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	07/25/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/25/23 Facility Number: 000325 Provider Number: 155379 AIM Number: 100274300 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 141 certified beds. At the time of the survey, the census was 55. Quality Review completed on 07/27/23	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 paper compliance.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Wagner	Executive Director	08/12/2023

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

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	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct			

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	exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop 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. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise. (B) If the [LTC facility] 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 a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator 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. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires			

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	activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual,			

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	facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and 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. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.			

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	(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. 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 a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. 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. (ii) Conduct an additional exercise that may	E 0039	Even though the facility did not have a second emergency drill per code, the facility did have an event where it in-acted its emergency plan related to a Covid-19 outbreak. The outbreak started on 12/4/22 thru 1/18/23. We will submit our after action report for compliance. The staff have been educated on requirements for emergency disaster drills. In-acting the facility emergency plan also meets code requirements. The Executive Director and/or leadership will review monthly through QAPI to ensure emergency drills are completed as	08/18/2023

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	include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or 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. (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). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 07/25/23 between 08:48 a.m. and 12:21 p.m., documentation of a facility-based exercise of an evacuation/fire disaster was provided during the survey. However, no documentation of a second exercise of choice could be provided. Based on interview with the Maintenance Director at the time of record review, he stated that he was unaware if a second exercise has been completed within the past 12 months. Both the Maintenance Director and Executive Director both acknowledged the missing drill during the exit conference at 2:44 p.m.		per code.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law	

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	483.90(a). Survey Date: 07/25/23 Facility Number: 000325 Provider Number: 155379 AIM Number: 100274300 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 Health Care Occupancies and 410 IAC 16.2. 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 141 and had a census of 55 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had one detached garage which was not sprinklered. Quality Review completed on 07/27/23		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 paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of			

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	emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge paths that lead through courtyard was readily accessible at all times. This deficient practice could affect approximately 15 residents and staff in the facility. Findings include: Based on observations and interview with the Maintenance Director during a tour of the facility on 07/25/2023 between 12:25 p.m. and 2:35 p.m., the main dining hall exit door had a sticker attached to the door stating that it was an emergency exit. This aforementioned door led into the fenced courtyard which serves as the resident smoking area. The discharge exit from the fenced courtyard led to a locked gate before accessing the public way. The gate was locked with a padlock and the Maintenance Director stated it was there to prevent non-authorized personnel to gain access to the courtyard area. The Maintenance Director stated that the gate does not have a key available and ready to use at the gate. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0211	The lock on the gait was immediately removed and the latch for the gait was moved up. Other residents have the potential to be affected by the deficient practice, therefore maintenance removed the lock and the latch was moved up on the gait. All courtyards were audited and any issues were identified and immediately addressed. Education was completed by the Executive Director on 8-11-23 which included the maintenance director, Housekeeping Supervisor and the Activity Director related to ensuring exit discharge paths are ready accessible at all times. The Maintenance Director and/or Designee to conduct courtyard audits 1x weekly for 6 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits.	08/18/2023
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1			

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	155379	A. BUILDING 01 B. WING	07/25/2023

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	Based on records review and interview, the facility failed to maintain itemized records of the inspections and tests for 1 of 1 battery backup lights. 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 all residents in the facility. Findings include: Based on records review with the Maintenance Director on 07/25/23 between 08:48 a.m. and 12:21 p.m., an itemized list was provided when reviewing the annual battery light testing forms. However, documentation for monthly emergency battery backup lighting in the computer system 'TELS' did not itemize the lights tested within the facility. Based on interview with the Maintenance Director at the time of record review, he stated that he was unaware that the documentation would have to be itemized and would fix the aforementioned documentation. This finding was reviewed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0291	TELS was reviewed and audit tool completed. TELS was notified that an audit tool was needed in the preventive maintenance. No residents have the potential to be affected by the deficient practice but does have the potential to effect maintenance and housekeeping staff. Education was completed by the Executive Director on 8-11-23 with the maintenance director to ensure that weekly audits will have an itemized list. TELS will be notified that an itemized list needs to be added to the weekly checks. The Maintenance Director and/or Designee to conduct emergency lighting 1x weekly for the next 6 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	08/18/2023
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in			

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	accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of 12 exit signs were continuously illuminated. This deficient practice could affect approximately 20 residents and staff in two smoke compartments. Findings include: Based on observations on 07/25/23 during a tour of the facility from 12:25 p.m. to 2:35 p.m. with the Maintenance Director, the exit signs above the exit doors near resident room 226 and 117 were not illuminated. Based on an interview with the Maintenance Director at the time of observations, the Maintenance Director stated that inspections of the exit signs were recently done and were in operation at that time. The Maintenance Director continued to acknowledge and agreed that two signs were not illuminated. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1.19(b)	K 0293	The exit lights were repaired. Residents have the potential to be affected by the deficient practice therefore Maintenance repaired the exit light. All exit lights were audited and any issues were identified and immediately addressed. Education was completed by the Executive Director on 8-11-23 with the maintenance director related to ensuring exit lights are in working order. 1. The Maintenance Director and/or Designee will conduct 1x weekly audits for the next 6 months to ensure exit lights are continuously illuminated utilizing the TELS system. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	08/18/2023

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review, interview, and observation, 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. Findings include: Based on records review with the Maintenance Director on 07/25/23 between 08:48 a.m. and 12:21 p.m., Documentation of battery-operated smoke detector testing was available for review on the computer program 'TELS'. However, the documentation only provided that 55 smoke detectors were tested. The list did not itemize each smoke detector and if they passed/failed. Furthermore, the documentation did not provide a date of which battery replacement had occurred.	K 0300	The smoke detectors were replaced in rooms 303 and 324. Other residents have the potential to be affected by the deficient practice therefore maintenance replaced the smoke detectors with new batteries. All smoke detectors were audited with any issues with expired detectors immediately discarded and new smoke detectors installed. p="" paraid="171397149" paraeid="{0f8e0c56-60b8-4b13-b28e-5ad11099359d}{239}"> Education was completed by the Executive Director on 8-10-23 with the maintenance director related to ensuring all smoke detectors were within manufacturer recommendations. The audit in TELS will be updated to include pass/fail and battery replacement p="" paraid="1571515515" paraeid="{80342bb3-c5b7-4b8d-b79d-408317eabfbc}{12}"> The Maintenance Director and/or Designee to conduct audits in 5 rooms weekly. Any issues	08/18/2023

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	During an interview at the time of record review, the Maintenance Director stated that he was unaware that the list had to be itemized and further stated that he had replaced a few batteries in some smoke detectors and did not document the battery replacement. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 50 battery operated smoke alarms installed in resident sleeping rooms were not over ten years old in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of Rooms 303 and 324. Findings include: Based on observations with the Maintenance Director on 07/25/23 during a tour of the facility from 12:25 p.m. to 2:35 p.m., manufacturer's documentation affixed to the battery operated smoke alarms installed on the ceilings in resident sleeping rooms 303 and 324 indicated each device was manufactured 06/26/2012 respectively. Based on interview at the time of each observation, the Maintenance Director agreed the aforementioned smoke alarms were more than ten years old and that, to his knowledge, all resident room smoke detectors were the same.		identified will be immediately addressed and all results will be discussed, and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	

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	These findings were reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)			

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	g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 hazardous rooms were 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 approximately 10 residents and staff in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/25/23 between 12:25 p.m. and 2:35 p.m., the file storage room adjacent to the main conference room was larger than 50 square feet, had numerous amount of paper and cardboard scattered around the room which had a door that was not self-closing. Based on interview at the time of observation, the Maintenance Director agreed that the room was a hazardous area and was not properly protected. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0321	The file storage room was cleaned and the door closure will be replaced on or before 8/11/23. No residents were affected by this deficient practice, however administrative staff could be affected by the deficient practice.: Education was completed by the Executive Director on 8-11-23 with the maintenance director and Administrative staff related to hazardous areas. The Executive Director and/or Designee to conduct a inspection of facility storage rooms and corridors 1x weekly for 6 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	08/18/2023
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2,			

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	19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing systems was maintained in proper working order. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. This deficient practice could affect approximately 20 residents who use the dining area connected to the kitchen and also affect kitchen staff. Findings include: Based on observation on 07/25/23 between 12:25 p.m. and 2:35 p.m. during a tour of the facility with the Maintenance Director, the kitchen range hood extinguishing system nozzles were not properly positioned over the cooking equipment under the hood and pushed up to be flush with the top of the range hood. Based on interview at the time of observation, the Maintenance Director confirmed	K 0324	The kitchen range hood extinguishing system nozzles were immediately properly positioned over the cooking equipment. Residents and staff have the potential to be affected by the deficient practice therefore the extinguishing nozzles were properly positioned. Education was completed by the Executive Director on 8-11-23 with the maintenance director and all dietary staff related to ensuring the hood extinguishing nozzles are appropriately placed over the cooking equipment. The Maintenance Director and/or designee will conduct audits 1x weekly for 6 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The	08/18/2023

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	the nozzles did not completely cover the cooking area and did not know why they were pushed up inside the hood. This finding was reviewed with the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director on 07/25/23 between 08:48 a.m. and 12:21 p.m., the facility provided two fire watch plans. One titled "Loss of Fire Protection Systems" and one titled "Alarm and Sprinkler System Failure". The fire watch policy titled "Loss of Fire Protection Systems" was missing a.) contacting	K 0346	The Fire Watch Policy in the Emergency Preparedness binder was updated with the gateway link for contacting the Incident Reporting System located on the IDOH Gateway. Residents and staff have the potential to be affected by the deficient practice, therefore the Emergency Preparedness binder was updated. Education was completed by the Executive Director on 8-11-23 which included the Maintenance Director and facility leadership. The Fire Watch Policy will be reviewed by the Executive Director and/or designee 1x monthly for 6	08/18/2023

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	the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov b.) Staff must be qualified and trained to conduct fire watch and shall have no other duties c.) A fire watch must be conducted every 15 minutes d.) Fire watch must be conducted if the sprinkler system is out for more than 10 hours in a 24 hour period. The second policy provided was missing all of the following plus indicating that a fire watch must be conducted if the fire alarm is out for more than 4 hours in a 24 hour period. Based on interview at the time of record review, the Maintenance Director stated that he was unaware which policy was the correct one the facility uses and agreed information was missing from the documentation's. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 07/25/23 between 08:48 a.m. and 12:21 p.m., Documentation of a monthly wet sprinkler system inspection was not available for the months of July and August of 2022. Furthermore, no weekly dry sprinkler system inspections were available for the months of July, August and September of 2022. Gauge and valve checks for the facility were documented on the computer program 'TELS.' During record review, the months listed above were marked as completed by the	K 0353	The TELS system will be used with the appropriate documentation. Missing documentation was from prior year under past maintenance director. New maintenance director was hired in October of 2022 with documentation current since that time. Residents and staff have the potential to be affected by the deficient practice. The TELS system will be utilized and supporting documentation will be completed. New maintenance director hired October 2022 with education provided on TELS system with documentation current since that time. The Maintenance Director will continue to utilize the TELS system along with the supporting documentation for the monthly checks/audit for preventive maintenance. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center	08/18/2023

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	previous Maintenance Director, but no documentation was able to verify that the gauges were visually inspection or whether they passed/failed. Based on interview at the time of record review, the Maintenance Director agreed that there were missing gauge inspections and stated he was hired in October of 2022 and was not at the facility. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		of Rochester is responsible in ensuring compliance in the Plan of Correction.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection	K 0354	The correct Fire Watch Policy was identified in the Emergency Management Manual. Residents and staff have the potential to be affected by the deficient practice, therefore the correct policy was made available to all staff. Education will be completed by	08/18/2023

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	155379	A. BUILDING 01 B. WING	07/25/2023

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	Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director on 07/25/23 between 08:48 a.m. and 12:21 p.m., the facility provided two fire watch plans. One titled "Loss of Fire Protection Systems" and one titled "Alarm and Sprinkler System Failure". The fire watch policy titled "Loss of Fire Protection Systems" was missing a.) contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov b.) Staff must be qualified and trained to conduct fire watch and shall have no other duties c.) A fire watch must be conducted every 15 minutes d.) Fire watch must be conducted if the sprinkler system is out for more than 10 hours in a 24 hour period. The second policy provided was missing all of the following plus indicating that a fire watch must be conducted if the fire alarm is out for more than 4 hours in a 24 hour period. Based on interview at		the Executive Director by 8-18-23 with facility staff to ensure staff are educated on the correct Fire Watch Policy. The Executive Director and/or Designee will conduct random interviews with staff utilizing a questionnaire related to the Fire Watch policy 1x a week for 6 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	

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	the time of record review, the Maintenance Director stated that he was unaware which policy was the correct one the facility uses and agreed information was missing from the documentation's. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 30 residents in two smoke compartments.	K 0374	The bracket on the fire door was repaired immediately Residents and staff have the potential to be affected by the deficient practice, therefore the bracket on the fire door was repaired, eliminating the gap between the doors when the doors were shut. Education was completed by the Executive Director on 8-11-23 with	08/18/2023

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	Findings include: Based on observation with the Maintenance Director on 07/25/23 between 12:25 p.m. and 2:35 p.m., the sets of smoke barrier doors by resident room 314 would not fully close due to the coordinating device on the door frame not correctly working. When tested, the coordinating device would hold both doors open when the door without the astragal was shut first. This condition creates an approximately two-inch gap between the doors when shut. Based on interview during the time of observations, the Maintenance Director stated the coordinating device was not function properly and not allowing the doors to completely shut. The finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)		the maintenance director related to ensuring all fire doors are in proper working order. The Executive Director and/or Designee will conduct walk throughs 3x monthly for 3 months and then 1x monthly for 3 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were	K 0522	The fresh air intake vent was cleaned out.	08/18/2023

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	provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for approximately 5 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 07/25/23 between 12:25 p.m. and 2:35 p.m., the laundry room had fuel-fired dryers with a fresh air intake that had automatic louvers that would open when the dryers are running, but when a dryer was turned on the louvers did not open. This condition does not allow for fresh air to completely enter the room when the dryers are turned on. Upon further examination, the area between the louver intake and vent outside the building was completely filled in with twigs, leaves, material that blocked the vent from properly working. Based on an interview at the time of observation, the Maintenance Director stated that the vent is an automatic louver and agreed that the louvers were not working when the dryer was turned on. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		Residents and staff have the potential to be affected by the deficient practice, therefore the fresh air vent was cleaned out. Education was completed with the Housekeeping Supervisor and laundry staff to ensure the fresh air intake vent is functioning appropriately. The Housekeeping Supervisor and/or designee will conduct inspections of the fresh air intake 1x weekly for 6 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	
K 0914 SS=C Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general			

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	anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on record review and interview, the facility failed to ensure the testing form for the hospital grade electrical receptacles in 55 of 55 resident sleeping rooms showed that each receptacle was tested. NFPA 99, Health Care Facilities Code 2012 Edition, section 6.3.4.2.1.2 states at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 07/25/23 between 08:48 a.m. and 12:21 p.m., a form provided titled "NFPA 99 Risk Assessment Worksheet" documented that each "electrical system" was inspected as and resulted	K 0914	The correct NFPA99 Risk Assessment form for testing hospital grade electrical receptacles was identified by the Executive Director. Residents had the potential to be affected by the deficient practice, therefore the correct NFPA99 Risk Assessment form will be implemented. Education was completed by the Executive Director on 8-15-23 with the maintenance director related to ensuring the correct NFPA99 Risk Assessment form is utilized to ensure each electrical system was inspected and documented correctly. The Maintenance Director will	08/18/2023

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	as either a "3" or "4". On the testing form, a "3" indicates that failure of such equipment or systems is likely to result in no injury but cause discomfort and a "4" indicates failure of such equipment would have no effect on residents. The form did not show if each receptacle passed its retention/grounding testing. The form used by the facility is a risk assessment used for emergency preparedness. Based on interview at the time of record review, the Maintenance Director stated that the numbers do not correlate with the indicated listings on the form and are representing the results taken from the tool used during receptacle testing. The Maintenance Director further stated that he agreed the form caused confusion with the testing results and was not clear if the receptacles passed or failed its indicated testing. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		retest prior to 8-18-2023 the facility hospital grade electrical receptacles to ensure results are properly documented. The Maintenance Director will utilize the NFPA99 Risk Assessment form for annual testing of hospital grade electrical receptacles. This process will be monitored and tracked through the TELS system. Any concerns identified will be addressed immediately. TELS audits/inspections be presented to QAPI ongoing with QAPI determining the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips			

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	for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affect approximately two residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/25/23 between 12:25 p.m. and 2:35 p.m., in room 217 there was a power strip in use within 6 feet of a resident care area that did not met 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power strips were in use in resident care areas and did not meet 1363A or 60601-1. The findings were reviewed with the Maintenance Director and the Executive Director during the exit conference. 3.1-19(b)	K 0920	The power strip in room #217 was immediately removed. Residents have the potential to be affected by the deficient practice, therefore a facility audit was completed. Any issues identified via this audit was immediately addressed. Education was completed by the Executive Director on 8-15-23 with the maintenance director related to ensuring power strips are not utilized in the facility. The Maintenance Director and/or designee will conduct facility audits 1x per week for 6 months. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x6 months then QAPI will determine the need for further audits. Compliance date: 8/18/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	08/18/2023