

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155379	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/30/2012
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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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K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 07/30/12</p> <p>Facility Number: 000325 Provider Number: 155379 AIM Number: 100274300</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Life Care Center of Rochester was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and no smoke detectors in the resident rooms. The facility has a capacity of 141 and had a census of 111 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage, however, not in compliance with smoke detector coverage.</p>	K0000		

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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	<p>All areas where the residents have customary access were sprinklered.</p> <p>The facility had one detached garage used for facility storage which were not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident 's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice could affect at least 111 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 07/30/12 from</p>			K9999	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of the federal and state law.</p> <p>K9999</p> <p>I. Smoke detectors were installed in additional 66 resident rooms identified in the citation as potentially affected.</p> <p>II. No additional residents were potentially affected by cited practice. An additional facility-wide audit was conducted to ensure that no further resident rooms required additional smoke detectors. None were required in resident rooms.</p> <p>III. Education will be provided to staff related to compliance with P.L. 73-2007. The additional smoke detectors were added to the center's existing preventative maintenance program. A performance improvement tool has been developed to ensure ongoing compliance. The Maintenance Director or designee will utilize the tool to monitor that additional smoke detectors are in place and are working properly weekly, for 30 days.</p> <p>IV. The Maintenance Director, or</p>		08/28/2012

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	<p>1:30 p.m. to 2:15 p.m. with the Maintenance Supervisor, all sixty six resident rooms were not provided with smoke detectors. Based on interview on 07/30/12 concurrent with the observations, the Maintenance Supervisor acknowledged all the resident rooms were not provided with smoke detectors.</p> <p>3.1-19(ff)</p>		<p>designee will review findings weekly and report to the Performance Improvement Committee monthly for 6 months to determine the need for continued monitoring thereafter. Compliance: 08.28.12</p>		