STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING -- B. WING	06/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/21/21 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 At this Emergency Preparedness survey, Lake County Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 117 beds which are dually certified for Medicare and Medicaid. At the time of the survey, the census was 61. Quality Review on 06/24/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a) Survey Date: 06/21/21 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410	K 0000	Please reference the enclosed 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 execution of this plan of correction does not constitute	

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

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	At this Life Safety Code Survey, Lake County Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in areas opened to the corridors. Battery operated smoke detectors are installed in all resident sleeping rooms. The building is partially protected by a diesel powered emergency generator. The facility has 117 beds which are dually certified for Medicare and Medicaid and a census of 61 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage sheds. Quality Review on 06/24/21		admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on July 1st 2021 serves as our allegation of compliance. The provider respectfully request a desk review on or after July 5th 2021 Should you have any questions or concerns regarding our Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA **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.**	
K 0100 SS=E	NFPA 101 General Requirements - Other			

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Bldg. 01	General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 6 smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff and at least 20 residents. Findings include: Based on observation with the Executive Director and Maintenance Director on 06/21/21 at 1:25 p.m., the set of smoke barrier doors by resident room 103 was provided with latching hardware but failed to latch when tested multiple times. Based on interview at the time of observation, the Executive Director and Maintenance Director acknowledged the aforementioned condition. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)	K 0100	PLAN OF CORRECTION **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.** **1.The corrective action taken for the resident found to have been affected by the deficient practice:** Latch on fire doors by 103 has been repaired. **2. The corrective action for those residents having the potential to be affected by the same deficient practice:** All residents are at risk for this alleged deficient practice. **3. The measures put into place and a systemic change made to ensure the deficient practice**	07/05/2021

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			not reoccur: Maintenance was re-inserviced regarding repairs of latching doors. Staff were reinserviced regarding communication with maintenance to report faulty doors. **4. To ensure the deficient practice does not reoccur, the monitoring system established is to:** **Administrator / Designee will monitor 2 fire doors weekly for 4 weeks. Then weekly for 3 months.** **Any issues will be addressed immediately.** **The audits will be discussed during our monthly QA meeting.** **QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated**. **5. Completion date systemic changes will be completed:** 7/5/21	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING			

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	Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure only new sprinklers were available to be utilized for its sprinkler system. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 6.1.2.2 states reconditioned sprinklers shall not be permitted to be utilized on any new or existing system and Section 6.2.1 states only new sprinklers shall be installed. Additionally, NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. This deficient practice could affect all occupants within the facility.	K 0351	**K 351** PLAN OF CORRECTION **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.** **1.The corrective action taken for the resident found to have been affected by the deficient practice:** Koorsen provided new spare	07/05/2021

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	Findings include: Based on observation with the Executive Director and Maintenance Director on 06/21/21 at 1:10 p.m., the spare sprinkler cabinet located in the sprinkler riser room contained three of nine spare sprinklers that appeared to be used sprinklers. The three spare sprinklers had Teflon tape in the threads, leaving six new spare sprinklers in the cabinet. Based on interview at the time of observation, the Executive Director acknowledged the three sprinklers in the spare sprinkler cabinet were used. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		sprinkler parts. **2. The corrective action for those residents having the potential to be affected by the same deficient practice:** All residents are at risk for this alleged deficient practice. **3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:** Maintenance was inserviced regarding replacement sprinkler heads. **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 immediately.** **The audits will be discussed during our monthly QA meeting.** **QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated**.	

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			5. Completion date systemic changes will be completed: 7/5/21	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Section 5.4.1.8 requires sprinklers shall not be altered in any respect or have any type of ornamentation, paint, or coatings applied after shipment from the place of manufacture. This deficient practice could affect 10 residents and staff in the dining room.	K 0353	**K 353** PLAN OF CORRECTION **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.**	07/05/2021

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	Findings include: Based on observation with the Executive Director and Maintenance Director during a tour of the facility from 12:55 p.m. to 1:55 p.m., a decorative ornamentation was hanging from a sprinkler in the first floor main dining room. Based on interview at the time of observation, the Executive Director acknowledged the ornamentation and stated the dining room had been decorated for a themed event a few months ago. The decoration was removed from the sprinkler by the Maintenance Director prior to survey exit. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		**1.The corrective action taken for the resident found to have been affected by the deficient practice:** Maintenance director removed decoration. **2. The corrective action for those residents having the potential to be affected by the same deficient practice:** All residents are at risk for this alleged deficient practice. **3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:** Maintenance was inserviced regarding hanging decorations from sprinkler heads. Staff were inserviced regarding this 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 immediately.** **The audits will be discussed during our monthly QA meeting.**	

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			QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. **5. Completion date systemic changes will be completed:** 7/5/21	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of			

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	unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 59 resident room doors to the corridor were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. This deficient practice could affect staff and up to 30 residents. Findings include: Based on observation with the Executive Director and Maintenance Director during a tour of the facility on 06/21/21 at 1:25 p.m., the corridor door to Resident Room 103 did not latch into the frame after several attempts. Based on interview at the time of observation, the door of room 103 not latching when closed was acknowledged by the Executive Director. This finding was reviewed with the Executive	K 0363	**K 363** PLAN OF CORRECTION **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.** **1.The corrective action taken for the resident found to have been affected by the deficient practice:** 103 door latch has been repaired. **2. The corrective action for those residents having the potential to be affected by the**	07/05/2021

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	155653	A. BUILDING 01 B. WING	06/21/2021

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	Director at the exit conference. 3.1-19(b)		**same deficient practice:** All residents are at risk for this alleged deficient practice. **3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:** Maintenance was inserviced regarding inspecting doors to ensure they latch. Staff were educated regarding reporting equipment in need of repair. **4. To ensure the deficient practice does not reoccur, the monitoring system established is to:** **Administrator / Designee will monitor 2 doors 2 times per week for 4 weeks. Then 2 doors weekly for 3 months.** **Any issues will be addressed immediately.** **The audits will be discussed during our monthly QA meeting.** **QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated**. **5. Completion date systemic changes will be completed:**	

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			7/5/21	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. LSC 19.7.1.6 requires drill shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required under varied conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Executive Director during record review at 10:51 a.m. on 06/21/2021, second shift (3:00 p.m. to 11:00 p.m.) fire drills conducted on 03/31/2021, 05/05/2021, 07/08/2020 and 10/07/2020 were conducted at 4:15 p.m., 4:30 p.m., 5:00 p.m., and 4:30 p.m. respectively. Based on interview at the time of record review, the Executive Director agreed that the aforementioned first shift fire drills were not conducted at	K 0712	**K 712** PLAN OF CORRECTION **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.** **1.The corrective action taken for the resident found to have been affected by the deficient practice:** A varied fire drill was held in june. & will be ongoing.	07/05/2021

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	unexpected times under varying conditions. This finding was reviewed with the Executive Director at the time of exit. 3.1-19(b) 3.1-51(c)		**2. The corrective action for those residents having the potential to be affected by the same deficient practice:** No residents are at risk for this alleged deficient practice. **3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:** Maintenance was inserviced regarding 2 hour varied time. **4. To ensure the deficient practice does not reoccur, the monitoring system established is to:** **Administrator / Designee will monitor monthly for 3 months.** **Any issues will be addressed immediately.** **The audits will be discussed during our monthly QA meeting.** **QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated**. **5. Completion date systemic changes will be completed:** 7/5/21	

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LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 01 B. WING	06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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 failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen transfilling/storage rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in 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 vicinity of the oxygen transfilling/storage room. Findings include: Based on observation on 06/21/21 between 12:55 p.m. and 1:55 p.m. during a tour of the facility with the Executive Director and Maintenance Director, one small oxygen E cylinders was freestanding on the floor in the Oxygen Transfilling/Storage room and were not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observations, the Executive Director acknowledged the oxygen E cylinder was not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Executive Director at the exit conference.	K 0923	**K 923** PLAN OF CORRECTION **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.** **1.The corrective action taken for the resident found to have been affected by the deficient practice:** E tank was secured. **2. The corrective action for those residents having the potential to be affected by the same deficient practice:** All residents are at risk for this alleged deficient practice. **3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:**	07/05/2021

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	3.1-19(b)		Maintenance was inserviced regarding securing oxygen. Staff were educated regarding securing oxygen. **4. To ensure the deficient practice does not reoccur, the monitoring system established is to:** **Administrator / Designee will monitor oxygen security 2 times per week for 4 weeks. Then weekly for 3 months.** **Any issues will be addressed immediately.** **The audits will be discussed during our monthly QA meeting.** **QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated**. **5. Completion date systemic changes will be completed:** 7/5/21	