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 04/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING & REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	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). Survey Date: 04/03/12 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Lake County Nursing & 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. This two story facility determined to be of Type II (222) construction	K0000	April 20, 2012To Whom It May Concern, Attached is the Plan of Correction for Lake County Nursing & Rehab in East Chicago, IN. Please accept this plan of correction as a credible allegation of compliance effective 4/27/2011.Thank you for the service you provide for our seniors in the State of Indiana. Sincerely yours, Kathleen B. Robertson HFA Any deficiency statement	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	and was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident sleeping rooms. The facility has a capacity of 117 and had a census of 76 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/09/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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K0018 SS=E	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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure corridor doors were free from impediments to closing in 2 of 3 first floor smoke compartments. This deficient practice affects the visitors, staff and 40 or more residents in the north and east first floor smoke compartments . Findings Include: Based on observations 04/03/12 with the maintenance supervisor and environmental director between 12:20 p.m. and 4:40 p.m., the corridor door to the conference room was blocked open by a chair. The physical	K0018	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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The corridor door to the conference room is no longer blocked. The physical therapy room is no longer blocked. **How will the facility identify other residents having the potential to be affected by the same deficient practice?**	04/27/2012

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	therapy room door was blocked open by a large free standing mirror. The maintenance supervisor and environmental director acknowledged at the time of the observations, the doors were prevented from closing. 3.1-19(b)		The Maintenance Supervisor did a visual audit of all rooms to ensure that no other rooms were deficient. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Staff has been in-serviced regarding not blocking doors. An audit form has been implemented for the Administrator or designee to ensure doors are not blocked. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator or designee will audit weekly to ensure that doors are not blocked. The Administrator or designee will present the findings at the QA meeting monthly for 3 months. Plan of Correction completion date: April 27, 2012	

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K0021 SS=E	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: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure a door in 1 of 5 smoke barrier door sets was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 8 residents in the east second floor smoke compartment. Findings include: Based on observation with the maintenance supervisor and environmental services director on 04/03/12 at 2:40 p.m., one door in the double fire door set in the smoke barrier near room 203	K0021	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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The double fire door was repaired. **How will the facility identify other residents having the potential to be affected by the same deficient practice?**	04/27/2012

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	failed to close when tested twice to ensure its proper operation. The door coordinator held the door with the astragal open, the second door closed and the coordinator failed to release the first door leaving an eight inch gap. The maintenance supervisor acknowledge at the time of observations, the coordinator was malfunctioning. 3.1-19(b)		A visual audit of all double fire doors has been completed. All doors are working properly. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** An audit form has been implemented for the Administrator or designee to ensure double doors close properly. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator or designee will audit monthly to ensure the double doors close properly. The Administrator or designee will present the findings at the QA meeting monthly for 3 months. Plan of Correction completion date: April 27, 2012	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to provide automatic closers for doors providing access to 5 of 12 hazardous areas including paint storage sites and combustible materials storage rooms larger than 50 square feet. This deficient practice could affect visitors, staff and 39 or more residents in the north smoke compartment and the first and second floor east smoke compartments. Findings include: Based on observations with the maintenance supervisor and environmental services director on 04/03/12 between 12:30 p.m. and 4:00 p.m., the doors	K0029	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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Self closers were installed for rooms 208, 209, shower room near 205, and paint storage room near 105 and the locker room. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** A visual audit of all doors was completed to ensure doors have self closer. Installing the self closers will remove the deficient practice. **What measures will be put into place or what systematic changes will be made to ensure that the**	04/27/2012

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	separating the following hazardous areas lacked self closers: a former resident room 209 filled to capacity with cardboard, paper, plastic and other combustible materials, former resident room 208, 24 by 12 feet in size, identified as nursing storage; the former north hall shower room near 205 used for supply storage, the paint storage room near room 105 with 13 five gallon cans of paint and nine boxes of medical records, and the locker room where a partitioned area housed shelves laden with one gallon paint cans. The maintenance supervisor acknowledged the lack of self closers on doors accessing these hazardous area at the time of observations. 3.1-19(b)		**deficient practice does not recur?** The Maintenance Director has been in-serviced regarding not removing door closers. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Maintenance Director will not remove the self closers on any door. Plan of Correction completion date: April 27, 2012	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 5 emergency exits was readily accessible at all times. LSC 7.2.1.4 requires any door in a means of egress shall be installed so it is capable of swinging from any position to the full required width of the opening in which it is installed. Additionally, 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice affects visitors, staff and 12 or more residents in the administration lobby and reception area. Findings include: Based on observation with the maintenance supervisor and environmental services director on 04/03/12 at 3:55 p.m., a gate providing access to the evacuation point from the service corridor exit had a length of chain and a	K0038	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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The chain and padlock hanging from corridor exit has been removed. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Maintenance Director completed a visual audit of all exit doors and determined that all other means of egress are readily accessible. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?**	04/27/2012

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	padlock hanging form it. The maintenance supervisor said at the time of observation, the chain and padlock were used after hours to prevent entry into the back courtyard by undesirable elements in the neighborhood. He agreed the padlock would not open with the fire alarm system and the key to the padlock was limited to a few people making the exit evacuation point inaccessible. 3.1-19(b)		A monthly checklist form has been implemented to ensure means of egress are readily accessible. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator or designee will audit monthly to ensure means of egress are readily accessible. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. Plan of Correction completion date: April 27, 2012	

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K0046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. 1. Based on observation and interview, the facility failed to ensure the exterior exit discharge paths for 2 of 4 emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 31 residents in the first and second floor west smoke compartments. Findings include: a. Based on observation with the maintenance supervisor and environmental services director on 04/03/12 at 2:45 p.m., the emergency light fixture above the exit discharge path from the first floor smoking room could not illuminate the exit discharge due to the installation of a large exhaust fan which obstructed the lighting provided for the patio area of the exit discharge. In	K0046	**K 046-1** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The emergency light fixture above the exit discharge path from the first floor smoking room will be repaired by 4/23/12. The evacuation point from the patio to the drive will have emergency lighting 4/23/12. The two emergency bulb fixture will have two bulbs installed 4/23/12. The exit discharge sidewalk from the employee lounge will have two bulbs installed 4/23/12.. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Maintenance Director will completed a visual audit of all exit doors to determined that appropriate lighting is in place. **What measures will be put into place or what systematic changes will be made to ensure that the deficient**	04/27/2012

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	addition, the 24 foot sidewalk discharge path from the patio to the evacuation point at the drive way had no emergency lighting. In addition, the two bulb emergency light fixture was equipped with a single bulb. The maintenance supervisor agreed at the time of observation, the lighting provided could not illuminate the path of discharge for the exit through the smoking room. b. Based on observation with the maintenance supervisor and environmental services director on 04/03/12 at 3:05 p.m., the exit discharge sidewalk from the employee lounge providing access to an evacuation point for occupants was illuminated by a light fixture mounted onto the patio wall. The fixture had a single bulb. In addition, the maintenance supervisor said at the time of observation, he could not say whether the power supply for this fixture was connected to the emergency generator. 3.1-19(b) 2. Based on record review and		**practice does not recur?** The Maintenance Director was in-serviced regarding completing monthly checks to ensure lighting is provided. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator or designee will audit monthly to ensure exit paths have lighting. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. Plan of Correction completion date: April 27, 2012 **K 046-2** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The 30 second and 1 ½ hour testing of generator light was completed. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Testing is complete, no other deficiencies. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director has been in-serviced regarding	

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	interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 1 of 1 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all residents. Findings include: Based on review of facility preventive maintenance records with the maintenance supervisor and the environmental services director on 04/03/12 at 1:15 p.m., there was no documentation of 30 second monthly and 1 1/2 hour annual tests for the battery powered emergency lighting fixture located in the emergency generator room. The maintenance supervisor said at the time of observation, he checked the light monthly but had no documentation of his tests. 3.1-19(b)		30 second monthly testing and 1 ½ annual testing of generator light. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator or designee will complete a monthly generator light check. The audit will be presented and reviewed monthly for the next 3 months at the Quality Assurance meeting. Plan of Correction completion date: April 27, 2012	

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K0048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 1. Based on observation, record review and interview; the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 76 of 76 residents. This deficient practice could affect occupants in the east and west smoke compartments on the first and second floors. Findings include: Based on observations with the maintenance supervisor and environmental services director on 04/03/12 between 12:30 p.m. and 3:15 p.m., individual smoke detectors were located in all resident rooms. Based on a review of the facility fire procedures with the maintenance supervisor and environmental services director on 04/03/12 at 12:45 p.m., there was no procedure specific to the response to a battery smoke detector alarm. The maintenance supervisor said	K0048	**K 048-1** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Staff has been in-serviced on how to respond to battery smoke detector alarms. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Fire Watch Policy has been updated. New employees will be informed regarding how to respond to battery smoke detectors. **What measures will be put into place or what systematic changes will be made to ensure that the deficient**	04/27/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at the time of record review, he knew of no procedure for responding to battery smoke detector alarms. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide 1 of 1 written fire safety plans addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2 in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire in the event of an emergency. in the event of an emergency. In the event of an emergency, this deficient practice could affect any		**practice does not recur?** Staff has been in-serviced regarding the update to the policy and the proper way to respond to battery operated smoke detectors. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The fire policy will be reviewed with new employees at orientation and annually for staff. Plan of Correction completion date: April 27, 2012 **K 048-2** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Staff has been in-serviced on the K class fire extinguisher.	

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	visitors, 5 staff and 12 residents in the vicinity of the kitchen and adjacent dining room. Findings include: Based on a review of the facility Fire Plan on 04/03/12 at 12:45 p.m. with the maintenance supervisor and environmental services director, the fire plan did not address the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance supervisor acknowledged at the time of record review, the written fire plan did not mention the activation of the overhead hood extinguishing system before using the K class fire extinguisher. 3.1-19(b)		**How will the facility identify other residents having the potential to be affected by the same deficient practice?** Review of the K class fire extinguisher will prevent any affects on the residents and staff of the facility. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Staff has been in-serviced regarding the K class fire extinguisher. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The fire extinguisher policy will be reviewed with dietary and maintenance staff annually. Plan of Correction completion date: April 27, 2012	

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K0051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 1. Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants. Findings include:	K0051	**K 051-1** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** A quote for installation of the annunciator panel has been obtained. Installation will be completed by 4/27/12. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Installation of the panel will remove this	04/27/2012

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	Based on observation with the maintenance director and environmental services director on 04/03/12 at 12:55 p.m., the fire alarm control panel located at the reception desk was flashing a trouble light. The maintenance supervisor reported at the time of observation, sprinkler contractors were in the building to integrate a sprinkler installation with the fire alarm system and the audible trouble was silenced. The maintenance supervisor acknowledged at the time of observation, the panel location was not located in an area which is monitored 24 hours per day since the reception desk is closed at night and there is a fire door and more then 50 feet to the nearest continuously monitored nurses station. The maintenance director agreed at the time of observation, an annunciator should be located at the nurses station to ensure 24 hour monitoring of the panel. 3.1-19(b) 2. Based on observation and interview, the facility failed to		deficient practice and ensures that this deficient practice not occur again. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Installation of a new annunciator panel at the nurses station will allow the staff to respond appropriately. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Maintenance Director shall make observations during fire drills to ensure staff is monitoring the panel. Plan of Correction completion date: April 27, 2012 **K 051-2** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The smoke detector in the reception corridor now has a deflector in place. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Installation of the deflector will remove this deficient practice. **What measures will be put into place or what systematic changes will be**	

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	ensure a smoke detector connected to the fire alarm system in 1 of 5 smoke compartments was properly separated from an air supply. LSC 9.6.2.10. requires smoke alarms shall be in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 12 or more residents in the north smoke compartment. Findings include: Based on observation with the maintenance supervisor and environmental services director on 04/03/12 at 3:55 p.m., the smoke detector in the reception corridor was located 12 inches from an air vent. The maintenance supervisor acknowledged the location and the time of observation and said he was unaware the smoke detector had been installed too close to an air supply. 3.1-19(b)		**made to ensure that the deficient practice does not recur?** The deflector is now in place. There are no plans to install any new smoke detectors. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Maintenance Director shall make visual observations to ensure this deficiency does not occur again. Plan of Correction completion date: April 27, 2012	

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K0052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 1. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in operating condition. NFPA 72 at 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals shall be distinctly and descriptively annunciated. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance supervisor and environmental services director on 04/03/12 at 3:55 p.m., the fire alarm annunciator at the reception desk reflected trouble with flashing lights and remained silenced since sprinkler contractors had been working on integrating sprinkler and fire systems during the day. The maintenance supervisor attempted to demonstrate the fire alarm	K0052	**K 052-1** K052-1 is being disputed.**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The smoke detector in the first floor elevator room and social services office has had sensitivity testing completed. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Maintenance Director maintains a copy of the sensitivity tests completed. All areas tested. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director has been in-serviced regarding ensuring all smoke detectors are tested. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator shall maintain a copy of the completed sensitivity test for review. Plan of Correction completion date: April 27, 2012	04/27/2012

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	function using a pull station in the north smoke compartment. No annunciation of the fire alarm occurred. He then attempted to sound the fire alarm using a manual pull station in the first floor west smoke compartment. The alarm failed again. He then discovered the contractors had left for the day. He could not determine the cause of the failure and the administrator was notified of the problem. A fire watch was initiated and the fire alarm and sprinkler contractors were called back to the facility. The sprinkler contractor arrived at 5:00 p.m., checked his work and determined his sprinkler activity was not causing the problem. The fire alarm contractor was called again by the maintenance supervisor on 04/03/12 at 5:10 p.m. and he reported the technician was on his way. " 3.1-19(b)		**K 052-2** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The fire alarm is now functioning properly. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Fixing the fire alarm functioning will prevent further affects. The Maintenance Director has been in-serviced regarding checking the fire system for proper functioning after service has been rendered. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The Maintenance Director has been in-serviced regarding checking the fire system for proper functioning after service has been rendered. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator or designee will maintain an audit of system checks after service provided. Plan of Correction completion date: April 27, 2012	

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K0064 SS=E	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 1. Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers in the kitchen were readily accessible. NFPA 10, 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. NFPA 10, 1-6.6 requires fire extinguishers shall not be obstructed or obscured from view. This deficient practice affects 5 staff in and near the kitchen. Findings include: Based on observation with the maintenance supervisor and environmental services director on 04/03/12 at 3:25 p.m., access to two ABC portable fire extinguishers located in the kitchen, was blocked by two carts. The maintenance supervisor and	K0064	**K 064-1** 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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The carts have been moved to allow the fire extinguishers to be readily accessible and immediately available in the event of a fire. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Moving the carts and in-servicing the dietary director, dietary staff, and maintenance of the deficiency will prevent further affects on staff in and near the kitchen. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Dietary staff have been in-serviced regarding having access to the portable fire extinguishers. **How does the facility plan to monitor its performance to make sure that**	04/27/2012

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	environmental services supervisor acknowledged at the time of observation, the carts were blocking access to the fire extinguishers. 3.1-19(b)		**solutions are sustained?** The Administrator or designee will audit 3 times a week to ensure there is access to the portable fire extinguisher and will report findings monthly for the next 3 months at the Quality Assurance meeting. Plan of Correction completion date: April 27, 2012 **K 064-2 K064-2 is being disputed.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The portable fire extinguishers do not need a verification of a service collar due to the fact that the extinguishers are not due to have a 6 year test. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The fire extinguishers were inspected by Northern Fire Equipment Corp. and it was determined the extinguishers were manufactured in 2007 and not due for maintenance until 2013. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The facility will continue to have Northern Fire Equipment Corp. inspect the extinguishers. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** Northern Fire Equipment Corp will continue to	

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			provide service checks for the fire extinguishers. The Administrator or designee will review reports for accuracy. Plan of Correction completion date: April 27, 2012	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 rooms where liquid oxygen transferring takes place was provided with continuous mechanical ventilation to the outside. This deficient practice affects visitors, staff and 12 or more residents in the dining room and front lobby adjacent to the service corridor. Findings include: Based on observation with the maintenance supervisor and environmental services supervisor on 04/03/12 at 3:40 p.m., the oxygen transfer and storage room	K0143	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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Mechanical vents will be installed in oxygen room by 4/27/12. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** Installing the vent in the oxygen room will prevent further deficiencies. **What measures will be put into place or what systematic changes will be made to ensure that the**	04/27/2012

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	located on the service corridor was identified as such by the maintenance supervisor. The room was vented to the outside but lacked the required mechanical vent for the room. The maintenance director acknowledged at the time of observation, there was no mechanical ventilation provided for the room. 3.1-19(b)		**deficient practice does not recur?** The deficient practice will not recur since the installation of the mechanical vent. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Maintenance Director will check the mechanical vent quarterly for proper functioning. Plan of Correction completion date: April 27, 2012	

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K0147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 9 of 9 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 66 residents in the east and west smoke compartments of the first floor, and west second floor smoke compartment. Findings include: Based on observations with the maintenance supervisor and environmental services supervisor on 04/03/12 between 12:30 p.m. and 4:15 p.m. power strip extension cords beside resident beds were used to supply power to a microwave and mini fridge in room 225 and the power strip was piggy backed to two other	K0147	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 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Power strip extension cords have been removed in rooms 225, 127, 111, 112, 113, 116, 114. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** A visual audit of all resident room was completed with no other deficiencies observed. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** Outlets have been installed in rooms 111, 112, 113, 114, 116, 127, 225. **How does the facility plan to monitor its performance to make sure that solutions are sustained?** The Administrator or designee will audit 3 times a week to ensure power strips or extension cords are not in use. The Administrator or designee will present the audit	04/27/2012

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 04/03/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	extension cords to power other equipment in the room including the therapeutic mattress on the bed; to a therapeutic mattress in room 127, to televisions in rooms 111, 112, 113, 116, and a fan clipped to the feeding tube pump in room 114. The maintenance supervisor said at the time of observations, there were not enough electrical outlets for the equipment in other locations. 3.1-19(b)		monthly for the next 3 months at the Quality Assurance meeting. Plan of Correction completion date: April 27, 2012	