CENTERS FOR MEDICARE & MEDICAID 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. BU	JILDING	<u></u>	_ COMPLETED 10/21/2024	
		155379	B. WI	NG			
		<u> </u>		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEI	R			13TH ST		
LIFE CA	RE CENTER OF RO	OCHESTER			ESTER, IN 46975		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHO)  CROSS-REFERENCED TO THE APP		IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 10/21/24				This plan of correction is prepared and executed because the		
					provisions of state and federa require it and not because Lit Care Center of Rochester ag	fe	
	Facility Number: 0 Provider Number:				with the allegations and citati listed. Life Care Center of Rochester maintains that the	ons	
	AIM Number: 1002	umber: 155379			alleged deficiencies do not jeopardize the health and saf	fety of	
	Center of Rocheste	r was found not in compliance			the residents nor is it of such character to limit our capabili	ties	
		reparedness Requirements for			to render adequate care. Ple		
		icaid Participating Providers			accept this plan of correction	as	
		CFR 483.73. The facility has 108 he time of the survey, the			our credible allegation of compliance that the alleged		
	census was 50.	ne time of the survey, the			deficiencies have or will be c		
	Quality Review con	mpleted on 10/23/24			by the date indicated to rema compliance with state and fer regulations, the facility has ta	deral	
					or will take the actions set for		
					this plan of correction. We respectfully request a desk re	eview.	
E 0004 SS=F Bldg	1 ' '	64(a), 418.113(a), 441.1 Review and Update					
ŭ	Based on record refailed to review and Preparedness Plan accordance with 42	view and interview, the facility d update the Emergency (EPP) at least annually in CFR 483.73(a). This deficient et all residents, staff and	E 00	004	This plan of correction is prepand executed because the provisions of state and federa require it and not because Lit Care Center of Rochester ag with the allegations and citatilisted. Life Care Center of Rochester maintains that the	al law fe rees ons	11/18/2024

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

Based on record review and interview with the

TITLE

alleged deficiencies do not

jeopardize the health and safety of

(X6) DATE

Suzanne Wagner Executive Director 11/18/2024

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3VS421 Facility ID: 000325 If continuation sheet Page 1 of 36

PRINTED: 11/20/2024 FORM APPROVED 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 COMPL				
		155379	B. WING 10/21/2024			/2024	
N	DROLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	C		827 W 1	13TH ST		
	RE CENTER OF RO	OCHESTER	ROCHESTER, IN 46975				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX		ICY 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
		and Maintenance Director from			the residents nor is it of such		
		a.m. on 10/21/24, no			character to limit our capabiliti		
		ld be found to show the EPP			to render adequate care. Plea		
	was reviewed and updated within the last year.  Based on interview during record review, the				accept this plan of correction a	as	
		stated the EPP had not been			our credible allegation of		
		d but she has it on her			compliance that the alleged	rraat	
	schedule.	d but she has it on her			deficiencies have or will be co		
	schedule.				by the date indicated to remain compliance with state and fed		
	This finding was ra	viewed with the Evecutive			regulations, the facility has tak		
	This finding was reviewed with the Executive Director and Maintenance Director at the exit				or will take the actions set fort		
	conference.				this plan of correction. We	11 111	
	conference.				respectfully request a desk re	view.	
					respectivity request a desk re-	VICVV.	
					E004 Develop EP Plan, Revi	014	
					and Update Annually	CVV	
					and opdate Annually		
					What corrective actions will	be	
					accomplished for those		
					residents found to have been	า	
					affected by the deficient		
					practice?		
					The Emergency Preparednes	ss	
				Plan (EPP) will be updated by			
					date of compliance.		
					·		
					How other residents have the		
					potential to be affected by th		
					same deficient practice will t		
					identified and what correctiv	е	
					actions will be taken?		
					All residents have the potenti	al to	
					be affected.		
					What measures will be put		
					into place or what systemic		
	l		1		changes will be made to		

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 2 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES  DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/21/2024			
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DE PRIATE COMPLETION DATE			
				ensure that the deficient practice does not recur?				
				Maintenance Director and Executive Director have be educated by the RVP on th Emergency Preparedness (EPP) including annual rev	ne Plan iews.			
				How will the corrective as be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will into place?	ne			
				Maintenance Director/ED/Designee to co auditing of TELS to ensure updated as indicated. Aud will occur monthly x's 6 mo	EPP iting			
				The results of these review be discussed at the monthl facility QAPI meeting mont 3 months and then quarter thereafter for a total of 6 m Frequency and duration of will be increased as neede areas of noncompliance ar identified during the auditin process.	hly for ly onths. reviews d if any			
				Compliance date: Nov 18, The Administrator at Life C Center of Rochester is resp in ensuring compliance in t Plan of Correction	are ponsible			

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

Event ID:

3VS421

Facility ID: 000325

25

If continuation sheet Page 3 of 36

PRINTED: 11/20/2024 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/21/2024	
	PROVIDER 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	
E 0013 SS=F Bldg	Based on record reversal failed to review and Preparedness Plan (at least annually in 483.73(b). The LTC implement emerger procedures, based of forth in paragraph (assessment at parage the communication section. The policie reviewed and update deficient practice control and visitors.  Findings include:  Based on record reverse Executive Director 9:00 a.m. to 11:35 and documentation coul Policies and Procedupdated within the during record reviews stated the EPP had a but she has it on her	A(b), 418.113(b), 441.1 P Policies and Procedures  A wiew and interview, the facility I update the Emergency EPP) Policies and Procedures accordance with 42 CFR C facility must develop and acy preparedness policies and an the emergency plan set a) of this section, risk raph (a)(1) of this section, and plan at paragraph (c) of this s and procedures must be ed at least annually. This build affect all residents, staff  A wiew and interview with the and Maintenance Director from a.m. on 10/21/24, no d be found to show the EPP ures were reviewed and last year. Based on interview w, the Executive Director not been reviewed or updated ar schedule.  A viewed with the Executive enance Director at the exit	E 0013	This plan of correction is prepared executed because the provisions of state and federal require it and not because Life Care Center of Rochester agricultation 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 capabilities to render adequate care. Plea accept this plan of correction accept this plan of correction accept that the alleged deficiencies have or will be compliance that the alleged deficiencies have or will be 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 revenue to the compliance with state and fed regulations and Procedures What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Emergency Preparedness Plan (EPP) will updated by date of compliance How other residents have the potential to be affected by the same deficient practice will to identified and what corrective will to identified and what corrective will to the potential to the corrective will to the cor	I law elees ees ons  ety of eles ese as  orrect n in eleral ken th in  view.  at  n  be e. e e e e e e e e e e e e e e e e	

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

Event ID:

3VS421

Facility ID: 000325

actions will be taken?All

If continuation sheet Page 4 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		(X2) MULTIPLE CONSTRUCTION (X3) DATE  A. BUILDING COMPL  B. WING 10/21/			ETED		
NAME OF P	ROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST				
LIFE CAF	RE CENTER OF RO	OCHESTER	ROCHESTER, IN 46975				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	COMPLETION DATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	residents have the potential to affected. Maintenance Direct audited all inspections for the kitchen to ensure they have been completed as required and that all corridor doors have than one releasing operation. Maintenance Direct and Executive Director have beeducated by the RVP on the Emergency Preparedness Pla (EPP) including annual reviews. How will the correctivactions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place? Maintenance Director/ED/Designee to compauditing of TELS to ensure EP updated as indicated. Auditing will occur monthly x's 6 month. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 month. Frequency and duration of rev will be increased as needed if areas of noncompliance are identified during the auditing process.  Compliance date: Nov 18, 202 The Administrator at Life Care Center of Rochester is respon in ensuring compliance in this Plan of Correction	be cor e ave or een n ve ure cor put blete p s rill be ty hs. iews any	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3VS421 Facility ID: 000325 If continuation sheet Page 5 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155379		A. BUILDING B. WING		COMPLETED 10/21/2024			
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
E 0024 SS=F Bldg		5.54(b)(5), 418.113(b)( es-Volunteers and Staffing					
Diug	failed to ensure eme and procedures inch an emergency or oth strategies, including integration of State of care professionals to an emergency in acc 483.73(b)(6). This diresidents, staff and visited in the staff and visit	iew and interview, the facility orgency preparedness policies and the use of volunteers in the energency staffing at the process and role for our Federally designated health to address surge needs during cordance with 42 CFR deficient practice could affect all evisitors.  iew and interview with the and Maintenance Director from the integration of State or definitely integration of State or definitely integration of State or during an emergency. During executive Director stated she was the policy at the time of the integration of State or during an emergency of the integration of State or during an emergency. Buring executive Director stated she was the policy at the time of the integration of State or during an emergency of the integration of State or during an emergency. Buring executive Director stated she was the policy at the time of	E 0024	This plan of correction is prepand executed because the provisions of state and federa require it and not because Lift Care Center of Rochester ag with the allegations and citatilisted. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safthe 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 compliance with state and federegulations, the facility has taken or will take the actions set for this plan of correction. We respectfully request a desk results of the compliance with state and federespectfully request a desk results. Procedures Volunteers and Staffing  What corrective actions will accomplished for those residents found to have been affected by the deficient practice?  The Emergency Preparedne policies and procedures will the second of the control of the c	al law fe grees grons  fety of ties ase as  orrect ain in deral aken rth in eview.		
	not able to provide t survey.  This finding was rev Director and Mainte	the policy at the time of viewed with the Executive		What corrective actions will accomplished for those residents found to have been affected by the deficient practice?  The Emergency Preparedne	ess ess pe		

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 6 of 36

PRINTED: 11/20/2024 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	(X3) DATE SURVEY COMPLETED 10/21/2024	
	ROVIDER OR SUPPLIE		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?  All residents have the potential be affected.  Maintenance Director audited	e e e
				all inspections for the kitcher to ensure they have been completed as required and the all corridor doors have more than one releasing operation.  Maintenance Director and Executive Director have been educated by the RVP on the	at
				Emergency Preparedness Plar (EPP) including annual reviews  How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be printo place?	ns
				Maintenance Director/ED/Designee to comp auditing of EPP to ensure polic and procedures are updated as indicated. Auditing will occur monthly x's 6 months.  The results of these reviews w be discussed at the monthly facility QAPI meeting monthly f	cy s

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 7 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155379			A. BUILDING  B. WING	INSTRUCTION	COMPLETED 10/21/2024	
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				3 months and then quarterly thereafter for a total of 6 month and the frequency and duration of rew will be increased as needed if areas of noncompliance are identified during the auditing process.	iews	
				Compliance date: Nov 18, 202 The Administrator at Life Care Center of Rochester is respon in ensuring compliance in this Plan of Correction		
E 0029 SS=F Bldg	, ,	4(c), 418.113(c), 441.1 ommunication Plan				
<b>5</b> *	failed to review and Preparedness Commannually in accordant facility must develop preparedness commainty with Federal, State a reviewed and update facilities. This deficit residents, staff and vibration of the Findings include:  Based on record reviewed and update facilities and the staff and vibration of the staff a	iew and interview with the and Maintenance Director from	E 0029	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 safe the residents nor is it of such character to limit our capabilitie to render adequate care. Pleas accept this plan of correction a our 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 or will take the actions set fortil	law ees ns  ty of es se as rrect n in eral en	

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 8 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/21/2024	
	ROVIDER OR SUPPLIER		STREET 827 W ROCH		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	updated but she has			this plan of correction. We respectfully request a desk re	eview.
	_	viewed with the Executive enance Director at the exit		E029 Development of Communication Plan	
				What corrective actions wil accomplished for those residents found to have bee affected by the deficient practice?	
				The Emergency Preparednes Communication Plan will be updated by date of compliance	
				How other residents have the potential to be affected by the same deficient practice will identified and what corrective actions will be taken?	ne be
				All residents have the potent be affected.	ial to
				What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	
				Maintenance Director and Executive Director have been educated by the RVP on the Emergency Preparedness Pla (EPP) including annual review	an
				How will the corrective action be monitored to ensure the	ons

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 9 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155379	B. Wl	ING		10/21	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS, REFERENCED TO THE APPROPRIA	)TF	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
E 0032		6.54(c)(3), 418.113(c)(			deficient practice will not recur, i.e., what quality assurance programs will be into place?  Maintenance Director/ED/Designee to comauditing of Emergency Preparedness Communication Plan to ensure it is updated a indicated. Auditing will occur monthly x's 6 months.  The results of these reviews be discussed at the monthly facility QAPI meeting monthly 3 months and then quarterly thereafter for a total of 6 months are requency and duration of rewill be increased as needed it areas of noncompliance are identified during the auditing process.  Compliance date: Nov 18, 202 The Administrator at Life Care Center of Rochester is responsin ensuring compliance in this Plan of Correction	plete n s will for ths. views any	
SS=F Bldg	Primary/Alternate	Means for Communication view and interview, the	E 00	032	This plan of correction is prep and executed because the	ared	11/18/2024

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 10 of 36

PRINTED: 11/20/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED	
		155379	1	B. WING			10/21/2024	
		100010		_		10/21/		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					13TH ST			
LIFE CA	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	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOW)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	T-	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	Communications Pl	lan failed to address primary			provisions of state and federal	law		
		s of communication in			require it and not because Life			
	accordance with 42	CFR 483.73(c)(3). The facility's			Care Center of Rochester agre			
		edness Communications Plan			with the allegations and citatio			
		rimary and alternate means for			listed. Life Care Center of			
	communicating wit	-			Rochester maintains that the			
	(i) [Facility] staff.	2			alleged deficiencies do not			
		ribal, regional, and local			jeopardize the health and safe	tv of		
	emergency manage	_			the residents nor is it of such	-,		
		ice could affect all residents,			character to limit our capabilities			
staff and visitors.				to render adequate care. Pleas				
					accept this plan of correction a			
Findings include:				our credible allegation of				
					compliance that the alleged			
	Based on record rev	view and interview with the			deficiencies have or will be con	rrect		
	Executive Director	and Maintenance Director from			by the date indicated to remain	n in		
		a.m. on 10/21/24, the Emergency			compliance with state and federal			
		nunications Plan did not			regulations, the facility has taken			
	_	d alternate means of			or will take the actions set forth in			
		sed on interview with the			this plan of correction. We			
	Executive Director	during record review, she			respectfully request a desk review.			
		ry and alternate means of			E032 Primary/Alternate Means			
	_	ey could use; however,			for CommunicationWhat			
	nothing was docum	ented.			corrective actions will be			
					accomplished for those			
	This finding was re	viewed with the Executive			residents found to have been	1		
	Director and Mainto	enance Director at the exit			affected by the deficient			
	conference.				practice?The Emergency			
					Preparedness Communication	1		
					Plan will be updated to addres	s		
					primary and alternative means			
					communication by date of			
					compliance. How other reside	ents		
					have the potential to be			
					affected by the same deficier	nt		
					practice will be identified and			
					what corrective actions will be			
					taken?All residents have the			

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

potential to be affected. What measures will be put into place

Page 11 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			ľ í	X3) DATE SURVEY COMPLETED	
		155379	B. WING 10/21/				
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R	827 W 13TH ST				
LIFE CAF	RE CENTER OF R	OCHESTER		ROCHE	ESTER, IN 46975		
(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)	TE	COMPLETION
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION		TAG			DATE
					or what systemic changes w be made to ensure that the	""	
					deficient practice does not		
					recur?Maintenance Director a	nd	
					Executive Director have been		
					educated by the RVP on the		
					Emergency Preparedness		
					Communication Plan including	ı	
					primary and alternative means	of	
					communication.How will the		
					corrective actions be		
					monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality	4	
					assurance programs will be into place?Maintenance	put	
					Director/ED/Designee to comp	Noto	
					auditing of TELS to ensure the		
					Emergency Preparedness	•	
					Communication Plan includes		
					primary and alternative means	of	
					communication. Auditing will		
					occur monthly x's 6 months. T	he	
					results of these reviews will be	,	
					discussed at the monthly facili	ty	
					QAPI meeting monthly for 3		
					months and then quarterly		
					thereafter for a total of 6 mont		
					Frequency and duration of rev		
					will be increased as needed if	any	
					areas of noncompliance are		
					identified during the auditing		
					process.		
					Compliance date: Nov 18, 202	24.	
					The Administrator at Life Care		
					Center of Rochester is respon	sible	
					in ensuring compliance in this		
					Plan of Correction		

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

Event ID:

3VS421 Facility ID: 000325

If continuation sheet Page 12 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155379	B. WING			10/21/2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					13TH ST		
LIFE CAF	RE CENTER OF RO	CHESTER		ROCHE	ESTER, IN 46975		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		DROWIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
E 0036	403.748(d), 416.54	4(d), 418.113(d), 441.1					
SS=F	EP Training and T	• • • • • • • • • • • • • • • • • • • •					
Bldg	Li Tranning and T	coung					
J	Based on record rev	view and interview, the facility	E 00	036	This plan of correction is prepared	ared	11/18/2024
	failed to review and update the Emergency			330	and executed because the	a. 0 G	11/10/2021
		ng and Testing Program at			provisions of state and federal	law	
	-	cordance with 42 CFR			require it and not because Life		
	-	C facility must develop and			Care Center of Rochester agre		
		ncy preparedness training and			with the allegations and citatio		
		t is based on the emergency			listed. Life Care Center of	. 1.5	
	0.0	agraph (a) of this section, risk			Rochester maintains that the		
	assessment at paragraph (a)(1) of this section,				alleged deficiencies do not		
	policies and procedures at paragraph (b) of this				jeopardize the health and safe	ty of	
	section, and the communication plan at paragraph				the residents nor is it of such	ty Oi	
		The training and testing			character to limit our capabilitie	26	
		viewed and updated at least			to render adequate care. Pleas		
		ient practice could affect all			accept this plan of correction a		
	residents, staff and	-			our credible allegation of	13	
	residents, starr and	visitors.			compliance that the alleged		
	Findings include:				deficiencies have or will be co	rect	
	i mamga meraac.				by the date indicated to remain		
	Based on record rev	riew and interview with the			compliance with state and fed		
		and Maintenance Director from			regulations, the facility has tak		
	9:00 a.m. to 11:35 a				or will take the actions set forth		
		d be found to show the			this plan of correction. We		
		dness Testing and training			respectfully request a desk rev	view.	
		wed and updated within the last			E036 EP Training and	1011.	
	-	view during record review, the			TestingWhat corrective actio	ns	
	•	stated the Emergency			will be accomplished for thos		
		and not been reviewed or			residents found to have been		
	updated but she has				affected by the deficient		
	apaated out she has	it on her selledate.			practice?The Emergency		
	This finding was rev	viewed with the Executive			Preparedness Training and Te	etina	
		enance Director at the exit			Program will be updated by da	-	
	conference.	chance Director at the exit			compliance. How other reside		
	controller.				have the potential to be		
					affected by the same deficier	nt	
					practice will be identified and		
					what corrective actions will be		
					taken?All residents have the	,,,	
					Lancii: All residents have the		

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 13 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/21/2024			
NAME OF P	ROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST				
LIFE CAF	RE CENTER OF RO	OCHESTER			ESTER, IN 46975		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					potential to be affected. What	t	
					measures will be put into pla		
					or what systemic changes w	ill	
					be made to ensure that the		
					deficient practice does not recur?Maintenance Director h	126	
					been educated by the Executi		
					Director on the Emergency		
					Preparedness Training and Te	esting	
					Program including annual		
					reviews.How will the correcti		
					actions be monitored to ensi		
					the deficient practice will not	i	
					recur, i.e., what quality assurance programs will be	nut	
					into place?Maintenance	put	
					Director/ED/Designee to comp	olete	
					auditing of TELS to ensure the		
					Emergency Preparedness Tra	ining	
					and Testing Program including	-	
					annual reviews. are updated a	ıs	
					indicated. Auditing will occur		
					monthly x's 6 months. The res		
					of these reviews will be discus at the monthly facility QAPI	seu	
					meeting monthly for 3 months	and	
					then quarterly thereafter for a		
					of 6 months. Frequency and		
					duration of reviews will be		
					increased as needed if any ar		
					of noncompliance are identifie	d	
					during the auditing process.		
					Compliance date: Nov 18, 202	24.	
					The Administrator at Life Care		
					Center of Rochester is respon		
					in ensuring compliance in this		
					Plan of Correction		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3VS421 Facility ID: 000325 If continuation sheet Page 14 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155379	B. WI	B. WING			10/21/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				13TH ST			
LIFE CAF	RE CENTER OF RO	CHESTER			ESTER, IN 46975			
,			1		.0121(, 114 +0070			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCE		DATE	
E 0039	, , , ,	6.54(d)(2), 418.113(d)(						
SS=F	EP Testing Requir	ements						
Bldg	Dogad on record ray	ion and interview the facility	E 00	20	n="" noroid="665671974"		11/10/2024	
	Based on record review and interview, the facility failed to conduct exercises to test the emergency		E 00	139	p="" paraid="665671874"		11/18/2024	
	plan at least twice p				paraeid="{e3324867-fcd0-4218-9ad			
	_	lrills using the emergency			a-0781dbc1c485}{189}">E039 Testing Requirements What	EF		
		C facility must do the			correction will be accomplishe	d for		
	-	ipate in an annual full-scale			those residents found to have	u 101		
	exercise that is com				been affected by this deficient			
		ity-based exercise is not			practice: A disaster drill will be			
		an annual individual,			conducted in the facility and			
	facility-based functional exercise.				documented by date of			
	-	y experiences an actual natural			compliance.¿ How other			
	· · · · · · · · · · · · · · · · · · ·	ency that requires activation			residents having the potential	to		
	-	an, the LTC facility is exempt			be affected by the same defici			
		ext required full-scale in a			practice will be identified and v			
	community-based or	r individual, facility-based			corrective action(s) will be			
	full-scale functional	exercise for 1 year following			taken: All residents have the			
	the onset of the actu	al event.			potential to be affected. ¿ Wha	at		
	(ii) Conduct an addi	tional exercise that may			measure will be put into place	or		
	include, but is not li	mited to the following:			what systemic changes will be			
	a. A second full-sca				made to ensure that the deficie	ent		
	•	r an individual, facility-based			practices does not recur: Dire	ctor		
	functional exercise.				and Executive Director have b	een		
	b. A mock disaster of				educated by the RVP on the			
		se or workshop that is led by a			Emergency Preparedness Pla	n		
		des a group discussion, using			(EPP) including annual			
	_	y-relevant emergency scenario,			reviews. Two Disaster Drills w			
	•	statements, directed			scheduled/conducted per year	-		
		ed questions designed to			regulation.¿ Documentation o	f		
	challenge an emerge				Disaster Drills will be			
		C facility's response to and			maintained.¿ Facility based			
		ation of all drills, tabletop			functional exercise is schedule			
	· ·	gency events, and revise the			for 11-15-24; How the correc	tive		
	-	gency plan, as needed in			action(s) will be monitored to	.:11		
	accordance with 42				ensure the deficient practice w	/III		
	•	ice could affect all residents,			not recur: Maintenance	1-4-		
	staff and visitors.				Director/ED/Designee to comp	lete		
		1		auditing of TELS to ensure				

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 15 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155379		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/21/2024			
	RE CENTER OF RO		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
IAU	Findings include:  Based on record rev Executive Director 9:00 a.m. to 11:35 a able to provide documentat facility-based function actual natural or ma required activation of the past 12 month p review the Executiv exercises were conducted.  This finding was rev	riew and interview with the and Maintenance Director from t.m. on 10/21/24, the facility was immentation of a table-top the facility was unable to ion of a community-based or onal exercise performed, or an in-made emergency that of the emergency plan during the end of the	TAG	disaster drills are completed a indicated. Auditing will occur monthly x's 6 months. The results of these reviews will b discussed at the monthly facil QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 month of Frequency and duration of rewill be increased as needed if areas of noncompliance are identified during the auditing process. ¿  Compliance date: Nov 18, 20. The Administrator at Life Care Center of Rochester is respor in ensuring compliance in this Plan of Correction	e ity ths. views f any 24.		
K 0000 Bldg. 01			K 0000	This plan of correction is prepand executed because the provisions of state and federa require it and not because Lift Care Center of Rochester agricultation 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 capabilit 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 remain	erees ons ety of ies ase as		

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 16 of 36

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155379			JILDING	onstruction  01	(X3) DATE : COMPL 10/21/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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  COMPLETED		(X5) COMPLETION DATE
	This one-story facil Type V (111) const sprinklered. The fa with smoke detection open to the corridor detectors in all resid facility has a capaci 50 at the time of thi All areas where resident	dents have customary access The facility had one detached			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 revenue.	en n in	
K 0291	Quality Review con	npleted on 10/23/24					
SS=E Bldg. 01	interview, the facilit battery powered em documented monthl provide lighting dur Section 7.9.3.1.1 (1 shall be conducted a weeks and a maxim for not less than 30 testing shall be conducted of 1 1/2 hours if the battery powered and inspections and test for inspection by the jurisdiction. This d staff in the boiler ro	on, record review and ty failed to ensure 1 of 1 ergency lights were tested and y to ensure the light would ring periods of power outages. ) requires functional testing monthly, with a minimum of 3 um of 5 weeks between tests, seconds, (3) Functional ducted annually for a minimum emergency lighting system is d (5) Written records of visual s shall be kept by the owner e authority having efficient practice could affect	K 0	291	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 safe the residents nor is it of such character to limit our capabilities to render adequate care. Pleas accept this plan of correction a our credible allegation of compliance that the alleged deficiencies have or will be could by the date indicated to remain compliance with state and feder regulations, the facility has take	law ees ns ty of es se is rrect in in eral	11/18/2024

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 17 of 36

11/20/2024 PRINTED: FORM APPROVED

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 COMPLETED 01 155379 B. WING 10/21/2024 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 Executive Director and Maintenance Director from or will take the actions set forth in 9:00 a.m. to 11:35 a.m. on 10/21/24, an annual 1 1/2 this plan of correction. We hour test of an emergency battery backup light respectfully request a desk review. located in the boiler room was completed and documented; however, there was no documentation of monthly 30 second testing of **K291 – Emergency Lighting** the emergency battery powered light. Based on observation with the Executive Director and What corrective actions will be Maintenance Director from 12:00 p.m. to 1:25 p.m. accomplished for those on 10/21/24, a battery powered emergency light residents found to have been was in the boiler room. During record review the affected by the deficient Maintenance Director stated he did not perform practice? monthly testing of the emergency light. A 1 ½ hour emergency test to be This finding was reviewed with the Executive performed on the emergency Director and Maintenance Director at the exit battery backup light in the boiler conference. room by date of compliance. 3.1-19(b) How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance Director has been educated by the Executive Director on the annual 1 ½ hour tests and monthly 30 second tests on battery powered

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

Event ID:

3VS421

Facility ID: 000325

emergency lighting.

If continuation sheet

Page 18 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/21/2024	
	ROVIDER OR SUPPLIE		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)  Maintenance Director/Design complete an annual emergen test on all battery powered emergency lighting by date of compliance.  How will the corrective actions be monitored to ens the deficient practice will no recur, i.e., what quality assurance programs will be into place?  Maintenance Director/ED/Designee to com auditing of TELS to ensure ar 1 ½ hour tests and monthly 3 second tests on battery powe emergency lighting is comple Auditing will occur monthly x's months.  The results of these reviews be discussed at the monthly facility QAPI meeting monthly	plete nnual 0 ored ted. s 6 will
				3 months and then quarterly thereafter for a total of 6 mon Frequency and duration of rewill be increased as needed it areas of noncompliance are identified during the auditing process.  Compliance date: Nov 18, 20. The Administrator at Life Care Center of Rochester is respor in ensuring compliance in this Plan of Correction	ths. views f any  24. e nsible

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 19 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/21/2024 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0300 **NFPA 101** SS=F Protection - Other Bldg. 01 Based on observation, record review and K 0300 This plan of correction is prepared 11/18/2024 interview, the facility failed to ensure and executed because the documentation for the preventative maintenance provisions of state and federal law of 55 of 55 battery operated smoke alarms in require it and not because Life resident rooms was complete. NFPA 101 in Care Center of Rochester agrees 4.6.12.3 states existing life safety features obvious with the allegations and citations to the public, if not required by the Code, shall be listed. Life Care Center of maintained. NFPA 72, 29.10 Maintenance and Rochester maintains that the Tests. Fire-warning equipment shall be maintained alleged deficiencies do not and tested in accordance with the manufacturer's jeopardize the health and safety of published instructions and per the requirements the residents nor is it of such of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, character to limit our capabilities testing, and maintenance programs shall satisfy to render adequate care. Please the requirements of this Code and conform to the accept this plan of correction as equipment manufacturer's published instructions. our credible allegation of This deficient practice could affect all residents, compliance that the alleged staff, and visitors. deficiencies have or will be correct by the date indicated to remain in Findings include: compliance with state and federal regulations, the facility has taken Based on record review and interview with the or will take the actions set forth in Executive Director and Maintenance Director from this plan of correction. We 9:00 a.m. to 11:35 a.m. on 10/21/24, when asked respectfully request a desk review. what type of smoke detectors were located in the resident rooms, the Maintenance Director stated K 300 Protection-Other they were battery-operated. Documentation of What corrective action(s) will battery-operated smoke detector testing was be accomplished for those available for review on the computer program residents found to have been 'TELS'; however, the documentation only affected by the deficient provided that smoke detectors were tested. There practice? was no itemized list of each smoke detector with a Itemized documentation regarding location or if they passed or failed. Furthermore, smoke alarms to be implemented the documentation did not provide if or a date by date of compliance. when battery replacement had occurred. Based on Documentation to include location, observation with the Executive Director and pass or fail, and date of battery Maintenance Director from 12:00 p.m. to 1:25 p.m. replacement.

on 10/21/24, battery-operated smoke detectors

How other residents having the

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/21/2024			
	PROVIDER OR SUPPLIEF		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 CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CITION (X5)  JLD BE COMPLETION PROPRIATE DATE			
TAG	were located in each interview at the time Maintenance Direct recording the batter testing in the "TEL additional document."  This finding was re	h of the resident rooms. During e of record review, the for stated that he was only y-operated smoke detector S" program and did not have	TAG	potential to be affected same deficient practice identified and what corn action(s) will be taken: All residents, staff, and what the potential to be a What measure will be place or what systemic changes will be made to ensure that the deficient practices does not recurred to the Maintenance Director on requirement a smoke alarm itemization of compliance. The Maintenance Director/Designee will condition and all smoke alarms by date of compliance to location, pass or fail, and battery change is documned the will be monitored to ensure deficient practice will not recur:  The Maintenance Director/ED/Designee will not be monitored to ensure itemization of smoke alar complete and up to date be ongoing. Any concernidentified will be address immediately.  The results of these review discussed at the monthly QAPI meeting monthly for months and then quarter thereafter for a total of 6	by the will be rective  isistors affected. ut into  out into  out in:  or to be we of need for by date  omplete a in facility ensure didate of ented. on(s) sure the ot  Il conduct onthly for the rms are and will as ed  ews will be a facility or 3 ely			

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 21 of 36

DEP	CPARTMENT OF HEALTH AND HUMAN SERVICES								
CEN	CENTERS FOR MEDICARE & MEDICAID SERVICES								
5	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3)					
Δ	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A RUILDING 01	ı					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER 155379  NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF ROCHESTER		A. BUILI B. WING S	TIPLE CONSTRUCTION DING  01  TREET ADDRESS, CITY, STATE, ZIP CITY 127 W 13TH ST ROCHESTER, IN 46975	COMI	(X3) DATE SURVEY COMPLETED 10/21/2024	
(X4) ID	1	STATEMENT OF DEFICIENCIE		D		(X5)
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	PROVIDER'S PLAN OF COR EFIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A AG DEFICIENCY)	RECTION HOULD BE APPROPRIATE	COMPLETION DATE
				Frequency and duratio will be increased as ne areas of noncompliance identified during the auprocess.	eded if any se are	
				Compliance date: Nov The Administrator at Li Center of Rochester is in ensuring compliance Plan of Correction.	ife Care responsible	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure				
	failed to ensure the hazardous area, a refeet in size used for supplies, was proving which would cause close and latch into practice could affect in 1 of 8 smoke confirmed in	on with the Executive Director Director from 12:00 p.m. to 1:25 the corridor door to room 114 in fied as "Zone 6" on the facility lose into the door frame. This ed for storage of cardboard per goods. Based on interview evation, the Executive Director Director agreed room 114 was age of combustible supplies	K 032	This plan of correction and executed because provisions of state and require it and not because with the allegations and listed. Life Care Center Rochester maintains the alleged deficiencies do jeopardize the health at the residents nor is it of character to limit our cast to render adequate can accept this plan of corrour credible allegation compliance that the alleged deficiencies have or with by the date indicated to compliance with state are gulations, the facility or will take the actions this plan of correction.	the federal law use Life ster agrees d citations r of nat the o not and safety of if such apabilities re. Please rection as of eged ill be correct o remain in and federal has taken set forth in We	11/18/2024

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

Event ID: 3VS421 Facility ID: 000325

If continuation sheet Page 22 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED  D. WING 10/24/202				
		155379	B. WING 10/21/2024				
	PROVIDER 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 DEFICIENCY 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
		viewed with the Executive enance Director at the exit			K321 – Hazardous Area - Enclosure		
	3.1-19(b)				What corrective actions will accomplished for those residents found to have beer affected by the deficient practice?		
					Maintenance Director to insta Self-Closing Device in room 1 by date of compliance.	14	
					How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?	ne De	
					Residents, staff, and visitors I the potential to be affected.	have	
					What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?		
					Maintenance Director has been educated by the Executive Director on Hazardous Area – Enclosures.		
					Maintenance Director to audit doors that require Self-Closing Devices to ensure they worked properly and are present on the said doors by date of complian	d nose	

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 23 of 36

PRINTED: 11/20/2024 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 01	(X3) DATE SURVEY COMPLETED 10/21/2024	
	PROVIDER OR SUPPLIE		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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
				How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place?	
				Maintenance Director/Design complete auditing of all hazar Areas-Enclosure to ensure Self-closing Devices to ensure they were working properly arinstalled. Auditing will occur ax's/weekly x's 4 weeks, 4 x's monthly x's 5 months.	dous e nd
				The results of these reviews be discussed at the monthly facility QAPI meeting monthly 3 months and then quarterly thereafter for a total of 6 mont Frequency and duration of rewill be increased as needed if areas of noncompliance are identified during the auditing process.	for ths. views
K 0324	NFPA 101			Compliance date: Nov 18, 20; The Administrator at Life Care Center of Rochester is respor in ensuring compliance in this Plan of Correction	e nsible
SS=E Bldg. 01	Cooking Facilities	on, record review and	K 0324	This plan of correction is prep	ared 11/18/2024

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

Event ID:

3VS421 Facility ID: 000325

If continuation sheet Page 24 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

	IENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	ľ	UILDING	ONSTRUCTION  01	(X3) DATE COMPL 10/21/	ETED
	F 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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
TAG	interview; the facilic kitchen exhaust system semiannually. NFF for Ventilation Concommercial Cooking states the entire exhibiting commercial for grease trained, qualified, and acceptable to the autinous and in accordance with Schedule for Inspective requires systems semiannually. NFF inspection, if the excontaminated with a vapors, the contaminated with a vapors, the contaminate	ty failed to ensure 1 of 1 tems was inspected PA 96, 2011 Edition, Standard trol and Fire Protection of ang Operations, Section 11.4 haust system shall be buildup by a properly and certified person(s) atthority having jurisdiction with Table 11.4. Table 11.4, betion for Grease Buildup, rving moderate volume		TAG	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 coupy 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  K324 – Cooking Facilities  What corrective actions will accomplished for those residents found to have been affected by the deficient practice?  The Hood Suppression Systems inspection was located and laccompleted on 7/17/24.  How other residents have the potential to be affected by the same deficient practice will indentified and what corrective identified and identified and identified and identified and identified and identified and identified identifie	I law e ees ees ens ety of es se as rrect n in eral ken h in view.	DATE

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 25 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED  B. WING 10/21/2024				
		155379	B. W	'ING		10/21	/2024
NAME OF P	DOMDED OF CURRY ICA			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		827 W 13TH ST				
	RE CENTER OF RO	OCHESTER	ROCHESTER, 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 APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION	_	TAG			DATE
	· ·	ation of semiannual kitchen			actions will be taken?		
		not available for review. Based			All Kitchen stoff have the not	ontial	
		interview with the Executive			All Kitchen staff have the pote to be affected.	Hillai	
		enance Director from 12:00 p.m.			to be affected.		
		21/24, a dated sticker with the			What measures will be put		
	-	applied to the side of the			into place or what systemic		
	· ·	od, indicated the next date of			changes will be made to		
	inspection would be	October 2024. At the time of			ensure that the deficient		
	observation the Exe				practice does not recur?		
		for both stated the company is					
	scheduled for Octob				Maintenance Director has be		
		viewed with the Executive			educated on Kitchen policies	and	
		enance Director at the exit			procedures.		
	conference.						
	2 1 10/b)				Maintenance Director to audit	all	
	3.1-19(b)				inspections for the kitchen to	otod	
					ensure they have been compl as required by date of complia		
					as required by date or complia	iiice.	
					How will the corrective action	ons	
					be monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality		
					assurance programs will be	put	
					into place?		
					Maintenance		
					Director/ED/Designee to comp	olete	
					auditing of all kitchen inspection		
					Auditing will occur 4 x's/weekl		
					x's 4 weeks, 4 x's monthly x's	-	
					months.		
					The results of these reviews	will	
					be discussed at the monthly	,	
					facility QAPI meeting monthly	tor	
					3 months and then quarterly thereafter for a total of 6 mont	ho	
					Frequency and duration of rev	riews	

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 26 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155379	A. BU B. W		01	COMPLETED 10/21/2024	
		100010	2	_		10/21/	72021
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD  13TH ST		
LIFE CA	RE CENTER OF R	OCHESTER			ESTER, IN 46975		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	will be increased as needed if	any	DATE
					areas of noncompliance are	arry	
					identified during the auditing		
					process. monthly x's 6 months	S.	
					Compliance date: Nov 18, 202	24	
					The Administrator at Life Care		
					Center of Rochester is respon		
					in ensuring compliance in this		
					Plan of Correction		
K 0511	NFPA 101						
SS=E	Utilities - Gas and	d Electric					
Bldg. 01							
		on and interview, the facility	K 0	511	This plan of correction is prep	ared	11/18/2024
		ctrical wires were enclosed to			and executed because the	l law.	
	-	SC Section 19.5.1.1 states ly with the provisions of			provisions of state and federa require it and not because Life		
	_	n 9.1.2 states: Electrical wiring			Care Center of Rochester agr		
		ll be in accordance with NFPA			with the allegations and citation		
	70. NFPA 70 Secti	on 406.5 (F) Exposed Terminals,			listed. Life Care Center of		
		e enclosed so that live wiring			Rochester maintains that the		
		xposed to contact. This			alleged deficiencies do not		
		ould affect visitors, staff and			jeopardize the health and safe	ety of	
	residents in 1 of 8 s	smoke compartments.			the residents nor is it of such character to limit our capabilit	ios	
	Finds include:				to render adequate care. Plea		
					accept this plan of correction		
		on with the Maintenance			our credible allegation of		
		0 p.m. to 1:25 p.m. on 10/21/24,			compliance that the alleged		
		n electrical junction boxes			deficiencies have or will be co		
		h exposed wiring. The junction			by the date indicated to remai		
		d to the wall above the drop ire doors in the Village Hall.			compliance with state and fed regulations, the facility has tal		
		at the time of observation, the			or will take the actions set fort		
		tor stated he did not know			this plan of correction. We		
Ī	1				'		1

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 27 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMPLI	(X3) DATE SURVEY COMPLETED 10/21/2024		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD			
LIFE CAF	RE CENTER OF RO	OCHESTER	827 W 13TH ST ROCHESTER, IN 46975					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		ΓAG	DEFICIENCY)		DATE	
		e for but suspected they were ic door hold devices for the			respectfully request a desk re K511– Utilities – Gas and Electric	view.		
	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.			What corrective actions accomplished for those residents found to have to				
	3.1-19(b)				affected by the deficient practice?			
					The junction boxes on Village will have new cover replaced enclose exposed wiring by da compliance.	to		
					How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?	ie De		
					Village Hall residents, staff, a visitors have the potential to b affected.			
					What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?			
					Maintenance Director has been educated that receptacle faceplates shall be installed so to completely cover the opening and seat against the mounting surface.	o as ng		
					How will the corrective action	ons		

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 28 of 36

PRINTED: 11/20/2024 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 01	(X3) DATE SURVEY  COMPLETED  10/21/2024				
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	recur,		deficient practice will not recur, i.e., what quality assurance programs will be into place?	put				
				Maintenance Director/ED/Designee to compauditing of all Electrical Outlet ensure receptacle faceplates be installed so as to complete cover the opening and seat against the mounting surface. Auditing will occur 4 x's/week x's 4 weeks, 4 x's monthly x's months.	s to shall ly			
				The results of these reviews be discussed at the monthly facility QAPI meeting monthly 3 months and then quarterly thereafter for a total of 6 mont Frequency and duration of revisible be increased as needed if areas of noncompliance are identified during the auditing process.	for hs. riews			
				Compliance date: Nov 18, 202 The Administrator at Life Care Center of Rochester is respor in ensuring compliance in this Plan of Correction	e nsible			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills							
-		riew and interview, the facility arterly fire drills for 1 of 4	K 0712	This plan of correction is prep and executed because the	ared 11/18/2024			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPLETED	
		155379	B. W	ING		10/21/	2024
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					13TH ST		
LIFE CA	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	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
	quarters. LSC 19.7.	1.6 requires drills to be			provisions of state and federal	law	
	conducted quarterly	on each shift under varied			require it and not because Life	,	
	conditions. This de	ficient practice affects all			Care Center of Rochester agre		
	residents and staff.	•			with the allegations and citatio		
				listed. Life Care Center of			
Findings include:				Rochester maintains that the			
					alleged deficiencies do not		
	Based on record rev	view and interview with the			jeopardize the health and safe	etv of	
		and Maintenance Director from			the residents nor is it of such	,	
		a.m. on 10/21/24, there was no			character to limit our capabiliti	es	
		a first shift fire drill in the third			to render adequate care. Plea		
	quarter of 2024. Ba	sed on interview at the time of			accept this plan of correction a		
record review, the Maintenance Director stated he				our credible allegation of			
	· · · · · · · · · · · · · · · · · · ·	t at the facility in August of			compliance that the alleged		
		pecoming familiar with the			deficiencies have or will be co	rrect	
		did a second shift fire drill in			by the date indicated to remain		
		complete a fire shift fire drill			compliance with state and fed		
	during the third qua	-			regulations, the facility has tak		
					or will take the actions set fort		
	This finding was re	viewed with the Executive			this plan of correction. We		
		enance Director at the exit			respectfully request a desk rev	view.	
	conference.				K 712 – Fire Drills		
					What correction will be		
	3.1-19(b)				accomplished for those		
	3.1-51(c)				residents found to have been	ո	
					affected by this deficient		
					practice:		
					Fire drill to be completed by da	ate	
					of compliance.		
					How other residents having t	the	
					potential to be affected by th		
					same deficient practice be		
					identified and what correctiv	e	
					action will be taken:		
					Timely completion of fire drills	will	
					affect all residents.		
					What measures will be put in	ito	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet Page 30 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/21/2024		
NAME OF P	ROVIDER OR SUPPLIEI	· ?			ADDRESS, CITY, STATE, ZIP COD		
LIFE CAF	RE CENTER OF RO	OCHESTER			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)	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	practice does not recur:		DATE
					Maintenance Director has bee	n	
					educated by Executive Directo		
					conducting fire drills on each s		
					quarterly to familiarize facility		
					personnel with the signals and		
					emergency action required un	der	
					varied conditions.	. ,	
					Maintenance Director will prove fire drill report on a monthly ba		
					for six months to ED to ensure		
					compliance.		
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place:		
					ED/Designee will audit fire dril		
					a monthly basis for six months	· to	
					ensure compliance. The results of these reviews w	ill be	
					discussed at the monthly facili		
					QAPI meeting monthly for 3	.,	
					months and then quarterly		
					thereafter for a total of 6 month	ns.	
					Frequency and duration of rev	iews	
					will be increased as needed if	any	
					areas of noncompliance are		
					identified during the auditing		
					process.		
					Compliance date: Nov 18, 202	<u>'</u> 4.	
					The Administrator at Life Care		
					Center of Rochester is respon	sible	
					in ensuring compliance in this		
					Plan of Correction		

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 31 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>		COMPLETED	
		155379	B. WI	B. WING 10/21/202			/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				13TH ST		
	RE CENTER OF RO	OCHESTER	ı	ROCHE	ESTER, IN 46975		
(X4) ID	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0914	NFPA 101						
SS=F	Electrical Systems	s - Maintenance and					
Bldg. 01	Testing						
		on, record review and	K 0	914	This plan of correction is prepare	ared	11/18/2024
		ty failed to ensure all			and executed because the		
		electrical receptacles at			provisions of state and federal	law	
		ons were tested at least			require it and not because Life	;	
		Health Care Facilities Code			Care Center of Rochester agre	ees	
		on 6.3.4.1.3 states receptacles			with the allegations and citation	ns	
	•	l-grade, at patient bed			listed. Life Care Center of		
		ations where deep sedation or			Rochester maintains that the		
		s administered, shall be tested			alleged deficiencies do not		
	at intervals not exce	eeding 12 months.			jeopardize the health and safe	ty of	
	Additionally, Section 6.3.3.2, Receptacle Testing				the residents nor is it of such		
		ms requires the physical			character to limit our capabiliti	es	
	integrity of each rec	eptacle shall be confirmed by			to render adequate care. Plea	se	
	visual inspection. T	he continuity of the			accept this plan of correction a	as	
	grounding circuit in	each electrical receptacle shall			our credible allegation of		
		polarity of the hot and neutral			compliance that the alleged		
		electrical receptacle shall be			deficiencies have or will be co	rrect	
		ntion force of the grounding			by the date indicated to remai	n in	
		ical receptacle (except			compliance with state and fed	eral	
		acles) shall be not less than			regulations, the facility has tak	en	
	- '	s). This deficient practice			or will take the actions set fort	h in	
	could affect all resid	lents, staff and visitors.			this plan of correction. We		
					respectfully request a desk rev	view.	
	Findings include:						
		riew and interview with the			K 914 – Electrical Systems –		
		and Maintenance Director from			Maintenance and Testing		
		.m. on 10/21/24, the facility was			What correction will be		
	-	documentation of annual			accomplished for those		
	_	receptacles. Based on			residents found to have been	า	
		e Executive Director and			affected by this deficient		
		or from 12:00 p.m. to 1:25 p.m.			practice:		
		ospital-grade electrical			Receptacle testing to be		
	-	use in all resident rooms			completed by date of complian		
	_	ity. During record review, the			How other residents having the potential to be affected by the		
		or stated he did not perform					
	testing of the electri	cal receptacles.			same deficient practice be		
			1		identified and what corrective	Δ.	

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/21/2024		
	PROVIDER OR SUPPLIE			827 W 1	ADDRESS, CITY, STATE, ZIP COD		
LIFE C	ARE CENTER OF RO	JCHESTER		ROCHE	STER, IN 46975		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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)	TE	(X5) COMPLETION DATE
	This finding was re	viewed with the Executive enance Director at the exit			action will be taken: All residents have the potential be affected. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director has bee educated by Executive Director non-hospital grade electrical receptacle testing requirement How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: Maintenance Director to provide documentation of required task and their completion to QAPI meeting monthly for a six-mon period. The results of these reviews we discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 month Frequency and duration of rev will be increased as needed if areas of noncompliance are identified during the auditing process.  Compliance date: Nov 18, 202 The Administrator at Life Care Center of Rochester is respon in ensuring compliance in this Plan of Correction	n or r/t is. he ut de ks th vill be ty ns. iews any	

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

Event ID:

3VS421 Facility ID: 000325

If continuation sheet Page 33 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155379			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/21/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 827 W 13TH ST ROCHESTER, IN 46975			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - T	Transfilling Cylinders				
Blag. U1	interview, the facility properly trained on 1 oxygen storage rotakes place. NFPA 11.5.2.3.1 (4) require the container(s) to be trans-filling procedu 11.5.2.1.3 require per application and main others who handle in cylinders that container and use. Health care programs of continuing personnel. Continuing personnel. Continuing personnel continuing the periodic revusage requirements cylinders. This deficient practical and staff.  Findings include:	on, record review and by failed to ensure staff was trans-filling procedures in 1 of om where oxygen transferring 199 2012 edition, Section res the individual trans-filling reproperly trained in the ares. Sections 11.5.2.1.1 thru tersonnel concerned with the intenance of medical gases and medical gases and the in the medical gases shall be associated with their handling refacilities shall provide using education for their ing education programs shall riew of safety guidelines and for medical gases and their diece could affect all residents	K 0927	This plan of correction and executed because provisions of state and require it and not because Care Center of Roche with the allegations are listed. Life Care Center Rochester maintains the alleged deficiencies dipeopardize the health of the residents nor is it of the character to limit our of the total this plan of corrections compliance that the allegation compliance that the allegation compliance with state regulations, the facility or will take the actions this plan of corrections respectfully request a K 927 Gas Equipment	e the d federal law ause Life ester agrees and citations er of that the o not and safety of of such capabilities are. Please rrection as a of lleged vill be correct to remain in and federal y has taken as set forth in . We desk review.	11/18/2024
	9:00 a.m. to 11:35 a documentation was	and Maintenance Director from .m. on 10/21/24, no available for review to ho trans-fill liquid oxygen was		Transfilling Cylinders What correction will accomplished for the residents found to ha	s be ose	
	properly trained or latransfilling. Based of Executive Director at 12:00 p.m. to 1:25 p storage and trans-fil oxygen containers, 'portable oxygen tam	nad a policy in place for on observation with the and Maintenance Director from o.m. on 10/21/24, the oxygen I room contained bulk-liquid "E" tanks and refillable ks. Based on interview at the w, the Executive Director		affected by this defice practice: Oxygen storage area reorganized to safely accommodate tanks, and personnel to stan perform transfilling as	has been equipment d and	

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 34 of 36

PRINTED: 11/20/2024 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 <u>01</u>	(X3) DATE SURVEY COMPLETED 10/21/2024	
	PROVIDER OR SUPPLIE		827 W	ADDRESS, CITY, STATE, ZIP COD 13TH ST ESTER, IN 46975		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY O	STATEMENT OF DEFICIENCIE NCY 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	
IAG	stated she was certannual training was if annual training of been conducted.  This finding was re-	ain no documentation of savailable and could not state of trans-filling liquid oxygen had eviewed with the Executive transce Director at the exit	TAU	How other residents having potential to be affected by the same deficient practice be identified and what corrective action will be taken:  All residents have the potential be affected.  What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:  All nursing staff will be educated on proper storage and filling techniques for O2. Education be documented and will include demonstration of staff knowled.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place:  O2 transfilling will be reviewed during monthly safety meeting include a random staff demonstration for safety committee to audit. Results caudit will be presented at mor QAPI X 6 months for review a analysis.	the ne /e al to nto ted will de dge. the out d g to of the nthly	
				The results of these reviews	will	

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

Event ID:

3VS421

Facility ID: 000325

If continuation sheet

Page 35 of 36

PRINTED: 11/20/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155379	ĺ	ILDING	onstruction 01	(X3) DATE COMPL 10/21/	ETED
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF ROCHESTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					be discussed at the monthly facility QAPI meeting monthly 3 months and then quarterly thereafter for a total of 6 month Frequency and duration of rev will be increased as needed if areas of noncompliance are identified during the auditing process.	hs. iews	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3VS421 Facility ID: 000325 If continuation sheet Page 36 of 36