STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00419069, IN00419110, IN00420938, IN00421224, and IN00421285. Complaint IN00419069- Federal/state deficiencies related to the allegation(s) are cited at F602. Complaint IN00419110- No deficiencies related to the allegation are cited. Complaint IN00420938- Federal/state deficiencies related to the allegation(s) are cited at F684 and F880. Compliant IN00421224- No deficiencies related to the allegation are cited. Complaint IN00421285- No deficiencies related to the allegation are cited. Unrelated deficiencies are cited. Survey dates: November 14, 15, 16, and 17, 2023 Facility number: 000325 Provider number: 155379 AIM number: 100274300 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 4 Medicaid: 45 Other: 4 Total: 53	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Wagner	Executive Director	01/02/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed 11/25/23.			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on record review and interview, the facility failed to prevent a misappropriation of resident property for 1 of 1 resident's reviewed for misappropriation of property. (Resident B) Finding includes: A Reportable Incident, dated 10/5/2023, indicated "...Description added- 10/5/2023 Allegation of fraudulent use of a debit card...." Immediate Action Taken- Staff member suspended, law enforcement notified. MD and family aware. Family canceled debit card. Preventative Measures Taken: Type of preventative measures added: 10/5/2023 Investigation initiated. Employee suspended pending investigation. Interviews being conducted with all residents for any concerns. Abuse inservice started...." A 5-day Follow up, dated 10/11/2023, indicated "... Investigation was initiated by Executive Director into [Name of Resident] family's concern with unauthorized online activity on his back account	F 0602	***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1. Suspected staff member was immediately suspended pending investigation 2. Law Enforcement notified 3. Incident reported to the IDOH 4. OIG was notified via email 5. Employee was terminated ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1. All residents were interviewed per questionnaire regarding Abuse Prohibition with no issues identified ***What measures and what***	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	with [Name of Bank]. Resident is his own responsible party with a BIMS (Brief Interview for Mental Status) score of 15- cognition intact. The Executive Director did speak with Deputy [Name of Deputy] during the investigation. Interviews with staff members were inconclusive and no issues identified. [Name of residents] family provided a bank statement from [Name of Bank].The bank statement showed a cash app to an [Name of Employee].The Executive Director reviewed the employee roster and identified [Name of Employee] as a staff member. [Name of Employee] was not working at the facility and was notified via telephone she was suspended pending investigation. The Executive Director interviewed the staff member over the phone about the allegation with the staff member denying any wrong doing. While following up the the resident's mother, she informed the Executive Director that another fraudulent charge had been discovered on the account on 9/25/2023. Staff to be reeducated on misappropriation of property and resident rights...." During an interview, on 11/5/2023 at 10:45 A.M., the Administrator indicated an investigation was initiated and the local police department had been notified During an interview, on 11/14/2023 at 11:00 A.M., Resident B indicated that he had his debit card used. He indicated his sister worked at the bank and saw the initials of (Initials of staff) on a withdrawal of money out of his account. He indicated he got the money back, and the staff person does not work at the facility anymore. The resident indicated he thought the staff member had taken a picture of the card. On 11/17/2023 at 10:00 A.M., the Director of		***systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1. All staff re-educated by the Executive Director on 12.12.23 on Abuse Prohibition. 2. All newly hired associates will receive Abuse Prohibition education during the orientation process. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1. Abuse audits will be completed with 5 random residents and be performed x3 weekly for 2 months, weekly for 2 months, and semi-monthly for 2 months. 2. Abuse Questionnaire will be completed with 3 random staff members on various shifts. This questionnaire will be performed x3 weekly for 2 months, weekly for 2 months, and semi-monthly for 2 months. 3. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 12.15.23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Nursing provided the policy titled,"Abuse -Identification of Types", undated, and indicated the policy is the one currently used by the facility. The policy indicated"...Misappropriation of resident property- is defined as thee deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent... Misappropriation of Property and Exploitation: ...3. Examples of misappropriation of resident property include, but are not limited to: ... c. Unauthorized /coerced use by staff of residents property. d. Theft of money from bank accounts...." This Federal tag relates to complaint IN00419069. 3.1-28(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to notify a State agency of an attempted suicide for 1 of 4 reportable incidents reviewed. (Resident B) Finding includes: A clinical record review was completed on 11/15/2023 at 8:50 A.M. Resident B was admitted on 6/21/2023 with diagnoses included, but were not limited to: hemiplegia, hemiparesis following cerebral infarct, epilepsy, anxiety, and psychosis not due to a substance or known physiological condition. An Admission Note, dated 6/16/2023, from (Name of hospital) indicated Resident B was seen in ER (Emergency Room) and admitted because resident threatened to kill himself by wrapping a ligature around his neck. On arrival to emergency department, he denied any suicidality. A care plan, dated 6/23/2023, indicated the resident used antidepressant medication r/t (related to) depression and was at risk of adverse reactions. Interventions included but were not limited to: Observe for and report PRN adverse	F 0609	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B was put on 1:1 supervision immediately at the time. The MD and family were notified, a suicide screen completed, psych services visited with the resident and completed an evaluation on the same day, and the phone cord charged was removed immediately. The resident remained on 1:1 supervision until successfully transferred to a local psychiatric unit within 24 hours. Care plan was updated immediately and reportable was submitted. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective**	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	reactions to antidepressant therapy; suicidal thoughts. An Admission MDS (Minimum Data Set) assessment, dated 6/27/2023, indicated Resident 2 had intact cognition. Feeling down and depressed 7-11 days, and never had thoughts that you would be better off dead or hurting yourself. A Behavior Note, dated 7/31/2023 at 5:48 P.M." ...resident propelled self to his room, rang his bell to get in bed. Resident assisted by staff. Approximately 10 minutes later [Name of Nurse] received phone call from ex-girlfriend that resident had posted a picture on [a social media application] with a cord around his neck attempting to commit suicide. [Name of Nurse] immediately went to resident room to find resident hold his phone with the picture posted with cord around his neck. Cord was telephone charger tightly wrapped around neck x 2. When [Name of Nurse] asked resident he began to pull hard and upward on the cord. [Name of Nurse] had to struggle with resident to get fingers under the phone cord due to attempting to strangulate self. [Name of Nurse] took phone cord and called management. Instructed to place resident with one-on-one care...." A Behavior Note, dated 7/31/2023 at 9:05 P.M. "...Resident on one-on-one supervision since 6:15 P.M. [Psych health] called for assessment for emergency psych placement. Resident initially refused, and EDO [Emergency Detention Order] was obtained by [Name of MD]. At this time has agreed to labs for placement and voiced understanding of need for psych eval and willingness to go. Openly admitted to writer, ED [Executive Director] and mobile crisis that he does not want to live and has suicidal ideation's.		**actions will be taken?** A one-time review of current resident population with history of or current diagnosis of suicidal ideation, or resident with a BIMS score of 13 or more and PHq9 score of 10 or more were reviewed by nursing management and Social Services using the suicide screener assessment to validate psych services was in place, had care plans reviewed, with any changes necessary as identified by the team. Education has been completed for facility staff on reportable guidelines/events, suicide attempt is considered an unusual occurrence including education to the ED by the RVP/RDCS on the definition of reportable events. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education has been provided to the ED and IDT team on the definitions of a reportable event. Education also includes the IDT team must monitor, assess, and implement changes in care plan interventions when changes are occurring and revisions are required. Reportable events and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident asked ED to notify parents...." A Psych Progress Note, 8/1/2023, indicated the resident was seen for a suicide attempt and increased ideation's. "...Received telephone from acting Social Worker stating that on Monday around 5:30 PM patient's girlfriend had called the facility stating patient had posted himself on [a social media application] via phone with telephone cord wrapped around his neck. Staff ran to his room and found patient with a telephone cord wrapped tightly around his neck. They wrestled the cord off his neck and patient continued to express suicidal ideation's to end his life. Pt has had Suicidal attempts in the past per family. Staff also report that last week he had reported SI with no plan, and he was put on: 1 to 1 staff monitoring over the weekend per social worker. Pt needs psychiatric referral for inpatient psychiatric stay for treatment and stabilization...." A Health Status Note dated 8/1/2023 at 2:36 P.M., "...resident transferred with one-on-one staff to [Name of Hospital]...." During an interview, on 11/15/2023 at 11:07 A.M., the Executive Director indicated the incident was not reported to the State Department of Health as she did not think it was a reportable incident. An Indiana Department of Health Care Abuse and Incident Reporting Policy, with the effective dates of 12/08/2022 to 12/08/2023, indicated, "... Policy Statement: Abuse and incidents will be reported and submitted to the Indiana Department of Health in compliance with federal regulations and/or state rules and the policy, as applicable... Comprehensive Care Facilities...Types of Incidents Reportable Under Federal and State Rules...16. Suicide attempt - any...."		care plans changes will be discussed daily in morning meeting by the IDT team to ensure compliance and assure completed notification to the attending physician and family. Any new interventions will be as determined by the resident, care team, physician, and family if applicable and care plan will be revised by the IDT team to validate completed. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The reportable event and the care plans will be reviewed by the IDT team upon occurrence. The Administrator once completed to ensure compliance. This will be an ongoing practice. Quality Assurance Performance Improvement Committee meetings monthly for 3 months, and then quarterly for 2 quarters. Any further action or revision will be determined by the QAPI review. The Administrator is responsible for achieving and maintaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-28(c)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to follow the physician's orders for reporting laboratory results timely, and providing oral medications as prescribed for 1 of 3 residents reviewed. (Resident D) Finding includes: A record review was completed, on 11/16/2023 at 8:30 A.M. Resident D had intact cognition and was his own Power of Attorney (POA). Resident D's diagnoses included, but were not limited to: Psoriasis, latent tuberculosis, and Type 1 diabetes mellitus. A Physician's order, dated 5/12/2023, indicated to obtain the following labs: comprehensive metabolic panel, complete blood count with differential, Hepatitis A, Hepatitis B, Hepatitis C, and QuantiFERON Gold test on the next lab day. A Health Status Note, dated 5/25/2023 at 3:52 P.M., indicated the nurse had called [Name of Hospital Lab] to inquire about Resident D's CBC,	F 0684	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D was assessed by the attending physician and determined to have no negative outcomes. The attending dermatologist was also notified, and the medications were reimplemented. Laboratory reports have been sent to the appropriate physician for review. The care plan has been updated to reflect the current status of the resident. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** A one-time review of current	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	CMP, Quantiferon Gold, Hepatitis A, B, and C lab results. It was at that time the nurse was informed that the labs would be drawn the next day on the normal lab draw day at the facility. A Health Status Note, dated 5/26/2023, indicated all ordered labs were completed at [Name of Hospital]. A Health Status Note, dated 5/30/2023, indicated that Resident D's lab results were received. A Health Status Note, dated 5//31/2023, indicated the lab called with a positive Tuberculosis (TB). NP (Nurse Practitioner) at facility and made aware. Resident D indicated, he had a chest X-ray for the situation in April 2023, and voiced several years ago having a positive PPD (Purified Protein Derivative) then having a chest X-ray done resulting in a negative result. Resident D's record, lacked the documentation to show that the laboratory results were forwarded to the ordering medical provider. Resident D's record lacked the documentation to show that his positive tuberculosis test results had been faxed to the dermatologist. A Health Status Note, dated 6/5/2023, indicated the Lab results had been faxed to the dermatologist. A Health Status Note, dated 6/6/2023, indicated the facility had called the dermatologist to inquire as to what they were waiting for from the facility, so resident can proceed with treatment for psoriasis. Lab work and X-ray results already sent. Message left for provider to return call.		resident population for signs and symptoms of TB has been completed with no other residents identified as having signs and symptoms of TB. A one-time review has been completed on medication orders and lab orders to validate compliance. Education has been completed for licensed nurse staff on following physician orders, to include obtaining labs as ordered. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** It is the responsibility of the Licensed Supervisory Nurse to follow physician orders. New orders will be reviewed during clinical meetings to review for accuracy of orders and lab monitoring has been ordered and scheduled for completion. In the event of a resident making negative statements related to self-harm or physical attempts to hurt themselves will be reviewed by the Interdisciplinary Team, reviewing possible new interventions, care plan review, updated education to the care team, and complete notification to the attending physician and family. Any new interventions will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A Health Status Note, dated 6/6/2023, indicated the facility had received a call from the dermatology office who stated "...resident is not an active patient in their office and hasn't been seen since 2021. An interview with resident stated he had been seeing a dermatologist at [Name of Hospital]. Writer called and left message...." A Health Status Note, dated 6/7/2023, indicated requested labs and X-rays were sent to the (Dermatology Office). A Physician's order, dated 9/7/2023, indicated pyridoxine (Vitamin B6) 50 mg (milligram) tablet, take 1 tablet every day for 30 days for 9 months, and isoniazid 300 mg tablet, take 1 tablet every day for 30 days for 9 months. A Physician's order, dated 10/7/2023, indicated to discontinued the isoniazid and the pyridoxine (Vitamin B6). A Physician's order, dated 10/30/2023, indicated to resume the pyridoxine (Vitamin B6) 50 mg tablet, take 1 tablet every day for 30 days for 8 months and isoniazid 300 mg tablet, take 1 tablet every day for 30 days for 8 months. During an interview, on 11/16/2023 at 2:40 P.M., the IP indicated that it was her responsibility to make sure Resident D's lab results were sent to the ordering provider and his medications for latent tuberculosis were correct. The IP indicated that Resident D's ordered labs were not reported to the Dermatologist because the facility had been sending the results to the wrong Dermatologist but should have sent the results to Resident D's current Dermatologist. IP indicated that Resident D's prescription for pyridoxine 50 mg and isoniazid 300 mg were ordered for one month, and both		be as determined by the resident, care team, physician, and family if applicable. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The reviews completed and actions taken will be reviewed by the Administrator upon occurrence. Results of the reviews will be reviewed in the Quality Assurance Performance Improvement Committee meetings monthly for 3 months, and then quarterly for 2 quarters. Any further action or revision will be determined by the QAPI review. The Administrator is responsible for achieving and maintaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	medications should have been ordered for nine months. On 11/15/2023 at 3:50 P.M., the Director of Nursing provided a policy title, "Laboratory Services", dated 3/21/2023, and identified as the policy currently used by the facility. The policy indicated, " ...The facility will ensure that laboratory services meet the needs of resident, that results are reported promptly to the ordering provider... and the facility is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource ...." On 11/16/2023 at 11:45 A.M., the Director of Nursing provided a policy title, "Physician Orders", dated 3/10/2023, and identified as the policy currently used by the facility. The policy indicated, " ...The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines ...6. Physician orders include the following ...b. Medications and Treatments ...f. Lab and x-ray requirements ...." This Federal tag relates to complaint IN00420938. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to act on a residents' statements of wanting to die, and failed to ensure environmental hazards were removed from a resident's room after a suicide attempt for 1 of 1 resident's reviewed for accidents. (Resident 2) Finding includes: A clinical record review was completed on 11/15/2023 at 8:50 A.M. Resident 2 was admitted on 6/21/2023 with diagnoses included, but were not limited to: hemiplegia, hemiparesis following cerebral infarct, epilepsy, anxiety, and psychosis not due to a substance or known physiological condition. An Admission Note, dated 6/16/2023, from (name of hospital) indicated Resident 2 was seen in ER (Emergency Room) and admitted because resident threatened to kill himself by wrapping a ligature around his neck. On arrival to emergency department, he denied any suicidality. A PASSAR (Pre-Admission Screening and Resident Review) Level II outcome, dated 6/21/2023, indicated "...we learned you were admitted to the hospital 6/16/2023 because of weakness and thoughts to harm yourself by placing an object around your neck to cause compression...." On 6/22/2023, a Suicidality Screener form, indicated Resident 2 had thoughts of actually hurting himself, had attempted to harm himself in the past, and thought about how he would actually harm himself. He indicated he had tried	F 0689	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident B was put on 1:1 supervision immediately at the time. The MD and family were notified, a suicide screen completed, psych services visited with the resident and completed an evaluation on the same day, and the phone cord charged was removed immediately. The resident remained on 1:1 supervision until successfully transferred to a local psychiatric unit within 24 hours. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** A one-time review of current resident population with history of or current diagnosis of suicidal ideation, or resident with a BIMS score of 13 or more and PHq9 score of 10 or more were reviewed by nursing management and Social Services using the suicide screener assessment to validate psych services was in place, had care plans reviewed, with any	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	hanging himself at home. He indicated he was not likely to act on his thoughts of harming himself or ending his life. He indicated he wanted to live. Minimal risk. A care plan, dated 6/22/2023, indicated the resident had psychosocial wellbeing problems (potential) related to anxiety, ineffective coping, recent admission, repeated accidents and falls, history of suicidal ideation. Interventions: consult with pastoral care, social services, and psych services. On 6/23/2023 Resident 2 was evaluated by Psych Services FNP (Nurse Practitioner) and indicated his diagnoses included adjustment disorder with mixed anxiety and depressed mood. At that time, was not a danger to self or others? No self-harm no suicidal ideation. A care plan, dated 6/23/2023, indicated the resident used antidepressant medication r/t (related to) depression and was at risk of adverse reactions. Interventions included but were not limited to: Observe for and report PRN adverse reactions to antidepressant therapy; suicidal thoughts. An Admission MDS (Minimum Data Set) assessment, dated 6/27/2023, indicated Resident 2 had intact cognition, feeling down and depressed 7-11 days, and never had thoughts that he would be better off dead or hurting himself. A PHQ-9/Staff Assessment of Resident Mood, dated 6/27/2023, indicated the resident triggered for: feeling down, trouble falling asleep, and poor appetite. The score of 7 did not indicate depression at that time.		changes necessary as identified by the team. Education has been completed for facility staff on reportable guidelines/events, suicide attempt is considered an unusual occurrence. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** It is the responsibility of the facility care team to monitor, assess, and implement changes in care plan interventions. In the event of a resident making negative statements related to self-harm or physical attempts to hurt themselves will be reviewed by the Interdisciplinary Team, reviewing possible new interventions, care plan review, updated education to the care team, and complete notification to the attending physician and family. Any new interventions will be as determined by the resident, care team, physician, and family if applicable. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A Social Service Note, dated 7/5/2023 at 3:26 P.M., indicated SSD (Social Service Director) and BOM (Business Office Manager), talked with the resident regarding a text he had sent to his sister. Resident 2 stated "...he was very upset with his sister about getting into his bank account and giving money to his parents for his phone...Resident texted his sister he was going to wrap something around his neck...SSD asked the resident if he had a plan to harm himself. The resident replied to no. he was upset with his family because they don't really care. Resident was asked a 2nd time if he had a plan, he indicated he did not and was upset with his family...." The note indicated the SSD would follow. A Suicidality screener, dated 7/5/2023 at 3:38 P.M., indicated the resident did not have thoughts of hurting himself. An IDT (Interdisciplinary Team) Note, dated 7/7/2023 at 2:57 P.M., indicated Resident 2 wished to discharge back to the community. A Psych Progress Note, dated 7/7/2023, indicated the resident was seen for an acute psych med visit and GDR (gradual dose reduction) for Hydoxyzine (antihistamine). Staff reported patient appeared depressed. Patient indicated he was not depressed and he was coping well with the adjustment. Refused medications at that time. No self-harm or suicidal ideations. A Suicidality Screener form, dated 7/22/2023, indicated the resident did not have thoughts of actually hurting himself. A Nurses Progress Note, dated 7/22/2023 at 5:50 P.M., indicated "...Resident has been in a bad mood all day, cussing at staff that can't do our		**assurance program will be put into place?** The review(s) completed and actions taken will be reviewed by the Administrator upon occurrence. Results of the reviews will be reviewed in the Quality Assurance Performance Improvement Committee meetings monthly for 3 months, and then quarterly for 2 quarters. Any further action or revision will be determined by the QAPI review. The Administrator is responsible for achieving and maintaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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*****g jobs right, it doesn't matter no one will fix the issues." Resident made the statement "I'm already dead. I wish they would have let me die on the table." Staff inquired if Resident 2 was having suicidal idealization. The resident stated, "If I was gonna to kill myself, I would have already hung myself with the call light. Management on call notified with the resident placed on 15 min (minute) checks. Oncoming shift alerted to statements with call light and any string cord material removed from room...." A Psychosocial Note, dated 7/22/2023 at 7:49 P.M., indicated the SSD met with Resident 2 to discuss why he would say he wanted to die. "...SSD asked do you want to hurt yourself. No. Do you have a plan? No. I have a bell. What do you mean? If I had a plan, I would have done it by now, I have been here for a while. So, tell me what the real issue is? I am frustrated. I get rice and keep telling people in dietary I don't want rice and I need my meat cut up. SSD replied there had to be more to his frustration than that for him to say, he wanted to die earlier. No, I just get to a point where I am frustrated. Do you have any other concerns? No, I just want to be back in Peru area so that my friends and family can see me more and I can get out. I have a brain injury and I may never walk the way I want to. SSD asked do you want to hurt yourself. No. Do you believe you will be happier in Peru? Yes. Resident does not appear to be threat to self and currently has a bell in his room. Staff are aware that he is to eat the next meal on paper...." A Suicidal Screener, dated 7/22/2023 at 7:49 P.M., indicated the resident did not have thoughts of hurting himself. A Nurses' Note, dated 7/23/2023 at 6:13 A.M.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	indicated Continues 15-minute checks. No suicidal ideations. A Behavior Note, dated 7/23/2023 at 12:30 P.M., indicated "...Resident refused all AM meds, meals, and fluids. Resident rang bell and request to get up to go outside to smoke. He will not be eating, drinking, or taking meds that he is leaving here today. Asked the nurse what do I have to do, hurt myself, to get out of here? States he is making phones calls to get a ride and understands the policy about AMA. States wants to return to PERU; states he will live under the bridge that he can fish and start a fire. Resident frustrated over care and waiting for someone to transfer him for any and all activities of daily care...." Management notified of concerns. A Psychosocial Note, dated 7/24/2023 at 1:34 P.M., indicated "...SSD asked resident if he felt like hurting himself and he said no. SSD called psych NP and discussed him voicing he wanted to die on Saturday. NP stated the bell was a good start and if he voiced that he wanted to die again, we will have to send him out ...." A PHQ-9/Staff Assessment of Resident Mood, dated 7/24/2023 at 1:47 P.M., indicated "...Resident 2 answered yes to feeling down, depressed, and hopeless for 12-14 days, feeling bad about himself or that you are a failure or had let yourself down or your family for 12-14 days. Had thoughts that he would be better off dead or hurting yourself in some way for 2-6 days. Resident 2 scored a 13 on the PHQ-9. He is currently taking Remeron for depression. Referral to Psych NP who is reviewing medications...." A PHQ-9/Staff Assessment of Resident Mood, completed 6 minutes after the previous			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	assessment, dated 7/24/2023 at 1:53 P.M., indicated "...Resident 2 answered yes to feeling down, depressed and hopeless for 12-14 days, feeling bad about himself or that you area a failure or had let yourself down or your family for 2- 6 days, and had no thoughts that he would be better off dead or hurting himself in any way. PHQ-9 assessment completed. The resident was able to express himself very briefly and to the point. Did not make eye contact and gave yes, no answers. The resident's answers did not trigger any signs and symptoms of depression. The resident denies being depressed. The resident scores 00 on the assessment which does not indicate depression at this time...." On 7/24/2023 at 1:44 P.M., the SSD indicated a Cognitive Pattern/BIMS note the Resident did not appear to have any cognitive deficits, scoring 15 on BIMS. A current care plan, dated 7/24/2023, indicated the resident had a behavior problem related to threats of suicide or suicidal ideation. Episode of threatening suicide in response to anger and frustration. Resident had episode of wrapping phone cord around neck (updated 11/14/2023). Interventions included: Administer medications as ordered, determine if a plan was in place for possible self-harm, intervene as necessary to protect the rights and safety of others, approach/speak in calm manner, divert attention, remove from situation and take to alternative location as needed, monitor resident closely during med administration, notify psych as needed, notify social services in assistance in suicide prevention, observe for behaviors. Document, observe behavior and attempted intervention, and praise any indication of the resident's progress/improvement in behavior,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	provide 1 on 1 supervision until Emergency Care Plan can be held to discuss next steps. Remove potentially dangerous items from room (belts, shoestrings, electrical cords, call bell cord, glass, aluminum cans, silverware date initiated 7/31/2023. Serve resident on disposable dishes and cups- date initiated 7/31/2023. Social Services or designee to arrange transfer to an acute inpatient setting- date initiated 7/31/2023. Social Services or designee to arrange transfer to an acute inpatient setting. Serve resident on disposable plates or cups. Provide one on one supervision until emergency care plan can be held to discuss next steps. The clinical record lacked the documentation to show the facility had tried to assist the resident in finding another placement closer to home. On 7/25/2023 at 10:12 A.M., the Psych NP called with a new order to increase Mirtazapine (Remeron) from 15 mg (milligrams) to 30 mg at HS (hour of sleep). A Suicidality Screener form, dated 7/25/2023, indicated Resident 2 had no thoughts of hurting himself. A Psychosocial Note, dated 7/25/2023 at 3:59 P.M., indicated the resident appeared to have a flat affect. "...The resident reported "I want to go to my room and lay down." SSD will follow...." A Health Status Note, dated 7/27/2023 at 3:16 P.M., indicated the resident refused all meds that morning. A Behavior Note, dated 7/27/2023 at 5:32 P.M., indicated LPN spoke to resident about AM medication refusal. Ask if med administration			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	times changed to HS if resident would take medications, then? Resident stated no he was already dead and hoped to have a seizure to die. Resident indicated the only reason he was taking his HS meds was for his sleeping pill. A Care Management Note, dated 7/28/2023 at 1:43 P.M., indicated "... the SSD met with resident to discuss his refusal of medication and making statements to nursing that he wanted to die. SSD asked if he wanted to hurt himself. He replied no. Why do you want to die? I don't know. What can we do to help you? Nothing. Do you want to try a short-term psych stay? No, that will not do any good. Can we discuss taking your medications? No. Do you want discharged? I have nowhere to go. Do you have friends you can stay with? No. Is there anything we can do to make it more acceptable? No...." A Suicidality Screener form dated 7/31/2023 indicated: "...A). Have you had thoughts of actually hurting yourself? Yes. (1) Have you attempted to harm yourself in the past? Yes. (2) Have you thought about how you might actually hurt yourself? Yes. How? Wrapping phone cord around neck, pulling hard, tight, and upward. (3) There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life sometime over the next month? His response was "c" very likely. (4) Anything that would prevent or keep you from harming yourself? No. Risk category...higher risk...." A Behavior Note, dated 7/31/2023 at 5:48 P.M."...resident propelled self to his room, rang his bell to get in bed. Resident assisted by staff. Approximately 10 minutes later [Name of Nurse]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	received phone call from ex-girlfriend that resident had posted a picture on [social media application] with a cord around his neck attempting to commit suicide. [Name of Nurse] immediately went to resident room to find resident hold his phone with the picture posted with cord around his neck. Cord was telephone charger tightly wrapped around neck x 2. When [Name of Nurse] asked resident he began to pull hard and upward on the cord. [Name of Nurse] had to struggle with resident to get fingers under the phone cord due to attempting to strangulate self. [Name of Nurse] took phone cord and called management. Instructed to place resident with one-on-one care...." A Behavior Note, dated 7/31/2023 at 9:05 P.M., indicated "...Resident on one-on-one supervision since 6:15 P.M. (Health facility) called for assessment for emergency psych placement. Resident initially refused, and EDO [Emergency Detention Order]was obtained by [Name of MD]. At this time has agreed to labs for placement and voiced understanding of need for psych eval and wiliness to go. Openly admitted to writer, ED [Executive Director] and mobile crisis that he does not want to live and has suicidal ideations. Resident asked ED to notify parents...." A Psych Progress Note, dated 8/1/2023, indicated "... the resident was seen for a suicide attempt and increased ideations. Received telephone from acting Social Worker stating that on Monday around 5:30 PM patient's girlfriend had called the facility stating patient had posted himself on [social media application] via phone with telephone cord wrapped around his neck. Staff ran to his room and found patient with a telephone cord wrapped tightly around his neck. They wrestled the cord off his neck and patient			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	continued to express suicidal ideations to end his life. Pt has had Suicidal attempts in the past per family. Staff also report that last week he had reported SI with no plan, and he was put on: 1 to 1 staff monitoring over the weekend per social worker. Pt needs psychiatric referral for inpatient psychiatric stay for treatment and stabilization...." A Health Status Note dated 8/1/2023 at 2:36 P.M., "...resident transferred with one-on-one staff to [Name of Hospital]...." During an observation, on 11/14/2023 at 3:45 P.M., the following items were noted in the resident's room: a gait belt, phone charger cord x2, and call light cord that was approximately at least 8 ft. in length, shoelaces in his tennis shoes and a play station cord, as well as 2 aluminum cans on bedside table. On 11/15/2023 at 4:30 P.M., the Director of Nursing provided the policy titled, "Suicide Precautions", with a reviewed date of 8/22/0223, and indicated the policy was the one currently used by the facility. The policy indicated " ...The facility will assess residents who verbalize either through the PHQ-9 interview, or through other conversations, thoughts of being better off dead, or hurting themselves in some way. Based on the assessment conducted by the facility, the facility will initiate additional interventions based on the risk category identified as part of the P4 Suicidality Screener. Residents who make attempts should be transferred to an acute setting for evaluation and reported in accordance with state regulations. Procedure: Resident with history of a suicide attempt or suicide ideation. 1. Complete the PHQ9 an P4 Suicidality Screener at or prior to admission or readmission. 2. Implement appropriate interventions based on risk level			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	identified. 3. Implement a resident specific safety plan that includes mental health follow-up. Expression of a Suicidal Ideation by a Resident. 1. Complete the P4 Suicidality Screener. 2. Report findings to the Director of Nursing, Executive Director, Social Service, and attending physician. 3. Make resident responsible party aware of risk and verbalizations. 4. Based on risk category, implement the following: Minimal Risk- Refer to mantal health provider. Develop/update an individualized care plan to address behavior. Lower Risk- Refer to mental health provider. Provide one on one supervision until emergency care plan meeting can be held to discuss next steps. Develop/update an individualized care plan to address behavior. Remove potentially dangerous items (e.g., belts, shoestrings, electrical cords, call bell cord, glass, aluminum cans, silverware). Resident should be served on disposable dishes and cups. Monitor resident closely during medication administration. Higher Risk- Refer to mantal health provider. Develop/update an individualized care plan to address behavior. Lower Risk- Refer to mental health provider. Provide one on one supervision until emergency care plan meeting can be held to discuss next steps. Develop/update an individualized care plan to address behavior. Remove potentially dangerous items (e.g., belts, shoestrings, electrical cords, call bell cord, glass, aluminum cans, silverware). Resident should be served on disposable dishes and cups. Monitor resident closely during medication administration. Documentation: 1. The 1-1 observations should be documented by the caregiver. 2. Nursing and Social Services documents observations, efforts, interventions, and resident response in progress notes. 3. Maintain communication with attending physician off recommendations made by mental health professionals. 4. End safety precautions			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	when the interdisciplinary team, mental health consultant, social worker, and attending physician concur that they are no longer necessary. Secure a physician order to terminate the precautions ...." During an interview, on 11/16/2023 at 8:58 A.M., LPN 3 indicated "...it was at the end of my shift when the ex-girlfriend called screaming at me to go and check on him. I found him lying in bed with the charger cord for the phone wrapped around his neck twice. I asked him what was going on. He kept pulling on the cord tighter with his right hand. I had to dig underneath the cord to get my fingers under the cord. We took out the call light until we could find a bell, and his tennis shoes were put out of reach. He was brought to the nurse's station . The ED [Executive Director], the MD were called. He was his own POA [Power of Attorney]." LPN 3 indicated a staff member from [name of psychiatric facility] came to do an assessment. The resident was on one on one." When questioned, LPN 3 indicated in her professional opinion, with all the documentation he was at high risk for trying to commit suicide. He should have been put on alert charting for 72 hours on 7/5/2023 until 7/8/2023. There was no alert charting put in place after 7/5/2023 to alert nursing of any concerns of suicide...." During an interview, on 11/16/2023 at 9:57 A.M., QMA (Qualified Medication Aide) 4 indicated, she did not remember a whole lot. She indicated she had removed the call light, shoelaces she thought and the phone cord. He was moved to the nurse's station and placed on one on ones. The ED was called, and we were all working together to get him sent out."			
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on record review and interview, the facility failed to report a positive QuantiFERON Gold test (Tuberculosis skin test) to the Indiana Department of Health for 1 of 1 resident reviewed for reportable diseases. (Resident D) Finding includes: A Health Status Note, dated 5//31/2023, indicated the lab called with a positive Tuberculosis (TB).	F 0880	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident D was assessed by the attending physician and determined to have no negative outcomes. The attending dermatologist was also notified,	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	NP (Nurse Practitioner) at facility and made aware. Resident D indicated, he had a chest X-ray for this situation in April 2023, and voiced several years ago having a positive PPD (Purified Protein Derivative) then having a chest X-ray done resulting in a negative result. A Health Status Note, dated 6/2/2023, indicated a Chest X-ray was required related to a positive TB result. A Health Status Note, dated 6/3/2023, indicated: Chest X-ray results received. No tuberculosis seen. NP notified. A Progress Note, dated 6/7/2023, from the Dermatologist indicated that Resident D had a positive tuberculosis skin test and was referred to Infectious Disease for treatment of tuberculosis. An Infectious Disease Progress Note, dated 9/7/2023, indicated the resident had latent tuberculosis and required oral medications (Isoniazid and Pyriodoxine) for nine months. During an interview, on 11/16/2023 at 2:40 P.M., the Infection Preventionist Nurse (IP) indicated that it was her responsibility to notify the Indiana Department of Health of certain diseases. The IP indicated that the facility didn't report Resident D's positive tuberculosis test but they should have. On 11/17/2023 at 9:50 A.M., the IP provided a policy title, "Reportable Conditions and Diseases (Indiana)", dated 4/17/2023, and indicated the policy was the one currently used by the facility. The policy indicated, " ...All practitioners, hospitals, and laboratories in Indiana are required to notify the Indiana State Department of Health		and the medications were reimplemented. Laboratory reports have been sent to the appropriate physician for review. The care plan has been updated to reflect the current status of the resident. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** A one-time review of current resident population for signs and symptoms of TB has been completed with no other residents identified as having signs and symptoms of TB. A one-time review has been completed on medication orders and lab orders to validate compliance. Education has been completed for the Infection Preventionist and back up person(s) for reporting communicable diseases to the appropriate entities. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** It is the responsibility of the facility staff to report communicable diseases to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	of diseases or conditions of public health significance ..." The policy cites, "2023 Indiana Reportable Disease List for Healthcare Providers and Hospitals" as a guide for which diseases or conditions need to be reported and the time frame to be reported...." On 11/17/2023 at 10:30 A.M., the IP provided a document titled, "2023 Indiana Reportable Disease List for Healthcare Providers and Hospitals", dated 3/2/2023, and identified it as the current list of diseases and time frames for reporting diseases to the Indiana Department of Health. The list had tuberculosis disease cases and suspected cases listed as a reportable disease that should be reported within one working day...." This Federal tag relates to complaint IN00420938. 3.1-18 (7)		appropriate entities. The DON/designee will be responsible to review residents with infections upon identification to validate the need for reporting a communicable disease, and validating the reporting criteria has been completed. Any issues identified will be immediately corrected, up to and including disciplinary action as determined necessary by the Director of Nursing and/or Administrator. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The reviews completed and actions taken will be reviewed by the Administrator upon occurrence. Results of the reviews will be reviewed in the Quality Assurance Performance Improvement Committee meetings monthly for 3 months, and then quarterly for 2 quarters. Any further action or revision will be determined by the QAPI review. The Administrator is responsible for achieving and maintaining compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	11/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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