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	11/01/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00445259. Complaint IN00445259 - Federal/state deficiencies related to the allegations are cited at F689 Survey dates: October 29, 30, 31 & November 1, 2024 Facility number: 000325 Provider number: 155379 AIM number: 100274300 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 5 Medicaid: 40 Other: 6 Total: 51 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 11/7/2024	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.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent an alert and oriented male resident (Resident B) from entering a severely cognitive impaired female resident's (Resident C) room and exposing himself, while kneeling on her	F 0689	**What corrective actions will be accomplished for those residents found to be affected by this deficient practice**: 1 Resident C no longer resides at this facility.	12/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Wagner	Executive Director	11/22/2024

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	bed. Finding includes: A self-reported incident #492, dated 10/12/24, indicated "...Male resident found in female resident's room sitting on the foot of the bed with pants around ankles. Female resident lying on her back with her pants down around her ankles. No observation of any physical contact...." The report indicated Residents B (male) and Resident C (female) were placed on 1:1 observations by facility staff members. Family members, the facility physician and police were notified of the incident. The incident follow-up, dated 10/17/24, indicated Resident B was provided education and Resident C was evaluated by the psychiatric NP, on 10/15/24, with no new orders received. The 1:1 observations were continued for both Residents and a motion sensor had been in place at Resident C's doorway. The incident follow-up indicated after the completion of the investigation, it was determined neither resident had any negative outcomes and the facility concluded this was not an abusive situation. A typed statement, signed by the Social Service Director (SSD) indicated " ...On 10/12/24, SSD walked down to [name of Resident B] room to let him know it was time for a shower. [Name of Resident B] walked down with SSD to the shower room when it was occupied by another resident. [Name of Resident B] turned around and walked back down the hallway. SSD assisted the other resident out of the shower room. Walked back down the hallway to inform [name of Resident B] that the shower room was open. When SSD walked into [name of Resident B] room he was not in there. SSD turned around to walk down the hall looking for [name of Resident B] when [name of		2 Resident B no longer resides at this facility. **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 Residents with cognitive impairment have the potential to be affected. These residents had their care plans and Kardex updated to reflect diversional interventions and staff to redirect if any suspicious behavior is noted between residents. 2 Residents with known sexual behaviors had care plans reviewed and updated to reflect measures being used to address. 3 Abuse audit completed on in-house residents. If non-interviewable responsible party contacted for interview. No issues were noted. **What measures and what systemic changes will be made to ensure the practice does not recur** 1 Associates of all disciplines will be provided with education on abuse, including types of abuse including sexual abuse, managing sexual behaviors with cognitively impaired residents that meet the above criteria including redirection techniques and increased supervision when indicated. No staff will work past date of compliance without this education being completed.	

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	Resident C] door was noticed to be closed. SSD opened [name of Resident C] door, door alarm did not sound, SSD pulled back the privacy curtain. [Name of Resident B] was sitting at the end of [name of Resident C] bed with his pants down around his ankles and [name of Resident C] was laying down at the head of the bed with her pants down around her ankles as well. [Name of Resident B] got up and pulled his pants up and walked out of the room with SSD. While walking out of the room SSD checked door alarm, turned it back on and ensured it was working before walking [name of Resident B] to the shower room...." A typed interview, signed by the Administrator and SSD, dated 10/12/24, indicated "...An interview was conducted with [name of Resident B] and Social Service Director (who had witnessed the incident). When asked what he was doing in room 214. He stated just talking. When it was explained to [name of Resident B] what the staff witnessed, [name of Resident B] denied that he was sitting on the end of the bed with his pants down around his ankles. When explained to [name of Resident B] what the witness had stated, [name of Resident B] still denied his pants were not down and he was just talking ...." 1. On 10/29/24 at 11:00 A.M., a review of the clinical record for Resident B was conducted. The resident's diagnoses included, but were not limited to; peripheral vascular disease, hypertension, anxiety and a left metatarsal (toe) amputation. A Behavioral Care Plan, dated 8/19/24, indicated the resident had sexual inappropriateness. Interventions included but were not limited to; "...discuss The resident's behavior.		2 New staff will receive this education prior to working. **How will the corrective action be monitored to ensure the deficient practice will not recur:** 1 The SSD/Designee will monitor the behavior documentation in the eMAR 5x/week to identify any documented sexual behaviors. This will be ongoing. 2 DON/Designee will review the 24/72 hour report 5x/week to identify documented sexual behaviors. This will be ongoing. 3 IDT will review and update care plans and Kardex with appropriate interventions as indicated. 4 The results of these reviews will be discussed monthly at the QAPI meeting for a total of 3 months and then quarterly thereafter. Frequency and duration of the reviews will be increased as needed. Compliance date: 12.01.24 The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	

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	Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident...." A Psychiatry Progress Note, dated 9/20/24, indicated "... Patient is NOT currently a danger to self/others...." The note indicated Resident B's judgement and thought processes were intact and he had "good insight." A Quarterly Minimum Data Set (MDS) assessment, dated 10/2/24, indicated the resident was cognitively intact, was independent with transfers, walked independently, required supervision/cues for lower body dressing/undressing, was able to sit to stand independently and able to lie flat in bed without any assistance. A Nursing Progress Note, dated 10/12/24 at 10:16 A.M., indicated the SSD had opened Resident C's door and found the privacy curtain pulled around Resident C's bed. After opening the curtain, Resident B had been found in Resident C's room, sitting at the end of the bed, with his pants down. Resident B was asked to leave the room. A Nursing Progress Note, dated 10/12/24 at 3:25 P.M., indicated Resident B remained on 1:1 observations and his room change, had been completed. A Psychiatry Progress Note, dated 10/14/24, indicated Resident B was seen due to sexually inappropriate behavior via telehealth by the Nurse Practitioner (NP). It was reported to the NP, Resident B had been found with another resident, who had dementia, with his pants down. Resident B "...denied his intentions but then confessed to the social worker of his intentions." When discussing the incident with the patient via			

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	telehealth, he reported " I do not remember anything" and refuses to talk about the incident. He was calm and kept repeating that he did not remember anything, although he had good recall of recent events such as what he ate for breakfast. Discussed boundaries with female residents. Pt [patient] has Dx [diagnoses] (depression). Pt is currently on 1:1 observation. ASSESSMENT AND PLAN 1. Inappropriate sexual behavior: Pt attempted to have sexual contact with a dementia resident Continue 1:1, Care plan with patient on boundaries....." A Psychiatry Progress Note, dated 10/18/24 indicated Resident B had been seen for a follow-up visit for sexually inappropriate behavior. Resident B continued to state he did not have any recollection of event. Resident B appeared to know and realize he would be transferred to another facility, per the plan of care. Resident B remained on 1:1 observations, from facility staff, until he was discharged to another facility on 10/18/24. 2. On 10/29/24 at 11:51 A.M., a review of the clinical record for Resident C was conducted. The record indicated the resident was admitted to the facility on 5/13/24. The resident's diagnoses included, but were not limited to; cancer, dementia and anxiety. A Quarterly Minimum Data Set (MDS) assessment, dated 8/19/24, indicated the resident was severely cognitively impaired, required supervision/cues for lower body dressing/undressing, was able to sit to stand independently and able to lie flat in bed without any assistance.			

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	A Care Plan, dated 8/19/24, indicated Resident C had episodes of masturbating with inappropriate objects and was at risk for self harm. The interventions included, but were not limited to: maintain safety during masturbation, offer privacy and consult psychiatric services as needed. A Care Plan, dated 8/19/24, indicated the resident had a behavior problem related to dementia, poor impulse control and had become sexually inappropriate in social areas. The interventions included, but were not limited to: document inappropriate behaviors, intervene as necessary to protect the safety of others, divert attention, offer to return resident to her room for privacy and refer to psychiatric services as needed. A Psychiatric Progress note, dated 8/23/24, indicated Resident C was a poor historian due to cognitive/psychiatric impairment. Resident had been seen for a follow-up visit for sexual hyperactivity. Resident C had been going into male rooms and soliciting sex. Pt has dementia and staff report that she has been having orgasms. Resident appeared calm and did not appear anxious. The Note indicated the resident had severe impairment of judgement and insight with poor short-term and long term memory. A Nursing Skin Integrity form, dated 10/12/24 at 10:28 A.M., indicated a skin inspection was conducted and indicated Resident C's skin was normal. There was no documentation which indicated the resident's vaginal area had been examined for tears, reddness or bruising. A Nursing Progress Note, documented by LPN 2, dated 10/12/24 at 3:17 P.M., indicated Resident C had left the dining room after her breakfast meal and followed LPN 2 to the medication cart, had			

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	medications administered and then the resident proceeded to return to her room. The note indicated LPN 2 had continued to pass more medications and then returned to her medication cart, near the nurse's station. LPN 2 was contacted by the Social Service Director, who reported she had found Resident B in Resident C's room. Resident C had her knees bent with legs apart, with her pants around her ankles. Resident B was sitting at the foot of the bed, pulling up his pants. The residents were separated from one another. Resident C went out of the facility with her daughter and will be place on 1:1 supervision when she returned. A form titled, "BIMS/Staff Assessment for Mental Status", dated 10/12/24, indicated Resident C had a cognitive x deficit and needs were anticipated by staff. "...Resident is able to make simple daily decisions, when presented with choices, such as what to wear, eat and activities to participate in...." A Nursing Progress Note, dated 10/12/24 at 10:08 P.M., indicated the resident returned from LOA (Leave Of Absence) with her daughter. A Nursing Progress Note dated 10/13/24 at 1:06 A.M., indicated Resident C continued to have 1:1 staff observations and had received a head to toe skin assessment, with no new skin issues noted. A Nursing Progress Note, dated 10/13/24 at 12:32 P.M., indicated Resident C had stayed in her room, with the doorway alarm activated. Resident C had been observed walking in her room, walking to the bathroom and showed no interest in coming out of her room. The note indicated the resident had meal trays delivered to her room. A Psychiatric Progress Noted, dated 10/16/24,			

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	indicated Resident C required a teleheath visit due to sexual inappropriate behaviors. The resident was unable to follow the conversation due to dementia and memory loss and had no recollection of the incident. The Resident had a tendency to wander around and into other resident rooms. The note indicated Resident C had been found with a male resident. A Psychosocial Note, dated 10/21/24 at 9:44 A.M., indicated the resident had been discharged to another facility on 10/18/24. During an interview, on 10/29/24 at 1:38 P.M., the Social Service Director (SSD) indicated she had walked with Resident B, to the shower room. When they arrived, the shower was occupied, so Resident B was observed by the SSD heading back towards his room. She then assisted the resident who had completed their shower out of the area, then proceeded to return to Resident B's room to inform him the shower room was available, but he was not in his room. As she walked back down the hallway, she noticed Resident C's door was closed, which was not normal, as she always had her door opened. The SSD indicated she stepped into the room and noticed the alarm (to alarm staff of anyone entering or exiting the room) had been turned off and Resident C's curtain was pulled. She pulled the curtain back to observe Resident B, on the bed, on his knees, with his pants/underpants around his ankles, facing Resident C. Resident C was observed to be lying down, face up, with her legs near where Resident B had been kneeling. The SSD indicated she observed Resident C with her pants/underwear down around her ankles. Resident B was observed by SSD to immediately pull up his pants and walk out of the room. She walked with him, away from Resident C's room, to			

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	the shower room, after she reset the door alarm. Resident B was then moved to a different room on another hallway, after his shower. The police had been contacted, as well as Resident C's daughter. The SSD indicated the daughter came to the facility and took the resident out of the facility for awhile and then brought her back to the facility, later the same day. The SSD indicated she had not observed if the male resident had an erection when she entered the room. During an interview, on 10/29/24 at 2:38 P.M., LPN 2 indicated she had went to the dining room to ask Resident C to walk with her to the medication cart, so she could administer Resident's medication. LPN 2 indicated Resident C went down the hallway and into her room and LPN 2 followed her and turned the doorway alarm on. LPN proceeded to go into another resident's room, across the hallway, to administer medications. After she had completed the administration task she went back to the nurse's station. Then she heard SSD yelling for assistance. She heard the SSD tell a resident to get dressed and heard her ask Resident B what he had been doing. Resident B replied "just talking and I'm sorry" LPN 2 went into Resident C's room and observed her dressed and seated on the side of her bed. LPN 2 then did a full skin assessment of Resident C and then she assessed Resident B. She did not talk to the daughter or call the police, as supervisors were in the facility. However, LPN indicated the daughter came in around lunch time and took Resident C out of the facility for a few hours. During an interview, on 10/29/24 at 253 P.M., the Administrator indicated she had contacted the daughter and the police. The Administrator indicated she had suggested, to the daughter, to			

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	take her out of the facility for a while. She indicated the physician had been notified, of the incident, and did not direct the facility staff to send Resident C for an examination at the local hospital. On 10/29/24 at 10:46 A.M., the Administrator provided a policy titled, "Abuse - Prevention", dated 6/17/24, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility to prevent and prohibit all types of abuse...Procedure...4. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as: a. Verbally aggressive behavior; b. Physically aggressive behavior; c. Sexually aggressive behavior; d. Taking, touching, or rummaging through other's property; e. Wandering into other's rooms/space...." This citation relates to Complaint IN00445259. 3.1-45(a)(2)			