]	DEPARTMENT OF HEALTH AND HUMAN SERVICES									
(	CENTERS FOR MEDICARE & MEDICAID SERVICES									
	CTATEMENT OF DEFICIENCIES	V1) DDOVIDED/CLIDDLIED/CLIA	(V2) MIII TI							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 09/20/2024		
	PROVIDER OR SUPPLIEF		827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg. 00	Licensure Survey.  Survey dates: Septer Facility number: 00 Provider number: 1 AIM number: 1002  Census Bed Type: SNF/NF: 53  Total: 53  Census Payor Type Medicare: 2  Medicaid: 43  Other: 8  Total: 53	55379 74300 : reflect State Findings cited in	F 00	000	This plan of correction is prepand executed because the provisions of state and federa require it and not because Life Care Center of Rochester agr with the allegations and citatic listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilit to render adequate care. Plea accept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be coby the date indicated to remain compliance with state and feder regulations, the facility has tall or will take the actions set for this plan of correction. We	I law eees ons ety of ies as orrect in in leral ken	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8 Notice Requirement Transfer/Discharge Based on record revisited to provide a failed to	ents Before le	F 06	523	This plan of correction is prep and executed because the provisions of state and federa require it and not because Lift Care Center of Rochester agr with the allegations and citatic listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safe	ared I law e ees ens	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Suzanne Wagner **Executive Director** 10/11/2024

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155379	B. W	ING		09/20/	2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t			13TH ST		
LIFF CA	RE CENTER OF RO	OCHESTER			ESTER, IN 46975		
	T				T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+-	TAG	DEFICIENCY)		DATE
	_	oaffective disorder, pressure			the residents nor is it of such		
	_	muscular dysfunction of			character to limit our capabiliti		
	_	d psychosis and presence of			to render adequate care. Plea		
	urogenital implants	•			accept this plan of correction a	as	
	An Amazzal Minima	m Data Sat (MDS) aggaggment			our credible allegation of		
		m Data Set (MDS) assessment,			compliance that the alleged deficiencies have or will be co	rraat	
	dated 7/11/2024, indicated Resident 16 was cognitively intact, and he received antipsychot						
	medication. He had four stage 4 pres				by the date indicated to remain		
					compliance with state and fed regulations, the facility has tak		
and had an indwelling bladder catheter.				or will take the actions set fort			
	A Nursing Progress Note, dated 3/27/2024 at 1:09				this plan of correction. We		
	P.M., indicated Resident 16 had exhibited an				respectfully request a desk rev	/iew/	
increase in delusional behavior and a referral was				F-623	viow.		
		sychiatric hospital. Resident			What Corrective Action will be	ı	
	_	d more assistance with			accomplished for those reside		
	_	due to his "mind was racing".	found to have been affected by				
		cepted for admission, and his			this deficient practice:	,	
		ned of the pending admission.			1. Residents #2, 16, and 44 st	ill	
					reside at the facility. An in-hou		
	A Behavioral Healt	h History and Physical			audit has been completed by t		
	Examination, dated	3/27/2024, indicated Resident			Social Service Director before		
	16 was admitted to	the neuropsychiatric hospital			survey exit to ensure		
	on 3/27/2024.				transfer/discharges were logge	ed	
					correctly which included		
	Resident 16 returne	d to the facility on 4/4/2024.			notification to the Ombudsmar	n. At	
					the time of the audit only 1		
		Note, dated 6/27/2024 at 7:36			transfer/discharge could be		
		sident 16 left the facility for			located.		
		or placement of a colostomy			How other residents having th	е	
	_	ounds with a possible skin			potential to be affected by the		
	graft in the future.				same deficient practice will be		
					identified and what corrective		
	Resident 16 returned to the facility on 7/1/2024.				action will be taken:		
					1 Other residents have the		
	A Nursing Progress Note, dated 7/7/2024 at 6:45				potential to be affected therefo	ore	
P.M., indicated Resident 16 had a significant					SSD will complete another in		
		ood coming from his penis after			house audit of		
	-	rapubic catheter. The nurse			transfers/discharges on reside		
	practitioner was con	ntacted and advised to send	1		who have left facility for the ab	ove	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155379 B. WING 09/20/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 827 W 13TH ST LIFE CARE CENTER OF ROCHESTER ROCHESTER, IN 46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Resident 16 to the emergency department for an reasons to ensure compliance by evaluation. Resident 16 was transferred to the date of compliance. local hospital via emergency management services What measures and what (EMS). systemic changes will be made to ensure that the deficient practice A Nursing Progress Note, dated 7/8/2024 at 1:30 doesn't recur: A.M., indicated Resident 16 returned from the 1. The Social Service Director was emergency department educated by the Executive Director on the Transfer/Discharge During an interview, on 9/19/2024 at 2:26 P.M., the policy. The SSD will educate Social Service Director indicated the transfer and licensed nursing on the discharge form could not be located for transfers transfer/discharge policy to ensure from the facility on 3/27/2024, 6/27/2024, and if after hours this will be completed 7/7/2024. accurately as well. This education will be completed upon hire, at During an interview, on 9/20/2024 at 10:26 A.M., least annually, and PRN. No LPN 4 indicated a transfer and discharge form was SSD/or designee/licensed nursing to be sent for any transfer to the hospital. staff will work past date of compliance with out this education 2. During an interview with Resident 2, on being completed. 9/17/2024 at 10:34 A.M., she indicated she had How the corrective action will be been hospitalized four times for pneumonia monitored to ensure the deficient recently. practice will not recur, i.e., what quality assurance program will be A record review for Resident 2 was completed on put in place: 9/18/2024 at 2:20 P.M. Diagnoses included, but 1. Transfers and discharges will be were not limited to: diabetes mellitus type 2 with reviewed Monday through Friday in neuropathy, emphysema, atrial fibrillation, and morning meeting. The Social paranoid personality disorder. Service Director/designee will audit transfer/discharges logs 3x A Significant Change Minimum Data Set (MDS) weekly for 3 months, 2x weekly for assessment, dated 7/31/2024, indicated Resident 2 2 months and 1x weekly for 1 was cognitively intact. The assessment indicated month. her primary medical categories were debility and 2. The results of these reviews will cardiorespiratory conditions. She had a diagnosis be discussed at the monthly of respiratory failure and chronic lung disease. facility Quality Assurance Committee meeting monthly for a A Nursing Progress Note, dated 2:55 P.M., total of 3 months and then indicated Resident 2 was lethargic, had oxygen quarterly thereafter once

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saturations of 87 percent and lungs sounds were

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compliance is at 100%.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD		00	COMPL	
		155379	B. WING			09/20/	/2024
NAME OF B	DROVIDED OF CUIPN IEE		S	TREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	C	8	27 W 1	13TH ST		
LIFE CAF	RE CENTER OF RO	OCHESTER	F	ROCHE	STER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T	AG		•	DATE
		air movement. New physician ed to treat Resident 2 in-house			Frequency and duration of rev will be increased as needed, if		
		oxygen, a chest x-ray,			compliance is below 100%.		
	_	c), Prednisone (steroid) and			Compliance date: 10-18-24. T	he	
	Mucinex (expectora				Administrator at Life Care Cen		
	` '				of Rochester is responsible in		
	A Nursing Progress	Note, dated 6/16/2024 at 10:49			ensuring compliance in this Pl	an	
		nurse practitioner gave an			of Correction.		
	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							
	·	placed in the Intensive Care					
	Unit (ICU) at the ho	ospital for altered mental status,					
	acute respiratory fa	ilure, sepsis, urinary tract					
	infection and bilate	ral lower extremity cellulitis.					
	A Nursing Progress	Note, dated 7/18/2024 at 2:17					
		order was received to send					
		nergency department for an					
	evaluation and treat	ment. A report was given to					
		artment nurse and indicated					
		fused, lethargic, responded to					
	her name, but falls	back asleep.					
	A Nursing Progress	Note, dated 7/22/2024 at 4:27					
		sident 2 returned to the facility					
	from the hospital.	•					
	A Nursing Progress	Note, dated 7/24/2024 at 1:07					
		nurse noted Resident 2's left					
	·	blish/blackish discoloration.					
		ned 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.						

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	
		155379	B. WING			09/20/	2024
NAME OF P	DOMDED OF CURRY TER		ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				3TH ST		
	RE CENTER OF RO	OCHESTER	R	OCHE	STER, IN 46975		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY		DATE
	~	y, on 9/19/2024 at 2:26 P.M., the ctor indicated a transfer and					
	discharge form could not be found for Resident						
	_	emergency department on					
	6/16/2024, 7/18/202						
	,						
	_	y, on 9/20/2024 at 10:26 A.M.,					
	LPN 4 indicated a transfer and discharge form						
	should be sent for a	ny transfer to the hospital.					
	3 During an intermi	ew with Resident 44 on					
	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.							
	occin nespriminger w						
	A record review for	Resident 44 was completed on					
	9/18/2024 at 1:33 P	.M. Diagnoses included, but					
	were limited to: chr	onic obstructive pulmonary					
	disease (COPD), tra	cheostomy, chronic					
	respiratory failure,	and obstructive sleep apnea.					
	A Ouarterly Minim	um Data Set (MDS)					
		/3/2024, indicated Resident 44					
	· ·	act. and she received					
		en, suctioning, tracheostomy					
	care, and non-invas	ive mechanical ventilation.					
		Note, dated 7/14/2024 at 9:00					
		ident 44 had difficulty					
	· ·	xygen saturation of 82 percent					
	on three liters of ox						
		continued to drop with oxygen					
		erratically between 36-46 tions of 28-34 per minute. EMS					
	-	dent 44 was transported to the					
	emergency departm	_					
A Nursing Progress Note, dated 7/29/2024 at 5:08							
	P.M., indicated Res	ident 44 was readmitted to the					
		tory failure due to pneumonia					
	and fluid overload.						
			1				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155379	B. Wl	NG		09/20/	2024
	ROVIDER OR SUPPLIER			827 W <sup>-</sup>	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0625 SS=D Bldg. 00	Social Service Direct discharge form could 44's transfer to the et 7/14/2024.  During an interview LPN 4 indicated a transfer to the et should have been seen hospital.  A policy for a transfer requested on 9/20/20 3.1-12(a)(6)(A)  483.15(d)(1)(2)  Notice of Bed Hold Based on record reviewed for the second review for the second reviewed for	m Data Set (MDS) assessment, dicated Resident 16 was nd he received antipsychotic four stage 4 pressure ulcers	F 06	525	This plan of correction is preparand executed because the provisions of state and federal require it and not because Life Care Center of Rochester agre with the allegations and citation listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabilitie to render adequate care. Pleas accept this plan of correction a cour credible allegation of compliance that the alleged deficiencies have or will be couply the date indicated to remain compliance with state and feder regulations, the facility has tak	law eees ns ety of es se as rrect n in eral	10/18/2024

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155379	B. WI	NG		09/20/	/2024
			-	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	I.R			13TH ST		
LIFF CA	RE CENTER OF R	OCHESTER			ESTER, IN 46975		
	Т						T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
		N 1 . 12/27/2024 1 . 02			or will take the actions set fort	h in	
		ss Note, dated 3/27/2024 at 1:09			this plan of correction. We		
	· ·	sident 16 had exhibited an			respectfully request a desk re	view.	
		nal behavior and a referral was			F-625		
	_	osychiatric hospital. Resident			What Corrective Action will be		
	_	ed more assistance with			accomplished for those reside		
		s due to his "mind was racing".			found to have been affected b	У	
	Resident 16 was accepted for admission, and his				this deficient practice:		
	guardian was informed of the pending admission.				1. Residents # 2, 16 and 44 h		
				had no negative outcomes rel	ated		
A Behavioral Health History and Physical				to alleged deficient practice.			
Examination, dated 3/27/2024, indicated Resident				2. An in-house audit was			
16 was admitted to the neuropsychiatric hospital				completed by Social Service			
	on 3/27/2024.				Director before survey exit to		
					ensure the notice of bed hold		
	Resident 16 return	ed to the facility on 4/4/2024.			policy was completed. During		
					audit Social Service could not		
		ss Note, dated 6/27/2024 at 7:36			locate bed hold documentatio	n for	
		esident 16 left the facility for			residents #2, 16 and 44.		
		for placement of a colostomy			How other residents having th		
	_	vounds with a possible skin			potential to be affected by the		
	graft in the future.				same deficient practice will be	<del>)</del>	
					identified and what corrective		
	Resident 16 return	ed to the facility on 7/1/2024.			action will be taken:		
					1. An In house audit will be		
		ss Note, dated 7/7/2024 at 6:45			completed on residents to ens		
		sident 16 had a significant			that bed hold policies are in pl	ace	
		ood coming from his penis after			and ensure compliance.		
		prapubic catheter. The nurse			What measures and what		
	*	ontacted and advised to send			systemic changes will be mad	le to	
		emergency department for an			ensure that the deficient pract	ice	
		nt 16 was transferred to the			doesn't recur:		
	local hospital via e	emergency management services			1.Nursing staff and SSD will		
	(EMS).				educated on the bed hold poli	-	
					by date of compliance by ED	and	
	A Nursing Progress Note, dated 7/8/2024 at 1:30		SSD. This education will also				
	A.M., indicated Resident 16 returned from the				include the use of binders that	t will	
	emergency departr	ment			be located at both nursing sta	tions	
					with a check list to ensure bed	Ł	
1	During an interview, on 9/19/2024 at 2:26 P.M., the				holds have been completed til	melv	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155379	B. W	ING		09/20/	2024
			<u> </u>	CTREET (	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
		COLECTED					
LIFE CAR	RE CENTER OF RO	DCHESTER		ROCHE	ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Social Service Dire	ctor indicated a bed hold form			and accurately. This educatior	n will	
	could not be located	d for Resident 16's transfers			be completed at least annually	/,	
	from the facility on	3/27/2024, 6/27/2024, and			upon hire and PRN. No licens	ed	
	7/7/2024.				Nurses or SS staff will work pa	ast	
					date of compliance with out th	is	
	_	v, on 9/20/2024 at 10:26 A.M.,			education completed.		
	LPN 4 indicated a b	ped hold policy should have			What measures will be put in		
	been sent for any tr	ansfer to the hospital.			place to ensure the deficient		
					practice will not recur, i.e., who	at	
	_	iew with Resident 2, on			quality assurance program wil	l be	
		A.M., she indicated she had			put in place:		
	•	our times for pneumonia			Bed hold documentation will	ll be	
	recently.				reviewed Monday through Frid	day in	
					morning meeting. The Social		
		Resident 2 was completed on			Service Director/designee will		
		.M. Diagnoses included, but			audit transfer/discharges logs	3x	
		diabetes mellitus type 2 with			weekly for 3 months, 2x weekl	ly for	
		sema, atrial fibrillation, and			2 months and 1x weekly for 1		
	paranoid personalit	y disorder.			month.		
					2. The results of these reviews	s will	
	_	ge Minimum Data Set (MDS)			be discussed at the monthly		
		/31/2024, indicated Resident 2			facility Quality Assurance		
		act. The assessment indicated			Committee meeting monthly for	or a	
		l categories were debility and			total of 3 months and then		
		onditions. She had a diagnosis			quarterly thereafter once		
	of respiratory failur	e and chronic lung disease.			compliance is at 100%.	_	
		N 1 . 10 55 P.35			Frequency and duration of rev		
		Note, dated 2:55 P.M.,			will be increased as needed, if	Ī	
		2 was lethargic, had oxygen			compliance is below 100%.		
		ercent and lungs sounds were					
		air movement. New physician					
		ed to treat Resident 2 in-house			Compliance date: 10-18-24. T		
	_	oxygen, a chest x-ray,			Administrator at Life Care Cer		
	Rocephin (antibiotic), Prednisone (steroid) and				of Rochester is responsible in		
	Mucinex (expectorant).				ensuring compliance in this Pl	an	
	A Murcina Dramasa	Note, dated 6/16/2024 at 10:49			of Correction.		
		nurse practitioner gave an					
		ent 2 to the emergency					
department for an evaluation and treatment.		1					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155379	B. WI	NG		09/20/	/2024
	PROVIDER OR SUPPLIER		•	827 W 1	ADDRESS, CITY, STATE, ZIP COD 13TH ST SSTER, IN 46975	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	A.M., indicated Res facility after being punit (ICU) at the hoacute respiratory fai infection and bilater.  A Nursing Progress P.M., indicated and Resident 2 to the enevaluation and treat the emergency department of the energency department of the hospital.  A Nursing Progress P.M., indicated Resident 2 was comber name, but falls but a Nursing Progress P.M., indicated Resident 2 complain foot. There was not left foot/toes. Resident 2 complain foot. There was not left foot/toes. Residemergency department back to the facility, but edema noted.  During an interview Social Service Direct could not be found the emergency department and 7/2024.  During an interview LPN 4 indicated a but the facility of the found the emergency department of the found the emergency department of the facility of the found the emergency department of the found the emergency department of the facility of the facility of the found the emergency department of the facility of the found the facility of the facili	Note, dated 6/22/2024 at 10:55 sident 2 was readmitted to the placed in the Intensive Care ospital for altered mental status, ilure, sepsis, urinary tract ral lower extremity cellulitis.  Note, dated 7/18/2024 at 2:17 order was received to send mergency department for an ament. A report was given to partment nurse and indicated fused, lethargic, responded to back asleep.  Note, dated 7/22/2024 at 4:27 ident 2 returned to the facility  Note, dated 7/24/2024 at 1:07 nurse noted Resident 2's left plish/blackish discoloration. The dof sharp pain to her left known injury to Resident 2's lent 2 was sent to the lent at 10:20 P.M. She arrived at 1:07 A.M., with no fracture,  Note, on 9/19/2024 at 2:26 P.M., the ctor indicated a bed hold form for the transfers to the lent on 6/16/2024, 7/18/2024  Note, on 9/20/2024 at 10:26 A.M., bed hold policy should have ansfer to the hospital.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2024
VI.) = 0==	AD OLUBED OF SUMP		<u> </u>	ADDRESS, CITY, STATE, ZIP COD	-
	PROVIDER OR SUPPLIER RE CENTER OF RO			13TH ST ESTER, IN 46975	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION iew with Resident 44, on	TAG	BEIGHACI	DATE
	9/17/2024 at 11:22	A.M., she indicated she had vith shortness of breath.			
	9/18/2024 at 1:33 F were limited to: chr disease (COPD), tra	r Resident 44 was completed on P.M. Diagnoses included, but ronic obstructive pulmonary acheostomy, chronic and obstructive sleep apnea.			
	assessment, dated 8 was cognitively inte treatments of oxyge	num Data Set (MDS) 8/3/2024, indicated Resident 44 act. and she received en, suctioning, tracheostomy sive mechanical ventilation.			
	P.M., indicated Res breathing with an o on three liters of ox oxygenation levels saturations reading percent with respira	s Note, dated 7/14/2024 at 9:00 sident 44 had difficulty exygen saturation of 82 percent exygen. Resident 44's continued to drop with oxygen erratically between 36-46 ations of 28-34 per minute. EMS ident 44 was transported to the nent.			
	P.M., indicated Res	s Note, dated 7/29/2024 at 5:08 sident 44 was readmitted to the story failure due to pneumonia			
	Social Service Dire could not be found	v, on 9/19/2024 at 2:26 P.M., the extor indicated a bed hold form for Resident 44's transfer to artment on 7/14/2024.			
	-	v, on 9/20/2024 at 10:26 A.M., bed hold form would be sent for nospital.			

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l í í		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155379	B. WI	NG		09/20/2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S BLANCE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	ULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A policy for the begg/20/24. A policy w	d hold policy was requested on was not provided.					
	3.1-12(a)(25)(A)						
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments						
	Encoding/Transmitting Resident		F 06	540	This plan of correction is prep and executed because the provisions of state and federa require it and not because Life Care Center of Rochester agr with the allegations and citatic listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safe the residents nor is it of such character to limit our capabiliti to render adequate care. Plea accept this plan of correction our credible allegation of compliance that the alleged deficiencies have or will be copy the date indicated to remai compliance with state and fed regulations, the facility has take or will take the actions set fort this plan of correction. We respectfully request a desk re F 640  What Corrective Action will be accomplished for those reside found to have been affected by this deficient practice:  1.Resident #20 and Resider #47 OBRA required assessment were transmitted and accepte into the CMS repository	I law elees ees ons ety of ies as orrect n in deral ken th in view.	10/18/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  09/20/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
		sident Assessment Instrument		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 pote to be affected, therefore, all required OBRA assessments 2024 were reviewed to ensure none were incorrectly marked "complete" in PCC. Any incorrectly closed OBRA assessments were corrected transmitted.  What measures and what systemic changes will be madensure that the deficient practice doesn't recur:  CRS, RN or designee RN will all assessments as complete Z0500 following completion or MDS document by MDSC, LF per RAI guidelines.  1.MDSC will check that all required OBRA assessments marked as "Export Ready" afticlosed by CRS, RN or design RN  How the corrective action will monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put in place:  1.CRS will review PCC "complete" report for list of assessment inaccurately mark as "complete" weekly x 3 more then every two weeks x 2 more the every two weeks x 2 more then every two weeks x 2 mor	ential for e as and de to tice sign at f the N are ee ee be ient iat II be			

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then monthly x 1 month to ensure

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY LETED 0/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE	
F 0656 SS=D Bldg. 00	Based on observation interview, the facility comprehensive persons resident with edema with a history of ite residents reviewed.  Findings include:  1. During an observation A.M., Resident 29 I with a slight indentabarely visible after bilateral lower legs.  During an observation of the facility of th	ation, on 9/16/2024 at 10:59 and +1 pitting edema (swelling ation in the skin that was pressure was applied) to his  on, on 9/18/2024 at 10:59 was noted to have +1 pitting	F 0656	compliance.  2. The results of these rewill be discussed at the metacility Quality Assurance Committee meeting month total of 3 months and then quarterly thereafter once compliance is at 100%.  Frequency and duration owill be increased as needed compliance is below 100%.  Compliance date: 10-18-2. Administrator at Life Care of Rochester is responsible ensuring compliance in this of Correction.  This plan of correction is pland executed because the provisions of state and feed require it and not because Care Center of Rochester with the allegations and cillisted. Life Care Center of Rochester maintains that alleged deficiencies do not jeopardize the health and the residents nor is it of such aracter to limit our capator render adequate care. If accept this plan of correct our credible allegation of compliance that the alleged deficiencies have or will be by the date indicated to residents and the residents of the correct our credible allegation of compliance that the alleged deficiencies have or will be by the date indicated to residents.	onthly  fly for a  freviews ed, if  6.  4. The Center le in is Plan  orepared ederal law e Life agrees tations  the th safety of uch bilities Please ion as ed e correct	10/18/2024	

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Facility ID: 000325

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155379	B. W	ING		09/20/2	2024
				<del></del>			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					13TH ST		
LIFE CAI	RE CENTER OF R	OCHESTER		ROCHE	ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					compliance with state and fed	eral	
	The record for Resident 29 was reviewed on				regulations, the facility has tak		
		A.M. Diagnoses included but			or will take the actions set fort		
	were not limited to: chronic venous idiopathic				this plan of correction. We		
		enital malformation syndrome,			respectfully request a desk re	view.	
		sleep apnea, chronic			F 656		
		nary disease, hypertension and			What Corrective Action will be	,	
	generalized edema.				accomplished for those reside		
					found to have been affected b		
	The record lacked	a person-centered care plan for			this deficient practice:	<b>'</b>	
	the resident's edem	-			1. A care plan with interventio	ns I	
					related to edema was added f		
	During an interview	w, on 9/19/2024 at 11:17 A.M.,			resident #29 on 9/20/2024. A		
	_	tor indicated she updated and			plan with interventions related		
		plans along with other			chronic scratching was added		
	_	nnel. MDS Coordinator			resident 34 on 9/20/2024.		
		s a plan which indicated the			How other residents having th	e l	
		for edema but there were no			potential to be affected by the		
	interventions regar				same deficient practice will be		
					identified and what corrective		
	During an interview	w, on 9/19/2024 at 11:36 A.M.,			action will be taken:		
	_	edema should have been			1. All residents have the poter	ntial	
	included in care pla	an for Resident 29.			to be affected, therefore, all		
	·				current residents will be asses	ssed	
	2. During an observ	vation, on 9/17/2024 at 9:47			for skin conditions and /or ede	ema	
		was noted to have scabbed			to ensure care plans are in pla		
	over scratches on h	is left leg shin.			as appropriate.		
					What measures and what		
	The record for Res	ident 34 was reviewed on			systemic changes will be mad	le to	
	9/18/2024 at 11:05	A.M. Diagnoses included but			ensure that the deficient pract		
		cerebral palsy, chronic			doesn't recur:		
		nary edema, epilepsy, cognitive			1.DON or Designee will revi	ew	
		ficit, muscle weakness,			all new orders and nursing		
		sema, hypertension and			documentation for evidence of	f I	
	difficulty in walking				exacerbation of chronic skin		
		-			conditions of scratching/itchin	g	
	Resident 29's curre	ent medications included:			and/or chronic edema.	<b>-</b>	
		etonide External Cream 0.5 % to			2.During Nursing Grand Rou	unds,	
		remities topically one time a day			DON or Designee will gather	, ,	
		irritated skin, ordered			information regarding		
	i	*	1		ı		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155379	B. WI	NG _		09/20/	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			13TH ST		
LIFE CAR	RE CENTER OF RO	OCHESTER			ESTER, IN 46975		
Lii L OAI	VE OF MILK OF M	JOHLOTEIX		NOOFIE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Acetyl Cysteine (NAC) 600 mg			exacerbations of chronic skin		
		psule by mouth two times a day			conditions of scratching/iotchi	ng	
	for skin itching, ord	lered 2/10/2023.			and or chronic edema.		
					3.Care Plans will be reviewe		
		der note, dated 7/29/2024,			daily during Clinical IDT meeti	-	
		34 took NAC for skin			ensure care plans are in place	for	
	itching/picking.				affected resident.		
					How the corrective action will		
		person-centered care plan for			monitored to ensure the defici		
	Resident 34's itching.				practice will not recur, i.e., who		
					quality assurance program wil	l be	
		v, on 9/19/2024 at 9:48 A.M.,			put in place:		
	LPN 4 indicated Resident 34 had scratched and				1.DON or Designee will obse		
		es for years. LPN 4 indicated			5 residents weekly x 2 months		
		ated lotion as well as			presence of edema and /or ch	ronic	
		ll medication for itching on a			itching and presence of		
	scheduled basis.				appropriate care plan, then 3		
					residents weekly x 2 months,		
	_	v, on 9/19/2024 at 11:23 A.M.,			then 2 res weekly for 2 months	s to	
		who completed and updated			ensure compliance.		
		th other departments. The			2.The results of these review		
		ndicated she was not aware of			will be discussed at the month	ly	
		g as a continued issue and			facility Quality Assurance		
	indicated itching wa	as not care-planned.			Committee meeting monthly for	or a	
					total of 3 months and then		
	_	v, on 9/19/2024 at 2:29 P.M.,			quarterly thereafter once		
		ON indicated Resident 34's			compliance is at 100%.		
		hould have been included on			Frequency and duration of rev		
	the resident's care p	lan.			will be increased as needed, if	Ť	
	0 0/00/2024	2004.36			compliance is below 100%.		
	·	0:00 A.M., requested a care plan					
	policy and was poli	cy was not provided.					
	2.1.25(.)				Compliance date: 10-18-24. T		
	3.1-35(a)				Administrator at Life Care Cer	iter	
					of Rochester is responsible in		
					ensuring compliance in this Pl	an	
					of Correction.		
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155379	B. W	ING		09/20/	/2024
		<u> </u>		STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			13TH ST		
LIFE CAF	RE CENTER OF RO	OCHESTER			ESTER, IN 46975		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTI			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
F 0684	483.25						
SS=D	Quality of Care						
Bldg. 00	D1	4 4b 6: 1:4	F 0.	CO 4	This when of comment on it many		10/10/2024
	Based on interview and record review, the facility failed to provide timely notification of a change in		F 00	584	This plan of correction is prepared to a second the	ared	10/18/2024
	-	· -			and executed because the		
	-	de timely treatment for 2 of 3			provisions of state and federal		
		for hospitalization and insulin			require it and not because Life		
	usage. (Resident 2 a	mu 10)			Care Center of Rochester agree		
	Findings include:				with the allegations and citatio	IIS	
	Findings include:				listed. Life Care Center of Rochester maintains that the		
	1 During on integri	ew with Resident 2, on			alleged deficiencies do not		
	_	A.M., she indicated she had			jeopardize the health and safe	ty of	
		our times for pneumonia			the residents nor is it of such	ty Oi	
	recently.	our times for pheumoma			character to limit our capabiliti	00	
	recently.				•		
	A record review for	Resident 2 was completed on			to render adequate care. Plea accept this plan of correction a		
		.M. Diagnoses included, but			our credible allegation of	15	
		diabetes mellitus type 2 with			compliance that the alleged		
		sema, atrial fibrillation, and			deficiencies have or will be co	rroot	
	paranoid personality				by the date indicated to remain		
	paranoia personant	y disorder.			compliance with state and fed		
	A Significant Chang	ge Minimum Data Set (MDS)			regulations, the facility has tak		
		/31/2024, indicated Resident 2			or will take the actions set fort		
		act and had a diagnosis of			this plan of correction. We		
		nd chronic lung disease. The			respectfully request a desk rev	view.	
		d her primary medical			F 684		
		ility and cardiorespiratory			What Corrective Action will be		
	conditions.	1 7			accomplished for those reside		
					found to have been affected b		
	A Nursing Progress	Note, dated 7/10/2024 at 8:48			this deficient practice:	•	
		sident 2's vital signs included a			1. Resident # 2 and 16 still res	side	
		6/43, an irregular heart rate of			in facility and both are stable.		
	_	ute and oxygen saturations			How other residents having th	e	
		on room air. The oxygen			potential to be affected by the		
		creased to 94 percent with two			same deficient practice will be		
		sident 2 was noncompliant			identified and what corrective		
		y during breakfast. Lungs			action will be taken:		
		shed with no air movement in			1. An In-house audit has been	l	
	the lower lobes, diminished in the middle lobes.				completed by nursing		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155379	B. W	ING	_	09/20/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER				13TH ST		
LIFE CAF	RE CENTER OF RO	OCHESTER			ESTER, IN 46975		
	Г				, I		W.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		X5)
TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPI	LETION
TAG		ard in the upper lobes. A		IAG			.IE
					management going back 30 d		
	cough was present. The nurse practitioner was to be notified of the findings.				prior to exit to ensure no chan		
	be nounted of the in	ndings.			in conditions were not reported		
	A Namain a Dua anaga	Note dated 7/11/2024 at 0.41			MD and Responsible parties.		
		Note, dated 7/11/2024 at 9:41			audit will include residents who	)	
		sident 2 fell asleep at the dining			are having their Blood sugar	_	
		reakfast and her oxygen			checked. Managers will ensure		
		room air was 87 percent, which			orders include call perimeters		
		the resident's levels without			MD was notified immediately i		
	oxygen therapy.				outside of ordered perimeters	- 1	
	A N	N-4- 4-4-47/12/2024 -4 12:05			concerns noted will be addres		
		Note, dated 7/12/2024 at 12:05			This audit will be completed by	/	
		ident 2 on antibiotic therapy			date of compliance.		
	_	oxygen therapy at three liters			What measures and what		
	1 ~	Resident 2's oxygen saturation			systemic changes will be mad		
	_	78-93 percent depending on			ensure that the deficient pract	ce	
	whether Resident 2	neid ner nead up.			doesn't recur:		
	4 NT ' D	N . 1 . 17/12/2024 . 12.07			1. licensed Nursing will be		
		Note, dated 7/12/2024 at 12:07			educated on reporting condition		
		ident 2 started the day awake,			changes including blood suga		
		e dining room at breakfast.			outside of ordered perimeters		
		s assisted her back to bed. She			the DON, MD and responsible		
		ted with an antibiotic for			party within an acceptable time		
	pneumonia.				frame and ensure treatment a	na	
	A N	N-4- 4-4-47/12/2024 -42-24			any new orders have been	_	
		Note, dated 7/12/2024 at 2:34			followed. This education will b		
		ident 2 was up and awake after			completed by the DON by date	9 01	
	sleeping most of the	cuay.			compliance.		
	A Muncip a Dua au	Note dated 7/12/2024 at 0.52			2. This education will be		
		Note, dated 7/13/2024 at 9:53			completed upon hire, at least		
		sident 2 continued antibiotic			annually, and prn. No licensed		
		nia, but was very lethargic			nursing staff will be work past	uate	
		ng sounds. Resident 2 dropped			of compliance without this		
		h during breakfast and eep during the meal.			education competed.	_	
	continued to fail asi	eep during the mear.			How the corrective action will a		
	A Niversia - De	Note detail 7/12/2024 -+ 1:57			monitored to ensure the defici	· ·	
		Note, dated 7/13/2024 at 1:57			practice will not recur, i.e., who		
		ident 2 was not following			quality assurance program wil	De	
		vas unable to remember to use			put in place:		
	her call light for ass	istance, was throwing items in			Nurse managers will review		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLET	
		155379	B. W	ING	_	09/20/20	024
N	NOTHER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	3			13TH ST		
LIFE CAF	RE CENTER OF RO	OCHESTER		ROCHE	STER, IN 46975		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		as unable to lock her			blood glucose results as well a		
	wheelchair brake, which she has done with ease in the past. Resident 2 seemed more confused on				nurses notes Monday through	I	
	-	seemed more confused on			Friday in morning meeting/clin	lical	
	this day.				for 6 months.	النبد	
	A Nursing Progress Note, dated 7/14/2024 at 11:33				2. The results of these reviews	S WIII	
		sident 2 was not following			be discussed at the monthly facility Quality Assurance		
	· ·	oped a carton of milk on the			Committee meeting monthly for	nra	
	-	asleep during breakfast. She			total of 3 months and then	J. G	
		d and unaware of her			quarterly thereafter once		
	-	rital signs were within normal			compliance is at 100%.		
	-	ands were diminished			Frequency and duration of rev	riews	
	_	and there were spaces with			will be increased as needed, i		
		the upper, middle, and lower			compliance is below 100%.		
	lung bases.				·		
	A Nursing Progress	Note, dated 7/16/2024 at 2:40			Compliance date: 10-18-24. T	he	
		ident 2 needed two staff			Administrator at Life Care of		
		num assistance with transfers,			Rochester is responsible in		
		ped mobility. She finished her			ensuring compliance in this Pl	an	
	-	or pneumonia. She had been			of Correction.		
		rnoon and required additional					
	assistance with AD	Ls (activities of daily living).					
	A Nursing Progress	Note, dated 7/16/2024 at 11:21					
		ident 2 was lethargic, needed					
	extra staff for care a	and needed fed dinner.					
	A Nurse Practitione	er Note, dated 7/16/2024,					
		ite visit was provided due to					
	recent hospitalization	on for decreased level of					
		argy, and pneumonia. The					
	note indicated Resid	dent 2 was compliant with					
	oxygen therapy, wa						
		quired 1-2 staff assistance due					
		s. The staff denied any acute					
	issues related to Re	sident 2 today.					
	A Nursing Progress	Note, dated 7/17/2024 at 10:54					
		sident 2's blood pressure was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3VS411

Facility ID: 000325

If continuation sheet Page 18 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  09/20/2024	
	PROVIDER OR SUPPLIER		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975	•
	ı			I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	98/54. She was very herself her breakfas more garbled speec aware of these symp	t without assistance. She had h. The nurse practitioner was potoms.			
	due to recent hospit on 7/16/2024 with t oxygen saturation le	ate visit day 2 was provided alization and the last visit was the resident being monitored for evels. The note indicted staff sues related to the resident on			
	that date.	New relation to the resident on			
	P.M., indicated Res	Note, dated 7/17/2024 at 5:48 ident 2 was not eating on her ne past. Her food continued to d her chest.			
	A.M., indicated Resimple directions, v food, was dropping falling asleep with l assistance of 2-3 stato weakness in the l	Note, dated 7/18/2024 at 8:58 sident 2 was not able to follow was having problems eating her drinks on her chest, was her meal and was needing aff members for transfers due ower extremities. She had no her lung fields with an irregular			
	A.M., indicated Res	Note, dated 7/18/2024 at 11:27 sident 2 was placed on the list imary medical practitioner.			
	resident had indicat	n Note, dated 7/18/2024, ed an altered mental status ns and to send to the ent.			
	P.M., indicated an o	Note, dated 7/18/2024 at 2:17 order was obtained to send nergency department for an			

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Event ID:

3VS411

Facility ID: 000325

If continuation sheet Page 19 of 33

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155379	B. W	'ING	_	09/20/	/2024
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	DDRESS, CITY, STATE, ZIP COD		
					13TH ST		
LIFE CAF	RE CENTER OF RO	OCHESTER		ROCHE	STER, IN 46975		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	evaluation and treat	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC 17		DATE
	evariation and treat	mon.					
	During an interview, on 9/24/2024 at 10:20 A.M.,						
		e nurse practitioner and/or					
		notified immediately of any					
	_	after vital signs were					
	obtained.						
	The record lacked d	locumentation the Nurse					
		ed the resident when she					
	initially displayed a	change in condition on					
		gh the resident was evaluated					
	•	tioner on 7/17/2024, the					
	1	t change in condition was not					
	communicated and						
		cated the resident continued hange in condition was not					
		8/2024 when the physician					
	noted the resident's						
		gave an order to send her to					
	an acute care facilit						
		for Resident 16 was completed					
		6 P.M. Diagnoses included, but					
		paraplegia, pressure ulcer paffective disorder, pressure					
	_	muscular dysfunction of					
		d psychosis and presence of					
	urogenital implants						
		m Data Set (MDS) assessment,					
		dicated Resident 16 was					
		eceived antipsychotic					
		four stage 4 pressure ulcers					
	and had an indwelli	ng bladder catheter.					
	A Nursing Progress	Note, dated 7/7/2024 at 2:51					
		ident 16 had no urinary output					
	since the suprapubi	c catheter had last been					
	changed. The bulb	was of the catheter was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3VS411

Facility ID: 000325

If continuation sheet Page 20 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		A. BUILDING <u>00</u> COI			ATE SURVEY MPLETED /20/2024	
	PROVIDER OR SUPPLIER		STREET 827 W ROCH			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	Blood-tinged urine	theter was pulled back.  was noted in the catheter bleeding was noted coming				
	P.M., indicated then frank blood coming nurse practitioner w	s Note, dated 7/7/2024 at 6:45 re continued to be significant a from Resident 16's penis. The was notified, and an order was resident to the emergency				
	blood was coming of blood had saturated saturated another be changed. An order to the emergency de trauma caused whe	te, dated 7/7/2024, indicated out of Resident 16's penis. The Resident 16's brief and had rief immediately when was given to send Resident 16 epartment due to possible in the the suprapubic catheter leeding had occurred for 3.5				
	LPN 4 indicated the physician should be	v, on 9/24/2024 at 10:20 A.M., e nurse practitioner and/or e notified immediately of any n after vital signs were				
	on 9/17/2024 at 1:3 were not limited to: sacral region, schiz	for Resident 16 was completed 6 P.M. Diagnoses included, but a paraplegia, pressure ulcer oaffective disorder, pressure liabetes mellitus type 2.				
	dated 7/11/2024, in	nm Data Set (MDS) assessment, dicated Resident 16 was nd received insulin medication.				
		r, dated 4/4/2024, indicated to a for a blood sugar less than 60				

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Event ID:

3VS411

Facility ID: 000325

If continuation sheet Page 21 of 33

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 09/20/2024	
	ROVIDER OR SUPPLIER		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		per deciliter) or greater than 400			
	8/24/2023, and a blo recorded on 9/4/202	9 mg/dL was recorded on ood sugar of 410 mg/dL was 24. There was no ohysician was notified.			
	on 12/7/2023, indic mellitus and was at	a, initiated 9/5/2023, and revised ated Resident 16 had diabetes risk for hypo/hyperglycemic ions included to obtain blood			
	the DON indicated	the physician should have blood sugars greater than 400.			
	by the Director of N titled, "Changes in I Status", indicated " resident, his/her prir resident/resident represident's condition immediately information resident's physician his or her authority, when there is(B) resident's physical,"	ded, on 9/20/2024 at 12:33 P.M., Rursing (DON). The policy Resident's Condition or This facility will notify the mary care provider, and presentative of changes in the or status(i) A facility must at the resident; consult with the ; and notify, consistent with the resident representative(s) A significant change in the mental, or psychosocial status			
F 0695	3.1-37(a) 483.25(i)				
SS=D Bldg. 00	Respiratory/Trach Suctioning Based on observation interview, the facility	eostomy Care and on, record review and ty failed to store respiratory tary manor for 3 of 3 residents	F 0695	This plan of correction is prepared and executed because the provisions of state and federal	

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Event ID:

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Facility ID: 000325

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	ЛLDING	00	COMPLE	TED
		155379	B. W	ING		09/20/2	2024
				CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD 13TH ST		
LIFE CA	RE CENTER OF RO	CHESTER			ESTER, IN 46975		
LII E CA	TE OLIVIER OF RO	JOHLOTEIX	T	NOCITE	_O   L       \ +03  J		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n therapy. (Resident 36, 44 &			require it and not because Lit		
	154)				Care Center of Rochester ag		
					with the allegations and citati	ons	
	Findings include:				listed. Life Care Center of		
					Rochester maintains that the		
	_	vation, on 9/16/2024 at 2:48			alleged deficiencies do not		
		equalizer tubing was dated			jeopardize the health and saf	-	
	8/2020/24 and unba	agged.			the residents nor is it of such		
	B 11 126				character to limit our capabili		
		nt Physician's Orders included:			to render adequate care. Ple		
change and date nebulizer tubing weekly every					accept this plan of correction	as	
	day shift on Tuesda	lys.			our credible allegation of		
	<u></u>	0/10/2024 / 2 17 73 7			compliance that the alleged	, [	
	_	v, on 9/18/2024 at 2:17 P.M.,			deficiencies have or will be co		
		ed the nebulizer tubing was			by the date indicated to rema		
	_	uring an observation, on			compliance with state and fee		
		A.M., Resident 44's nebulizer			regulations, the facility has ta		
		a bedside table with the			or will take the actions set for	τn in	
		ed 8/20/2024, and the			this plan of correction. We		
		on tip was observed with the			respectfully request a desk re	eview.	
	outside the wrapper	ated, with the suction tip					
	outside tile wrapper				E 605		
	During an observat	ion, on 9/16/2024 at 1:58 P.M.,			F 695 What Corrective Action will b		
	_	missing from the suctioning			accomplished for those resid		
	_	ioning tubing was open to air.			found to have been affected		
	aoing, out the suct	ronning tuoning was open to an.			this deficient practice:	~y	
	During an observati	ion, on 9/17/1024 at 9:30 A.M.,			1. Residents # 36, 44, and 15	54	
		kauer (tonsil tip suctioning			have had no negative outcon		
	_	ecretions) was opened, placed			alleged deficient practice. Nu		
		aging, undated and the sterile			management rounded and er	-	
	water was opened a				all respiratory equipment was		
	and a spender				dated, bagged, and in the		
	During an interview	w with Resident 44, on			appropriate manner of storage	<sub>ie.</sub>	
	1 -	A.M., she indicated her			How other residents having t		
		eleaned everyday with			potential to be affected by the		
	•	preferred for daily cleaning or			same deficient practice will b		
	-	g with suctioning. She			identified and what corrective		
		g was changed once weekly.			action will be taken:		
					1. An in-house audit will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155379	B. W	NG		09/20/	2024
		<u> </u>	<u> </u>	CTD FET	ADDRESS CITY STATE ZIR COR		
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD 13TH ST		
		CUECTED					
LIFE CAP	RE CENTER OF RO	JCHESTER		ROCHE	ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an observati	ion, on 9/20/2024 at 10:14			conducted by nursing		
		mask was observed on the			management with residents w	ith	
	bed.				resp equipment by date of		
					compliance to ensure all		
	A record review for Resident 44 was completed on				respiratory equipment in use is	S	
	9/18/2024 at 1:33 P.M. Diagnoses included, but				labeled and stored as well as		
		onic obstructive pulmonary			dated appropriately. Any issue		
	, , , , , , , , , , , , , , , , , , ,	acheostomy, chronic			noted will be corrected to ensu	ıre	
	respiratory failure,	and obstructive sleep apnea.			compliance.		
					What measures and what		
		ssessment, dated 8/3/2024,			systemic changes will be mad		
		44 was cognitively intact and			ensure that the deficient pract	ice	
		of oxygen, suctioning,			doesn't recur:		
		and non-invasive mechanical			1. Licensed Nursing, QMAS, a	and	
	ventilation.				aides will be educated on the		
					policy of proper storage and		
		, initiated on 6/12/2024, and			labeling including appropriate		
		, indicated Resident 44 had a			dating of resp equipment by		
		vas at risk for infection and/or			DON/Designee by date of		
	1 -	rventions included to suction			compliance. Education will be		
	as needed.				completed upon hire, annually		
	A D1	1 4 17/20/2024 : 1: 4 14			prn. No nursing staff will be we		
	1	r, dated 7/29/2024, indicated to			past date of compliance witho	ut	
	change nebulizer tu	bing every Friday.			this education competed.	<b>.</b> -	
	A Dharaiaianta Ondar	r dated 9/12/2024 indicated to			How the corrective action will		
		er circuit every Tuesday on the			monitored to ensure the defici		
		er circuit every Tuesday on the			practice will not recur, i.e., who		
	day shift.				quality assurance program wil	i be	
	During on interview	y, on 9/20/2024 at 10:15 A.M.,			put in place:		
	_	bulizer equipment should have			The nurse managers will observe 5 residents weekly will	th	
		aced by the nebulizer			resp equipment x 2 months, th		
		pag was to be changed out			3 res weekly x2 months, and t		
		or as needed. The nebulizer			2 res weekly for 2 months to	11011	
		e placed in the respiratory bag			ensure compliance.		
					2. The results of these reviews	s will	
	when not in use. She indicated the suctioning tips				be discussed at the monthly	• <b>VVIII</b>	
	should be thrown away after an initial use and not reused. LPN 4 indicated the Yankauers were used				facility Quality Assurance		
		d and stored in the packaging			Committee meeting monthly for	nr a	
	they were removed				total of 3 months and then	ла	
	I are were removed	110111 101 450.	1		Local of a months and then		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION 155379		IDENTIFICATION NUMBER	A. BU B. WI	ILDING NG	00	COMPLETED 09/20/2024		
		100018						
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD			
LIFE CAF	LIFE CARE CENTER OF ROCHESTER			827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ļ	(X5)	
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	quarterly thereafter once		DATE	
	A policy was provide	ded on 9/20/2024 at 12:33 P.M.,			compliance is at 100%.			
		Nursing. The policy was titled,			Frequency and duration of rev	iews		
	-	bulizer Therapy". The policy			will be increased as needed, it			
	indicated, "Policy	yThe facility will provide			compliance is below 100%.			
		ulizer Treatments in accordance			Compliance date: 10-18-24. T			
	_	andards of practice, as			Administrator at Life Care Cer			
	* *	ott through the procedure			of Rochester is responsible in			
		eral RegulationThe services ed by the facility, as outlined			ensuring compliance in this Plot of Correction.	an		
		ve care plan, must(i) Meet			of Correction.			
		rds of quality" Lippincott's						
	*	Sebulizer treatment, small						
	_	"Nebulizer circuit should be						
	_	eare set-up bag. Labeled with						
	the patient's name a	and dated"						
	by the Director of N Suctioning", indicat oral suctioning in ac standards of practic clear secretions fror resident is unable to matter by effective	ded, on 9/20/2024 at 12:33 P.M., Nursing. The policy titled, "Oral ted, " The facility will provide ecordance with professional e and physicians order, to m the mouth in the event a premove secretions or foreign coughing 4. Yankauer and ored in a patient setup bag						
	3.1-47(a)(6)							
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs							
_	review, the facility a medications were re and failed to ensure free from a large bu	on, interview and record failed to ensure discontinued emoved from a medication room a medication refrigerator was a medication for 1 of 2 observed. (Skilled hall	F 07	61	This plan of correction is preparand executed because the provisions of state and federal require it and not because Life Care Center of Rochester agreewith the allegations and citation listed. Life Care Center of	law e ees	10/18/2024	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	MPLETED	
		155379	B. W	ING			0/2024	
				CTD DET	ADDRESS CITY STATE 719 COD			
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
	RE CENTER OF R	OCHESTER	827 W 13TH ST					
LIFE CAP	VE CENTER OF R	OUTESTER		ROCHESTER, IN 46975				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Rochester maintains that the			
	Finding includes:				alleged deficiencies do not			
					jeopardize the health and safe	ety of		
	-	tion of the South/Skilled hall			the residents nor is it of such			
	· ·	on 9/19/2024 at 9:23 A.M. with			character to limit our capabilit			
		g was observed: a plastic bag			to render adequate care. Plea			
	_	medications, along with a hand			accept this plan of correction	as		
	· ·	5/12/2024, of the following			our credible allegation of			
		ldol 5 mg (milligram) tablets			compliance that the alleged			
		Hydrocodone 10/325 mg			deficiencies have or will be co			
	· · · · · ·	15 Lorazepam 0.5 mg tablets;			by the date indicated to remai			
		ulfate (narcotic); 2 Fentanyl 20			compliance with state and fed			
	mcg (micrograms)	and 3 25 mcg patches (narcotic).			regulations, the facility has tal			
	TEL C	Cd 11 di Ci			or will take the actions set for	th in		
		of the medication refrigerator			this plan of correction. We			
	had a large build up	p of ice.			respectfully request a desk re F 761	view.		
	During an interview	w, on 9/19/2024 at 9:25 A.M.,			What Corrective Action will be	•		
	-	medications that had been			accomplished for those reside	ents		
	discontinued ahsou	lld have been desgtroyed and			found to have been affected b			
	the medication refr	igerator should not have had			this deficient practice:			
	an ice build up.				1. The medications found in the	ne		
					medication room were dispos	ed of		
		0:00 A.M., the Regional Director			immediately per facility policy			
		s provided the policy titled,			Facility checked the other me	d		
		nce Destruction Process",			room and no meds found.			
	· ·	d indicated the policy was the			Medication refrigerator and fre	eezer		
		by the facility. The policy			were cleaned and defrosted			
		ce an order has been received			immediately.			
		edication, facility staff should			How other residents having th			
		ation from the resident's			potential to be affected by the			
		4. Destruction of controlled			same deficient practice will be			
	substances should	occur as soon as possible"			identified and what corrective			
	ONI 0/10/2024 - 11	0.05 A.M. d. B. ' . 1.D.'			action will be taken:			
		0:05 A.M., the Regional Director			1. Nursing management valid			
		s provided the policy titled,			that med and tx carts as well			
	_	e in Refrigerator/Freezer", dated			med rooms had no medication			
		icated the policy was the one			treatments stored inappropria	-		
		he facility. The policy			and medication refrigerators a			
	indicated"8. If the	ere is excessive ice build-up in	1		freezers are at an acceptable			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/20/2024
	PROVIDER OR SUPPLIEF		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION PRIATE DATE
		ntenance department should be he unit to ensure proper		temperature and defrosted needed by date of compliar other issues were found. What measures and what systemic changes will be mensure that the deficient prodoesn't recur:  1. Licensed nursing and QN will be educated on the menoration policy including strateling and destruction perpolicy. This education will a include the defrosting of the medication refrigerator/free. This education will be compannually, upon hire, and prolicensed nursing staff or QN work past the date of compositing this. How the corrective action with put competing this. How the corrective action will not recur, i.e., a quality assurance program put in place:  1. Nurse managers will audit med rooms and medication refrigerators/freezers daily through Friday. Designated licensed nursing;/will observe weekends and holidays for months. DON will validate 2 weekly x 6 months.  2. The results of these reviews designated at the monthly facility Quality Assurance. Committee meeting monthly total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of the composition of the composition of the compliance is at 100%.	ade to actice  MAS dication brage, r LCCA also escer. bleted in No MA will aliance will be ficient what will be to the Monday rive on 6 escens ews will be ews will by y for a

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155379	B. WING 09/20/2024				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					will be increased as needed, it compliance is below 100%. Compliance date: 10-18-24. T Administrator at Life Care Cer of Rochester is responsible in ensuring compliance in this Pl of Correction.	he nter	
F 0812 SS=E Bldg. 00	Based on observation failed to store and so conditions related to foods for 1 of 1 kitch kitchen) and serving. This issue had the presidents who reside food from these dieth food from the following items - in the walk-in cool shredded carrots with 9/11/2024 and 1 ope pork chops, undated -In the dry pantry, the opened bag of brow and stuffing mix with 10/19/2023.  During an interview the Dietary Manage	ur of the main kitchen on  I., with the Dietary Manager, were observed: ler there was 1 plastic bag with th an expiration date of ened plastic bag with cooked I and unlabeled. here was an unlabeled and mie mix and powdered sugar, th an expiration date of  y, on 9/16/2024 at 9:40 A.M., r indicated nothing should be en and food should have labels	F 08	312	This plan of correction is prepared and executed because the provisions of state and federal require it and not because Life Care Center of Rochester agreewith the allegations and citation listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safethe residents nor is it of such character to limit our capabilitie to render adequate care. Pleat accept this plan of correction a our credible allegation of compliance that the alleged deficiencies have or will be compliance with state and federegulations, the facility has take or will take the actions set forth this plan of correction. We respectfully request a desk restricted in the state of the s	I law eees ees ens ety of es se as rrect n in eral sen h in view.	10/18/2024
	On 9/16/2024, at 12	2:01 P.M., 33 residents were			1. No residents in the facility h	ad	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/20/2024 155379 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 827 W 13TH ST LIFE CARE CENTER OF ROCHESTER ROCHESTER, IN 46975 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE observed in main dining area. Two different staff any negative outcomes from the were noted to have their thumbs on the eating alleged deficient practice. portion of the dinner plates when serving 3 Undated, unlabeled and expired residents in the dining room. food items were removed immediately. During an interview, on 9/20/2024 at 9:51 A.M., How other residents having the the Dietary Manager indicated staff should not potential to be affected by the have had their thumbs on the eating portion of the same deficient practice will be dinner plates when serving meals and dishes identified and what corrective should be handled by the outside at an angle. action will be taken: 1. Other residents have the On 9/17/2024, at 1:30 P.M., the Administrator potential to be affected therefore provided the policy titled, "Use By Date Guide," random dining room observations dated 3/18/2020, and indicated the policy was the were completed by various one currently used by the facility. The policy department heads during indicated "determine a "use by date" when mealtimes to ensure no thumbing labeling unopened and opened food...if uncertain of the plates occurred. Random of the appropriate date to place on an item, observations were made in the contact Director of Food Services all opened kitchen to ensure food had the containers of food in dry storage area should appropriate dating, expiration date be...labeled and dated with the open date and the and labeling. Any issues identified use by date." were corrected immediately What measures and what On 9/20/2024, at 10:55 A.M., the DON provided systemic changes will be made to the policy titled, "Resident Dining Services," ensure that the deficient practice dated 4/30/2024, and indicated the policy was the doesn't recur: one currently used by the facility. The policy 1. Education will be provided by indicated, "the facility has an established process the DON/IP on how to serve to ensure food is served in accordance with residents their plates while professional standards for food safety service..." maintaining sanitary conditions by date of compliance. Education will 3.1-21(i)(3)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

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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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155379	B. WING 09/20/2024			/2024		
				OTT PET	ADDRESS SITU STATE TO SOF			
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD			
		OCUESTED			13TH ST			
LIFE CAI	RE CENTER OF RO	JCHE91EK		ROCHESTER, IN 46975				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					working in the kitchen will be allowed to work without this education being completed by date of compliance.  How the corrective action will monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put in place:  1. Department heads will obse 5 meals weekly x 6 months to ensure compliance of serving residents their meals under sanitary conditions. The ED w observe five food items in the kitchen for open dates, expiradates, and appropriate labelin times weekly x 2 months, ther time weekly x 2 months to ensure compliance.  2. The results of these reviews the discussed at the monthly conditions.	be sent at ll be erve iill tion g 3 n 2 n 1 sure		
F 0880	483.80(a)(1)(2)(4)	n(e)(f)			be discussed at the monthly facility Quality Assurance Committee meeting monthly for total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of rewill be increased as needed, in compliance is below 100%. Compliance date: 10-18-24. The Administrator at Life Care Certof Rochester is responsible in ensuring compliance in this Plof Correction.	riews f he nter		
SS=D	Infection Prevention							

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		155379	B. W	NG		09/20/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIEF	R			13TH ST			
LIFE CA	LIFE CARE CENTER OF ROCHESTER				ESTER, IN 46975			
	T		1		T		1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	F 0/	TAG			DATE	
		on, interview and record	F 08	380	This plan of correction is prep	ared	10/18/2024	
	review, the facility failed to ensure staff change				and executed because the			
	-	te hand hygiene when			provisions of state and federa			
		care for 1 of 1 residents			require it and not because Life			
	reviewed for incont	tinence needs. (Resident 7)			Care Center of Rohester agre			
	F: 1: : 1 1				with the allegations and citation	ons		
	Finding includes:				listed. Life Care Center of			
	Daning on all annual	:			Rochester maintains that the			
	_	ion on, 9/17/2024 at 9:06 A.M.,			alleged deficiencies do not			
		ed to provide incontinence care			jeopardize the health and safe	ety of		
		donned gloves and removed the resident. CNA 3 put the			the residents nor is it of such			
	1 '	-			character to limit our capabiliti			
		lirty wipes she had used on the ne resident. With her dirty			to render adequate care. Plea			
		went into the bathroom to			accept this plan of correction a	aS		
	_	She placed the wet brief and			our credible allegation of			
		rash bag. CNA 3 then went to			compliance that the alleged	rraat		
	_	pair of clean pants without			deficiencies have or will be co			
		minated gloves. CNA 3 then			by the date indicated to remai			
		ints on, and repositioned the			compliance with state and fed			
	1 -	r mat. CNA 3 rubbed the			regulations, the facility has take or will take the actions set fort			
		then moved a pillow under her			this plan of correction. We	11 111		
	head.	then moved a pinow under her			respectfully request a desk re	viow		
	nead.				F 880	view.		
	During an interview	v, on 9/17/2024 at 9:13 A.M.,			What Corrective Action will be			
	_	ne should have removed her			accomplished for those reside			
		her hands after cleaning the			found to have been affected b			
	resident's perineal	_			this deficient practice:	У		
	resident's permear	area.			1. Resident # 7 had no negative	Ve		
	On 9/19/2024 at 9-4	43 A.M., the Regional Director			outcomes to alleged deficient			
		s provided the policy titled,			practice. Certified Aide # 3 wa			
		ated 6/3/2024, and indicated			immediately educated on hand			
		one currently use by the			hygiene by the DON.	ч		
		indicated"2. Associated			How other residents having th	<u> </u>		
		ene (even if gloves are uses) in			potential to be affected by the			
		ions: b. After contact with			same deficient practice will be			
		d. after removing personal			identified and what corrective	•		
					action will be taken:			
protective equipment) e.g., gloves"			I		action will be taken.		I	

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1. Other residents have the

potential to be affected therefore

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	OF CORRECTION	IDENTIFICATION NUMBER  155379	A. BUILDING B. WING	00	COMPLETED 09/20/2024
	ROVIDER OR SUPPLIER		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				nursing management did ran observations to ensure compwith hand hygiene by date of compliance.  What measures and what systemic changes will be maensure that the deficient pracedoesn't recur:  1. Licensed Nursing and cert nursing aides will be educated appropriate hand hygiene fol the facilities policy. Hand hygicompetencies will be compled on licensed nursing and certicates by the IP and nursing managers by date of compliance ducation will be completed hire, at least annual, and prolicensed nursing staff will be past date of compliance with this education competed. How the corrective action will monitored to ensure the deficities practice will not recur, i.e., with quality assurance program with put in place:  1. The IP/designee will obsest staff members weekly for appropriate IC practices involved hygiene x 6 months to ensure compliance. Nursing management will perform 2 competencies weekly on hand hygiene rotating shifts x 6 modes. 2. Results of these reviews be discussed at the monthly facility Quality Assurance. Committee meeting monthly total of 3 months and then quarterly thereafter once.	de to ctice dified ed on lowing giene sted dified ance. upon . No work out  If be cient that will be erve 5 elving

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICARD SERVICES							
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
155379			B. WING		09/20/	2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				compliance is at 100%. Frequency and duration of rev will be increased as needed, it compliance is below 100%. Compliance date: 10-18-24. T Administrator at Life Care Cer of Rochester is responsible in ensuring compliance in this Plof Correction.	f 'he nter		

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