

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 06/20/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 827 W 13TH ST ROCHESTER, IN 46975
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/20/13</p> <p>Facility Number: 000325 Provider Number: 155379 AIM Number: 100274300</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Life Care Center of Rochester was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</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 battery powered smoke detectors in the resident rooms. The facility has a</p>	K010000		

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>capacity of 141 and had a census of 93 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had one detached garage used for facility storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 22 residents on 200 hall as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 06/20/13 at 1:46 p.m. with the Maintenance Supervisor, the oxygen storage room on 200 hall used to store and transfer oxygen was provided with electrically powered mechanical ventilation, but it was not working. Based on interview on 06/20/13 at 1:50 p.m., it was acknowledged by the the</p>	K010143	<p>The oxygen storage room on 200 hall is to store and transfer oxygen and is provided with electrically powered mechanical ventilation. What corrective action will be accomplished for those residents found to have been affected: 1. Oxygen storage room mechanical ventilation fan replaced on 7.1.13 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: 2. Facility has only 1 oxygen room, whole house audit not applicable, no other residents are affected What measures will be put into place or what systemic changes will be made to ensure that the</p>	07/01/2013			

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	Maintenance Supervisor this room was used to transfer oxygen and though it had an electrically powered mechanical vent, it was not working at the time of inspection. 3.1-19(b)		deficient practice does not recur: 3. Director of Maintenance educated to ensure ventilation in working order and audit to be conducted weekly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4. Director of Maintenance will complete weekly audit tool and will submit results monthly to QA for 6 months. What date the systemic changes will be completed: 5. Date of Completion: 7.1.13		