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	10/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	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: 10/11/2022 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 At this Emergency Preparedness survey, Harbor Health & Rehab 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 70. Quality Review completed on 10/14/22	E 0000	Please reference the enclosed 2567 as “plan of correction” For the Annual Life Safety Survey that was conducted at Harbor Health & Rehab I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute 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 10/22/22 serves as our allegation of compliance. The provider respectfully request a desk review on or after 10/22/22. Should you have any questions or concerns	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			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 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: 10/11/2022 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 At this Life Safety Code Survey, Harbor Health & Rehab 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	K 0000	Please reference the enclosed 2567 as "plan of correction" For the Annual Life Safety Survey that was conducted at Harbor Health & Rehab I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute 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	

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	155653	A. BUILDING 01 B. WING	10/11/2022

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	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 70 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 completed on 10/14/22		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 10/22/22 serves as our allegation of compliance. The provider respectfully request a desk review on or after 10/22/22. 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 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING 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			

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	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 maintain the ceiling construction in 1 of 1 kitchen in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff. Findings include: Based on observation made with the facility Administrator during a tour of the facility at on 10/11/22 at 12:15 p.m., a sprinkler in the kitchen had a missing escutcheon, leaving a one-inch annular space around the sprinkler. Based on interview at the time of observation, the Administrator agreed an escutcheon was missing and would have it taken care of as soon as possible. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0351	**K 351 NFPA 101 SPRINKLER SYSTEM – INSTALLATION** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is* **1) Immediate actions taken for those residents identified:** · Kitchen sprinkler escutcheon was installed. There were no residents cited in regard to this regulation.	10/13/2022

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			2) How the facility identified other residents: · Staff and residents have the potential to be affected by the alleged deficient practice. All other sprinklers were assessed, and no further issues were identified. **3) Measures put into place/ System changes:** · Sprinkler heads inspections are completed weekly and documented on the Preventative Maintenance Worksheet Log by the Maintenance Department. · The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 10/13/22. · The Maintenance Director is responsible for compliance. **4. How the corrective actions will be monitored:** · The Sprinkler Check Log is part of the Preventative Maintenance Manual. The Administrator will review the Preventative Maintenance Manual weekly for four weeks, and monthly thereafter to ensure compliance.	

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			· The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated 5. **Compliance Date:** 10/13/22	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance	K 0374	**K374 NFPA 101 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER** **The facility requests paper compliance for this citation.**	10/13/2022

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	necessary for proper operation. This deficient practice could affect as many as 35 residents, staff and visitors. Findings include: Based on observation made with the Administrator during a tour of the facility on 10/11/22 at 12:05 p.m., the set of smoke barrier doors by resident room 203 did not close completely leaving a two-inch gap when tested on three separate occasions. Based on interview at the time of observation, the Administrator agreed the smoke barrier doors did not close completely leaving a two-inch gap when closed at their fullest. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. · The smoke barrier door near room 203 was inspected and is closing properly. **2) How the facility identified other residents:** · Residents, staff, and visitors have the potential to be affected by the alleged deficient practice. · All other smoke barrier doors were assessed following directly after survey and no further issues were identified. **3) Measures put into place/ System changes:**	

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			· Smoke barrier door inspections are completed weekly and documented on the Preventative Maintenance Worksheet Log by the Maintenance Department. · The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator/designee by 10/13/22. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · The Smoke Barrier Door Inspection Log is part of the Preventative Maintenance Manual. The Administrator will review the Preventative Maintenance Manual weekly for four weeks, and monthly thereafter to ensure compliance. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance:**	

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