

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  05/23/2013
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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a)</p> <p>Survey Date: 05/23/13</p> <p>Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410</p> <p>Surveyor: Joe L. Brown, Jr., Life Safety Code Specialist.</p> <p>At this Life Safety Code Survey, Lake County Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2</p> <p>This two story facility determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas opened to the corridors,</p>	K010000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a desk review be scheduled on or after June 8th 2013.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 100 with a census of 52 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the detached shed used for the facility storage.</p> <p>Quality Review by Dennis Austill, Life Safety Code Supervisor on 05/24/13.</p> <p>The facility was not found in compliance with the aforementioned regulatory requirements.</p>			

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K010018 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 52 resident room doors closed and latched into the door frame. This deficient practice had the potential to affect 10 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation on 05/23/13 with the Maintenance Director during the tour from 8:30 a.m. to 12:45 p.m., resident room door 225 would not latch in its frame. Based on interview at the time of observation, the Maintenance Director acknowledged the door to resident room 225 would not latch in its frame.</p> <p>3.1-19(b)</p>	K010018	<p><b>K018 NFPA 101 LIFE SAFETY CODE STANDARD</b> Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those contrasted of 1 ¾ in solid-bonded core wood or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist passage of smoke. There is no impediment to the closing of the doors. Doors are provided with the means suitable for keeping the doors 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. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the</b></p>	06/08/2013

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			<p><b>deficient practice</b> The door to residents 225 was fixed so it does latch to its frame. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> Resident rooms at the facility have the potential to be affected by this alleged deficient practice. On June 4<sup>th</sup>, 2013 rounds were conducted by the maintenance department checking to ensure the same alleged deficient practice does not re-occur. Any issues identified will be corrected by 6/8/2013. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> The maintenance director will do rounds of the facility to ensure this same alleged deficient practice does not re-occur using the Environmental Rounds audit tool. He will look at 10 resident room doors per month (5 downstairs and 5 upstairs) ongoing. Any issues identified will be immediately addressed. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be</p>	

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			developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going.	

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K010033 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview the facility failed to maintain the vertical opening protection of 2 of 2 exit stairs. LSC 8.2.5.2 requires openings shall be protected as appropriate for the fire resistance rating of the barrier. LSC 7.1.3.2.1(a) requires a one hour rating in existing buildings of three stories or less. 7.1.3.2.1(c) requires openings in separations shall be protected by fire door assemblies. NFPA 80, the Standard for Fire Doors and Fire Windows, at 2-1.4.1 requires swinging doors to be equipped with self closing devices which will cause the door to close and latch each time it is opened. This deficient practice could affect all residents and staff using the stairwells.</p> <p>Findings include:</p> <p>Based on observation on 05/23/13 with the Maintenance Director during the tour from 8:30 a.m. to 12:45 p.m., both exit stairwells door labels indicating a fire resistance rating was painted. Based on interview at the time of observation, the</p>	K010033	<p><b>K033 NFPA 101 LIFE SAFETY CODE STANDARD</b> Exit components (such as Stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <p>The fire rating labels on both exit stairwell doors were cleaned and the rating labels are completely visible.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>The fire rating doors in the facility have the potential to be affected by this same alleged practice.</p>	06/08/2013			

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	Maintenance Director acknowledged the painted fire door labels.  3.1-19(b)		<p>On June 4, 2013 the maintenance director did rounds of the fire rating doors to ensure this same alleged deficient practice did not re-occur.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>The maintenance director will do rounds of the facility to ensure this same alleged deficient practice does not re-occur using the Environmental Rounds audit tool. He will look at 2 fire rated doors per month (1 downstairs and 1 upstairs) ongoing. Any issues identified will be immediately addressed.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met.</li> <li>· Noncompliance with facility procedures will result in education and/or disciplinary action on going.</li> </ul>		

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K010046 SS=C	<p>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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice had the potential to affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/23/13 with the Maintenance Director during the tour from 8:30 a.m. to 12:45 p.m., a battery operated emergency light was observed in the generator room. Based on an interview with the Maintenance Director</p>	K010046	<p><b>K046 NFPA 101 LIFE SAFETY CODE STANDARD</b> Emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. 19.2.9.1</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <p>On 5/23/2013 the maintenance director had already initiated the 90 minute annual test while the inspector was in the facility. The last annual 90 minute test was in April of 2012.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>The facility has the potential to be affected by this same alleged deficient practice if we do not complete the 90 minute annual test yearly.</p> <p>There are no corrective actions to be taken at this time for this alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic</b></p>	06/08/2013			

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	<p>at the time of observation, there were no written records of a monthly test or an annual test regarding the battery operated emergency light available for review.</p> <p>3.1-19(b)</p>		<p><b>changes you will make to ensure that the deficient practice does not recur</b></p> <p>The maintenance director will complete the annual 90 minute test every 11 months to ensure ongoing compliance is met.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The Administrator and/or designee will look at the maintenance director's generators testing log to ensure this same alleged deficient practice does not reoccur.</p> <p>Noncompliance with facility procedures will result in education and/or disciplinary action on going.</p>		

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K010066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 area where smoking was permitted. This deficient practice had the potential to affect any staff utilizing the designated smoking area.</p> <p>Findings include:</p>	K010066	<p><b>K066 NFPA 101 LIFE SAFETY CODE STANDARD</b> Smoking regulations are adopted and included no less than the following provisions:</p> <p>1. Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>2. Smoking by patients classified as not responsible is</p>	06/08/2013

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	<p>Based on observation on 05/23/13 with the Maintenance Director during the tour from 8:30 a.m. to 12:45 p.m., the smoking area had a twenty three cigarette butts scattered around the smoke area. Based on interview at the time of observations, the Maintenance Director acknowledged the facility's employees disposed of cigarette butts on the ground instead of using the approved long neck vessel which was provided.</p> <p>3.1-19(b)</p>		<p>prohibited, except when under direct supervision.</p> <p>3. Ashtrays of noncombustible materials and safe smoking design are provided in all areas where smoking is permitted.</p> <p>4. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.</p> <p>19.7.4</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <p>The smoking area was immediately cleaned up after it was observed on 5/23/2013.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>Residents who smoke have the potential to be affected by this same alleged deficient practice.</p> <p>On June 4, 2013, the Administrator updated the smoking policy and outlined a procedure for the staff to follow while supervising the resident smoking times. Part of the policy states that the smoking area will be cleaned immediately after</p>		

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			<p>each smoking time by the assigned staff.</p> <p>On 6/4/2013 the activity staff was in-serviced on the new smoking policy and procedure by the Administrator.</p> <p>On 6/5/2013 all staff was in-serviced on the new smoking policy and procedure.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>The Activity Director will observe the smoking times 2 days per week ongoing using the smoking observation tool to ensure the same alleged deficient practice does not re-occur. Any issues identified will be immediately corrected.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>· Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met.</li> <li>· Noncompliance with facility procedures will result in education and/or disciplinary</li> </ul>		

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect any staff using the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 05/23/13 with the Maintenance Director during the tour from 8:30 a.m. to 12:45 p.m., a 24 inch by 12 inch electrical junction box with numerous wire connections jutting out of the box without a cover plate was in the kitchen adjacent to the freezer. Based on an interview with the Maintenance Director at the time of observation, acknowledged that there was no cover plate on the junction box.</p> <p>3.1-19(b)</p>	K010147	<p><b>K147 NFPA 101 LIFE SAFETY CODE STANDARD</b> Electrical wiring and equipment is in accordance with NFPA 70, National Electric Code n9.1.2 <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b>The cover was immediately replaced upon observation on 5/23/2013. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> Electrical junction boxes located in the facility have the potential to be affected by this same alleged deficient practice. On June 4, 2013 the maintenance director completed rounds of the facility to ensure this same alleged deficient practice did not reoccur. No other issues were identified. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> The maintenance director will conduct rounds of the facility monthly ongoing using the environmental rounds audit tool to ensure this same alleged deficient practice</p>	06/08/2013			

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  05/23/2013
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
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			does not reoccur. Any issues identified will be immediately corrected. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going.		