

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/11/2015
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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a)</p> <p>Survey Date: 06/11/2015</p> <p>Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410</p> <p>At this Life Safety Code Survey, Lake County Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2</p> <p>This two story facility determined to be of Type II (222) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in areas opened to the corridors. Battery operated smoke detectors are installed in all resident sleeping rooms. The facility has a</p>	K 0000	<p>July 3, 2015</p> <p>Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006</p> <p>Dear Ms.Rhoades:</p> <p>Please reference the enclosed 2567 as "Plan of Correction" for the June 11, 2015 Life Safety code Survey Recertification that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>capacity of 117 and a census of 63 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage sheds.</p>		<p>July3, 2015. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal</p> <p>State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community.</p> <p>The Plan of Correction submitted on July 3, 2015 serves as our allegation of compliance. The provider respectfully request a Desk review on or after June 29, 2015. Should you have any question or concerns regarding the Plan of Corrections, please contact me.</p> <p>Respectfully,</p>	

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K 0018 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure 2 of 16 residents sleeping room doors on the 2nd floor West smoke compartment latched into the door frame. This deficient practice could affect 16 residents.</p> <p>Findings include:</p> <p>Based on observation on 6/11/15 at 10:33 a.m. then again at 10:42 a.m. with the Maintenance Director and Environmental Service Director, resident room 227 and then resident room 221 failed to latch when tested. Based on interview at the time of each observation, the Maintenance Director and Environmental</p>	K 0018	<p>Neysa Stewart, HFA</p> <p><b>K018</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory</b></p>	06/29/2015
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	<p>Service Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the 1 of 1 Dietary Doors were provided with positive latching hardware. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation on 06/11/15 at 12:12 p.m. with the Maintenance Director and Environmental Service Director the set of Dietary doors only had a deadbolt on one of the doors which was not a positive latching mechanism for one of the doors which did latch into the frame. Based on interview at the time of observation, the Maintenance Director and Environmental Service Director acknowledged the Dietary door was not provided with positive latching hardware.</p> <p>3.1-19(b)</p>		<p><b>requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>"Based on observation and interview, the facility failed to ensure 2 of 16 residents sleeping room doors on the 2nd floor west smoke compartment latched into the door frame and one of Dietary doors had a deadbolt which was not a positive latching mechanism which did latch into the door frame.</p> <p>No visitors, staff or residents residing in the facility were identified as being adversely affected.</p> <p>The facility immediately repaired the door latches in rooms 227 and 221. On 6/12/15 the deadbolt on Dietary's door was removed and a new positive latching mechanism was installed.</p>	

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			<p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All visitors, staff and residents residing in the facility have the potential to be affected. No residents were identified as being adversely affected. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Maintenance Director conducted a facility wide audit to ensure all resident sleeping room doors latch properly and determined no other resident sleeping room doors were identified.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will audit 10 resident sleeping room doors twice monthly to ensure resident sleeping room</p>	

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K 0021 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 sets of fire</p>	K 0021	<p>doors are latching properly. Any issues identified will be addressed immediately. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary.</p> <p><b>5. Completion date systemic changes will be completed: 6/29/15</b></p>	06/29/2015

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	<p>barrier doors would close and latch when tested. This deficient practice could affect two of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Environmental Service Director on 06/11/15 at 11:43 a.m. then again at 12:01 p.m., the fire barrier doors near resident room 114 failed to latch when tested. Then the fire barrier doors near resident room 103 failed to latch when tested as well. Based on interview at the time of each observation, the Maintenance Director and Environmental Service Director acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		<p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>"Based on observation and interview, the facility failed to ensure 2 of 4 sets of fire barrier doors would not close and latch when tested."</p> <p>No visitors, staff or residents residing in the facility were identified as being adversely affected.</p> <p>The facility immediately replaced the self-closures and door</p>	

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			<p>coordinators on both fire barrier doors near room 103 and 114.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All visitors, staff and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Maintenance Director or designee will conduct an audit weekly for 4 weeks and then twice monthly for 2 months of all 4 fire barrier doors to ensure they are closing and latching properly. Any doors requiring additional equipment will be repaired in a timely manner. The maintenance department was re-educated on the importance of ensuring that all fire barrier doors are working properly.</p>	

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K 0022 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily		<p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will conduct an audit weekly for 4 weeks and then twice monthly for 2 months of all 4 fire barrier doors to ensure they are closing and latching properly. Any issues identified will be addressed immediately. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary.</p> <p><b>5. Completion date systemic changes will be completed: 6/29/15</b></p>	

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	<p>apparent to the occupants. 7.10.1.4 Based on observation, the facility failed to ensure 1 of 1 exit signs near Rehabilitation was marked with directional indicators to make the direction of travel to reach the public way obvious. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. LSC 7.10.2 requires a sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. This deficient practice could affect at least 34 residents on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Environmental Service Director on 06/11/15 at 11:38 a.m., the exit sign near Rehabilitation was pointing towards the Rehabilitation room. Once inside the Rehabilitation room, there is no other exit. Based on interview at the time of observation, the Maintenance Director and Environmental Service Director acknowledged the exit sign did not point to an exit.</p>	K 0022	<p><b>K022</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>"Based on observation and interview, the facility failed to ensure 1 of 1 exit sign near Rehabilitation was marked with the directional indicators to make the direction of travel to reach the public way obvious."</p>	06/29/2015	

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	3.1-19(b)		<p>No visitors, staff or residents residing in the facility were identified as being adversely affected.</p> <p>The facility Maintenance Director immediately turned the Exit sign arrows in the correct direction during tour with surveyors on 6/11/15.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All visitors, staff and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Maintenance Director completed a visual audit of all exit signs with directional indicators to ensure the directional indicators are pointing in the correct direction of travel to reach the</p>	

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K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in		<p>public way, no other issues identified.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will audit twice monthly for 3 months to ensure exit signs with directional indicators are pointing in the correct direction of travel to reach the public way.</p> <p>Any issues identified will be addressed immediately. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary.</p> <p><b>5. Completion date systemic changes will be completed: 6/29/15</b></p>	

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	<p>accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation and interview on 06/11/15 at 12:21 p.m. with the Maintenance Director and Environmental Service Director, there were two 1/2 inch size unsealed penetrations around conduit in the ceiling of the soiled linen transfer room. Measurements were provided by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K 0025	<p><b>K025</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p>	06/29/2015

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			<p>"Based on the observation and interview the facility failed to ensure 1of 1 ceiling smoke barriers was maintained to provide a one half hour resistance rating,"</p> <p>No residents, staff or visitors were identified as being adversely affected.</p> <p>The Maintenance Department repaired the two 1/2 inch gap around the conduit in the ceiling of soiled linen transfer room by applying fire rated caulking to both areas on 6/11/15.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All visitors, staff, and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p>	

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			<p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Maintenance Director or designee will monitor facility ceiling smoke barriers and complete Environmental Audit twice a month for 3 months to ensure that facility is in compliance. Any issues identified will be addressed immediately.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will monitor facility ceiling smoke barriers and complete Environmental Audit tool twice a month for 3 months. Any issues found will be addressed immediately. The audits will be discussed during monthly QA meeting for the next 3 months. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p>	

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K 0062 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace 1 of 2 painted sprinklers in the Clean Utility room and 1 of 2 painted sprinklers in Soiled Utility room. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Environmental</p>	K 0062	<p><b>5. Completion date systemic changes will be completed: 6/29/15</b></p> <p><b>K062</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice: No residents, staff or</b></p>	06/29/2015

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	<p>Service Director on 06/11/15 at 10:53 a.m. then again at 10:52 a.m., one of two automatic sprinklers in the Clean Utility room by resident room 215 and then in the Soiled Utility room by resident room 214 was covered in white paint. Based on interview at the time of each observation, the Maintenance Director and Environmental Service Director acknowledged the condition of the sprinkler heads.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p>		<p>visitors were adversely affected.</p> <p>1. "Based on observation and interview, the facility failed to replace 1 of 2 painted sprinkler heads in the clean utility room and 1 of 2 painted sprinkler heads in the soiled utility room."</p> <p>2. "Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system."</p> <p>1. On 6/16/15 Consolidated Fireproction Company replaced the painted sprinkler heads in the clean Utility room and Soiled Utility room.</p> <p>2. On 6/16/15 Consolidation Fireprotection Company furnished 2 spare intermediate temperature green sprinkler heads and 2 red sprinkler heads during service visit.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All staff, visitors, and residents residing in the facility have the potential to be affected. Any</p>	

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director and Environmental Service Director on 06/11/15 between 10:25 a.m. and 1:55 p.m., there was an intermediate temperature green bulb sprinkler head in the Elevator Machine room. Based on observation at 12:19 p.m., the Maintenance Director and Environmental Service Director confirmed the spare sprinkler cabinet lacked two spare intermediate temperature green bulb sprinkler heads.</p> <p>3.1-19(b)</p>		<p>concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Administrator re- in-serviced the Maintenance and Maintenance Assistance regarding painted sprinkler heads and the importance have spare sprinkler heads in the facility on 6/24/15. An audit was conducted on 6/24/15 of sprinkler heads in the facility to ensure sprinkler heads were free of paint. No issues were identified.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will audit 5 sprinkler heads weekly for 3 months to ensure sprinkler heads are free of paint and check spare sprinkler head inventory monthly to ensure spare sprinkler heads are available at all times. Any issues found will be addressed immediately. The</p>	

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K 0064 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 2 Kitchen K type fire extinguishers was provided maintenance when the gauge on the fire extinguisher indicated it needed recharging. NFPA 10, Standard for Portable Fire Extinguishers, in Section 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. This deficient practice could affect staff only.</p> <p>Findings include:</p>	K 0064	<p>audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed: 6/29/16</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in</b></p>	06/29/2015

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	<p>Based on an observation with the Maintenance Director and Environmental Service Director on 06/11/15 at 12:29 p.m., the gauge on the portable fire extinguisher located in the Kitchen indicated the extinguisher needed to be recharged. This was acknowledged by the Maintenance Director and Environmental Service Director at the time of observation.</p> <p>3.1-19(b)</p>		<p><b>response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>“Based on observation and interview, the facility failed to ensure 1 of 2 Kitchen K type fire extinguishers was provided maintenance when the gauge on the fire extinguisher indicated it needed recharging.”</p> <p>No visitors, staff or residents residing in the facility were identified as being adversely affected. The Maintenance Director immediately replaced the K-extinguisher on 6/11/15</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All visitors, staff and residents residing in the facility have the potential to be affected. Any concerns will be addressed immediately.</p>	

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			<p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Maintenance Director or designee will conduct an audit twice a month for 4 weeks and then monthly for 2 months of facility fire extinguishers. The maintenance department was re-educated on the importance of ensuring that all fire extinguishers are charged appropriately on 6/24/15</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will conduct an audit twice a month for 4 weeks and then monthly for 2 months of facility fire extinguisher gauge to ensure they are charged properly. Any issues identified will be</p>	

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K 0066 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the</p>	K 0066	<p>addressed immediately. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary.</p> <p><b>5. Completion date systemic changes will be completed: 6/29/15</b></p>	06/29/2015	

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	<p>facility failed to ensure 1 of 2 areas where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations and interview on 06/11/15 at 11:55 a.m., the Maintenance Director and Environmental Service Director acknowledged there were at least 45 cigarette butts on the ground in the designated employee smoke area.</p> <p>3.1-19(b)</p>		<p><b>K066</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>"Based on observation and interview, the facility failed to ensure 1 of 2 areas where smoking was permitted for staff and residents were maintained and the metal container with the self-closing cover was used for an ashtray.</p> <p>No staff employed by the facility were identified as being adversely</p>	

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			<p>affected. The Maintenance Director Assistant immediately cleaned the designated employee smoke area on 6/11/15.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All staff employed by the facility have the potential to be affected. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>On 6/12/15 the Administrator In-serviced the all staff on proper disposal of cigarette butts. The Maintenance Director or designee will conduct an audit 5 days a week for 4 weeks and then 3 days a week for 2 months of employee designated smoking area to ensure proper disposal of cigarette butts.</p>	

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K 0147 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National		<p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will conduct an audit 5 days a week for 4 weeks and then 3 days a week for 2 months of employee designated smoking area to ensure proper disposal of cigarette butts. Any issues identified will be addressed immediately. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary.</p> <p><b>5. Completion date systemic changes will be completed: 6/29/15</b></p>	

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	<p>Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 7 of 7 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff in all the observations except for the Rehabilitation area which had about 5 residents at the time of observation.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 06/11/2015 between 10:32 a.m. to 12:09 p.m. the following was discovered:</p> <p>a. Environmental office: a refrigerator was plugged into a power strip</p> <p>b. Activities room by resident room: 213 a coffee pot was plugged into a surge protector</p> <p>c. MDS Coordinator office: a surge protector was plugged into a surge protector power computer equipment and a separate surge protector was powering a toaster oven, microwave, and refrigerator.</p> <p>d. Rehabilitation: two microwaves were plugged into a surge protector also a</p>	K 0147	<p><b>K147</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</b></p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b></p> <p>1. Based on observation, the facility failed to ensure 7 of 7 flexible cords were not used as a substitute for wiring. Power strip extension cords were located:</p> <p>a. Environmental office: a refrigerator was plugged into a power strip</p> <p>b. Activities room by resident</p>	06/29/2015

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	<p>power strip was plugged into another surge protector powering computer equipment.</p> <p>e. Medical Records a refrigerator was plugged into a power strip.</p> <p>Based on interview at the time of each observation, the Maintenance Director and Environmental Service Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Department of Nursing office and 1 of 1 First floor Nurse's station. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only. Findings include: Based on observation with the Maintenance Director and Environmental Service Director on 06/11/15 at 11:46 a.m. then again at 12:04 p.m., an electric receptacle in the Department of Nursing office and then at First floor Nurse's station was uncovered, lacking a face</p>		<p>room 213 a coffee pot was into a surge protector</p> <p>c. MDS coordinator office: a surge protector was plugged into a surge protector power computer equipment and separate surge protector was powering a toaster oven, microwave and refrigerator.</p> <p>d. Rehabilitation: two microwave were plugged into a surge protector also a power strip was plugged into another surge protector was powering a toaster oven, microwave and refrigerator.</p> <p>e. Medical Records: a refrigerator was plugged into a power strip</p> <p>2 -Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 Department of Nursing office and then the first floor Nurse's station was uncovered, lacking a face plate.</p> <p>1. a. The Maintenance Director removed the power strip in Environmental office</p> <p>b. The Maintenance Director</p>	

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	<p>plate. The Maintenance Director and Environmental Service Director acknowledged at the time of each observation, the wiring should have been protected by a face plate. 3.1-19(b)</p>		<p>removed the power strip in Activities room by resident room 213</p> <p>c. The Maintenance Director plugged the refrigerator and the microwave to the wall outlet, and the toaster oven is no longer in use in the MDS coordinator office</p> <p>d. The Maintenance Director removed all power strips in Rehabilitation</p> <p>e. The Maintenance Director plugged the refrigerator to the wall outlet in Medical Records.</p> <p>2. The Maintenance Department repaired the faceplates on the outlets in the Department of Nursing Office and first floor Nurse's station</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p> <p>All staff, visitors, and residents residing in the facility have the potential to be affected by the alleged deficient practice. Any concerns will be addressed</p>	

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			<p>immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>The Maintenance Director conducted a facility wide visual audit to ensure that all outlets are in working condition and no further extension cord or power strip equipment is being used</p> <p>Inappropriately. The Maintenance Director and Department Heads were in-serviced regarding inappropriate use of power strips and informed staff that power strips cannot be used as a substitution for electrical wiring on 6/24/15 by the Administrator.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</b></p> <p>Maintenance Director / Designee will audit department head's office twice a month for 3 months to ensure flexible cords are not used</p>	

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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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K 0160 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage.</p>	K 0160	<p>as a substitute for wiring, electrical power strips are used properly and electrical outlet faceplates are not damaged. Any issues found will be addressed immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once compliance threshold is achieved. This plan to be amended when indicated.</p> <p><b>5. Completion date systemic changes will be completed: 6/29/15</b></p>	10/16/2015

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	<p>NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect any residents, as well as visitors and staff in the elevator if the sprinkler system was activated in the elevator equipment room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Environmental Service Director on 06/11/15 at 11:24 a.m., the elevator equipment room was provided with a sprinkler and a smoke/heat detector. Based on interview at the time of observation, the Maintenance Supervisor acknowledged it was unknown if a shunt trip for the elevator machine room sprinkler was provided.</p> <p>3.1-19(b)</p>		<p><b>PLAN OF CORRECTION</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>1. The corrective action taken for the resident found to have been affected by the deficient practice:</b> No visitors, staff or residents residing in the facility were identified as being adversely affected.</p> <p>"Based on observation, record review and interview, the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an Electrical Shunt Trip when provided with sprinkler coverage." The facility immediately called Esco Communication to install the Electric Shunt Trip.</p> <p><b>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</b></p>	

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			<p>All residents, staff and visitors have the potential to be affected. No residents, staff or visitors were adversely affected. Any concerns will be addressed immediately.</p> <p><b>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</b></p> <p>On 6/22/15 Esco Communication installed the Electric Shunt Trip, however the Electric Shunt Trip wasn't compatible with the elevator panel due to the age of the elevator system. On 6/30/15 Administrator spoke with the Life Safety Supervisor regarding other options to achieve compliance. The facility is now consulting with and outside contractors regarding the installation of the Clean Agent Suppression System and tying in to the Fire Alarm System vs possible updated current elevator panel. On 6/30/15 the Maintenance Director in- serviced All Staff regarding Fire Safety and procedures to take in the event of a fire.</p> <p><b>4. To ensure the deficient practice does not reoccur, the monitoring system established</b></p>	

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			<p><b>is to:</b></p> <p>Maintenance Director / Designee will conduct Inspection of Elevator room 5 days a week and Fire Drills weekly to increase fire safety awareness until compliance is met. Any issues identified will be addressed immediately. The audit will be presented and reviewed monthly until compliance is met at the Quality Assurance meeting. QA committee will determine if continued auditing is necessary.</p> <p><b>5. Completion date systemic changes will be completed: 10/16/15</b></p> <p><b>REQUEST FOR TEMPORARY WAIVER FOR K160</b></p>	