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	09/20/2024

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 a Recertification and State Licensure Survey. Survey dates: September 16, 17, 18, 19 & 20, 2024. Facility number: 000325 Provider number: 155379 AIM number: 100274300 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 2 Medicaid: 43 Other: 8 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 10/01/2024	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 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to provide a transfer and discharge form for 3 of 3 residents reviewed for hospitalization. (Residents 16, 2 and 44) Findings include: 1. A record review for Resident 16 was completed on 9/17/2024 at 1:36 P.M. Diagnoses included, but were not limited to: paraplegia, pressure ulcer	F 0623	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	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Wagner	Executive Director	10/11/2024

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	sacral region, schizoaffective disorder, pressure ulcer left hip, neuromuscular dysfunction of bladder, unspecified psychosis and presence of urogenital implants. An Annual Minimum Data Set (MDS) assessment, dated 7/11/2024, indicated Resident 16 was cognitively intact, and he received antipsychotic medication. He had four stage 4 pressure ulcers and had an indwelling bladder catheter. A Nursing Progress Note, dated 3/27/2024 at 1:09 P.M., indicated Resident 16 had exhibited an increase in delusional behavior and a referral was made to the neuropsychiatric hospital. Resident 16 agreed he needed more assistance with psychiatric services due to his "mind was racing". Resident 16 was accepted for admission, and his guardian was informed of the pending admission. A Behavioral Health History and Physical Examination, dated 3/27/2024, indicated Resident 16 was admitted to the neuropsychiatric hospital on 3/27/2024. Resident 16 returned to the facility on 4/4/2024. A Nursing Progress Note, dated 6/27/2024 at 7:36 A.M., indicated Resident 16 left the facility for outpatient surgery for placement of a colostomy related to stage 4 wounds with a possible skin graft in the future. Resident 16 returned to the facility on 7/1/2024. A Nursing Progress Note, dated 7/7/2024 at 6:45 P.M., indicated Resident 16 had a significant amount of frank blood coming from his penis after a change of the suprapubic catheter. The nurse practitioner was contacted and advised to send		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-623 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Residents #2, 16, and 44 still reside at the facility. An in-house audit has been completed by the Social Service Director before survey exit to ensure transfer/discharges were logged correctly which included notification to the Ombudsman. At the time of the audit only 1 transfer/discharge could be located. *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 Other residents have the potential to be affected therefore SSD will complete another in house audit of transfers/discharges on residents who have left facility for the above	

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	Resident 16 to the emergency department for an evaluation. Resident 16 was transferred to the local hospital via emergency management services (EMS). A Nursing Progress Note, dated 7/8/2024 at 1:30 A.M., indicated Resident 16 returned from the emergency department During an interview, on 9/19/2024 at 2:26 P.M., the Social Service Director indicated the transfer and discharge form could not be located for transfers from the facility on 3/27/2024, 6/27/2024, and 7/7/2024. During an interview, on 9/20/2024 at 10:26 A.M., LPN 4 indicated a transfer and discharge form was to be sent for any transfer to the hospital. 2. During an interview with Resident 2, on 9/17/2024 at 10:34 A.M., she indicated she had been hospitalized four times for pneumonia recently. A record review for Resident 2 was completed on 9/18/2024 at 2:20 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 with neuropathy, emphysema, atrial fibrillation, and paranoid personality disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 7/31/2024, indicated Resident 2 was cognitively intact. The assessment indicated her primary medical categories were debility and cardiorespiratory conditions. She had a diagnosis of respiratory failure and chronic lung disease. A Nursing Progress Note, dated 2:55 P.M., indicated Resident 2 was lethargic, had oxygen saturations of 87 percent and lungs sounds were		reasons to ensure compliance by date of compliance. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. The Social Service Director was educated by the Executive Director on the Transfer/Discharge policy. The SSD will educate licensed nursing on the transfer/discharge policy to ensure if after hours this will be completed accurately as well. This education will be completed upon hire, at least annually, and PRN. No SSD/or designee/licensed nursing staff will work past date of compliance with out this education being completed. *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. Transfers and discharges will be reviewed Monday through Friday in morning meeting. The Social Service Director/designee will audit transfer/discharges logs 3x weekly for 3 months, 2x weekly for 2 months and 1x weekly for 1 month. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%.	

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	diminished with no air movement. New physician orders were obtained to treat Resident 2 in-house with the following: oxygen, a chest x-ray, Rocephin (antibiotic), Prednisone (steroid) and Mucinex (expectorant). A Nursing Progress Note, dated 6/16/2024 at 10:49 P.M., indicated the nurse practitioner gave an order to send Resident 2 to the emergency department for an evaluation and treatment. A Nursing Progress Note, dated 6/22/2024 at 10:55 A.M., indicated Resident 2 was readmitted to the facility after being placed in the Intensive Care Unit (ICU) at the hospital for altered mental status, acute respiratory failure, sepsis, urinary tract infection and bilateral lower extremity cellulitis. A Nursing Progress Note, dated 7/18/2024 at 2:17 P.M., indicated an order was received to send Resident 2 to the emergency department for an evaluation and treatment. A report was given to the emergency department nurse and indicated Resident 2 was confused, lethargic, responded to her name, but falls back asleep. A Nursing Progress Note, dated 7/22/2024 at 4:27 P.M., indicated Resident 2 returned to the facility from the hospital. A Nursing Progress Note, dated 7/24/2024 at 1:07 A.M., indicated the nurse noted Resident 2's left toes/foot had a purplish/blackish discoloration. Resident 2 complained of sharp pain to her left foot. There was no known injury to Resident 2's left foot/toes. Resident 2 was sent to the emergency department at 10:20 P.M. She arrived back to the facility, at 1:07 A.M., with no fracture, but edema noted.		Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	

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	During an interview, on 9/19/2024 at 2:26 P.M., the Social Service Director indicated a transfer and discharge form could not be found for Resident 2's transfers to the emergency department on 6/16/2024, 7/18/2024 and 7/2024. During an interview, on 9/20/2024 at 10:26 A.M., LPN 4 indicated a transfer and discharge form should be sent for any transfer to the hospital. 3. During an interview with Resident 44, on 9/17/2024 at 11:22 A.M., she indicated she had been hospitalized with shortness of breath. A record review for Resident 44 was completed on 9/18/2024 at 1:33 P.M. Diagnoses included, but were limited to: chronic obstructive pulmonary disease (COPD), tracheostomy, chronic respiratory failure, and obstructive sleep apnea. A Quarterly Minimum Data Set (MDS) assessment, dated 8/3/2024, indicated Resident 44 was cognitively intact. and she received treatments of oxygen, suctioning, tracheostomy care, and non-invasive mechanical ventilation. A Nursing Progress Note, dated 7/14/2024 at 9:00 P.M., indicated Resident 44 had difficulty breathing with an oxygen saturation of 82 percent on three liters of oxygen. Resident 44's oxygenation levels continued to drop with oxygen saturations reading erratically between 36-46 percent with respirations of 28-34 per minute. EMS was called and Resident 44 was transported to the emergency department. A Nursing Progress Note, dated 7/29/2024 at 5:08 P.M., indicated Resident 44 was readmitted to the facility with respiratory failure due to pneumonia and fluid overload.			

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	During an interview, on 9/19/2024 at 2:26 P.M., the Social Service Director indicated a transfer and discharge form could not be found for Resident 44's transfer to the emergency department on 7/14/2024. During an interview, on 9/20/2024 at 10:26 A.M., LPN 4 indicated a transfer and discharge form should have been sent for any transfer to the hospital. A policy for a transfer and discharge form was requested on 9/20/24. A policy was not provided. 3.1-12(a)(6)(A)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to provide a bed hold form for 3 of 3 residents reviewed for hospitalization. (Residents 16, 2, and 44) Findings include: 1. A record review for Resident 16 was completed on 9/17/2024 at 1:36 P.M. Diagnoses included, but were not limited to: paraplegia, pressure ulcer sacral region, schizoaffective disorder, pressure ulcer left hip, neuromuscular dysfunction of bladder, unspecified psychosis, and presence of urogenital implants. An Annual Minimum Data Set (MDS) assessment, dated 7/11/2024, indicated Resident 16 was cognitively intact, and he received antipsychotic medication. He had four stage 4 pressure ulcers and had an indwelling bladder catheter.	F 0625	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	10/18/2024

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	A Nursing Progress Note, dated 3/27/2024 at 1:09 P.M., indicated Resident 16 had exhibited an increase in delusional behavior and a referral was made to the neuropsychiatric hospital. Resident 16 agreed he needed more assistance with psychiatric services due to his "mind was racing". Resident 16 was accepted for admission, and his guardian was informed of the pending admission. A Behavioral Health History and Physical Examination, dated 3/27/2024, indicated Resident 16 was admitted to the neuropsychiatric hospital on 3/27/2024. Resident 16 returned to the facility on 4/4/2024. A Nursing Progress Note, dated 6/27/2024 at 7:36 A.M., indicated Resident 16 left the facility for outpatient surgery for placement of a colostomy related to stage 4 wounds with a possible skin graft in the future. Resident 16 returned to the facility on 7/1/2024. A Nursing Progress Note, dated 7/7/2024 at 6:45 P.M., indicated Resident 16 had a significant amount of frank blood coming from his penis after a change of the suprapubic catheter. The nurse practitioner was contacted and advised to send Resident 16 to the emergency department for an evaluation. Resident 16 was transferred to the local hospital via emergency management services (EMS). A Nursing Progress Note, dated 7/8/2024 at 1:30 A.M., indicated Resident 16 returned from the emergency department During an interview, on 9/19/2024 at 2:26 P.M., the		or will take the actions set forth in this plan of correction. We respectfully request a desk review. F-625 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Residents # 2, 16 and 44 have had no negative outcomes related to alleged deficient practice. 2. An in-house audit was completed by Social Service Director before survey exit to ensure the notice of bed hold policy was completed. During the audit Social Service could not locate bed hold documentation for residents #2, 16 and 44. *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. An In house audit will be completed on residents to ensure that bed hold policies are in place and ensure compliance. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1.Nursing staff and SSD will be educated on the bed hold policy by date of compliance by ED and SSD. This education will also include the use of binders that will be located at both nursing stations with a check list to ensure bed holds have been completed timely	

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	Social Service Director indicated a bed hold form could not be located for Resident 16's transfers from the facility on 3/27/2024, 6/27/2024, and 7/7/2024. During an interview, on 9/20/2024 at 10:26 A.M., LPN 4 indicated a bed hold policy should have been sent for any transfer to the hospital. 2. During an interview with Resident 2, on 9/17/2024 at 10:34 A.M., she indicated she had been hospitalized four times for pneumonia recently. A record review for Resident 2 was completed on 9/18/2024 at 2:20 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 with neuropathy, emphysema, atrial fibrillation, and paranoid personality disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 7/31/2024, indicated Resident 2 was cognitively intact. The assessment indicated her primary medical categories were debility and cardiorespiratory conditions. She had a diagnosis of respiratory failure and chronic lung disease. A Nursing Progress Note, dated 2:55 P.M., indicated Resident 2 was lethargic, had oxygen saturations of 87 percent and lungs sounds were diminished with no air movement. New physician orders were obtained to treat Resident 2 in-house with the following: oxygen, a chest x-ray, Rocephin (antibiotic), Prednisone (steroid) and Mucinex (expectorant). A Nursing Progress Note, dated 6/16/2024 at 10:49 P.M., indicated the nurse practitioner gave an order to send Resident 2 to the emergency department for an evaluation and treatment.		and accurately. This education will be completed at least annually, upon hire and PRN. No licensed Nurses or SS staff will work past date of compliance with out this education completed. What measures will be put in place to *ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:* 1. Bed hold documentation will be reviewed Monday through Friday in morning meeting. The Social Service Director/designee will audit transfer/discharges logs 3x weekly for 3 months, 2x weekly for 2 months and 1x weekly for 1 month. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	

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	A Nursing Progress Note, dated 6/22/2024 at 10:55 A.M., indicated Resident 2 was readmitted to the facility after being placed in the Intensive Care Unit (ICU) at the hospital for altered mental status, acute respiratory failure, sepsis, urinary tract infection and bilateral lower extremity cellulitis. A Nursing Progress Note, dated 7/18/2024 at 2:17 P.M., indicated an order was received to send Resident 2 to the emergency department for an evaluation and treatment. A report was given to the emergency department nurse and indicated Resident 2 was confused, lethargic, responded to her name, but falls back asleep. A Nursing Progress Note, dated 7/22/2024 at 4:27 P.M., indicated Resident 2 returned to the facility from the hospital. A Nursing Progress Note, dated 7/24/2024 at 1:07 A.M., indicated the nurse noted Resident 2's left toes/foot had a purplish/blackish discoloration. Resident 2 complained of sharp pain to her left foot. There was no known injury to Resident 2's left foot/toes. Resident 2 was sent to the emergency department at 10:20 P.M. She arrived back to the facility, at 1:07 A.M., with no fracture, but edema noted. During an interview, on 9/19/2024 at 2:26 P.M., the Social Service Director indicated a bed hold form could not be found for the transfers to the emergency department on 6/16/2024, 7/18/2024 and 7/2024. During an interview, on 9/20/2024 at 10:26 A.M., LPN 4 indicated a bed hold policy should have been sent for any transfer to the hospital.			

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	3. During an interview with Resident 44, on 9/17/2024 at 11:22 A.M., she indicated she had been hospitalized with shortness of breath. A record review for Resident 44 was completed on 9/18/2024 at 1:33 P.M. Diagnoses included, but were limited to: chronic obstructive pulmonary disease (COPD), tracheostomy, chronic respiratory failure, and obstructive sleep apnea. A Quarterly Minimum Data Set (MDS) assessment, dated 8/3/2024, indicated Resident 44 was cognitively intact. and she received treatments of oxygen, suctioning, tracheostomy care, and non-invasive mechanical ventilation. A Nursing Progress Note, dated 7/14/2024 at 9:00 P.M., indicated Resident 44 had difficulty breathing with an oxygen saturation of 82 percent on three liters of oxygen. Resident 44's oxygenation levels continued to drop with oxygen saturations reading erratically between 36-46 percent with respirations of 28-34 per minute. EMS was called and Resident 44 was transported to the emergency department. A Nursing Progress Note, dated 7/29/2024 at 5:08 P.M., indicated Resident 44 was readmitted to the facility with respiratory failure due to pneumonia and fluid overload. During an interview, on 9/19/2024 at 2:26 P.M., the Social Service Director indicated a bed hold form could not be found for Resident 44's transfer to the emergency department on 7/14/2024. During an interview, on 9/20/2024 at 10:26 A.M., LPN 4 indicated a bed hold form would be sent for any transfer to the hospital.			

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	A policy for the bed hold policy was requested on 9/20/24. A policy was not provided. 3.1-12(a)(25)(A)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted timely for 2 of 2 resident assessments reviewed. (Resident 20 & 47) Findings include: 1. The record for Resident 47 was reviewed on 9/19/2024. Resident 47 was admitted on 10/27/2023. A Quarterly Minimum Data Set (MDS) assessment, dated 8/5/2024, was not locked and transmitted until 9/17/2024, which was over 120 days from the admission MDS assessment that was transmitted. 2. The record for Resident 20 was reviewed on 9/19/2024. Resident 20 was admitted on 4/21/2024. A Quarterly MDS assessment, dated 5/12/2024, was not transmitted and accepted until 9/17/2024. The accepted date was over 120 days from the last assessment that was transmitted. During an interview, on 9/19/2024 at 11:20 A.M., the MDS Coordinator indicated the next assessments due were listed on her schedule and that the MDS assessment in question had been transmitted. She indicated she completed the schedule for the MDS assessments and it did not trigger on the report . She indicated she had not gone back far enough and would begin reviewing for the previous 120 days. She indicated the	F 0640	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 640 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1.Resident #20 and Resident #47 OBRA required assessments were transmitted and accepted into the CMS repository	10/18/2024

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	facility used the Resident Assessment Instrument (RAI).		9/17/2024. *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 have the potential to be affected, therefore, all required OBRA assessments for 2024 were reviewed to ensure none were incorrectly marked as “complete” in PCC. Any incorrectly closed OBRA assessments were corrected and transmitted. *What measures and what systemic changes will be made to ensure that the deficient practice doesn’t recur:* CRS, RN or designee RN will sign all assessments as complete at Z0500 following completion of the MDS document by MDSC, LPN per RAI guidelines. 1.MDSC will check that all required OBRA assessments are marked as “Export Ready” after closed by CRS, RN or designee RN *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.CRS will review PCC “complete” report for list of assessment inaccurately marked as “complete” weekly x 3 months; then every two weeks x 2 months, then monthly x 1 month to ensure	

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	155379	A. BUILDING 00 B. WING	09/20/2024

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			compliance. 2.The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, record review and interview, the facility failed to develop comprehensive person-centered care plans for a resident with edema (Resident 29) and a resident with a history of itching (Resident 34) for 2 of 20 residents reviewed. Findings include: 1. During an observation, on 9/16/2024 at 10:59 A.M., Resident 29 had +1 pitting edema (swelling with a slight indentation in the skin that was barely visible after pressure was applied) to his bilateral lower legs. During an observation, on 9/18/2024 at 10:59 A.M., Resident 29 was noted to have +1 pitting edema to his bilateral lower legs.	F 0656	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	10/18/2024

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	The record for Resident 29 was reviewed on 9/18/2024 at 10:17 A.M. Diagnoses included but were not limited to: chronic venous idiopathic hypertension, congenital malformation syndrome, muscle weakness, sleep apnea, chronic obstructive pulmonary disease, hypertension and generalized edema. The record lacked a person-centered care plan for the resident's edema. During an interview, on 9/19/2024 at 11:17 A.M., the MDS Coordinator indicated she updated and completed the care plans along with other departments personnel. MDS Coordinator indicated there was a plan which indicated the resident was at risk for edema but there were no interventions regarding edema. During an interview, on 9/19/2024 at 11:36 A.M., the DON indicated edema should have been included in care plan for Resident 29. 2. During an observation, on 9/17/2024 at 9:47 A.M., Resident 34 was noted to have scabbed over scratches on his left leg shin. The record for Resident 34 was reviewed on 9/18/2024 at 11:05 A.M. Diagnoses included but were not limited to cerebral palsy, chronic obstructive pulmonary edema, epilepsy, cognitive communication deficit, muscle weakness, dysphagia, emphysema, hypertension and difficulty in walking. Resident 29's current medications included: Triamcinolone Acetonide External Cream 0.5 % to bilateral lower extremities topically one time a day for chronic red and irritated skin, ordered		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 656 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. A care plan with interventions related to edema was added for resident #29 on 9/20/2024. A care plan with interventions related to chronic scratching was added for resident 34 on 9/20/2024. *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 have the potential to be affected, therefore, all current residents will be assessed for skin conditions and /or edema to ensure care plans are in place as appropriate. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1.DON or Designee will review all new orders and nursing documentation for evidence of exacerbation of chronic skin conditions of scratching/itching and/or chronic edema. 2.During Nursing Grand Rounds, DON or Designee will gather information regarding	

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	7/16/2024, and N-Acetyl Cysteine (NAC) 600 mg (milligrams) one capsule by mouth two times a day for skin itching, ordered 2/10/2023. A psychiatric provider note, dated 7/29/2024, indicated Resident 34 took NAC for skin itching/picking. The record lacked a person-centered care plan for Resident 34's itching. During an interview, on 9/19/2024 at 9:48 A.M., LPN 4 indicated Resident 34 had scratched and itched his extremities for years. LPN 4 indicated staff applied medicated lotion as well as administered an oral medication for itching on a scheduled basis. During an interview, on 9/19/2024 at 11:23 A.M., MDS Coordinator, who completed and updated care plans along with other departments. The MDS Coordinator indicated she was not aware of Resident 34's itching as a continued issue and indicated itching was not care-planned. During an interview, on 9/19/2024 at 2:29 P.M., MDS Nurse and DON indicated Resident 34's itching/scratching should have been included on the resident's care plan. On 9/20/2024, at 10:00 A.M., requested a care plan policy and was policy was not provided. 3.1-35(a)		exacerbations of chronic skin conditions of scratching/iotching and or chronic edema. 3.Care Plans will be reviewed daily during Clinical IDT meeting to ensure care plans are in place for affected resident. *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.DON or Designee will observe 5 residents weekly x 2 months for presence of edema and /or chronic itching and presence of appropriate care plan, then 3 residents weekly x 2 months, and then 2 res weekly for 2 months to ensure compliance. 2.The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to provide timely notification of a change in condition and provide timely treatment for 2 of 3 residents reviewed for hospitalization and insulin usage. (Resident 2 and 16) Findings include: 1. During an interview with Resident 2, on 9/17/2024 at 10:34 A.M., she indicated she had been hospitalized four times for pneumonia recently. A record review for Resident 2 was completed on 9/18/2024 at 2:20 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 with neuropathy, emphysema, atrial fibrillation, and paranoid personality disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 7/31/2024, indicated Resident 2 was cognitively intact and had a diagnosis of respiratory failure and chronic lung disease. The assessment indicated her primary medical categories were debility and cardiorespiratory conditions. A Nursing Progress Note, dated 7/10/2024 at 8:48 A.M., indicated Resident 2's vital signs included a blood pressure of 96/43, an irregular heart rate of 94-97 beats per minute and oxygen saturations levels of 87 percent on room air. The oxygen saturation levels increased to 94 percent with two liters of oxygen. Resident 2 was noncompliant with oxygen therapy during breakfast. Lungs sounds were diminished with no air movement in the lower lobes, diminished in the middle lobes,	F 0684	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 684 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident # 2 and 16 still reside in facility and both are stable. *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. An In-house audit has been completed by nursing	10/18/2024

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	and rhonchi was heard in the upper lobes. A cough was present. The nurse practitioner was to be notified of the findings. A Nursing Progress Note, dated 7/11/2024 at 9:41 A.M., indicated Resident 2 fell asleep at the dining room table during breakfast and her oxygen saturation level on room air was 87 percent, which was consistent with the resident's levels without oxygen therapy. A Nursing Progress Note, dated 7/12/2024 at 12:05 P.M., indicated Resident 2 on antibiotic therapy for pneumonia with oxygen therapy at three liters per nasal cannula. Resident 2's oxygen saturation levels ranged from 78-93 percent depending on whether Resident 2 held her head up. A Nursing Progress Note, dated 7/12/2024 at 12:07 P.M., indicated Resident 2 started the day awake, but fell asleep in the dining room at breakfast. Three staff members assisted her back to bed. She continued to be treated with an antibiotic for pneumonia. A Nursing Progress Note, dated 7/12/2024 at 2:34 P.M., indicated Resident 2 was up and awake after sleeping most of the day. A Nursing Progress Note, dated 7/13/2024 at 9:53 A.M., indicated Resident 2 continued antibiotic therapy for pneumonia, but was very lethargic with diminished lung sounds. Resident 2 dropped food from her mouth during breakfast and continued to fall asleep during the meal. A Nursing Progress Note, dated 7/13/2024 at 1:57 P.M., indicated Resident 2 was not following simple directions, was unable to remember to use her call light for assistance, was throwing items in		management going back 30 days prior to exit to ensure no changes in conditions were not reported to MD and Responsible parties. This audit will include residents who are having their Blood sugar checked. Managers will ensure orders include call perimeters and MD was notified immediately if outside of ordered perimeters Any concerns noted will be addressed This audit will be completed by date of compliance. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. licensed Nursing will be educated on reporting condition changes including blood sugars outside of ordered perimeters to the DON, MD and responsible party within an acceptable time frame and ensure treatment and any new orders have been followed. This education will be completed by the DON by date of compliance. 2. This education will be completed upon hire, at least annually, and prn. No licensed nursing staff will be work past date of compliance without this education competed. *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. Nurse managers will review	

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	the trash can and was unable to lock her wheelchair brake, which she has done with ease in the past. Resident 2 seemed more confused on this day. A Nursing Progress Note, dated 7/14/2024 at 11:33 A.M., indicated Resident 2 was not following directions. She dropped a carton of milk on the floor due to falling asleep during breakfast. She was very disheveled and unaware of her surroundings. Her vital signs were within normal limits. Her lung sounds were diminished throughout the lung and there were spaces with no air movement in the upper, middle, and lower lung bases. A Nursing Progress Note, dated 7/16/2024 at 2:40 P.M., indicated Resident 2 needed two staff members for maximum assistance with transfers, and dependent for bed mobility. She finished her antibiotic therapy for pneumonia. She had been lethargic in the afternoon and required additional assistance with ADLs (activities of daily living). A Nursing Progress Note, dated 7/16/2024 at 11:21 P.M., indicated Resident 2 was lethargic, needed extra staff for care and needed fed dinner. A Nurse Practitioner Note, dated 7/16/2024, indicated a post-acute visit was provided due to recent hospitalization for decreased level of consciousness, lethargy, and pneumonia. The note indicated Resident 2 was compliant with oxygen therapy, was on antibiotics for pneumonia, now required 1-2 staff assistance due to not using her legs. The staff denied any acute issues related to Resident 2 today. A Nursing Progress Note, dated 7/17/2024 at 10:54 A.M., indicated Resident 2's blood pressure was		blood glucose results as well as nurses notes Monday through Friday in morning meeting/clinical for 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care of Rochester is responsible in ensuring compliance in this Plan of Correction.	

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	98/54. She was very lethargic and unable to feed herself her breakfast without assistance. She had more garbled speech. The nurse practitioner was aware of these symptoms. A Nurse Practitioner Note, dated 7/17/2024, indicated a post-acute visit day 2 was provided due to recent hospitalization and the last visit was on 7/16/2024 with the resident being monitored for oxygen saturation levels. The note indicted staff denied any acute issues related to the resident on that date. A Nursing Progress Note, dated 7/17/2024 at 5:48 P.M., indicated Resident 2 was not eating on her own as she had in the past. Her food continued to drop on the floor and her chest. A Nursing Progress Note, dated 7/18/2024 at 8:58 A.M., indicated Resident 2 was not able to follow simple directions, was having problems eating her food, was dropping drinks on her chest, was falling asleep with her meal and was needing assistance of 2-3 staff members for transfers due to weakness in the lower extremities. She had no air movement in all her lung fields with an irregular heartbeat. A Nursing Progress Note, dated 7/18/2024 at 11:27 A.M., indicated Resident 2 was placed on the list to be seen by the primary medical practitioner. A Medical Physician Note, dated 7/18/2024, resident had indicated an altered mental status with no obvious signs and to send to the emergency department. A Nursing Progress Note, dated 7/18/2024 at 2:17 P.M., indicated an order was obtained to send Resident 2 to the emergency department for an			

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	evaluation and treatment. During an interview, on 9/24/2024 at 10:20 A.M., LPN 4 indicated the nurse practitioner and/or physician should be notified immediately of any change of condition after vital signs were obtained. The record lacked documentation the Nurse Practitioner evaluated the resident when she initially displayed a change in condition on 7/11/2024. Although the resident was evaluated by the Nurse Practitioner on 7/17/2024, the resident's significant change in condition was not communicated and addressed. The documentation indicated the resident continued to decline and her change in condition was not addressed until 7/18/2024 when the physician noted the resident's altered level of consciousness and gave an order to send her to an acute care facility for an evaluation. 2. A record review for Resident 16 was completed on 9/17/2024 at 1:36 P.M. Diagnoses included, but were not limited to: paraplegia, pressure ulcer sacral region, schizoaffective disorder, pressure ulcer left hip, neuromuscular dysfunction of bladder, unspecified psychosis and presence of urogenital implants. An Annual Minimum Data Set (MDS) assessment, dated 7/11/2024, indicated Resident 16 was cognitively intact, received antipsychotic medication. He had four stage 4 pressure ulcers and had an indwelling bladder catheter. A Nursing Progress Note, dated 7/7/2024 at 2:51 P.M., indicated Resident 16 had no urinary output since the suprapubic catheter had last been changed. The bulb was of the catheter was			

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	deflated and the catheter was pulled back. Blood-tinged urine was noted in the catheter tubing, and active bleeding was noted coming from his penis. A Nursing Progress Note, dated 7/7/2024 at 6:45 P.M., indicated there continued to be significant frank blood coming from Resident 16's penis. The nurse practitioner was notified, and an order was obtained to send the resident to the emergency department. An Care Triage Note, dated 7/7/2024, indicated blood was coming out of Resident 16's penis. The blood had saturated Resident 16's brief and had saturated another brief immediately when changed. An order was given to send Resident 16 to the emergency department due to possible trauma caused when the the suprapubic catheter was changed and bleeding had occurred for 3.5 hours. During an interview, on 9/24/2024 at 10:20 A.M., LPN 4 indicated the nurse practitioner and/or physician should be notified immediately of any change of condition after vital signs were obtained. 3. A record review for Resident 16 was completed on 9/17/2024 at 1:36 P.M. Diagnoses included, but were not limited to: paraplegia, pressure ulcer sacral region, schizoaffective disorder, pressure ulcer left hip, and diabetes mellitus type 2. An Annual Minimum Data Set (MDS) assessment, dated 7/11/2024, indicated Resident 16 was cognitively intact and received insulin medication. A Physician's Order, dated 4/4/2024, indicated to notify the physician for a blood sugar less than 60			

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	mg/dL (milligrams per deciliter) or greater than 400 mg/dL. A blood sugar of 489 mg/dL was recorded on 8/24/2023, and a blood sugar of 410 mg/dL was recorded on 9/4/2024. There was no documentation the physician was notified. A current Care Plan, initiated 9/5/2023, and revised on 12/7/2023, indicated Resident 16 had diabetes mellitus and was at risk for hypo/hyperglycemic reactions. Interventions included to obtain blood sugars as ordered. During an interview, on 9/20/2024 at 12:34 P.M., the DON indicated the physician should have been notified of the blood sugars greater than 400. A policy was provided, on 9/20/2024 at 12:33 P.M., by the Director of Nursing (DON). The policy titled, "Changes in Resident's Condition or Status", indicated " ...This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status ...(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is ...(B) A significant change in the resident's physical, mental, or psychosocial status ...." 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to store respiratory equipment in a sanitary manor for 3 of 3 residents	F 0695	This plan of correction is prepared and executed because the provisions of state and federal law	10/18/2024

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	reviewed for oxygen therapy. (Resident 36, 44 & 154) Findings include: 1. During an observation, on 9/16/2024 at 2:48 P.M., Resident 36's equalizer tubing was dated 8/2020/24 and unbagged. Resident 36's current Physician's Orders included: change and date nebulizer tubing weekly every day shift on Tuesdays. During an interview, on 9/18/2024 at 2:17 P.M., Resident 36 indicated the nebulizer tubing was never in a bag.2. During an observation, on 9/16/2024 at 10:13 A.M., Resident 44's nebulizer mask was lying on a bedside table with the respiratory bag, dated 8/20/2024, and the tracheostomy suction tip was observed with the outer wrapper, undated, with the suction tip outside the wrapper. During an observation, on 9/16/2024 at 1:58 P.M., the suction tip was missing from the suctioning tubing, but the suctioning tubing was open to air. During an observation, on 9/17/1024 at 9:30 A.M., the suctioning Yankauer (tonsil tip suctioning device to remove secretions) was opened, placed in the opened packaging, undated and the sterile water was opened and not dated. During an interview with Resident 44, on 9/17/2024 at 11:23 A.M., she indicated her tracheostomy was cleaned everyday with suctioning and she preferred for daily cleaning or twice daily cleaning with suctioning. She indicated the tubing was changed once weekly.		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 695 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Residents # 36, 44, and 154 have had no negative outcomes to alleged deficient practice. Nursing management rounded and ensured all respiratory equipment was dated, bagged, and in the appropriate manner of storage. *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. An in-house audit will be	

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	During an observation, on 9/20/2024 at 10:14 A.M., the nebulizer mask was observed on the bed. A record review for Resident 44 was completed on 9/18/2024 at 1:33 P.M. Diagnoses included, but were limited to: chronic obstructive pulmonary disease (COPD), tracheostomy, chronic respiratory failure, and obstructive sleep apnea. A Quarterly MDS assessment, dated 8/3/2024, indicated Resident 44 was cognitively intact and received treatments of oxygen, suctioning, tracheostomy care and non-invasive mechanical ventilation. A current Care Plan, initiated on 6/12/2024, and revised on 9/5/2024, indicated Resident 44 had a tracheostomy and was at risk for infection and/or complications. Interventions included to suction as needed. A Physician's Order, dated 7/29/2024, indicated to change nebulizer tubing every Friday. A Physician's Order dated 9/12/2024 indicated to change the nebulizer circuit every Tuesday on the day shift. During an interview, on 9/20/2024 at 10:15 A.M., LPN 4 indicated nebulizer equipment should have a respiratory bag placed by the nebulizer equipment and the bag was to be changed out weekly on Fridays or as needed. The nebulizer equipment should be placed in the respiratory bag when not in use. She indicated the suctioning tips should be thrown away after an initial use and not reused. LPN 4 indicated the Yankauers were used for a 24-hour period and stored in the packaging they were removed from for use.		conducted by nursing management with residents with resp equipment by date of compliance to ensure all respiratory equipment in use is labeled and stored as well as dated appropriately. Any issues noted will be corrected to ensure compliance. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Licensed Nursing, QMAS, and aides will be educated on the policy of proper storage and labeling including appropriate dating of resp equipment by DON/Designee by date of compliance. Education will be completed upon hire, annually and prn. No nursing staff will be work past date of compliance without this education competed. *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. The nurse managers will observe 5 residents weekly with resp equipment x 2 months, then 3 res weekly x2 months, and then 2 res weekly for 2 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then	

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	A policy was provided on 9/20/2024 at 12:33 P.M., by the Director of Nursing. The policy was titled, "Small Volume Nebulizer Therapy". The policy indicated, " ...Policy ...The facility will provide Small Volume Nebulizer Treatments in accordance with professional standards of practice, as outlined in Lippincott through the procedure linked below ...Federal Regulation ...The services provided or arranged by the facility, as outlined by the comprehensive care plan, must---(i) Meet professional standards of quality ...." Lippincott's procedure titled, "Nebulizer treatment, small volume", indicated, " ...Nebulizer circuit should be stored in a patient-care set-up bag. Labeled with the patient's name and dated ...." A policy was provided, on 9/20/2024 at 12:33 P.M., by the Director of Nursing. The policy titled, "Oral Suctioning", indicated, " ...The facility will provide oral suctioning in accordance with professional standards of practice and physicians order, to clear secretions from the mouth in the event a resident is unable to remove secretions or foreign matter by effective coughing ...4. Yankauer and tubing should be stored in a patient setup bag when not in use ...." 3.1-47(a)(6)		quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure discontinued medications were removed from a medication room and failed to ensure a medication refrigerator was free from a large build up of ice for 1 of 2 medication rooms observed. (Skilled hall medication room)	F 0761	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	10/18/2024

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	Finding includes: During an observation of the South/Skilled hall medication room, on 9/19/2024 at 9:23 A.M. with RN 2, the following was observed: a plastic bag with the following medications, along with a hand written list, dated 6/12/2024, of the following medications 30 Haldol 5 mg (milligram) tablets (antipsychotic); 70 Hydrocodone 10/325 mg tablets (narcotic); 45 Lorazepam 0.5 mg tablets; liquid Morphine Sulfate (narcotic); 2 Fentanyl 20 mcg (micrograms) and 3 25 mcg patches (narcotic). The freezer section of the medication refrigerator had a large build up of ice. During an interview, on 9/19/2024 at 9:25 A.M., RN 2 indicated the medications that had been discontinued ahsould have been desgtroyed and the medication refrigerator should not have had an ice build up. On 9/19/2024 at 10:00 A.M., the Regional Director of Clinical Services provided the policy titled, "Controlled Substance Destruction Process", dated 5/6/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Once an order has been received to discontinue a medication, facility staff should remove this medication from the resident's medication supply...4. Destruction of controlled substances should occur as soon as possible...." ON 9/19/2024 at 10:05 A.M., the Regional Director of Clinical Services provided the policy titled, Medication Storage in Refrigerator/Freezer", dated 8/24/2023, and indicated the policy was the one currently used by the facility. The policy indicated"...8. If there is excessive ice build-up in		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 761 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. The medications found in the medication room were disposed of immediately per facility policy. Facility checked the other med room and no meds found. Medication refrigerator and freezer were cleaned and defrosted immediately. *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. Nursing management validated that med and tx carts as well as med rooms had no medications or treatments stored inappropriately and medication refrigerators and freezers are at an acceptable	

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	the freezer, the maintenance department should be notified to defrost the unit to ensure proper functioning...." 3.1-25(o) 3.1-25(r)		temperature and defrosted as needed by date of compliance. No other issues were found. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Licensed nursing and QMAS will be educated on the medication /narcotic policy including storage, labeling and destruction per LCCA policy. This education will also include the defrosting of the medication refrigerator/freezer. This education will be completed annually, upon hire, and prn. No licensed nursing staff or QMA will work past the date of compliance with put competing this. *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.Nurse managers will audit the med rooms and medication refrigerators/freezers daily Monday through Friday. Designated licensed nursing ;/will observe on weekends and holidays for 6 months. DON will validate 2 times weekly x 6 months. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews	

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			will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to store and serve food under sanitary conditions related to undated and unlabeled foods for 1 of 1 kitchen areas observed (Main kitchen) and serving of plates during meal service. This issue had the potential to affect all 53 residents who resided in the facility and received food from these dietary areas. Findings include: During the initial tour of the main kitchen on 9/16/202 at 9:4 A.M., with the Dietary Manager, the following items were observed: - in the walk-in cooler there was 1 plastic bag with shredded carrots with an expiration date of 9/11/2024 and 1 opened plastic bag with cooked pork chops, undated and unlabeled. -In the dry pantry, there was an unlabeled and opened bag of brownie mix and powdered sugar, and stuffing mix with an expiration date of 10/19/2023. During an interview, on 9/16/2024 at 9:40 A.M., the Dietary Manager indicated nothing should be expired in the kitchen and food should have labels and expiration dates. On 9/16/2024, at 12:01 P.M., 33 residents were	F 0812	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 812** *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. No residents in the facility had	10/18/2024

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	observed in main dining area. Two different staff were noted to have their thumbs on the eating portion of the dinner plates when serving 3 residents in the dining room. During an interview, on 9/20/2024 at 9:51 A.M., the Dietary Manager indicated staff should not have had their thumbs on the eating portion of the dinner plates when serving meals and dishes should be handled by the outside at an angle. On 9/17/2024, at 1:30 P.M., the Administrator provided the policy titled, "Use By Date Guide," dated 3/18/2020, and indicated the policy was the one currently used by the facility. The policy indicated "determine a "use by date" when labeling unopened and opened food...if uncertain of the appropriate date to place on an item, contact Director of Food Services all opened containers of food in dry storage area should be...labeled and dated with the open date and the use by date." On 9/20/2024, at 10:55 A.M., the DON provided the policy titled, "Resident Dining Services," dated 4/30/2024, and indicated the policy was the one currently used by the facility. The policy indicated, "the facility has an established process to ensure food is served in accordance with professional standards for food safety service..." 3.1-21(i)(3)		any negative outcomes from the alleged deficient practice. Undated, unlabeled and expired food items were removed immediately. *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. Other residents have the potential to be affected therefore random dining room observations were completed by various department heads during mealtimes to ensure no thumbing of the plates occurred. Random observations were made in the kitchen to ensure food had the appropriate dating, expiration date and labeling. Any issues identified were corrected immediately *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Education will be provided by the DON/IP on how to serve residents their plates while maintaining sanitary conditions by date of compliance. Education will be provided by the ED to the dietary manager on the policy related to the date opened, date expired and labeling, The Dietary manager will then educate all of her staff as well. This education will be provided upon hire, at least annually, and as needed. No staff involved in serving food and	

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			working in the kitchen will be allowed to work without this education being completed by date of compliance. *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. Department heads will observe 5 meals weekly x 6 months to ensure compliance of serving residents their meals under sanitary conditions. The ED will observe five food items in the kitchen for open dates, expiration dates, and appropriate labeling 3 times weekly x 2 months, then 2 times weekly x 2 months, then 1 time weekly x 2 months to ensure compliance. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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	Based on observation, interview and record review, the facility failed to ensure staff change gloves and complete hand hygiene when providing perineal care for 1 of 1 residents reviewed for incontinence needs. (Resident 7) Finding includes: During an observation on, 9/17/2024 at 9:06 A.M., CNA 3 was observed to provide incontinence care for Resident 7. She donned gloves and removed the dirty brief from the resident. CNA 3 put the dirty brief and the dirty wipes she had used on the floor mat next to the resident. With her dirty gloves still on, she went into the bathroom to obtain a trash bag. She placed the wet brief and the wipes into the trash bag. CNA 3 then went to the closet and got a pair of clean pants without changing her contaminated gloves. CNA 3 then put the residents pants on, and repositioned the resident on the floor mat. CNA 3 rubbed the residents back and then moved a pillow under her head. During an interview, on 9/17/2024 at 9:13 A.M., CNA 3 indicated she should have removed her gloves and washed her hands after cleaning the resident's perineal area. On 9/19/2024 at 9:43 A.M., the Regional Director of Clinical Services provided the policy titled, "Hand Hygiene", dated 6/3/2024, and indicated the policy was the one currently use by the facility, The policy indicated" ...2. Associated perform hand hygiene (even if gloves are uses) in the following situations:... b. After contact with blood, body fluids...d. after removing personal protective equipment) e.g., gloves...." 3.1-18(a)	F 0880	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 Rohester 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 880 *What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:* 1. Resident # 7 had no negative outcomes to alleged deficient practice. Certified Aide # 3 was immediately educated on hand hygiene by the DON. *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. Other residents have the potential to be affected therefore	10/18/2024

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			nursing management did random observations to ensure compliance with hand hygiene by date of compliance. *What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:* 1. Licensed Nursing and certified nursing aides will be educated on appropriate hand hygiene following the facilities policy. Hand hygiene competencies will be completed on licensed nursing and certified aides by the IP and nursing managers by date of compliance. Education will be completed upon hire, at least annual, and prn. No licensed nursing staff will be work past date of compliance without this education competed. *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.The IP/designee will observe 5 staff members weekly for appropriate IC practices involving hand hygiene x 6 months to ensure compliance. Nursing management will perform 2 competencies weekly on hand hygiene rotating shifts x 6 months. 2.Results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 3 months and then quarterly thereafter once	

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			compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction.	