| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155379 | A. BUILDING -- B. WING | 10/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| LIFE CARE CENTER OF ROCHESTER | 827 W 13TH ST ROCHESTER, IN 46975 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 10/21/24<br><br>Facility Number: 000325<br>Provider Number: 155379<br>AIM Number: 100274300<br><br>At this Emergency Preparedness survey, Life Care Center of Rochester was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 108 certified beds. At the time of the survey, the census was 50.<br><br>Quality Review completed on 10/23/24 | E 0000 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. | |
| E 0004<br>SS=F<br>Bldg. -- | 403.748(a), 416.54(a), 418.113(a), 441.1<br>Develop EP Plan, Review and Update Annually<br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the | E 0004 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of | 11/18/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Suzanne Wagner | Executive Director | 11/18/2024 |

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| | Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, no documentation could be found to show the EPP was reviewed and updated within the last year. Based on interview during record review, the Executive Director stated the EPP had not been reviewed or updated but she has it on her schedule.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | | the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br><br>**E004 Develop EP Plan, Review and Update Annually**<br><br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>The Emergency Preparedness Plan (EPP) will be updated by date of compliance.<br><br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>All residents have the potential to be affected.<br><br>**What measures will be put into place or what systemic changes will be made to** | |

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| | | | **ensure that the deficient practice does not recur?**<br><br>Maintenance Director and Executive Director have been educated by the RVP on the Emergency Preparedness Plan (EPP) including annual reviews.<br><br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?**<br><br>Maintenance Director/ED/Designee to complete auditing of TELS to ensure EPP updated as indicated. Auditing will occur monthly x's 6 months.<br><br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |

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| E 0013 SS=F Bldg. -- | 403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures<br><br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(b). The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, no documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on interview during record review, the Executive Director stated the EPP had not been reviewed or updated but she has it on her schedule.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | E 0013 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br>**E013 Development of EP Policies and ProceduresWhat corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**The Emergency Preparedness Plan (EPP) will be updated by date of compliance.<br>**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 | 11/18/2024 |

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| | | | residents have the potential to be affected. **Maintenance Director audited all inspections for the kitchen to ensure they have been completed as required and that all corridor doors have more than one releasing operation.**Maintenance Director and Executive Director have been educated by the RVP on the Emergency Preparedness Plan (EPP) including annual reviews.**How will the corrective actions 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 complete auditing of TELS to ensure EPP updated as indicated. Auditing will occur monthly x's 6 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |

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| E 0024 SS=F Bldg. -- | 403.748(b)(6), 416.54(b)(5), 418.113(b)( Policies/Procedures-Volunteers and Staffing<br><br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, the facility's Emergency Preparedness Policies and Procedures did not address the use of volunteers in an emergency, emergency staffing strategies, or the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. During record review the Executive Director stated she believed they did have a policy; however, she was not able to provide the policy at the time of survey.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | E 0024 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br><br>**E024 Policies/Procedures Volunteers and Staffing**<br><br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>The Emergency Preparedness policies and procedures will be updated by date of compliance. | 11/18/2024 |

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| | | | **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>All residents have the potential to be affected.<br><br>**Maintenance Director audited all inspections for the kitchen to ensure they have been completed as required and that all corridor doors have more than one releasing operation.**<br><br>Maintenance Director and Executive Director have been educated by the RVP on the Emergency Preparedness Plan (EPP) including annual reviews.<br><br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?**<br><br>Maintenance Director/ED/Designee to complete auditing of EPP to ensure policy and procedures are updated as indicated. Auditing will occur monthly x's 6 months.<br><br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for | |

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| | | | 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |
| E 0029 SS=F Bldg. -- | 403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan<br><br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Communication Plan at least annually in accordance with 42 CFR 483.73(c). The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually for LTC facilities. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, no documentation could be found to show the Emergency Preparedness Communication Plan was reviewed and updated within the last year. Based on interview during record review, the Executive Director stated the Emergency | E 0029 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in | 11/18/2024 |

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| | Preparedness Plan had not been reviewed or updated but she has it on her schedule.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | | this plan of correction. We respectfully request a desk review.<br><br>**E029 Development of Communication Plan**<br><br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>The Emergency Preparedness Communication Plan will be updated by date of compliance.<br><br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>All residents have the potential to be affected.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>Maintenance Director and Executive Director have been educated by the RVP on the Emergency Preparedness Plan (EPP) including annual reviews.<br><br>**How will the corrective actions be monitored to ensure the** | |

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| | | | **deficient practice will not recur, i.e., what quality assurance programs will be put into place?**<br><br>Maintenance Director/ED/Designee to complete auditing of Emergency Preparedness Communication Plan to ensure it is updated as indicated. Auditing will occur monthly x's 6 months.<br><br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |
| E 0032 SS=F Bldg. -- | 403.748(c)(3), 416.54(c)(3), 418.113(c)( Primary/Alternate Means for Communication<br><br>Based on record review and interview, the facility's Emergency Preparedness | E 0032 | This plan of correction is prepared and executed because the | 11/18/2024 |

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| | Communications Plan failed to address primary and alternate means of communication in accordance with 42 CFR 483.73(c)(3). The facility's Emergency Preparedness Communications Plan must include: (3) Primary and alternate means for communicating with the following:<br>(i) [Facility] staff.<br>(ii) Federal, State, tribal, regional, and local emergency management agencies.<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, the Emergency Preparedness Communications Plan did not address primary and alternate means of communication. Based on interview with the Executive Director during record review, she advised what primary and alternate means of communications they could use; however, nothing was documented.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | | provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br>**E032 Primary/Alternate Means for CommunicationWhat corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**The Emergency Preparedness Communication Plan will be updated to address primary and alternative means of communication by date of compliance. **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** | |

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| | | | **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 Communication Plan including 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 assurance programs will be put into place?**Maintenance Director/ED/Designee to complete 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. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |

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| E 0036 SS=F Bldg. -- | 403.748(d), 416.54(d), 418.113(d), 441.1<br>EP Training and Testing<br><br>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Training and Testing Program at least annually in accordance with 42 CFR 483.73(d). The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, no documentation could be found to show the Emergency Preparedness Testing and training Program was reviewed and updated within the last year. Based on interview during record review, the Executive Director stated the Emergency Preparedness Plan had not been reviewed or updated but she has it on her schedule.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | E 0036 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br>**E036 EP Training and TestingWhat corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**The Emergency Preparedness Training and Testing Program will be updated by date of compliance. **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 | 11/18/2024 |

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| | 155379 | A. BUILDING -- B. WING | 10/21/2024 |

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| | | | 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 Emergency Preparedness Training and Testing Program including annual reviews.**How will the corrective actions 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 complete auditing of TELS to ensure the Emergency Preparedness Training and Testing Program including annual reviews. are updated as indicated. Auditing will occur monthly x's 6 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |

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| E 0039 SS=F Bldg. -- | 403.748(d)(2), 416.54(d)(2), 418.113(d)( EP Testing Requirements<br><br>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or<br>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or<br>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2).<br>This deficient practice could affect all residents, staff and visitors. | E 0039 | p="" paraid="665671874" paraeid="{e3324867-fcd0-4218-9ada-0781dbc1c485}{189}">E039 EP Testing Requirements What correction will be accomplished for those residents found to have been affected by this deficient practice: A disaster drill will be conducted in the facility and documented by date of compliance.¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. ¿ What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur: Director and Executive Director have been educated by the RVP on the Emergency Preparedness Plan (EPP) including annual reviews. Two Disaster Drills will be scheduled/conducted per year per regulation.¿ Documentation of Disaster Drills will be maintained.¿ Facility based functional exercise is scheduled for 11-15-24¿ How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Maintenance Director/ED/Designee to complete auditing of TELS to ensure | 11/18/2024 |

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| | Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, the facility was able to provide documentation of a table-top exercise, however, the facility was unable to provide documentation of a community-based or facility-based functional exercise performed, or an actual natural or man-made emergency that required activation of the emergency plan during the past 12 month period. At time of record review the Executive Director stated no other exercises were conducted other than fire drills.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | | disaster drills are completed as indicated. Auditing will occur monthly x's 6 months. The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.¿<br>Compliance date: Nov 18, 2024.<br>The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 10/21/24<br><br>Facility Number: 000325<br>Provider Number: 155379<br>AIM Number: 100274300<br><br>At this Life Safety Code survey, Life Care Center of Rochester was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing | K 0000 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in | |

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| | Health Care Occupancies and 410 IAC 16.2.<br><br>This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 108 and had a census of 50 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered. The facility had one detached garage which was not sprinklered.<br><br>Quality Review completed on 10/23/24 | | compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. | |
| K 0291<br>SS=E<br>Bldg. 01 | NFPA 101<br>Emergency Lighting<br><br>Based on observation, record review and interview, the facility failed to ensure 1 of 1 battery powered emergency lights were tested and documented monthly to ensure the light would provide lighting during periods of power outages. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect staff in the boiler room only.<br><br>Findings include:<br><br>Based on record review and interview with the | K 0291 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken | 11/18/2024 |

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

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| | | | Maintenance Director/Designee to complete an annual emergency test on all battery powered emergency lighting by date of compliance.<br><br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?**<br><br>Maintenance Director/ED/Designee to complete auditing of TELS to ensure annual 1 ½ hour tests and monthly 30 second tests on battery powered emergency lighting is completed. Auditing will occur monthly x's 6 months.<br><br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |

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

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| | were located in each of the resident rooms. During interview at the time of record review, the Maintenance Director stated that he was only recording the battery-operated smoke detector testing in the "TELS" program and did not have additional documentation.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br>All residents, staff, and visitors have the potential to be affected.<br>**What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:**<br>The Maintenance Director to be educated by the Executive Director on requirement of need for smoke alarm itemization by date of compliance.<br>The Maintenance Director/Designee will complete audit of all smoke alarms in facility by date of compliance to ensure location, pass or fail, and date of battery change is documented.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**<br>The Maintenance Director/ED/Designee will conduct observations in facility monthly for next 6 months to ensure the itemization of smoke alarms are complete and up to date, and will be ongoing. Any concerns identified will be addressed immediately.<br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. | |

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| | | | Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction. | |
| K 0321 SS=E Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 hazardous area, a resident room over 50 square feet in size used for storage of combustible supplies, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect visitors, staff and residents in 1 of 8 smoke compartments.<br><br>Findings include:<br><br>Based on observation with the Executive Director and Maintenance Director from 12:00 p.m. to 1:25 p.m. on 10/21/24, the corridor door to room 114 in the corridor identified as "Zone 6" on the facility map, did not self-close into the door frame. This room was being used for storage of cardboard boxes and other paper goods. Based on interview at the time of observation, the Executive Director and Maintenance Director agreed room 114 was being used for storage of combustible supplies and lacked a door-closure. | K 0321 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. | 11/18/2024 |

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| | This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **K321 – Hazardous Area - Enclosure**<br><br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>Maintenance Director to install Self-Closing Device in room 114 by date of compliance.<br><br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>Residents, staff, and visitors have the potential to be affected.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>Maintenance Director has been educated by the Executive Director on Hazardous Area – Enclosures.<br><br>Maintenance Director to audit all doors that require Self-Closing Devices to ensure they worked properly and are present on those said doors by date of compliance. | |

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| | | | **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?**<br><br>Maintenance Director/Designee to complete auditing of all hazardous Areas-Enclosure to ensure Self-closing Devices to ensure they were working properly and installed. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months.<br><br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |
| K 0324<br>SS=E<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br><br>Based on observation, record review and | K 0324 | This plan of correction is prepared | 11/18/2024 |

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| | interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, documentation of an annual cleaning the kitchen exhaust system cleaning had been completed on 04/16/24; | | and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br><br>**K324 – Cooking Facilities**<br><br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>The Hood Suppression System inspection was located and last completed on 7/17/24.<br><br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective** | |

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| | however, documentation of semiannual kitchen exhaust system inspection six months before or after 04/16/24 was not available for review. Based on observation and interview with the Executive Director and Maintenance Director from 12:00 p.m. to 1:25 p.m. on 10/21/24, a dated sticker with the contractor's name, applied to the side of the kitchen exhaust hood, indicated the next date of inspection would be October 2024. At the time of observation the Executive Director and Maintenance Director both stated the company is scheduled for October 2024.<br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **actions will be taken?**<br><br>All Kitchen staff have the potential to be affected.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>Maintenance Director has been educated on Kitchen policies and procedures.<br><br>Maintenance Director to audit all inspections for the kitchen to ensure they have been completed as required by date of compliance.<br><br>**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?**<br><br>Maintenance Director/ED/Designee to complete auditing of all kitchen inspections. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months.<br><br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews | |

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| | | | will be increased as needed if any areas of noncompliance are identified during the auditing process. monthly x's 6 months.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |
| K 0511 SS=E Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br><br>Based on observation and interview, the facility failed to ensure electrical wires were enclosed to prevent contact. LSC Section 19.5.1.1 states utilities shall comply with the provisions of Section 9.1. Section 9.1.2 states: Electrical wiring and equipment shall be in accordance with NFPA 70. NFPA 70 Section 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect visitors, staff and residents in 1 of 8 smoke compartments.<br><br>Finds include:<br><br>Based on observation with the Maintenance Director from 12:00 p.m. to 1:25 p.m. on 10/21/24, there were two open electrical junction boxes without covers with exposed wiring. The junction boxes were attached to the wall above the drop ceiling above the fire doors in the Village Hall. Based on interview at the time of observation, the Maintenance Director stated he did not know | K 0511 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We | 11/18/2024 |

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| | what the wires were for but suspected they were used for the magnetic door hold devices for the fire doors.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | respectfully request a desk review.<br>**K511– Utilities – Gas and Electric**<br><br>**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>The junction boxes on Village Hall will have new cover replaced to enclose exposed wiring by date of compliance.<br><br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>Village Hall residents, staff, and visitors have the potential to be affected.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>Maintenance Director has been educated that receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface.<br><br>**How will the corrective actions be monitored to ensure the** | |

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| | | | **deficient practice will not recur, i.e., what quality assurance programs will be put into place?**<br><br>Maintenance Director/ED/Designee to complete auditing of all Electrical Outlets to ensure receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Auditing will occur 4 x's/weekly x's 4 weeks, 4 x's monthly x's 5 months.<br><br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |
| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br><br>Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 | K 0712 | This plan of correction is prepared and executed because the | 11/18/2024 |

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| | quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents and staff.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, there was no documentation for a first shift fire drill in the third quarter of 2024. Based on interview at the time of record review, the Maintenance Director stated he started employment at the facility in August of 2024 and was still becoming familiar with the facility and that he did a second shift fire drill in August but did not complete a fire shift fire drill during the third quarter of 2024.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b)<br>3.1-51(c) | | provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br>**K 712 – Fire Drills**<br>**What correction will be accomplished for those residents found to have been affected by this deficient practice**:<br>Fire drill to be completed by date of compliance.<br>**How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken**:<br>Timely completion of fire drills will affect all residents.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient** | |

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| | | | **practice does not recur**:<br>Maintenance Director has been educated by Executive Director r/t conducting fire drills on each shift quarterly to familiarize facility personnel with the signals and emergency action required under varied conditions.<br>Maintenance Director will provide fire drill report on a monthly basis for six months to ED to ensure compliance.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**:<br>ED/Designee will audit fire drills on a monthly basis for six months to ensure compliance.<br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months.<br>Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024.<br>The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |

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| K 0914 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Maintenance and Testing<br>Based on observation, record review and interview, the facility failed to ensure all non-hospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, the facility was not able to provide documentation of annual testing of electrical receptacles. Based on observation with the Executive Director and Maintenance Director from 12:00 p.m. to 1:25 p.m. on 10/21/24, non-hospital-grade electrical receptacles were in use in all resident rooms throughout the facility. During record review, the Maintenance Director stated he did not perform testing of the electrical receptacles. | K 0914 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br><br>**K 914 – Electrical Systems – Maintenance and Testing**<br>**What correction will be accomplished for those residents found to have been affected by this deficient practice**:<br>Receptacle testing to be completed by date of compliance.<br>**How other residents having the potential to be affected by the same deficient practice be identified and what corrective** | 11/18/2024 |

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| | This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **action will be taken**:<br>All residents have the potential to be affected.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**:<br>Maintenance Director has been educated by Executive Director r/t non-hospital grade electrical receptacle testing requirements.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**:<br>Maintenance Director to provide documentation of required tasks and their completion to QAPI meeting monthly for a six-month period.<br>The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process.<br><br>Compliance date: Nov 18, 2024.<br>The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in this Plan of Correction | |

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| K 0927 SS=F Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br><br>Based on observation, record review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, Section 11.5.2.3.1 (4) requires the individual trans-filling the container(s) to be properly trained in the trans-filling procedures. Sections 11.5.2.1.1 thru 11.5.2.1.3 require personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. Health care facilities shall provide programs of continuing education for their personnel. Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.<br>This deficient practice could affect all residents and staff.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Maintenance Director from 9:00 a.m. to 11:35 a.m. on 10/21/24, no documentation was available for review to indicate that staff who trans-fill liquid oxygen was properly trained or had a policy in place for transfilling. Based on observation with the Executive Director and Maintenance Director from 12:00 p.m. to 1:25 p.m. on 10/21/24, the oxygen storage and trans-fill room contained bulk-liquid oxygen containers, "E" tanks and refillable portable oxygen tanks. Based on interview at the time of record review, the Executive Director | K 0927 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.<br><br>**K 927 Gas Equipment – Transfilling Cylinders**<br>**What correction will be accomplished for those residents found to have been affected by this deficient practice**:<br>Oxygen storage area has been reorganized to safely accommodate tanks, equipment and personnel to stand and perform transfilling as needed. | 11/18/2024 |

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| | stated she was certain no documentation of annual training was available and could not state if annual training of trans-filling liquid oxygen had been conducted.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | | **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken**:<br>All residents have the potential to be affected.<br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**:<br>All nursing staff will be educated on proper storage and filling techniques for O2. Education will be documented and will include demonstration of staff knowledge.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**:<br>O2 transfilling will be reviewed during monthly safety meeting to include a random staff demonstration for safety committee to audit. Results of the audit will be presented at monthly QAPI X 6 months for review and analysis.<br><br>The results of these reviews will | |

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| | | | be discussed at the monthly facility QAPI meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process. | |