 interview over the phone and did not write the interview down. The Director of Nursing indicated the CNA should have reported the bruise at that time.</p> <p>When interviewed on 12/2/11 at 1:05 p.m., the Director of Nursing indicated the resident was unaware of how the 9/25/11 bruise occurred and there was no documentation of the resident having a fall or other incident. The Director of Nursing indicated no investigation was initiated related to the bruise observed on the resident's buttock on 9/25/11.</p>			

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	<p>When interviewed via telephone on 12/1/11 a Detective assigned to the case from the local Police Department indicated the detective had reviewed the case and had spoken to the resident at the facility on 11/28/11. The Detective indicated the resident denied abuse and the case was closed at this time.</p> <p>The facility Abuse Policy was received from the Director of Nursing and reviewed on 12/1/11 at 11:30 a.m. There was no date on the policy. The Director of Nursing indicated the policy was current. The section titled "Abuse Prevention" indicated bruises, burns, skin tears, staff to resident physical and or verbal abuse, sexual abuse, and other accidents resulting in injury were to be considered incidents and the policy was to rule out the possibility of neglect and provide a timely analysis of incidents. The policy also indicated the facility was to determine the names of all staff members/visitors who came into contact with the resident for the entire 24 hours prior to the incident and conduct an interview with each staff member.</p> <p>This Federal tag relates to Complaint IN00100394.</p> <p>3.1-28(a)</p>				

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F0226 SS=D	<p>3.1-28(d)</p> <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 interview, the facility failed to follow the Abuse Policy for investigating 1 of 1 allegation of sexual abuse and 2 of 3 allegations of injuries of unknown origin for 2 of 5 residents reviewed for allegations of abuse and injuries of unknown origin in the sample of 10. (Residents #D and #G)</p> <p>Findings include:</p> <p>1. The record for Resident #G was reviewed on 12/1/11 at 11:15 a.m. The resident's diagnoses included, but were not limited to, dementia, arthritis, depression, vertigo, difficulty walking, and osteoarthritis.</p> <p>Review of the October 2011 Nurses' Notes indicated an entry was made on 10/7/11 at 8:00 p.m. This entry indicated the CNA found a bruise on the resident's left lower arm. The bruise measured 5.5 cm (centimeters) x 6 cm. The entry also indicated the resident did not know how it got there. The next entry was made on 10/8/11 at 1:00 a.m. This entry indicated</p>	F0226	Resident B bruises healed from 10/7/2011. Bruises noted on Resident G on 10/14/2011 were determined to be from a previous fall per resident interview. Causes for current bruises have been identified and documented per facility policy. Resident D bruise from 9/25/2011 healed. The 3-11pm nurse's statement was obtained and contained no information of value to the investigation. Causes for current bruises have been identified and documented per facility policy. Alert and oriented residents were interviewed for possible abuse by the social service department on 12/9/2011 and 12/12/2011 and all other resident's skin was assessed for injuries of unknown origin and abuse on 12/8/2011. Those with injuries of unknown origin were investigated immediately by the DON/Designee and documented per facility policy. Allegation of abuse and injuries of unknown origin will be investigated completely and immediately by ED/designee per facility policy. A new investigation check-off sheet and call log was initiated with the current abuse procedures. Staff	01/01/2012
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	<p>the bruise remained to the resident's left lower arm and the resident had no complaints. An entry made 10/12/11 at 10:00 a.m. indicated the entry was made as a PIA (pressure/accident/incident) entry. The entry indicated a bruise was noted to the resident's left arm on 10/7/11. There was no documentation of any investigation to determine the cause of the bruise in this entry.</p> <p>An entry made in the Nurses' Notes on 10/14/11 at 10:30 p.m., indicated a CNA found a bruise to the resident's left arm measuring 15.2 cm x 8 cm. When the resident was asked what happened, the resident's roommate stated the resident fell in the morning and the roommate went and got help. The next entry was made on 10/15/11 at 2:00 a.m. This entry indicated the resident had a bruise to the left arm measuring 15.2 cm x 8 cm and the resident denied pain. The next entry was made on 10/15/11 at 11:00 a.m. This entry indicated the writer spoke to the resident regarding the bruise on her arm and the resident denied abuse or mistreatment. The resident also stated she fell in the bathroom, and when asked if she had gotten up on her own, the resident stated "no, the girls helped me." The entry also indicated the resident was unable to identify who helped her.</p>		<p>were Inservice on 12/2/2011 and 12/5/2011 by the SDC on the policy and procedure of abuse and investigations by Administration. Nurses were In-serviced by the Staff Development Coordinator (SDC) on proper documentation and follow up with resident changes in condition on 12/5/2011. Staff will be in-serviced on abuse and reporting and investigation of abuse and injuries of unknown origin monthly X3 and quarterly thereafter by the SDC. The ED/designee will audit the 24 hour report sheets, Incidents and Accidents, resident, family and staff complaints on working business days Monday –Friday for potential abuse. The weekend manager is available for immediate notification of potential abuse. All new staff will continue to be educated on abuse polices in orientation and in ongoing education by the SDC. Allegations of abuse and injuries of unknown origin will be reported to the Performance Improvement Committee monthly. The ED is responsible for ensure on-going compliance. Compliance date is January 1, 2012.</p>		

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	<p>When interviewed on 12/2/11 at 1:05 p.m., the Director of Nursing indicated there was no investigation of the 5.5 cm x 6 cm bruise observed to the resident's left lower arm on 10/7/11.</p> <p>When interviewed on 12/1/11 at 3:15 p.m., the Director of Nursing indicated all injuries of unknown origin, including bruises, required an investigation.</p> <p>When interviewed on 12/2/11 at 12:00 p.m., the Assistant Director of Nursing indicated she was informed of the 10/14/11 bruise. The Assistant Director of Nursing indicated the Nurse called her the evening it occurred. The Assistant Director of Nursing indicated she came into facility the next day and talked with the resident and the resident's roommate. The Assistant Director of Nursing indicated the roommate was legally blind and the roommate told her the resident was on the floor in the bathroom, and she went to the hallway and yelled for help. The Assistant Director of Nursing indicated she interviewed the two midnight CNAs and the midnight Nurse and also the Nurse and the two CNAs who worked the day shift that day related to the bruise and if the resident had a fall. The staff members stated they did not observe the resident have any fall or any other occurrence related to the bruise or</p>			

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	<p>hearing the resident or roommate yelling for help. The Assistant Director of Nursing indicated she did not interview the CNA who was working the evening shift on the day the bruise was observed. The Assistant Director of Nursing indicated she did not document any of the staff interviews she completed. The Assistant Director of Nursing also indicated the facility policy indicates all staff involved with the resident over the past 24 hours were to be interviewed, and she should have interviewed the evening shift CNA that was working to complete the investigation of the cause of the resident's bruise. The Assistant Director of Nursing also indicated she did not complete an investigation of the bruise observed on 10/7/11.</p> <p>2. The record for Resident #D was reviewed on 11/30/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, convulsions, iron deficiency anemia, encephalopathy, and osteoarthritis.</p> <p>Review of the September 2011 Nurses' Notes indicated an entry was made on 9/25/11 at 1:30 a.m. The entry indicated a new bruise was observed to the resident's left outer buttock measuring 10 cm (centimeters) x 4 cm. The entry indicated the bruise was "possibly from</p>				

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	<p>seizure in sleep." The resident was unaware of the bruise. Review of the Nurses' Notes from 9/16/11 through 9/25/11 indicated there was no documentation of the resident having a fall or any injury. Review of the Nurses' Notes from 9/25/11 through 10/4/11 indicated there was no documentation related to an investigation of how the resident's bruise occurred.</p> <p>Review of the November 2011 Nurses' Notes of an entry made on 11/22/11 at 5:45 a.m. indicated the resident was found on the floor in the bathroom and was having a seizure. A cut was observed on the right side of the resident's forehead. An ambulance was called and arrived at 6:00 a.m. The next entry at 6:15 a.m. indicated the resident was transferred by ambulance to the hospital. There was no documentation in the Nurses' Notes from 11/14/11 through 11/22/11 at 5:45 a.m. of the resident having any accident, injury, or leg or pelvic bruising.</p> <p>When interviewed on 11/30/11 at 11:20 a.m., the Director of Nursing indicated she was notified by the hospital case manager the afternoon of 11/22/11 informing her the resident was being admitted to the hospital for seizures, urinary tract infection, and possible sexual abuse. The Director of Nursing indicated</p>			

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	<p>she called the Emergency Room and was informed the resident had bruises on her legs and pelvic area. The Director of Nursing indicated she initiated her investigation at this time, notified the Indiana State Department of Health, Adult Protective Services, and the local Police. The Director of Nursing indicated she then called the nursing staff members who had worked on 11/21/11 and 11/22/11 and interviewed them related to the allegation and bruising. The Director of Nursing indicated she was able to talk to the CNAs and Nurses on the 11/21/11 and 11/22/11 shifts except for the Nurse who worked the 3:00 p.m. to 11:00 p.m. shift on 11/21/11. The Director of Nursing also indicated she had not obtained a statement from that Nurse as of this date. The Director of Nursing indicated the Nurse should have been interviewed as the facility policy indicates all staff caring for the resident in the past 24 hours were to be interviewed.</p> <p>Review of the facility investigation of the allegation of sexual abuse indicated staff interviews were completed. A "Witness Statement Form" was completed and signed by CNA #1 on 11/24/11. The form indicated the CNA wrote that she answered the resident's light and took the resident to the bathroom. The CNA left the bathroom and heard a sound and then</p>				

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	<p>saw the resident on the floor in a fetal position. The statement form also indicated CNA #1 and another CNA stood the resident up and put her in the wheelchair and then put her back in the bed. The statement also indicated one of the EMTs (Emergency Medical Technician) saw a dark purple/plum colored bruise about the size of a tangerine on the resident's right inner thigh and the EMT asked the CNA "where did this come from?" The statement indicated CNA #1 then told the EMT "I don't know, you can ask the nurse, she got a book that will tell you."</p> <p>When interviewed on 11/30/11 at 12:30 p.m., the Director of Nursing indicated CNA #1 did not tell her about the bruise the EMT asked about when she first interviewed her on 11/22/11. The Director of Nursing indicated she did the 11/22/11 interview over the phone and did not write the interview down. The Director of Nursing indicated the CNA should have reported the bruise at that time.</p> <p>When interviewed on 12/2/11 at 1:05 p.m., the Director of Nursing indicated the resident was unaware of how the 9/25/11 bruise occurred and there was no documentation of the resident having a fall or other incident. The Director of</p>				

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F0282 SS=D	<p>Nursing indicated no investigation was initiated related to the bruise observed on the resident's buttock on 9/25/11.</p> <p>The facility Abuse Policy was received from the Director of Nursing and reviewed on 12/1/11 at 11:30 a.m. There was no date on the policy. The Director of Nursing indicated the policy was current. The section titled "Abuse Prevention" indicated bruises, burns, skin tears, staff to resident physical and or verbal abuse, sexual abuse, and other accidents resulting in injury were to be considered incidents and the policy was to rule out the possibility of neglect and provide a timely analysis of incidents. The policy also indicated the facility was to determine the names of all staff members/visitors who came into contact with the resident for the entire 24 hours prior to the incident and conduct an interview with each staff member.</p> <p>This Federal tag relates to Complaint IN00100394.</p> <p>3.1-28(a)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the</p>	F0282	C.N.A #1 was educated on 11/24/11 by the ADON on	01/01/2012	

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	<p>facility failed to provide services in accordance with the resident's plan of care related to a CNA not following the resident's plan of care for supervision while in the bathroom for 1 of 3 residents reviewed for following the plan of care for falls in the sample of 10. (Resident #D) (CNA #1)</p> <p>Finding include:</p> <p>The record for Resident #D was reviewed on 11/30/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, epilepsy (seizures), difficulty in walking, osteoporosis, osteoarthritis, iron deficiency anemia, general muscle weakness, and debility.</p> <p>The November 2011 Nurses' Notes were reviewed. An entry made on 11/22/11 at 5:45 a.m., indicated the resident was found on the floor with bleeding from the right side of her head. The entry indicated the resident was having a seizure and fell off the toilet and hit her head. Ice wrapped in towel was applied to the cut on the right side of the resident's forehead and the 911 ambulance was called. The next entry was made at 6:15 a.m. This entry indicated the resident left the facility by ambulance.</p>		<p>following the residents Plan of care and C.N.A. care guides for supervision. Resident D's Care Plan was updated on 12/2/11 by the MDS Coordinator to reflect the resident's current changes and condition. A new padded commode was installed with a Velcro self release belt for resident D. Residents Care Plans were reviewed for correctness on 12/2/2011 by the MDS Coordinator. Residents with the diagnosis of seizure and who uses the commode were assessed for proper supervision and positioning. (Velcro belts added to commodes) Those resident Care Plans and C.NA. care guides were updated by the SDC and MDS Coordinator on 12/2/11 to reflect current status. Staff were in-serviced by SDC on following Care Plans and care guides for supervision on 12/8/2011. Nurses were in-serviced by SDC on 12/5/11 on proper documentation and follow up with resident changes in condition and Alert charting. Care plans will be audited weekly and PRN by the MDS Coordinator. Care Guides will be audited 2X weekly for 6 months and weekly thereafter by the SDC. Staff will be in-serviced on supervision and follow up on Care Plan monthly for 3 months and quarterly thereafter. The ED/Designee will audit the 24 hour report, incident and accident reports on working business days</p>				

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	<p>A care plan initiated on 7/12/2010 indicated the resident was at risk for falls and fall related injuries. The care plan was last updated on 11/7/11. Care plan approaches included staff were not to leave the resident alone in the bathroom. The 11/21/11 Daily Care Guide for the resident indicated the resident was on the Falling Star Program and staff were not to leave the resident unattended in the bathroom.</p> <p>Review of the facility investigation of the 11/22/11 fall indicated CNA #1 was interviewed. The CNA indicated she had answered Resident #D's call light and assisted the resident up and put her on the toilet. The CNA then left to get an incontinence brief for the resident from her closet and heard a noise. The CNA then saw the resident on the floor between the wall and the wheelchair laying on her right side. The CNA indicated blood was observed from a cut on her forehead.</p> <p>When interviewed on 11/30/11 at 11:20 a.m., the Director of Nursing indicated the resident had a seizure and fell off the toilet on 11/22/11. The Director of Nursing indicated the CNA was outside of the bathroom at the time obtaining a brief for the resident. The Director of Nursing indicated the resident should not have been left alone in the bathroom as per the</p>		<p>Monday –Friday for resident falls and injuries and ensure proper supervision status is reflected in the residents Care Plan and care guide. Random CNA audits will be conducted by nursing managment to verify that care guides are being implemented correctly for 6 months.Incidents are reviewed in daily morning stand-up meeting Monday-Friday. All falls will be reported and reviewed in Performance Improvement Committee monthly.The ED is responsible for ensuring ongoing compliance. Compliance date is January 1, 2012.</p>				

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F0323 SS=G	<p>plan of care.</p> <p>This Federal tag relates to Complaint IN00100394.</p> <p>3.1-35(g)(2)</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure adequate supervision was provided related to leaving a resident unattended in the bathroom for 1 of 3 residents reviewed for falls in the sample of 10. This resulted in the resident being sent to the hospital for a head laceration requiring Dermabond (a liquid bonding agent that holds many cuts, wounds, and incisions together as effectively as sutures).</p> <p>(Resident #D) (CNA #1)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 11/30/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, epilepsy (seizures), difficulty in walking, osteoporosis, osteoarthritis, iron deficiency anemia, general muscle</p>	F0323	<p>C.N.A #1 was educated on 11/24/11 by the ADON on following the residents Plan of care and C.N.A. care guides for supervision. Resident D's Care Plan was updated on 12/2/11 by the MDS Coordinator to reflect the resident's current changes and condition. A new padded commode was installed with a Velcro self release belt for resident D. Residents Care Plans were reviewed for correctness on 12/2/2011 by the MDS Coordinator. Residents with the diagnosis of seizure and who uses the commode were assessed for proper supervision and positioning. (Velcro belts added to commodes) Those resident Care Plans and C.NA. care guides were updated by the SDC and MDS Coordinator on 12/2/11 to reflect current status. Staff were in-serviced by SDC on following Care Plans and care guides for supervision on</p>	01/01/2012

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	<p>weakness, and debility.</p> <p>A fall risk evaluation completed on 10/6/11 indicated the resident's score was (14). The evaluation indicated a resident with a score of 10 or above was at high risk for falls. The fall risk evaluation indicated the resident had 1-2 falls in the last 90 days.</p> <p>The 10/31/11 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance of one staff member for bed mobility, transfers, and toilet use. The assessment also indicated the resident used a walker and wheelchair as mobility devices and had one fall with a major injury since her last assessment. The MDS assessment also indicated the resident was not steady moving on and off the toilet and was only able to stabilize with human assist.</p> <p>Review of a 8/5/11 Physical Therapy Plan of Treatment indicated the resident was seen for Physical Therapy 8/5/11 through 10/31/11. The Discharge Summary indicated the resident had sustained a compression fracture to the lower back from hitting her back when on the toilet. The resident was discharged from skilled therapy due to refusing therapy because of pain.</p>		<p>12/8/2011. Nurses were in-serviced by SDC on 12/5/11 on proper documentation and follow up with resident changes in condition and Alert charting. Staff will be in-serviced on supervision and follow up on Care Plan monthly for 3 months and quarterly thereafter. The ED/Designee will audit the 24 hour report, incident and accident reports on working business days Monday –Friday for resident falls and injuries and ensure proper supervision status is reflected in the residents Care Plan and care guide. Care plans will be audited weekly and PRN by the MDS Coordinator. Care Guides will be audited 2X weekly for 6 months and weekly thereafter by the SDC. Random CNA audits will be conducted by nursing management to verify that care guides are being implemented correctly for 6 months. Incidents are reviewed in daily morning stand-up meeting Monday-Friday. All falls will be reported and reviewed in Performance Improvement Committee monthly. The ED is responsible for ensuring ongoing compliance. Compliance date is January 1, 2012.</p>	

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	<p>The November 2011 Nurses' Notes were reviewed. An entry made on 11/22/11 at 5:45 a.m., indicated the resident was found on the floor with bleeding from the right side of her head. The entry indicated the resident was having a seizure and fell off the toilet and hit her head. Ice wrapped in towel was applied to the cut on the right side of the resident's forehead and the 911 ambulance was called. The next entry was made at 6:15 a.m. This entry indicated the resident left the facility by ambulance.</p> <p>A care plan initiated on 7/12/2010 indicated the resident was at risk for falls and fall related injuries. The care plan was last updated on 11/7/11. Care plan approaches included staff were not to leave the resident alone in the bathroom. The 11/21/11 Daily Care Guide for the resident indicated the resident was on the Falling Star Program and staff were not to leave the resident unattended in the bathroom.</p> <p>Review of the facility investigation of the 11/22/11 fall indicated CNA #1 was interviewed. The CNA indicated she had answered Resident #D's call light and assisted the resident up and put her on the toilet. The CNA then left to get an incontinence brief for the resident from the resident's closet and heard a noise.</p>			

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	<p>The CNA then saw the resident on the floor between the wall and the wheelchair laying on her right side. The CNA indicated blood was observed from a cut on her forehead.</p> <p>The 11/22/11 hospital Emergency Department Record was reviewed. The record indicated the resident arrived at the hospital at 6:40 a.m. The resident was alert and had a 2 centimeter laceration (cut) to the forehead. The 11/22/11 Emergency Physician Record indicated the resident had a laceration to the forehead and bleeding was controlled. The record also indicated the forehead laceration was washed with saline and closed with Dermabond.</p> <p>When interviewed on 11/30/11 at 11:20 a.m., the Director of Nursing indicated the resident had a seizure and fell off the toilet on 11/22/11. The Director of Nursing indicated the CNA was outside of the bathroom at the time as she was obtaining a brief for the resident. The Director of Nursing indicated the resident should not have been left alone in the bathroom as per the plan of care.</p> <p>This Federal tag relates to Complaint IN 00100394.</p> <p>3.1-45(a)(2)</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HWY 20 E MICHIGAN CITY, IN46360
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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