STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	02/19/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00428075. Complaint IN00428075 - Federal/State deficiencies related to the allegation are cited at F921. Unrelated deficiency is cited Survey dates: February 19, 2024 Facility number: 000325 Provider number: 155379 AIM number: 100274300 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 4 Medicaid: 45 Other: 5 Total: 54 Life Care Center of Rochester was found not to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00428075. Quality review completed on 2/22/24.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
F 0803 SS=F Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed Based on observation, record review, and interviews, the facility failed to ensure the menu was followed for 54 of 54 residents who consumed	F 0803	***What Corrective Action will be accomplished for those residents found to have been***	03/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Wagner	Executive Director	03/02/2024

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

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	food in the facility. Finding includes: During an observation of the noon meal service in the kitchen and dining and resident halls, conducted on 2/19/2024 between 11:30 A.M. - 12:55 P.M., the following was observed: Cook 4 utilized a 3 ounce scoop to serve all the residents Dijon potatoes, except for two residents receiving pureed food. Cook 4 served two residents a pureed diet. There were only pureed hamburger steak and gravy and pureed Dijon potatoes on the plate. In addition, the two residents received a container of chocolate ice cream and beverages. The residents did not receive a dinner roll or a vegetable. Cook 4 served eight residents a mechanical soft diet, but they did not receive any dinner roll. Review of the facility menu for the day, provided by the Food Service Supervisor on 2/19/2024 at 1:00 P.M., indicated staff should have utilized a #8 (4 ounce) scoop for the Dijon potatoes for all residents, a #16 (2 ounce scoop) for pureed bread for those residents receiving a pureed and mechanical soft diet, and a #8 scoop (4 ounce) of pureed spinach for those residents receiving a pureed diet. During an interview with the Food Service Supervisor, on 2/19/2024 at 2:38 P.M., she indicated the wrong size scoop was used by Cook 4 for the potatoes. She also indicated the pureed and mechanical soft diet residents should have received pureed bread and the pureed residents should have received a pureed serving of		***affected by this deficient practice:*** 1 All residents will be served the appropriate menu with correct portions to ensure nutritional adequacy. No residents were identified to be affected by the alleged deficient practice. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1 All residents have the potential to be affected by the deficient practice, therefore dietician approved menus and recipes will be followed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** 1 All dietary staff will be re-educated on menus meeting resident needs/preparation and following menus by the Dietary Manager. 2 An inventory of all serving scoops was completed by the Dietary Manager and an order placed. 3 The Dietary Manager will be educated by the Executive Director to ensure dietary staff have the appropriate equipment needed during meal service. ***How the corrective action will***	

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	vegetable. The facility policy and procedure, titled, "Menus, Substitutions, and Alternatives" provided by the Administrator on 2/19/2024 at 3:27 P.M. included the following: "Menus are planned in advance and are followed as written in order to meet the nutritional needs of the residents in accordance with established national guidelines...." 1.3-20(i)(1)		***be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1 The Dietary Manager and/or Designee to conduct meal quality audits 3x weekly for 3 months, 2x weekly for 2 months and 1x weekly for 1 month 2 The results of the audits will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter. Any issues 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: 3/13/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment was maintained in 1 of 4 halls observed for environment. (Central Hall)	F 0921	**What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:**	03/13/2024

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	Findings include: During an initial tour, on 2/19/2024 from 9:20 A.M. to 9:34 A.M., the following items were observed on the Central Hall: - Room 200 had brown and yellow stains in the bathroom with a strong urine smell. - Rooms 203-204's shared bathroom had stained flooring, and a strong urine smell. - Room 211-212's shared bathroom had stained flooring with a slimy black substance along the wooden cove wall base. The wooden cove wall base had black stains. A liquid substance was seen around the toilet to the cove wall base. The drywall above the cove wall base was wavy in appearance. - Rooms 216-217's shared bathroom had stained flooring, debris on floor and a strong urine odor. - Rooms 220-221's shared bathroom had stained flooring, and odor of urine. - Rooms 222-223's shared bathroom had stained flooring, and odor of urine. During an observation and interview, on 2/19/2024 at 2:26 P.M., the Maintenance Director observed the black slimy substance in the shared bathroom of rooms 211-212. He indicated the black slimy substance was from the wood cove wall base "giving away". The Maintenance Director moved the trash can, and gnats were observed flying from the black slimy substance. He indicated the facility had been repairing rooms and bathrooms when a room became available for repair. He provided a map of the facility, titled "Refresh Rooms," that indicated rooms 213-225 had been completed. During an interview, on 2/19/2024 at 2:38 P.M., the Housekeeping Supervisor indicated the housekeeping staff were assigned to a hall daily,		1 The bathroom floors in rooms 200, 203, 211, 216, 220, 222, were cleaned and an audit was completed by the Maintenance Director for any repairs needed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** 1 Other residents have the potential to be affected by the deficient practice, therefore maintenance and housekeeping have completed rounds and are compiling a list of environmental concerns to be addressed and put on schedule for repairs. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** 1 The Maintenance Director/Environmental Supervisor will be in-serviced on the Preventative Maintenance Program by the Executive Director. 2 The Environmental Supervisor will be in-serviced on the Environmental Program by the Executive Director. 3 All housekeeping staff will be in-serviced on environmental services by the Environmental Manager and/or designee. 4 Maintenance Director and/or designee will include identified areas in the current preventative	

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	and daily residents' rooms responsibilities included, sweeping, and mopping of the residents' rooms and mopping the entirety of the residents' bathrooms. During an observation, on 2/19/2024 at 2:41 P.M., the Executive Director and the Housekeeping Supervisor observed the condition of the shared bathroom of rooms 211-212. They could not identify the black slimy substance, but agreed the bathroom had a strong urine odor. On 2/19/2024 at 2:45 P.M., the Executive Director indicated a plan was put in place after the last annual recertification in June 2023 for room renovations. She provided a form titled, Floor Care Plan, Started January 2024, Monday-Friday". The form had all rooms from Central East, Central West, Skilled, and South Halls listed. The form indicated on the Skilled Hall, room 305 had the walls completed, room 306 had the floors completed and bathroom completed, and the South Hall had room 320 with the floors completed and the completed. The Executive Director, the renovation or refresh of the rooms was not part of the Quality Assurance/Quality Improvement Plan of the facility. On 2/19/2024 at 3:36 P.M., the Executive Director provided the policy titled," Preventative Maintenance Program", dated 1/11/2023, and indicated the policy was the one currently used by the facility. The policy indicated, "...The Plan Operations/Maintenance Department will respond to and correct identified problems within the scope of their operations or arrange for the correction by a qualified individual in a timely manner. Corrective actions will be recorded in TELS [a building management platform system]...."		maintenance program and conduct routine resident room rounds according to facility protocol utilizing the TELS system. 5 The Environmental Supervisor will conduct routine room rounds according to the facility protocol. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** 1 The Maintenance Director and/or Designee to conduct resident bathroom observations 3x weekly for the next 3 months, and then weekly ongoing through the facility preventive maintenance process through TELS to ensure the resident's environment is in good repair from all general repairs. 2 The Environmental Supervisor and/or Designee to conduct resident room observations 3x weekly for the next 3 months, 2x weekly for the next 2 months and 1x weekly for the next month. 3 The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter. Any issues identified will be immediately	

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	This Federal tag relates to complaint IN00428075. 3.1-19 (f)		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: 3/13/24. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	