	F OF HEALTH AND HU R MEDICARE & MEDIO				FORM APPROVED OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/21/2021
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG E 0000	SUMMARY (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 APPROPRI/ DEFICIENCY)	ATE (X5) COMPLETION DATE
Bldg	conducted by the I accordance with 42 Survey Date: 06/2 Facility Number: Provider Number: AIM Number: 100 At this Emergency County Nursing ar found in compliand Preparedness Requ Medicaid Participa CFR 483.73 The facility has 11	<ul> <li>1/21</li> <li>000108</li> <li>155653</li> <li>0267410</li> <li>Preparedness survey, Lake and Rehabilitation Center was be with Emergency and the supplication of the supplication of the supplication of the supplication.</li> <li>7 beds which are dually certified Medicaid. At the time of the was 61.</li> </ul>	E 0000		
K 0000 Bldg. 01	Licensure Survey	000108	K 0000	Please reference the enclose 2567 as "plan of correction" For the Annual survey that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing. Preparation and / or	-
	AIM Number: 100			execution of this plan of correction does not constitute	

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

TITLE

(X6) DATE

PRINTED: 07/08/2021

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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/21/2021
	PROVIDER OR SUPPLIE OUNTY NURSING	R AND REHABILITATION CENTER	5025 M	address, city, state, zip cod ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O At this Life Safety Nursing and Rehal in compliance with in Medicare/Medic Life Safety from F National Fire Proto Life Safety Code ( Health Care Occup This two story factors	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> Code Survey, Lake County politation Center was found not a Requirements for Participation eaid, 42 CFR Subpart 483.90(a), ire and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing pancies and 410 IAC 16.2	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) admission or agreement by the provider of the truth facts alleged or conclusion set fort in the statement of deficiencies. This plan of correction is prepared and / or executed solely because i is required by the provision of the Federal State Laws. This facility appreciates the time	t f
	facility has a fire a smoke detection ir opened to the corri detectors are instal rooms. The buildin diesel powered em has 117 beds whic Medicare and Med time of this survey			and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on July 1st 2021 serves as our allegation of compliance. The provider respectfully request a desk	
	were sprinklered.	sidents have customary access All areas providing facility iklered except two detached 06/24/21		review on or after July 5th 2d Should you have any questions or conce regarding our Plan of Correction , please d hesitate to Contact me. Sherri Shelby RN, HFA Please accept the following the facility's plan of correct This plan of correction does not constitute an admission	erns on't as ion. s
0100 SS=E	NFPA 101 General Require	ments - Other		guilt or liability by the facili and is submitted only in response to the regulatory requirement.	ty

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OR6L21 Facility ID: 000108

If continuation sheet Page 2 of 16

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPI	LETED
		155653	B. WI	ING		06/21	/2021
	PROVIDER OR SUPPLIEI	AND REHABILITATION CENTER	२	5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01	Section 18.1 and that are not addre K-tags, but are de along with the app NFPA standard ci on Form CMS-250 Based on observation failed to maintain la smoke barrier door requires existing lift the public if not rece either maintained of	RKS section any LSC 19.1 General Requirements essed by the provided eficient. This information, blicable Life Safety Code or tation, should be included	К 0	100	PLAN OF CORRECTION Please accept the following a the facility's plan of correctio This plan of correction does constitute an admission of g or liability by the facility and submitted only in response t the regulatory requirement.	on. not uilt is	07/05/20
	and Maintenance D the set of smoke ba 103 was provided w failed to latch wher on interview at the Executive Director acknowledged the a	on with the Executive Director Director on 06/21/21 at 1:25 p.m., rrier doors by resident room with latching hardware but in tested multiple times. Based time of observation, the and Maintenance Director aforementioned condition. wiewed with the Executive conference.			<ol> <li>1.The corrective action take for the resident found to have been affected by the deficien practice:</li> <li>Latch on fire doors by 103 has been repaired.</li> <li>2. The corrective action for those residents having the potential to be affected by th same deficient practice:         <ul> <li>All residents are at risk this alleged deficient practice.</li> <li>The measures put into pla and a systemic change made to ensure the deficient practice</li> </ul> </li> </ol>	e nt e for	

	R MEDICARE & MEDI						MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTI A. BUILD B. WING		NSTRUCTION 01	(X3) DATE SURVEY COMPLETED <b>06/21/2021</b>	
	PROVIDER OR SUPPLIE	AND REHABILITATION CENTER	50	025 MC	ddress, city, state, zip cod CCOOK AVE HICAGO, IN 46312		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTIV PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO			(X5) COMPLETION	
TAG	REGULATORY C	DR LSC IDENTIFYING INFORMATION	TA	4G	DEFICIENCY) not reoccur:		DATE
					Maintenance was re-inserviced regarding repa latching doors. Staff were reinserviced regarding communication with mainten to report faulty doors. <b>4. To ensure the deficient</b>		
					practice does not reoccur, monitoring system establis is to:		
					Administrator / Designee w monitor 2 fire doors weekly 4 weeks. Then weekly for 3 months. Any issues will be addre immediately. The audits will be discussed during our monthly QA meeting. QA committee will determin continued auditing is necessonce 100% compliance threshold is achieved for tw consecutive months. This p to be amended when indicated. 5. Completion date system changes will be completed 7/5/21	r for ssed d ne if ssary vo blan	
< 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System Spinkler System 2012 EXISTING						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	. ,			(X3) DATE SURVEY COMPLETED 06/21/2021	
	PROVIDER OR SUPPLIE OUNTY NURSING	R AND REHABILITATION CENTE	50	REET ADDRESS, CITY, STATE, ZII 025 MCCOOK AVE AST CHICAGO, IN 46312	P COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
	by construction ty throughout by an sprinkler system 13, Standard for Systems. In Type I and II c protection measu substituted for sp areas where state sprinklers. In hospitals, sprin clothes closets of where the area of 6 square feet and the closet footprin Standard for Inst Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, Based on observat failed to ensure on to be utilized for it Standard for the In 2010 Edition; Sect sprinklers shall no any new or existin states only new sp Additionally, NFP Inspection, Testing Water-Based Fire Edition, Section 5. sprinklers (never ff maintained on the that have been oped can be promptly re correspond to the to of the sprinklers on	and hospitals where required /pe, are protected approved automatic in accordance with NFPA the Installation of Sprinkler onstruction, alternative are permitted to be winkler protection in specific e or local regulations prohibit onklers are not required in f patient sleeping rooms f the closet does not exceed d sprinkler coverage covers on as required by NFPA 13, allation of Sprinkler 2, 19.3.5.3, 19.3.5.4, 19.3.5.10, 9.7, 9.7.1.1(1) ion and interview, the facility ly new sprinklers were available s sprinkler system. NFPA 13, istallation of Sprinkler Systems, ion 6.1.2.2 states reconditioned t be permitted to be utilized on g system and Section 6.2.1 rinklers shall be installed. A 25, Standard for the g, and Maintenance of Protection Systems, 2011 4.1.4 states a supply of spare ewer than six) shall be premises so that any sprinklers rated or damaged in any way placed. The sprinklers shall ypes and temperature ratings n the property. This deficient ct all occupants within the	K 0351	K 351 PLAN OF CORRECT Please accept the for the facility's plan of This plan of correct constitute an admiss or liability by the fac submitted only in re- the regulatory requires 1.The corrective and for the resident four been affected by the practice:	ollowing as f correction. tion does not asion of guilt cility and is esponse to irement. Action taken nd to have e deficient	07/05/20	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE COMPL 06/21/	ETED
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST 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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETIC DATE
	Findings include: Based on observati and Maintenance D the spare sprinkler riser room containe that appeared to be spare sprinklers had leaving six new spa Based on interview Executive Director sprinklers in the sp	on with the Executive Director Director on 06/21/21 at 1:10 p.m., cabinet located in the sprinkler ed three of nine spare sprinklers used sprinklers. The three d Teflon tape in the threads, are sprinklers in the cabinet. T at the time of observation, the acknowledged the three are sprinkler cabinet were used.		<ul> <li>sprinkler parts.</li> <li>2. The corrective action for those residents having the potential to be affected by t same deficient practice: <ul> <li>All residents are at rist this alleged deficient practice</li> </ul> </li> <li>3. The measures put into p and a systemic change made to ensure the deficient practice not reoccur: <ul> <li>Maintenance was inserviced regarding replaced sprinkler heads.</li> </ul> </li> <li>4. To ensure the deficient practice does not reoccur, to monitoring system establist is to: <ul> <li>Administrator / Designee with monitor monthly for 3 month then q 6 months on going.</li> <li>Any issues will be address immediately.</li> <li>The audits will be discussed during our monthly QA meeting.</li> <li>QA committee will determine continued auditing is necess once 100% compliance threshold is achieved for two consecutive months. This p to be amended when indicated.</li> </ul></li></ul>	k for lace le tice ment hed hed hs ssed d lill hs ssed d le if ssary ro	

	R MEDICARE & MEDION NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155653	(X2) MULTI A. BUILD B. WING	ple construction ing <u>01</u>	СОМ	(X3) DATE SURVEY COMPLETED 06/21/2021	
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTER	50	REET ADDRESS, CITY, STATE, ZIP C )25 MCCOOK AVE AST CHICAGO, IN 46312	COD		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE T/	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
< 0353 SS=E Bldg. 01	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testif Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observat failed to maintain accordance with L automatic sprinkle and maintained in Standard for the Ir Maintenance of W Systems. NFPA 2 requires sprinklers respect or have any or coatings applied of manufacture. T	RKS information on non-required or partial er system.	K 0353	7/5/21 K 353 PLAN OF CORRECTION Please accept the foll the facility's plan of c This plan of correction constitute an admission or liability by the facility submitted only in resist the regulatory required	owing as orrection. n does not on of guilt ity and is ponse to	07/05/202	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION (X:	3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155653	B. WING		06/21/2021	
		D	STREET	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE			ICCOOK AVE		
AKE C	OUNTY NURSING	AND REHABILITATION CENTER	R EAST (	CHICAGO, IN 46312		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Findings include:			1.The corrective action taken		
				for the resident found to have		
		ion with the Executive Director		been affected by the deficient		
		Director during a tour of the		practice:		
		p.m. to 1:55 p.m., a decorative				
		hanging from a sprinkler in the		Maintenance director removed		
	first floor main dining room. Based on interview a the time of observation, the Executive Director			decoration.		
		ornamentation and stated the		2. The corrective action for		
	-	een decorated for a themed		those residents having the		
		s ago. The decoration was sprinkler by the Maintenance		potential to be affected by the		
	Director prior to su			same deficient practice:		
	Director prior to st	n'vey exit.		All residents are at risk for	<b>,</b>	
	This finding was re	eviewed with the Executive		this alleged deficient practice.		
	Director at the exit			this alleged dencient practice.		
	Director at the exit	conterence.		3. The measures put into place		
	3.1-19(b)			and a systemic change made	,	
	0.1 17(0)			to ensure the deficient practice		
				not reoccur:		
				Maintenance was		
				inserviced regarding hanging		
				decorations from sprinkler heads	. I	
				Staff were inserviced regarding t		
				alleged deficient practice.		
				4. To ensure the deficient		
				practice does not reoccur, the		
				monitoring system established		
				is to:		
				Administrator / Designee will		
				monitor monthly for 3 months		
				then q 6 months on going.		
				Any issues will be addressed	1	
				immediately.		
				The audits will be discussed		
				during our monthly QA		
				meeting.		

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	( <b>V</b> 2) MI	II TIDI E CO	ONSTRUCTION		1B NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	ILDING	<u>01</u>	(X3) DATE SURVEY COMPLETED 06/21/2021	
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTER	2	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 PROVIDERS PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		N BE IRIATE	(X5) COMPLETION DATE
INC				ING	QA committee will determine continued auditing is necessive once 100% compliance threshold is achieved for the consecutive months. This to be amended when indicated.	ine if essary wo	
					5. Completion date system changes will be completed 7/5/21		
< 0363 SS=E Bldg. 01	than required end exits, or hazardou of smoke and are solid-bonded core capable of resisti minutes. Doors in compartments ar passage of smok to rooms containi combustible mate hardware. Roller CMS regulation. apply to auxiliary flammable or com Clearance betwe covering is not ex doors complying if provided with a the door closed w applied. There is closing of the door release when the	corridor openings in other closures of vertical openings, us areas resist the passage e made of 1 3/4 inch e wood or other material ng fire for at least 20 n fully sprinklered smoke e only required to resist the e. Corridor doors and doors ng flammable or erials have positive latching latches are prohibited by These requirements do not spaces that do not contain nbustible material. en bottom of door and floor acceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is e no impediment to the ors. Hold open devices that door is pushed or pulled are ted protective plates of					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 06/21/2021		
	PROVIDER OR SUPPLIE OUNTY NURSING	R AND REHABILITATION CENTER	२	5025 N	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETH DATE
	meeting 19.3.6.3 frames shall be la other materials in unless the smoke sprinklered. Fixe allowed per 8.3. there are no rest resistance of glas assemblies. 19.3.6.3, 42 CFF 483, and 485 Show in REMAR fire protection rat devices, etc. Based on observat failed to ensure 1 of corridor were main Section 19.3.6.3. corridor doors shal keeping the door of that doors shall no than those that rele or pulled. This de and up to 30 reside Findings include: Based on observat and Maintenance I facility on 06/21/2 at 1:25 p.m., the co 103 did not latch i attempts. Based on observation, the do when closed was a Director.	d fire window assemblies are In sprinklered compartments rictions in area or fire ss or frames in window R Parts 403, 418, 460, 482, KS details of doors such as ings, automatics closing ion and interview, the facility of 59 resident room doors to the ntained in accordance with LSC Section 19.3.6.3.5 states that II be provided with a means for losed. Section 19.3.6.3.10 states t be held open by devices other ease when the door is pushed ficient practice could affect staff ents.	К 0	363	K 363 PLAN OF CORRECTION Please accept the followin the facility's plan of correct This plan of correction dot constitute an admission of or liability by the facility and submitted only in respons the regulatory requirement 1.The corrective action to for the resident found to has been affected by the defici- practice: 103 door latch has been rep 2. The corrective action for those residents having the potential to be affected by	aken ave ent paired.	07/05/20

STATEME	R MEDICARE & MEDIO NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED 06/21/2021	
	PROVIDER OR SUPPLIE DUNTY NURSING	R AND REHABILITATION CENTER	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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETI DATE
	Director at the exit	conference.		same deficient practice:		
	3.1-19(b)			All residents are at risk this alleged deficient practice.	for	
				3. The measures put into pla and a systemic change made to ensure the deficient practi not reoccur:	<b>)</b>	
				Maintenance was inserviced regarding inspecting doors to ensure they latch. Sta were educated regarding repo equipment in need of repair.	aff	
				4. To ensure the deficient practice does not reoccur, th monitoring system establishe is to:		
				Administrator / Designee will monitor 2 doors 2 times per week for 4 weeks. Then 2 doo weekly for 3 months. Any issues will be address immediately. The audits will be discussed during our monthly QA	ors sed	
				meeting. QA committee will determine continued auditing is necess once 100% compliance threshold is achieved for two consecutive months. This pla to be amended when indicated.	ary	
				5. Completion date systemic changes will be completed:		

CENTERS FO	T OF HEALTH AND HU R MEDICARE & MEDIC	CAID SERVICES	(VA) ) (( III ( TTTA) =	CONSTRUCTION	FORM APPROVE OMB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION ()	(X3) DATE SURVEY COMPLETED 06/21/2021	
	PROVIDER OR SUPPLIE	R R AND REHABILITATION CENTER	5025	T ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE T CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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) 7/5/21	(X5) COMPLETIC DATE	
( 0712 SS=F Bldg. 01	alarm signal and conditions. Fire d and unexpected t conditions, at leas The staff is familia aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record re failed to conduct q times under varyin shift for 4 of 4 qua shall be conducted familiarize facility emergency action n conditions. This d residents, staff and Findings include: Based on review of documentation wit record review at 10 shift (3:00 p.m. to on 03/31/2021, 05/ 10/07/2020 were c 5:00 p.m., and 4:30 interview at the tin Executive Director	ay be used instead of	K 0712	K 712 PLAN OF CORRECTION Please accept the following as the facility's plan of correction This plan of correction does n constitute an admission of gu or liability by the facility and i submitted only in response to the regulatory requirement. 1.The corrective action take for the resident found to have been affected by the deficient practice: A varied fire drill was held in jur & will be ongoing.	n. not nilt s	

LAKE COU (X4) ID PREFIX TAG U I 3	SUMMARY (EACH DEFICIE) REGULATORY O unexpected times u This finding was re Director at the time	AND REHABILITATION CENTER STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION under varying conditions.	5025 N	ADDRESS, CITY, STATE, ZIP COD ACCOOK AVE CHICAGO, IN 46312 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY) 2. The corrective action for	06/21/2021 (X5) COMPLET DATE
LAKE COU (X4) ID PREFIX TAG U I 3	SUMMARY SUMMARY (EACH DEFICIEN REGULATORY O unexpected times u This finding was re Director at the time	AND REHABILITATION CENTER STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION under varying conditions.	R 5025 M EAST ID PREFIX	ACCOOK AVE CHICAGO, IN 46312 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLET
LAKE COU (X4) ID PREFIX TAG U I 3	SUMMARY SUMMARY (EACH DEFICIEN REGULATORY O unexpected times u This finding was re Director at the time	AND REHABILITATION CENTER STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION under varying conditions.	EAST ID PREFIX	CHICAGO, IN 46312 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET
(X4) ID PREFIX TAG U TAG 3	SUMMARY (EACH DEFICIE) REGULATORY O unexpected times u This finding was re Director at the time	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION under varying conditions.	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLET
PREFIX TAG U I 3	(EACH DEFICIEN REGULATORY O unexpected times u This finding was re Director at the time	NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> under varying conditions. eviewed with the Executive	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLET
TAG U TAG J TAG J TAG J TAG J TAG J TAG J TAG J TAG J TAG J S	REGULATORY O unexpected times u This finding was re Director at the time	R LSC IDENTIFYING INFORMATION under varying conditions. eviewed with the Executive			E COMPLET
1 1 3	unexpected times u This finding was re Director at the time	under varying conditions.	TAG		DATE
ר ו ו	This finding was re Director at the time	eviewed with the Executive			
I 3	Director at the time				
I 3	Director at the time			those residents having the	
3		c of call.		potential to be affected by the same deficient practice:	
				same dencient practice.	
	3.1-19(b)			No residents are at risk	for
	3.1-51(c)			this alleged deficient practice.	
				3. The measures put into place	ce
				and a systemic change made	
				to ensure the deficient practic	
				not reoccur:	
				Maintenance was	
				inserviced regarding 2 hour var	ried
				time.	
				4. To ensure the deficient	
				practice does not reoccur, the	e
				monitoring system establishe	d
				is to:	
				Administrator / Designee will	
				monitor monthly for 3 months	
				Any issues will be addresse	ed
				immediately.	
				The audits will be discussed during our monthly QA	
				meeting.	
				QA committee will determine	if
				continued auditing is necessa	ary
				once 100% compliance	
				threshold is achieved for two	
				consecutive months. This pla	n
				to be amended when indicated.	
				5. Completion date systemic	
				changes will be completed: 7/5/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING			(X3) DATE SURVEY COMPLETED 06/21/2021	
	PROVIDER OR SUPPLIE OUNTY NURSING	AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CO ICCOOK AVE CHICAGO, IN 46312	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 0923 SS=E Bldg. 01	Storag Gas Equipment - Storage Greater than or e Storage location and ventilated in and 5.1.3.3.3. >300 but <3,000 Storage location enclosure or with space of non- or construction, with that can be secu stored with flamm from combustible minimum 1/2 hr. Less than or equ In a single smok cylinders availab patient care area of less than or equ cylinders must b as specified in 1 A precautionary on each door or room, where the a minimum "CAU STORED WITHI Storage is planm order of which th supplier. Empty from full cylinder	s are outdoors in an hin an enclosed interior limited- combustible in door (or gates outdoors) red. Oxidizing gases are not nables, and are separated es by 20 feet (5 feet if nclosed in a cabinet of construction having a fire protection rating. hal to 300 cubic feet e compartment, individual le for immediate use in his with an aggregate volume qual to 300 cubic feet are not ored in an enclosure. he handled with precautions					

## CENTERS FOR MEDICARE & MEDICAID SERVICES 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 06/21/2021 155653 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE LAKE COUNTY NURSING AND REHABILITATION CENTER 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 threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility K 0923 K 923 07/05/2021 failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling PLAN OF CORRECTION in 1 of 1 oxygen transfilling/storage rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Please accept the following as Section 11.3.3 states storage for nonflammable the facility's plan of correction. gases with a total volume equal to or less than This plan of correction does not greater than 8.5 cubic meters (300 cubic feet) shall constitute an admission of guilt comply with 11.3.3.1 and 11.3.3.2. NFPA 99, or liability by the facility and is Section 11.3.3.2 states precautions in handling submitted only in response to cylinders specified in 11.3.3.1 shall be in the regulatory requirement. accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff in the 1.The corrective action taken vicinity of the oxygen transfilling/storage room. for the resident found to have been affected by the deficient Findings include: practice: Based on observation on 06/21/21 between 12:55 E tank was secured. p.m. and 1:55 p.m. during a tour of the facility with the Executive Director and Maintenance Director, 2. The corrective action for one small oxygen E cylinders was freestanding on those residents having the the floor in the Oxygen Transfilling/Storage room potential to be affected by the and were not supported in a proper cylinder stand same deficient practice: or otherwise secured from falling. Based on interview at the time of the observations, the All residents are at risk for Executive Director acknowledged the oxygen E this alleged deficient practice. cylinder was not supported in a cylinder stand or otherwise secured from falling. 3. The measures put into place and a systemic change made This finding was reviewed with the Executive to ensure the deficient practice Director at the exit conference. not reoccur:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

If continuation sheet

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07/08/2021 PRINTED: FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

**OR6L21** 

Facility ID: 000108

TERS FOR MEDICARE & MEDICAID SERVICES         TATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER         155653		(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 06/21/2021		
	ROVIDER OR SUPPLIEI PUNTY NURSING /	REHABILITATION CENTER	•	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 & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) Maintenance was inserviced regarding securing oxygen. Staff were educated regarding securing oxygen. 4. To ensure the deficient practice does not reoccur, f monitoring system establis is to: Administrator / Designee wi monitor oxygen security 2 times per week for 4 weeks. Then weekly for 3 months. Any issues will be address immediately. The audits will be discussed during our monthly QA meeting. QA committee will determin continued auditing is necess once 100% compliance threshold is achieved for tw consecutive months. This p	che hed ill ssed d e if ssary	(X5) COMPLETION DATE
					to be amended when indicated. 5. Completion date systemi changes will be completed: 7/5/21		

OR6L21

Facility ID: 000108

If continuation sheet

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