

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 09/26/2013
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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, IN 46975
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F000000	<p>This visit was for the Investigation of Complaint IN00136209.</p> <p>Complaint IN00136209 - Substantiated. Federal deficiencies related to the allegation are cited at F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: 9/26/13</p> <p>Facility number: 000325 Provider number: 155379 AIM number: 100274300</p> <p>Survey team: Shelley Reed, RN TC</p> <p>Census bed type: SNF/NF: 85 Total: 85</p> <p>Census payor type: Medicare: 7 Medicaid: 59 Other: 19 Total: 85</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000		
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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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	IAC 16.2. Quality review completed by Debora Barth, RN.			
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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</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 interview and record</p>	F000225	1. Corrective Action that will be	10/18/2013			

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	<p>review, the facility failed to report an unwitnessed accident that resulted in injury to the appropriate agency for 1 of 3 residents who were reviewed for accidents. (Resident C) Findings include:</p> <p>During clinical record review on 9/26/13 at 10:00 a.m., nursing progress notes, dated 8/4/13 at 6:31 p.m., indicated Resident (C) was found sitting on her bedroom floor by a CNA. A small amount of red drainage on her right shirt sleeve was noted. Resident (C) indicated "my leg hurts bad". Resident (B) was also noted to be on the floor at the foot of the bed. Resident (C) stated "she was trying to come in my room. I tried to help her out of my room and we both are on the floor". Resident (C) was assessed and sent out to the local hospital.</p> <p>A nursing note, dated 8/4/13 at 8:19 p.m., indicated Resident (C) had a fracture of the right hip and was admitted to the hospital.</p> <p>The nursing progress notes, dated 8/10/13 at 5:42 p.m., indicated Resident (C) returned to the facility. Resident (C) had a post surgical wound with nine staples in place.</p>		<p>accomplished for those residents affected by the deficient practice:Resident C's accident was reported to ISDH on 9.30.13. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:100% whole house audit began on 9.27.13 which identified 2 residents that were affected by the deficient practice. Both reports were submitted to ISDH on 9.30.13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:DON,ADON and Unit Manager educated on 9.27.13 regarding State Reportable Guidelines. Nursing staff education regarding State Reportable Guidelines to be completed by 10.18.13. All incidents with or without injury will be investigated and reviewed daily to determine if reportable to the State Board of Health. 4. How the corrective action will be monitored to ensure the deficient practice will not recur:Facility will audit all investigated and reviewed incidents weekly x 6 months and submit findings to QA. 5. Date the system changes will be completed: October 18, 2013</p>		

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	<p>The Minimum Data Set (MDS) assessment, dated 5/19/13, indicated Resident (C) had moderate cognitive impairment. Resident (C)'s diagnoses included, but were not limited to, cardiomegaly, hypertension, anxiety and vascular dementia. Resident (C) resided in the locked dementia unit.</p> <p>During an interview on 9/26/13 at 10:15 a.m., the Corporate Nurse indicated the the facility reported all resident to resident contact regardless of any injury to the State of Indiana.</p> <p>During an interview on 9/26/13 at 11:40 a.m., the Director of Nursing and the Corporate Nurse indicated the accident was not reported because it was not witnessed.</p> <p>Review of a current facility policy, dated 1/15/13, titled "Reportable Incidents Policy" which was provided by the Nurse Consultant on 9/26/13 at 12:50 p.m., indicated the following:</p> <p>"I. Reportable Incidents</p> <p>Facilities are required by law to report incidents within 24 hours of occurrence to the Long Term Care</p>				

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	<p>Division. CFT 483.13(c)(2) states:</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>A corporate policy was requested on /9/26/13 at 1:15 p.m. The Nurse Consultant indicated the facility followed the state policy and could not provide any additional policies.</p> <p>This Federal tag relates to Complaint #IN00136209.</p> <p>3.1-28(c)</p>						

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</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.</p> <p>Based on interview and record review, the facility failed to implement their policy related to an accident for 1 of 3 residents who were reviewed for abuse prohibition in the facility. (Resident C)</p> <p>Findings include:</p> <p>During record review on 9/26/13 at 10:00 a.m., nursing progress notes, dated 8/4/13 at 6:31 p.m., indicated Resident (C) was found sitting on her bedroom floor by a CNA. A small amount of red drainage on her right shirt sleeve was noted. Resident (C) indicated "my leg hurts bad". Resident (B) was also noted to be on the floor at the foot of the bed. Resident (C) stated "she was trying to come in my room. I tried to help her out of my room and we both are on the floor". Resident (C) was assessed and sent out to the local hospital.</p> <p>A nursing note, dated 8/4/13 at 8:19 p.m., indicated Resident (C) had a fracture of the right hip and was</p>	F000226	<p>1. What corrective acion will be accomplished for those residents found to have been affected by the deficient practice:Resident C's incident was reported to ISDH on 9.30.13. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:100% whole house audit of incidents from August 1, 2013 to current to be completed by 10.18.13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Staff education on following Abuse Policy conducted on October 3-4, 2013 with all staff to be completed by 10.18.13. All incidents to be investigated and reviewed daily to ensure reportable guidelines are being met. 4. How the corrective action will be monitored to ensure the deficient practice will not recur?Facility will audit all incidents on a weekly basis and submit findings to QA monthly for 6 months. 5. What date the systemic changes will be completed? October 18, 2013</p>	10/18/2013			

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	<p>admitted to the hospital.</p> <p>The nursing progress notes, dated 8/10/13 at 5:42 p.m., indicated Resident (C) returned to the facility. Resident (C) had a post surgical wound with nine staples in place.</p> <p>The Minimum Data Set (MDS) assessment, dated 5/19/13, indicated Resident (C) had moderate cognitive impairment. Resident (C)'s diagnoses included, but were not limited to, cardiomegaly, hypertension, anxiety and vascular dementia. Resident (C) resided in the locked dementia unit.</p> <p>During an interview on 9/26/13 at 2:10 p.m., staff member #1 indicated the staff had to keep an eye on Resident (B). She indicated her mood was unpredictable and she would often wander in and out of other rooms.</p> <p>During an interview on 9/26/13 at 2:20 p.m., staff member #2 indicated Resident (C) was the most alert and oriented person in the dementia unit. She indicated Resident (C) stated that she was trying to get Resident (B) out of her room when Resident (B) pushed her.</p>			

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	<p>During an interview on 9/26/13 at 10:15 a.m., the Corporate Nurse indicated the the facility reported all resident to resident contact regardless of any injury to the State of Indiana.</p> <p>During an interview on 9/26/13 at 11:40 a.m., the Director of Nursing and the Corporate Nurse indicated the accident was not investigated or reported because it was not witnessed.</p> <p>Review of a current facility policy dated 1/15/13 titled "Reportable Incidents Policy" which was provided by the Nurse Consultant on 9/26/13 at 12:50 p.m., indicated the following:</p> <p>"I. Reportable Incidents</p> <p>Facilities are required by law to report incidents within 24 hours of occurrence to the Long Term Care Division. CFT 483.13(c)(2) states:</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</p>						

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	<p>State law through established procedures (including to the State Survey and Certification Agency)."</p> <p>A corporate policy was requested on /9/26/13 at 1:15 p.m. The Nurse Consultant indicated the facility follows the state policy and could not provide any additional policies.</p> <p>This Federal tag relates to Complaint #IN00136209.</p> <p>3.1-28(a)</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 interview and record review, the facility failed to ensure a resident was provided with an environment that was free from hazards following an accident for 1 of 3 residents who were reviewed for accidents. (Resident C) Findings include: During record review on 9/26/13 at 10:00 a.m., nursing progress notes, dated 8/4/13 at 6:31 p.m., indicated Resident (C) was found sitting on her bedroom floor by a CNA. A small amount of red drainage on her right shirt sleeve was noted. Resident (C) indicated "my leg hurts bad". Resident (B) was also noted to be on the floor at the foot of the bed. Resident (C) stated "she was trying to come in my room. I tried to help her out of my room and we both are on the floor". Resident (C) was assessed and sent out to the local hospital. A nursing note, dated 8/4/13 at 8:19 p.m., indicated Resident (C) had a</p>	F000323	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:Resident C incident reported to ISDH on 9.30.13 and 10.11.13. Resident C no longer resides in facility.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:100% whole house audit of incidents from August 1, 2013 to current to be completed by 10.18.13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Staff education on behavior management to be completed by 10.18. 2013. New and/or worsening behaviors to be reviewed and investigated daily with new interventions to be implemented. 4. How the corective action will be monitored to ensure the deficient practice will not recur:New and/or worsening behaviors to be audited weekly and findings submitted to QA monthly for 6 months. 5. What date the systemic changes will be</p>	10/18/2013			

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	<p>fracture of the right hip and was admitted to the hospital.</p> <p>The nursing progress notes, dated 8/10/13 at 5:42 p.m., indicated Resident (C) returned to the facility. Resident (C) had a post surgical wound with nine staples in place.</p> <p>The Minimum Data Set (MDS) assessment, dated 5/19/13, indicated Resident (C) had moderate cognitive impairment. Resident (C)'s diagnoses included, but were not limited to, cardiomegaly, hypertension, anxiety and vascular dementia. Resident (C) resided in the locked dementia unit.</p> <p>During record review on 9/26/13 at 11:00 a.m., nursing progress notes, dated 8/4/13 at 5:20 p.m., indicated Resident (B) was noted to be on the floor at the foot of the bed in Resident (C)'s room. Resident (B) was on her back yelling obscenities.</p> <p>During chart review, nursing notes from 6/10/13-8/4/13 were reviewed. On 6/10/13, the notes indicated Resident (B) required constant supervision because she was in and out of other resident rooms. On 6/13/13, Resident (B) was again</p>		completed:October 18, 2013				

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	<p>found entering other resident rooms. She was again noted to be in other resident rooms on 6/14/13, 7/13/13, 7/24/13, 7/25/13 and 7/29/13. On 7/13/13, Resident (B) was found sitting on the floor in another resident's room. Resident (B) was mumbling incoherently and staff were educated to observe closely and assist while ambulating. On 7/29/13, Resident (B) was again found in another resident's room lying on her back with incoherent speech.</p> <p>A social service note, dated 5/14/13, indicated Resident (B) walked throughout the unit and wandered in and out of rooms. A social service note, dated 8/6/13, indicated Resident (B) had 10 episodes of yelling and cursing at others. Resident (B) was noted to walk up to other residents and began to yell and scream. A social service note, dated 8/7/13 related to 8/4/13, indicated Resident (B) had increased agitation, wandering in and out of rooms, rummaging and beating fists against the walls. Resident (B) was admitted to an inpatient psychiatric unit on 8/7/13.</p> <p>A history and physical exam, dated 8/21/13, indicated Resident (B) was admitted to a local hospital after a</p>			

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	<p>stay at an neuropsychiatric hospital. The note indicated Resident (B) pushed a resident at her previous facility (Life Care) which resulted in a fractured hip of the other resident.</p> <p>During an interview on 9/26/13 at 2:10 p.m., staff member #1 indicated the staff had to keep an eye on Resident (B). She indicated her mood was unpredictable and she would often wander in and out of other rooms.</p> <p>During an interview on 9/26/13 at 2:20 p.m., staff member #2 indicated Resident (C) was the most alert and oriented person in the dementia unit. She indicated Resident (C) stated that she was trying to get Resident (B) out of her room when Resident (B) pushed her.</p> <p>During an interview on 9/26/13 at 11:40 a.m., the Director of Nursing and the Corporate Nurse indicated the fall was not investigated since it was not witnessed.</p> <p>This Federal tag relates to Complaint # IN00136209.</p> <p>3.1-19(a)(2)</p>				

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

PRINTED: 10/22/2013

FORM APPROVED

OMB NO. 0938-0391

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