DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA				
AND BLAN OF CORRECTION	IDENTIFICATION NUMBER	A DUILDING	COL				

	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155653		A. BUILDING COMPLETED  B. WING 08/14/2023			ETED	
	PROVIDER OR SUPPLIER			5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
E 0000	REGGENTORT OR	ESC IDENTIFY THING INTOKWATION		1710			DATE
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000			
	Survey Date: 08/14	/2023					
E 0041	Health & Rehab was Emergency Prepared Medicare and Medicand Suppliers, 42 Cl The facility has 117 for Medicare and M survey, the census was Quality Review com 482.15(e), 483.73(	Preparedness survey, Harbor s found not in compliance with dness Requirements for caid Participating Providers FR 483.73  beds which are dually certified edicaid. At the time of the was 67.  helpleted on 08/15/23  (e), 485.625(e)					
SS=F Bldg	§482.15(e) Conditi (e) Emergency and The hospital must standby power systemergency plan set this section and in procedures plan set (i) and (ii) of this set §483.73(e), §485.6 (e) Emergency and The [LTC facility and	et forth in paragraphs (b)(1) ection. 625(e) d standby power systems.					

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

TITLE (X6) DATE

Rosa McGowen VP of Operations 08/30/2023

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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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155653		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/14/2023		
	PROVIDER OR SUPPLIEF		5025 M	ADDRESS, CITY, STATE, ZIP COE ICCOOK AVE CHICAGO, IN 46312	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE COMPLETION	I
	_	n the emergency plan set (a) of this section.				
	Emergency gener generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built o structure or buildin 482.15(e)(2), §48: Emergency gener The [hospital, CAI implement the eminspection, testing requirements four	83.73(e)(1), §485.625(e)(1) rator location. The relocated in accordance with rements found in the Health de (NFPA 99 and Tentative rist TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing right is renovated.  3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must rergency power system g, and [maintenance] and in the Health Care FPA 110, and Life Safety				
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the s it evacuates.				
	§483.73(g), and C The standards inc this section are ap reference by the I Federal Register i	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation by Director of the Office of the n accordance with 5 U.S.C. a part 51. You may obtain				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.			2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING COMPLE  B. WING 08/14/2		ETED	
	PROVIDER OR SUPPLIEI		50	25 MC	DDRESS, CITY, STATE, ZIP COD CCOOK AVE HICAGO, IN 46312		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	HOULD BE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
		the sources listed below.					
		a copy at the CMS urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
		ARA, call 202-741-6030, or					
	go to:						
		es.gov/federal_register/code					
	_of_federal_regulations/ibr_locations.html.  If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.						
	(1) National Fire Protection Association, 1						
	Batterymarch Par						
	Quincy, MA 0216						
	1.617.770.3000.	•					
	(i) NFPA 99, Heal	th Care Facilities Code,					
		ed August 11, 2011.					
	` '	rim amendment (TIA) 12-2 to					
	NFPA 99, issued	_					
	(III) 11A 12-3 to NI   2012.	FPA 99, issued August 9,					
	-	FPA 99, issued March 7,					
	2013.	11 A 33, Issued Water 1,					
		FPA 99, issued August 1,					
	2013.	, ,					
	(vi) TIA 12-6 to NI	FPA 99, issued March 3,					
	2014.						
	` '	ife Safety Code, 2012					
	edition, issued Au	•					
	(viii) TIA 12-1 to N   11, 2011.	NFPA 101, issued August					
		FPA 101, issued October					
	30, 2012.						
	· '	PA 101, issued October					
	22, 2013.						
	(xi) TIA 12-4 to NI	FPA 101, issued October					
	22, 2013.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 08/14/2023			
	PROVIDER OR SUPPLIER		5025	T ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE T CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
140	(xiii) NFPA 110, S Standby Power Sy including TIAs to of 2009 Based on records re failed to implement requirements found Code, NFPA 110, a accordance with 42 deficient practice co Findings include:  Based on records re Director and VP of between 09:15 a.m. lacked monthly load inspections required Based on interview the Maintenance Di agreed that the only available in the pap	tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, view and interview, the facility the emergency power system in the Health Care Facilities and Life Safety Code in CFR 483.73(e)(2). This build affect all occupants.  Eview with the Maintenance Operations on 08/14/23 to 11:29 a.m., the generator of testing and weekly by LSC and NFPA 110. at the time of record review, rector acknowledged and odocumentation he had was	E 0041	E 041- Hospital CAH and L'Emergency Power  The facility requests paper compliance for this citation  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does a constitute admission or agree by the provider of the truth of facts alleged or conclusions forth in the statement of deficiencies. The plan of correction is prepared and/of executed solely because it is required by the provisions of federal and state law.  1) Immediate actions take for those residents identified.  The generator monthly testing and weekly inspection are current and in compliance.  2) How the facility identified other residents:  Visitors, staff, and resident that reside at the facility have potential to be affected by the alleged deficient practice.	n. e of not element of the set  ref en ed: load n log ce. d dents e the

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES  DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  G <u></u>	(X3) DATE SURVEY COMPLETED 08/14/2023
	ROVIDER OR SUPPLIEI HEALTH & REHA		502	EET ADDRESS, CITY, STATE, ZIP COD 5 MCCOOK AVE ST CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
				2) Measures put into pla System changes:	ce/
				<ul> <li>Maintenance Director complete weekly inspection will document on the Prevent Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventa Maintenance Program by the Administrator /designee by 8/23/23.</li> <li>The Maintenance Director responsible for compliance.</li> <li>4) How the corrective act will be monitored: <ul> <li>The Administrator will refer the Preventative Maintenance Worksheets monthly.</li> <li>The results of these aut will be reviewed in Quality Assurance Meeting monthly months or until 100% complis achieved. The QA Commonity will identify any trends or parand make recommendations revise the plan of correction indicated.</li> </ul> </li> <li>5) Date of compliance: 8/23/23</li> </ul>	and ntative ne native nat

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155653		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 08/14/2023			IPLETED
	PROVIDER OR SUPPLIEF		5025 M	ADDRESS, CITY, STATE, ZIP CO ICCOOK AVE CHICAGO, IN 46312	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 0000 Bldg. 01	Licensure Survey we Department of Head 483.90(a)  Survey Date: 08/14  Facility Number: 08/14  Facility Number: 100  At this Life Safety of Rehab was found in Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I Health Care Occupation)  This two story facil (222) construction of facility has a fire all smoke detection in opened to the corridetectors are install rooms. The building diesel powered emethas 117 beds which Medicare and Meditime of this survey  All areas where reswere sprinklered.	000108 155653 267410 Code Survey, Harbor Health & ot in compliance with	K 0000			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING ()1 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED  B. WING 08/14/2023				
		155653	B. W.	ing		06/14/	2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Quality Review con	npleted on 08/15/23					
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lightin Emergency Lightin Emergency Lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1 Based on records reinterview, the facilit battery backup light Section 7.9.3.1.1 (1) shall be conducted reweeks and a maxim for not less than 30 records of visual inskept by the owner for having jurisdiction. affect all building or in the transfer swite.  Findings include:  Based on an observate facility with the Ma Operations on 08/14 1:33 p.m., there was light in the generator the fire pump room. between 09:15 a.m. of a monthly 30 sec powered emergency of survey, but the rewas missing monthl November and Decordanuary and February and Februa	or of at least 1-1/2-hour and automatically in 1.9.  view, observation, and by failed to ensure 2 of 2 is were tested monthly.  requires functional testing monthly, with a minimum of 3 is seconds and (5) Written is spections and tests shall be for inspection by the authority. This deficient practice could is coupants when work is needed in room during a power outage.  The deficient practice and VP of 1.23 between 11:56 a.m. and is a battery powered emergency or transfer room and another in in Based on records review and 11:29 a.m., documentation and test for the battery alight was available at the time incords were incomplete. There y testing for October, ember of 2022 along with ry of 2023. Based on an	K 0	291	K291- NFPA 101 Emergency Lighting  The facility requests paper compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of the facts alleged or conclusions so forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1)Immediate actions taken for those residents identified:  Battery powered emerge light inspection records for the generator transfer room and fi	of it ment the et ncy re	08/23/2023
	observation, the Ma	e of record review and intenance Director agreed			pump room are current and in compliance.		
there was missing monthly testing and stated he							

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	INT OF DEFICIENCIES  N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (	x3) date survey  COMPLETED  08/14/2023
	PROVIDER OR SUPPLIE		5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	could not find any confirm if the tests	other documentation to had been done.		2) How the facility identified other residents:	
	_	eviewed with the VP of anintenance Director during the		<ul> <li>Visitors, staff, and residen that reside at the facility have the potential to be affected by the alleged deficient practice.</li> <li>Measures put into place/System changes:</li> </ul>	ne
				The Maintenance Director Designee will inspect battery powered emergency lights monthly and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on Preventative Maintenance Programmer Programmer Maintenance Programmer Maintena	he the gram
				<ul> <li>The Maintenance Director responsible for compliance.</li> <li>4)How the corrective actions will be monitored:</li> </ul>	is
				The Administrator will revithe Preventative Maintenance Worksheets monthly.	ew
				The results of these audits will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliantis achieved. The QA Committe will identify any trends or patter and make recommendations to revise the plan of correction as	6 ce e ns

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  08/14/2023	
	PROVIDER OR SUPPLIER		5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				indicated.		
				5)Date of compliance: 8/23/2	23	
K 0321 SS=E Bldg. 01	barrier having 1-h- (with 3/4 hour fire automatic fire exti- accordance with 8 approved automat- option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 7.7.1 or 19.3.5.9. When the cic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.				
	b. Laundries (large c. Repair, Mainter d. Soiled Linen Ro	Automatic Sprinkler N/A -Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64				
	(over 50 square fe g. Laboratories (if Hazard - see K32	lons) orage Rooms/Spaces eet) classified as Severe 2)				
	Based on observation	on and interview, the facility	K 0321	K321 NFPA 101 HAZARDOU	s 08/23/2023	

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/14/2023 155653 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE HARBOR HEALTH & REHAB EAST CHICAGO, IN 46312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure the corridor doors to 1 of 1 AREAS- ENCLOSURE storage rooms which is a hazardous area containing combustible storage and greater than The facility requests paper 50 square feet was provided with a self-closing compliance for this citation. device which would cause the door to automatically close and latch into the door frame. This Plan of Correction is the This deficient practice could affect approximately center's credible allegation of 20 staff and residents. compliance. Findings include: Preparation and/or execution of this plan of correction does not Based on observations during a tour of the facility constitute admission or agreement with the Maintenance Director on 08/14/23 by the provider of the truth of the between 11:56 a.m. and 1:33 p.m., room 122, a facts alleged or conclusions set hazardous storage room that was greater than 50 forth in the statement of square feet, was equipped with self-closing device deficiencies. The plan of but did not latch into the frame when tested. correction is prepared and/or Based on interview at the time of observation, the executed solely because it is Maintenance Director agreed the room was used required by the provisions of as storage, was larger than 50 square feet, and federal and state law. stated the latching hardware of the door and door frame was damaged and would need to be fixed. 1)Immediate actions taken for those residents identified: Findings were discussed with the Maintenance Director and VP of Operations at exit conference. Room 122 door latching hardware was replaced to ensure 3.1-19(b) proper closure. 2) How the facility identified other residents: Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/

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System changes:

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The Maintenance Director or

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE COMPI 08/14	LETED
	PROVIDER OR SUPPLIE		5025 M	ADDRESS, CITY, STATE, ZIP CO ICCOOK AVE CHICAGO, IN 46312	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PPROPRIATE	(X5) COMPLETION DATE
				Designee will inspect te doors weekly for one monthly thereafter to en compliance. The Mainten Director will document of Preventative Maintenant Worksheet. The Mainten Director will be re-educed Preventative Maintenant by the Administrator /de 8/23/23.  The Maintenance I responsible for compliant 4) How the corrective a will be monitored:  The Administrator the Preventative Mainten Worksheets monthly.  The results of these will be reviewed in Qual Assurance Meeting monthmonths or until 100% con is achieved. The QA Con will identify any trends of and make recommendate revise the plan of correctindicated.	onth and asure enance on the ace nance ated on the acide Program esignee by  Director is accions  will review enance are audits lity anthly for 6 compliance committee or patterns ations to action as	
K 0345 SS=C Bldg. 01	1					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY  COMPLETED  08/14/2023	
	PROVIDER OR SUPPLIEF		5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	National Electric C National Fire Alam Records of system and testing are re- 9.6.1.3, 9.6.1.5, N Based on record rev failed to maintain 1 accordance with NE Sections 19.3.4.5.1	FPA 70, NFPA 72 view and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section	K 0345	K345 NFPA 101 Fire Alarm System- Testing and Maintenance The facility requests paper	08/23/2023	
	14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:  a. Control unit trouble signals			Compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.		
	fire alarm boxes, he etc.) d. Notification appl e. Magnetic hold-op	(e.g. duct detectors, manual eat detectors, smoke detectors,		Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of the facts alleged or conclusions seforth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	t ment he	
	Findings include:			executed solely because it is required by the provisions of federal and state law.		
	During records review with the Maintenance Director and VP of Operations on 08/14/23 between 09:15 a.m. and 11:29 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted			1)Immediate actions taken for those residents identified:     Fire Alarm System visual inspection completed.		
	on 07/25/23. Based records review, the no documentation c	on interview at the time of Maintenance Director stated ould be found about a visual n and was unaware if the		2) How the facility identified other residents:  Staff, and residents that reside at the facility have the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MUL A. BUIL B. WING	DING	nstruction  01	(X3) DATE SURVEY  COMPLETED  08/14/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID PREFIX TAG	SUMMARY  (EACH DEFICIEN  REGULATORY OR  This finding was re	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION viewed with the VP of Intenance Director at the exit	PF	EAST C ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  potential to be affected by the alleged deficient practice.  3) Measures put into place/ System changes:  The Maintenance Direct Designee will complete visual inspection by-annually of Fire Alarm System and will docume on the Preventative Maintenance Director will be re-educated or Preventative Maintenance Director will be re-educated or Preventative Maintenance Proby the Administrator /designee 8/23/23.  The Maintenance Director responsible for compliance.  4) How the corrective actions will be monitored:  The Administrator will revente the Preventative Maintenance Worksheets monthly.  The results of these audi will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliant is achieved. The QA Committed will identify any trends or pattern and make recommendations to revise the plan of correction as indicated.	or or ent nce n the ogram e by or is view ts or 6 nce dee erns o	(X5) COMPLETION DATE
					5)Date of compliance: 8/23/2	23	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			SURVEY
AND PLAIN	OF CORRECTION	155653	B. W		<u>01</u>	COMPL 08/14/	
	ROVIDER OR SUPPLIER			5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
K 0351	NFPA 101						
SS=E	Sprinkler System -	- Installation					
Bldg. 01	Spinkler System - 2012 EXISTING	Installation					
	Nursing homes, a	nd hospitals where required					
	by construction type						
	throughout by an a	approved automatic					
	sprinkler system ir	n accordance with NFPA					
	13, Standard for th	ne Installation of Sprinkler					
	Systems.						
		nstruction, alternative					
	_ ·	es are permitted to be					
	·	inkler protection in specific					
		or local regulations prohibit					
	sprinklers.						
		ders are not required in					
		patient sleeping rooms					
		the closet does not exceed					
	-	sprinkler coverage covers					
	•	t as required by NFPA 13,					
	Standard for Insta Systems.	liation of Sprinkler					
	_	19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	K351 NFPA 101 Sprinkler		08/23/2023
	failed to maintain th	ne ceiling construction in 1 of 4 ts in accordance with NFPA	l c	331	System- Installation		00/23/2023
	_	Installation of Sprinkler			The facility requests paper		
		, 2010 edition, Section 6.2.7.1			compliance for this citation.		
	_	heons, or other devices used			Comprising the time creation		
	-	space around a sprinkler shall			This Plan of Correction is the		
		be listed for use around a			center's credible allegation of		
	sprinkler. This defic	cient practice could affect			compliance.		
	approximately 5 sta	ff and an unknown number of					
	residents.				Preparation and/or execution	of	
					this plan of correction does no	ot	
	Findings include:				constitute admission or agree	ment	
					by the provider of the truth of		
		ons during a tour of the facility			facts alleged or conclusions s	et	
	with the Maintenand	ce Director 08/14/23 between			forth in the statement of		

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	OF CORRECTION	IDENTIFICATION NUMBER  155653	A. BUILDING B. WING	01	COMPLETED 08/14/2023
	ROVIDER OR SUPPLIER		5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Medical Records Of missing escutcheon cover the hole arour approximately half- and the sprinkler he	p.m., in the back closet of the ffice, the sprinkler head had a plate that did not completely and the sprinkler which left an inch hole between the ceiling ad. Based on interview at the the Maintenance Director		deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1)Immediate actions taken for	or
	agreed the aforemer escutcheon and state supposed to be in th	ntioned area was missing an ed the sprinkler company is e facility soon and wiould the missing escutcheon.		those residents identified:  Sprinkler head escutcher was installed.	
	Findings were discu Director and VP of	ssed with the Maintenance Operations		2) How the facility identified other residents:	
	3.1-19(b)			Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.	
				3) Measures put into place/ System changes:	
				The Maintenance Direct Designee will complete month visual inspection of Sprinkler Heads and will document it or Preventative Maintenance Worksheet. The Maintenance Director will be re-educated or Preventative Maintenance Proby the Administrator /designer 8/23/23.	n the ogram
				The Maintenance Director responsible for compliance.  4)How the corrective actions will be monitored:	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULT A. BUILD B. WING		NSTRUCTION  01	(X3) DATE COMPL <b>08/14</b> /	ETED
	PROVIDER OR SUPPLIES		5	025 M	DDRESS, CITY, STATE, ZIP COD		
HARBOF	R HEALTH & REHA	В		ASIC	HICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					the Preventative Maintenance Worksheets monthly.  The results of these audi will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliar is achieved. The QA Committ will identify any trends or patter and make recommendations to revise the plan of correction as	ts or 6 nce ee erns	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system inspection and tes secure location ar a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAR coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record	supply source  RKS information on non-required or partial er system.  and NFPA 25 review and interview, the	K 0353	3	indicated.  5)Date of compliance: 8/23/2  K353 NFPA 101 Sprinkler	3	08/23/2023
	facility failed to pro	wide written documentation or sprinkler system components	K 0353	,	System- Maintenance and Testing		08/23/2023

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155653	B. W	ING		08/14/	2023
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			CCOOK AVE		
H∆RR∩E	R HEALTH & REHA	В			CHICAGO, IN 46312		
TIAINDOI	·			LAGIC			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	and tested for 3 of 4 quarters.					
	_	res any device, equipment or			The facility requests paper		
	system required for compliance with this Code be				compliance for this citation.		
	maintained in accordance with applicable NFPA						
		nkler systems shall be properly			This Plan of Correction is the		
		dance with NFPA 25, Standard			center's credible allegation of		
	_	Testing, and Maintenance of			compliance.		
		rotection Systems. NFPA 25,					
	_	ds shall be made for all			Preparation and/or execution		
		nd maintenance of the system			this plan of correction does no		
	_	all be made available to the			constitute admission or agree		
		risdiction upon request. 4.3.2			by the provider of the truth of		
		s shall indicate the procedure		facts alleged or conclusions set			
		spection, test, or maintenance),			forth in the statement of		
	-	at performed the work, the			deficiencies. The plan of		
		e. NFPA 25, 5.2.5 requires that			correction is prepared and/or		
		vices shall be inspected			executed solely because it is		
		hey are free of physical			required by the provisions of		
	_	, 5.3.3.1 requires the mechanical			federal and state law.		
		vices including, but not limited					
		gs, shall be tested quarterly.			1)Immediate actions taken fo	or	
	_	ne-type and pressure			those residents identified:		
		ow alarm devices shall be					
		v. This deficient practice could			Sprinkler Quarterly		
		staff, and visitors in the			inspections is current and in		
	facility.				compliance.		
	Pindings in ded.				· Sprinkler heads in		
	Findings include:				breakroom, laundry room and		
	Dagad or massed	view with the VP of Operations			second floor dining room were	;	
		rirector on 08/14/23 between			cleaned.		
		29 a.m., the only sprinkler			2) How the facility identified		
		provided was from 08/05/22.			2) How the facility identified other residents:		
		Inspections within the past 12			other residents.		
	_	ovided. Based on interview at			Staff, Visitors, and reside	ante	
	_	eview, the Maintenance			that reside at the facility have		
		the facility was in the process			potential to be affected by the		
		ers and the sprinkler company			alleged deficient practice.		
		the last 12 months, however			anoged denoterit practice.		
		work could be provided. Later			3) Measures put into place/		
	1 mspection paper	om some of provided Later	1		o, moasares put into piace/		i

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CENTERS FOR MEDICARE & MEDICAID SERVICES						_	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPI	LETED
		155653	B. WING			08/14	/2023
				ED FET.	ADDRESS CITY STATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
LIADDOE		В			CCOOK AVE		
HARBUR	R HEALTH & REHA	rR		ASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)	NIE.	DATE
	during record revie	w, the VP of Operations was			System changes:		
	able to get ahold of	the sprinkler inspection			j		
	_	ested documentation, but the			· The Maintenance Direct	or or	
		provide documentation by the			Designee will complete month		
	end of the survey.				visual inspection of Sprinkler	,	
					Heads and monthly inspection	n of	
	Findings were disc	ussed with the Maintenance			the wet pipe system to include		
	_	Operations at exit conference.			gauges and valves. Inspection		
	Birector and VI or	operations at exit conference.			will document it on the	13	
	3.1-19(b)				Preventative Maintenance		
	3.1-17(0)				Worksheet. The Maintenance		
	2 Deced on record	review and interview, the			Director will be re-educated o		
	-	aintain 1 of 1 sprinkler system in			Preventative Maintenance Pro	-	
		SC 9.7.5. LSC 9.7.5 requires all			by the Administrator /designe	e by	
	_	systems shall be inspected			8/23/23.		
		accordance with NFPA 25,					
		spection, Testing, and			The Maintenance Director	or is	
		ater-Based Fire Protection			responsible for compliance.		
	-	5, 2011 edition, Table 5.1.1.2					
	_	red frequency of inspection and			4)How the corrective actions	<b>;</b>	
	_	5.2.4.1 states gauges on wet			will be monitored:		
		ems shall be inspected monthly					
		systems (5.2.4.2) shall be			· The Administrator will re		
		o ensure normal water or air			the Preventative Maintenance	:	
	-	naintained. NFPA 25 13.3.2.1			Worksheets monthly.		
		d be inspected weekly or					
		as or supervised (13.3.2.1.1)			· The results of these aud	its	
	_	to be inspected monthly. This			will be reviewed in Quality		
	deficient practice c	ould affect all occupants.			Assurance Meeting monthly for		
					months or until 100% complia		
	Findings include:				is achieved. The QA Commit	tee	
					will identify any trends or patte		
		eview with the Maintenance			and make recommendations		
		Operations on 08/14/23			revise the plan of correction a	s	
	between 09:15 a.m.	and 11:29 a.m., there was no			indicated.		
	monthly inspection	of the wet pipe sprinkler					
	system's gauges and	d valves for the months prior			5)Date of compliance: 8/23/2	23	
	to March of 2023.	During an interview at the time			_		
		ne Maintenance Director stated					

that the only documentation he has was the forms

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		01	COMPL	
		155653	B. WING	<del>-</del>		08/14/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Г	ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I E	DATE
	that he had started v	when hired and that other					
	inspections could no	ot be located.					
	_	ussed with the Maintenance Operations at exit conference.					
	3 Rased on observa	ation and interview, the facility					
		f 4 sprinkler heads in the					
		6 sprinkler heads in laundry					
	were not loaded or	covered with foreign material					
		LSC 9.7.5. NFPA 25, 2011					
		sprinklers shall not show signs					
	_	free of corrosion, foreign d physical damage; and shall					
	_	orrect orientation (e.g.,					
		r sidewall). Furthermore, at					
		tler that shows signs of any of					
		be replaced: (1) Leakage (2)					
	Corrosion (3) Physi	cal Damage (4) Loss of fluid in					
		responsive element (5)					
	U V /	g unless painted by the					
		urer. This deficient practice imately 20 residents and staff					
	in one smoke comp	•					
	in one smoke comp	ur urreitt.					
	Findings include:						
	Based on observation	on during a tour of the facility					
		ce Director on 08/14/23					
		and 1:33 p.m. two sprinkler					
		floor dining lounge were					
		l lint could barely see the color					
		on interview at the time of					
		intenance Director confirmed					
	accumulation and lo	sprinkler heads showed dirt					
	accumulation and it	aung.					
	Findings were discu	ussed with the Maintenance					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155653 B. WING 08/14/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE HARBOR HEALTH & REHAB EAST CHICAGO. IN 46312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Director and VP of Operations at exit conference 3.1-19(b)K 0355 **NFPA 101** SS=E Portable Fire Extinguishers Bldg. 01 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility K 0355 K355 NFPA 101 Portable Fire 08/23/2023 failed to ensure 1 of 1 portable fire extinguishers in Extinguisher the maintenance shop were installed in accordance with NFPA 10, Standard for Portable The facility requests paper Fire Extinguishers, 2010 Edition. Section 6.1.3.4 compliance for this citation. states portable fire extinguishers other than wheeled extinguishers shall be installed using any This Plan of Correction is the of the following means. (1) Securely on a hanger center's credible allegation of intended for the extinguishers. (2) In the bracket compliance. supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a Preparation and/or execution of cabinet or wall recess. This deficient practice was this plan of correction does not not in a resident care area but could affect staff constitute admission or agreement by the provider of the truth of the and residents near the second floor nurses station. facts alleged or conclusions set forth in the statement of Findings include: deficiencies. The plan of correction is prepared and/or Based on observations during a tour of the facility executed solely because it is with the Maintenance Director on 08/14/23 required by the provisions of between 11:56 a.m. and 1:33 p.m., an ABC portable federal and state law. fire extinguisher behind the nurses desk was sitting on the floor unsecured. Based on 1)Immediate actions taken for interview at the time of observation, the those residents identified: Maintenance Director agreed the extinguisher was sitting on the floor and stated it is left over from Portable fire extinguishers when the wing of the building had some work removed.

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done and was left there by accident.

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	OF CORRECTION	IDENTIFICATION NUMBER  155653	A. BUILDING B. WING	01	COMPLETED 08/14/2023
	PROVIDER OR SUPPLIER		5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		assed with the Maintenance Operations at exit conference.		2) How the facility identified other residents:  Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.  3) Measures put into place/System changes:  The Maintenance Direct Designee will complete month visual inspection of Portable fextinguishers to ensure proper installation and will document the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on Preventative Maintenance Preventative Maintenance Preventative Maintenance Preventative Maintenance Director will be re-educated on Preventative Maintenance Preventative Maintenance Preventative Maintenance Preventative Maintenance Myladis and the corrective actions will be monitored:  The Administrator will rethe Preventative Maintenance Worksheets monthly.  The results of these aud will be reviewed in Quality Assurance Meeting monthly femonths or until 100% compliations or until 100% com	cor or only ire or it on each of the program each by or is each of the program each of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155653	B. WI	NG		08/14/	2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				CCOOK AVE		
HARROR	HEALTH & REHA	3			CHICAGO, IN 46312		
TIANDON	TILALITI & NETIAL			LAST	7 110AGO, 111 40312		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					revise the plan of correction as	3	
					indicated.		
					5)Date of compliance: 8/23/2	3	
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	_						
ام Diag. U	Corridor - Doors	corridor openings in other					
		osures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
		g fire for at least 20					
	•	fully sprinklered smoke					
		only required to resist the					
		. Corridor doors and doors					
	to rooms containing						
		rials have positive latching					
		atches are prohibited by					
		hese requirements do not					
	_	spaces that do not contain					
	flammable or com						
	Clearance betwee	n bottom of door and floor					
	covering is not exc	ceeding 1 inch. Powered					
	-	vith 7.2.1.9 are permissible					
	if provided with a	device capable of keeping					
	the door closed wh	nen a force of 5 lbf is					
	applied. There is	no impediment to the					
	closing of the door	rs. Hold open devices that					
	release when the	door is pushed or pulled are					
	permitted. Nonrate	ed protective plates of					
	unlimited height ar	re permitted. Dutch doors					
	meeting 19.3.6.3.6	3 are permitted. Door					
	frames shall be lab	peled and made of steel or					
	other materials in	compliance with 8.3,					
	unless the smoke						
	-	fire window assemblies are					
	allowed per 8.3. In	sprinklered compartments					
	there are no restric	ctions in area or fire					

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	A. BUILDING <u>01</u> B. WING				
		155653	B. WI	NG		08/14	12023	
NAME OF F	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD			
H∆₽R∩E	R HEALTH & REHA	R			CCOOK AVE CHICAGO, IN 46312			
HARBUR	TEALIN & RENA	D		EAST				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION S or frames in window		TAG	DEFECTI		DATE	
	assemblies.	s of frames in window						
	accombilec.							
	19.3.6.3, 42 CFR	Parts 403, 418, 460, 482,						
	483, and 485							
		S details of doors such as						
		ngs, automatics closing						
	devices, etc.	ation and interview, the facility	K 03	262			08/23/2023	
		f 57 resident room corridor	K 0.	303	K363 NFPA 101 Corridor- Do	ors	06/23/2023	
		vest wing were provided with						
	a means suitable for	r keeping the door closed, had			The facility requests paper			
	_	losing, latching and would			compliance for this citation.			
		f smoke. This deficient						
	practice could affec	et approximately 6 residents.			This Plan of Correction is the			
	Findings include:				center's credible allegation of			
	Findings include.				compliance.			
	Based on observation	on with the Maintenance			Preparation and/or execution	of		
	Director on 08/14/2	3 between 11:56 a.m. and 1:33			this plan of correction does no			
	1 -	oors to resident rooms 116, 120,			constitute admission or agree	ment		
		ch into the frame when tested.			by the provider of the truth of			
		at the time of observation, the			facts alleged or conclusions s	et		
	Maintenance Direct	ors did not latch into the frame			forth in the statement of deficiencies. The plan of			
	and would need adj				correction is prepared and/or			
		usung.			executed solely because it is			
	The finding was rev	viewed with the VP of			required by the provisions of			
		Maintenance Director during			federal and state law.			
	the exit conference.							
	2 1 10/1				1)Immediate actions taken fo	or		
	3.1-19(b)				those residents identified:			
	2. Based on observa	ation and interview, the facility			The corridor doors to			
		f 1 door to the corridor would			resident's rooms 116, 120, an	d		
	completely resist th	e passage of smoke. This			212 were adjusted to ensure			
	_	ould affect approximately 20			proper closure.			
	· /	s staff and visitors. Doors			<ul> <li>Janitor closet door handl</li> </ul>	е		
		openings in other than			near room 212 replaced.			
	required enclosures	of vertical openings, exits, or						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	r í	JILDING	onstruction  01	(X3) DATE : COMPL 08/14/	ETED
	PROVIDER OR SUPPLIER		•	5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	are made of 1 3/4 in other material capal	ist the passage of smoke and nch solid-bonded core wood or ble of resisiting fire for at least			2) How the facility identified other residents:		
	compartments are of passage of smoke. Of rooms containing floor	in fully sprinklered smoke only required to ressit the Corridor doors and doors to ammable or combustible			Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.		
	latches are prohibite requirements do no	tive latching hardware. Roller ed by CMS regulation. These t apply to auxillary spaces that mable or combustible material.			3) Measures put into place/ System changes:		
	covering is not exce complyyying with	bottom of door and floor eeding 1 inch. Powered doors 7.2.1.9 are permissible if vice capable of keeping the			The Maintenance Direct Designee will complete month visual inspection of doors to ensure proper operation and v	lly	
	is no impediment for Hold open devices	force of 5 lbf is applied. There or the closing of the doors. that release when the door is e permitted. Nonrated			document it on the Preventation Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventation	ve e	
	protective plates of permitted. Dutch do permitted. Door fra	funlimited height are pors meeting 19.3.6.3.6 are mes shall be labeled and made terials in compliance with 8.3,			Maintenance Program by the Administrator /designee by 8/23/23.		
	unless the smoke co Fixed fire window a In sprinklered comp	ompartment is sprinklered. assemblies are allowed per 8.3. oartments there are no			· The Maintenance Director responsible for compliance.		
	flames in window a	or fire resistance of glass or ssemblies.			4)How the corrective actions will be monitored:		
		on on 08/14/23 between 11:56			the Preventative Maintenance Worksheets monthly.		
	the Maintenance Di Closet next to resid floor was latched in	during a tour of the facility with frector, the door to the Janitor ent room 212 on the second place while awaiting repair alling off. However, the door			The results of these audi will be reviewed in Quality Assurance Meeting monthly for months or until 100% complia	or 6	
	handle was missing through the door. T	which left a 4 inch penetration his was acknowledged by the tor at the time of observation			is achieved. The QA Committ will identify any trends or patte and make recommendations t	tee erns	

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` ′		` ′		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	- 1	UILDING	01	COMPL	
		155653	B. W	ING		08/14/	2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWINERS BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and stated parts are	on order to fix the door.		revise the plan of correction		s	
					indicated.		
	_	assed with the Maintenance					
	Director and VP of	Operations at exit conference.			5)Date of compliance: 8/23/23		
	3.1-19(b)						
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
	Fire drills include t	he transmission of a fire					
	•	simulation of emergency fire					
		ills are held at expected					
		mes under varying					
		t quarterly on each shift.					
		r with procedures and is					
		re part of established ills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	ay be assa metsaa et					
	19.7.1.4 through 1	9.7.1.7					
		riew and interview, the facility	K 0	712	K712 NFPA 101 Fire Drill		08/23/2023
	failed to conduct fir	e drills on each shift for 2 of 4					
	-	1.6 states drills shall be			The facility requests paper		
		on each shift to familiarize			compliance for this citation.		
		iurses, interns, maintenance					
		inistrative staff) with the			This Plan of Correction is the		
	-	ncy action required under			center's credible allegation of		
	all staff and residen	This deficient practice affects			compliance.		
	an stan and residen	w.			Preparation and/or execution	of	
	Findings include:				this plan of correction does no		
					constitute admission or agree		
	Based on records re	view with the Maintenance			by the provider of the truth of t		
	Director and the VP	of Operations on 08/14/23			facts alleged or conclusions se		
	between 09:15 a.m.	and 11:29 a.m., the following			forth in the statement of		
	shifts were missing	documentation of a completed			deficiencies. The plan of		
	fire drill:				correction is prepared and/or		
	a) A first, second an	nd third shift fire drills in the			executed solely because it is		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPLET	
		155653	B. W			08/14/20	JZ3
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
HARROR	R HEALTH & REHA	В			ICCOOK AVE CHICAGO, IN 46312		
	T				J. 110, 100, 111 70012	ı	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION DATE
	first quarter of 2023				required by the provisions of		
	b) A first, second as	nd third shift fire drill in the			federal and state law.		
	fourth quarter of 20						
		at the time of record review,			1)Immediate actions taken fo	or	
		rector stated he was unaware nducted and stated he had no			those residents identified:		
		n to confirm if the fire drills			· Facility unable to locate		
	were conducted.				Q1-23 and Q4-22 documental	tion.	
					Fire Drills are currently in		
		issed with the Maintenance			compliance.		
	Director and VP of	Operations at exit conference.					
	3.1-19(b)				2) How the facility identified other residents:		
	3.1-51(c)				other residents.		
					· Staff, and residents that		
					reside at the facility have the		
					potential to be affected by the		
					alleged deficient practice.		
					3) Measures put into place/		
					System changes:		
					The Maintenance Direct	or or	
					Designee will complete month		
					fire drill and will document on	-	
					Drill Exercise form.		
					The Maintenance Directs	or ic	
					<ul> <li>The Maintenance Director</li> <li>responsible for compliance.</li> </ul>	פו וע	
					. 15 periolisio for compilarioo.		
					4)How the corrective actions	;	
					will be monitored:		
					The Administrator will rev	viow	
					the Fire Drills Log monthly.	view	
					and the Brine Log monary.		
					· The results of these audi	its	
					will be reviewed in Quality		
					Assurance Meeting monthly fo		
	I		ı		months or until 100% complia	nce I	

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	OF CORRECTION	IDENTIFICATION NUMBER  155653	A. BUILDING B. WING	01	COMPLETED 08/14/2023
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB		5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				is achieved. The QA Committ will identify any trends or patter and make recommendations to revise the plan of correction as indicated.	erns o
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and assoc of supplying service 10-second criterion monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test und a complete simula automatic or manuloads, and are con personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ of maintenance ar and readily availat	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the possess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised in this for 4 continuous hours. Indeed the continuous hours are with the continuous hours.		5)Date of compliance: 8/23/2	23

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/14/2023	
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Minimizing the pose emergency power consideration for r 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record reversided to maintain a monthly generator I and weekly inspection 6.4.4.1.1.4(a) of 20 testing of the generated electrical system to 110, the Standard for Powers Systems, Clarequires diesel generatories at least or 30 minutes. Section Power Supply Systems appurtenant composition weekly and exercise Appurtenant composition of the properties apperformance, exercised at least or 30 minutes. Section Power Supply Systems appurtenant composition of the properties apperformance, exercised at least or 30 minutes. Section Power Supply Systems appurtenant composition of the properties apperformance, exercised at least or 30 minutes. Section Power Supply Systems appurtenant composition of the properties apperformance, exercised at least or 30 minutes. Section Power Supply Systems appurtenant composition of the properties appeared to the properties appeare	(NFPA 99), NFPA 110, 0 (NFPA 70) riew and interview, the facility complete written record of oad testing for 5 of 12 months on for 20 of 52 weeks. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby napter 8. NFPA 110 8.4.2 rator sets in service to be accompany to the emergency em (EPSS) including all nents, shall be inspected and monthly. Chapter 6.4.4.2 of written record of inspection, using period, and repairs for the alarly maintained and available	K 0918	K918 NFPA 101 Electrical Systems- Essential Electric Syste  The facility requests paper compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	of ot ment the et
	Director and VP of	view with the Maintenance Operations on 08/14/23		1)Immediate actions taken for those residents identified:	
	could be found for l 13, 2022 and April load testing could n	weekly visual inspection between the dates of October 4, 2023. Furthermore, monthly ot be located for the months		<ul> <li>Generator weekly visual inspection and load testing documentation are currently in compliance.</li> </ul>	
	interview at the tim	and February 2023. Based on e of record review, the or stated that all the		2) How the facility identified other residents:	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/14/2023
	PROVIDER OR SUPPLIER		5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	(X5) E COMPLETION DATE
	Maintenance Direct and was unable to l	was left from the previous tor was in the binder provided ocate any further documents if the inspections and tests had		Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.	e ne
	_	reviewed with the Maintenance Operations during the exit		3) Measures put into place. System changes:  The Maintenance Dire Designee will complete Gen weekly inspection and mont minutes under load testing a document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventation Maintenance Program by the Administrator /designee by 8/23/23.  The Maintenance Director will responsible for compliance.  4) How the corrective action will be monitored:  The Administrator will refer the Preventative Maintenance worksheets monthly.  The results of these audither will be reviewed in Quality Assurance Meeting monthly months or until 100% complist achieved. The QA Committed will identify any trends or particulated.	ctor or erator hly 30 and will we he e ative e ctor is  review ce dits for 6 iance sittee tterns is to

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155653	B. WI	NG	08/14		2023
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB			5025 M	ADDRESS, CITY, STATE, ZIP COD CCOOK AVE CHICAGO, IN 46312			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		DROVIDED'S BLANGE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	_	DATE
					5)Date of compliance: 8/23/2	3	
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the pinstalled and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3( 1. Based on observa failed to ensure 1 of properly and used in Section 10.2.4.2 stat cords meeting the re through 10.2.4.2.3 s 10.2.4.2.3 states the 10.2.3. Section 10.2 shall be provided at	d electrical equipment	K 09	920	K920 NFPA 101 Electrical Equipment- Power Cords and Extension Cords  The facility requests paper compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.	1	08/23/2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653  NAME OF PROVIDER OR SUPPLIER  HARBOR HEALTH & REHAB		î ´	JILDING	onstruction 01	(X3) DATE SURVEY  COMPLETED  08/14/2023	
			-	5025 N	ADDRESS, CITY, STATE, ZIP CO ICCOOK AVE CHICAGO, IN 46312	OD	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION
TAG	either pull, twist, o internal connection affect approximate.  Findings include:  Based on observation Director on 08/14/1 p.m., in the Medical used to power equivas dangling by the This condition councausing damage to interview at the time Maintenance Direct dangling, not security will need to be mo	R LSC IDENTIFYING INFORMATION r bend, is not transmitted to as. This deficient practice could		TAG	Preparation and/or exe this plan of correction of constitute admission or by the provider of the trifacts alleged or conclust forth in the statement of deficiencies. The plan correction is prepared a executed solely because required by the provision federal and state law.  1) Immediate actions to those residents idention was proper or Physical Therapy power strip was replaced medical grade.  Extension cord in closet was removed.	ecution of does not ragreement ruth of the sions set of and/or se it is ons of aken for ified:  office dy mounted. room e with	DATE
	failed to ensure 1 of in patient care local rating of 1363A or affect approximate.  Findings include:  Based on observation with the Maintenant between 11:56 a.m. therapy gym there 6 feet of a resident 1363A or 60601-1 of observation, the	ration and interview, the facility of 1 flexible cords power strips strions met the required UL 60601-1. This deficient practice ly 6 residents and staff.  This deficient practice ly 6 residents and staff.  The domain of the facility flower director on 08/14/23 and 1:33 p.m., in the physical was a power strip in use within care area that did not met  Based on interview at the time Maintenance Director agreed a use in a resident care area and			2) How the facility idea other residents:  Staff, and resident reside at the facility has potential to be affected alleged deficient practice.  3) Measures put into possible system changes:  The Maintenance Designee will complete weekly inspection audit ensure power strips are installed and no extensi	ts that ve the by the ce.  place/ e Director or e visual t tool to e properly	

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		X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED	
		155653	B. W	ING		08/14/	2023	
	ROVIDER OR SUPPLIER			5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	did not meet 1363A	or 60601-1.			are in use.			
	_	eviewed with the Maintenance of Operations during the exit			All staff will be re-educating the use of power cords and extension cords.			
	failed to ensure 1 of as a substitute for fi	ation and interview, the facility f 1 flexible cords were not used xed wiring. NFPA-70/2011,			The Maintenance Direct will be re-educated on the Preventative Maintenance Proby the Administrator /designed 8/23/23.	ogram		
		pecifically permitted in 400.7 ables shall not be used for (1)			The Maintenance Director	or ic		
		xed wiring. This deficient			responsible for compliance.	) 15		
		t up to 2 staff and 5 residents			responsible for compliance.			
	in the area.				4)How the corrective actions will be monitored:	<u>;</u>		
	Findings include:				Will be monitored.			
					The Administrator will rev	view		
	Based on observation	on during a tour of the facility			the Preventative Maintenance	; ;		
		ce Director on 08/14/23			worksheets monthly.			
	between 11:56 a.m.	and 1:33 p.m., an extension						
	cord was located in	a janitor closet on the North			· The results of these audi	ts		
	end of the second fl	oor powering a phone			will be reviewed in Quality			
	charger. Based on in	nterview at the time of			Assurance Meeting monthly for	or 6		
	observation, the Ma				months or until 100% complia	nce		
	acknowledged an ex	stension cord was in use.			is achieved. The QA Committ	iee		
					will identify any trends or patte	erns		
	_	riewed with the Maintenance			and make recommendations t	0		
		of Operations during the exit			revise the plan of correction as	S		
	conference.				indicated.			
	3.1-19(b)				5)Date of compliance: 8/23/2	23		
K 0923	NFPA 101							
SS=B		Cylinder and Container						
Bldg. 01	Storag	-						
	_	Cylinder and Container						
	Storage							

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01  B. WING			(X3) DATE SURVEY COMPLETED 08/14/2023	
	PROVIDER OR SUPPLIER		5025	ET ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE F CHICAGO, IN 46312	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
		qual to 3,000 cubic feet			
		are designed, constructed,			
	-	accordance with 5.1.3.3.2			
	and 5.1.3.3.3.				
	>300 but <3,000 d	cubic feet			
	Storage locations	are outdoors in an			
		n an enclosed interior			
	•	imited- combustible			
		door (or gates outdoors)			
		ed. Oxidizing gases are not			
		ables, and are separated			
		s by 20 feet (5 feet if			
		closed in a cabinet of			
		onstruction having a			
		ire protection rating. Il to 300 cubic feet			
		compartment, individual			
	-	e for immediate use in			
	•	s with an aggregate volume			
		ual to 300 cubic feet are not			
		red in an enclosure.			
	-	e handled with precautions			
	as specified in 11				
		ign readable from 5 feet is			
	on each door or g	ate of a cylinder storage			
	room, where the s	sign includes the wording as			
		TION: OXIDIZING GAS(ES)			
	STORED WITHIN				
		d so cylinders are used in			
		ey are received from the			
		cylinders are segregated			
		. When facility employs			
	•	gral pressure gauge, a			
	-	e considered empty is			
		ty cylinders are marked to			
	avoid confusion. ( are protected fron	Cylinders stored in the open			
	· ·				
	11.3.1, 11.3.2, 11   99)	.3.3, 11.3.4, 11.6.5 (NFPA			
		on and interview, the facility	K 0923	K923 NFPA 101 Gas Equipm	nent- 08/23/2023

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46V721

Facility ID: 000108

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLE			ETED
		155653	B. W	B. WING		08/14/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ICCOOK AVE		
HARROE	R HEALTH & REHA	R			CHICAGO, IN 46312		
TIANDOI	·			LAGIC			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NTE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		f 7 cylinders were segregated			Cylinder and Container		
		y cylinders and were marked to			Storage		
		FPA 99, Section 11.6.5.2 states,					
		linders are stored within the			The facility requests paper		
		npty cylinders shall be			compliance for this citation.		
		Il cylinders. Section 11.6.5.3					
		ers shall be marked to avoid			This Plan of Correction is the		
	1	y if a full cylinder is needed in			center's credible allegation of		
	_	is deficient practice could affect			compliance.		
		y 5 staff and an unknown					
	number of residents	S			Preparation and/or execution		
	F' 1' ' 1 1				this plan of correction does no		
	Findings include:				constitute admission or agree	I	
	   D 1 1 4'	id d Maria			by the provider of the truth of		
		on with the Maintenance		facts alleged or conclusions set			
		23 between 11:56 a.m. and 1:33		forth in the statement of			
		orage area contained 7 oxygen			deficiencies. The plan of		
	1 -	not marked or separated as full			correction is prepared and/or		
		s. Based on interview at the			executed solely because it is		
		the Maintenance Director		required by the provisions of			
		cylinders were not marked as nders and could easily be			federal and state law.		
	confused if needed				1)Immediate actions taken for		
	confused if fleeded	in a rapid manner.			those residents identified:	"	
	This finding was re	eviewed with the VP of			those residents identified.		
		intenance Director at exit			Oxygen room properly		
	conference.	milliance Bricolor at CAIL			marked to identify full and em	<sub>ntv</sub>	
					cylinders to avoid confusion a		
	3.1-19(b)				ensure proper storage.	114	
					chedre proper disrage.		
					2) How the facility identified		
					other residents:		
					Staff, and residents that		
					reside at the facility have the		
					potential to be affected by the		
					alleged deficient practice.		
					3) Measures put into place/		
					System changes:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. building <u>01</u>			COMPL	COMPLETED	
		155653	B. WI	B. WING		08/14/2023	
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB				5025 M	ADDRESS, CITY, STATE, ZIP COD CCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	REGULATORY OR	LSC IDENTIFY ING INFORMATION		TAU	The Maintenance Director Designee will complete visual weekly inspection audit tool to Oxygen Cylinders are properly stored.  Nursing staff will be in-service in the proper storag and labeling of Oxygen Cylind	/ e ers.	DATE
					4)How the corrective actions will be monitored:  The Administrator will review the Audit tool Monthly.  The results of these audit will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliant is achieved. The QA Committ will identify any trends or pattern and make recommendations to revise the plan of correction as indicated.	view ts or 6 nce eee erns	
					5)Date of compliance: 8/23/2	23	

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