PRINTED: 10/25/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/11/2022		
	PROVIDER OR SUPPLIE		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 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) COMPLETION DATE
Bldg	conducted by the Ir accordance with 42 Survey Date: 10/12 Facility Number: 0 Provider Number: 100 At this Emergency Health & Rehab wa Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 117 for Medicare and Medicar	200108 155653 267410 Preparedness survey, Harbor as found in compliance with edness Requirements for acaid Participating Providers 2FR 483.73 7 beds which are dually certified fedicaid. At the time of the	E 0000	Please reference the enclosed 2567 as "plan of correction" For the Annual Life Safety Surthat 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.	rvey	

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

TITLE

have any questions or concerns

Should you

(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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155653	B. WING		10/11/2022
	PROVIDER OR SUPPLIER		5025 M	ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE CHICAGO, IN 46312	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				regarding our Plan of Correction , please do hesitate to Contact me. Sherri Shelby RN, HFA Please accept the following a the facility's plan of correction does not constitute an admission guilt or liability by the facility and is submitted only in response to the regulatory requirement.	as on. of
K 0000					
Bldg. 01					
	Licensure Survey w Department of Head 483.90(a) Survey Date: 10/11 Facility Number: 0 Provider Number: 100 At this Life Safety of Rehab was found in Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protectife Safety Code (I Health Care Occupa	00108 155653 267410 Code Survey, Harbor Health & ot in compliance with	K 0000	Please reference the enclosed 2567 as "plan of correction" For the Annual Life Safety Surthat 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	rvey
	1	was fully sprinklered. The		the Federal State Laws. This	

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facility has a fire alarm system with hard wired

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facility appreciates the time

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA	TE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COL	MPLETED	
	10/11/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD FOR MCCOOK AVE		
5025 MCCOOK AVE		
HARBOR HEALTH & REHAB EAST CHICAGO, IN 46312		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
smoke detection in the corridors and in areas and dedication of the Survey		
opened to the corridors. Battery operated smoke Team; the facility will accept		
detectors are installed in all resident sleeping the survey as a tool for our		
rooms. The building is partially protected by a facility to use in continuing to		
diesel powered emergency generator. The facility better our Elders in our		
has 117 beds which are dually certified for community.		
Medicare and Medicaid and a census of 70 at the The Plan of Correction		
time of this survey submitted on 10/22/22		
serves as our allegation		
All areas where residents have customary access of compliance. The provider		
were sprinklered. All areas providing facility respectfully request a desk		
services were sprinklered except two detached review on or after 10/22/22.		
storage sheds. Should you		
have any questions or concerns		
Quality Review completed on 10/14/22 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.		
IX 0254 NEDA 404		
K 0351 NFPA 101 SS=D Sprinkler System - Installation		
Bldg. 01 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		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155653	B. WI	NG			/2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			CCOOK AVE		
H∆RR∩F	R HEALTH & REHA	В			CHICAGO, IN 46312		
11/11/1001				2,101			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		inkler protection in specific					
		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						
	1	t as required by NFPA 13,					
		llation of Sprinkler					
	Systems.	mation of opinice					
	l •	, 19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	K 351 NFPA 101 SPRINKLER		10/13/2022
		ne ceiling construction in 1 of 1		SYSTEM - INSTAL			10/13/2022
		ce with NFPA 13, Standard for					
	the Installation of S	prinkler Systems. NFPA 13,			The facility requests paper		
	2010 edition, Section	on 6.2.7.1 states plates,			compliance for this citation.		
	escutcheons, or oth	er devices used to cover the			•		
	annular space arour	nd a sprinkler shall be metallic			This Plan of Correction is the		
	or shall be listed for	r use around a sprinkler. This			center's credible allegation of		
	deficient practice co	ould affect staff.			compliance.		
	Findings include:				Preparation and/or execution of	of	
					this plan of correction does no	t	
	Based on observation	on made with the facility			constitute admission or agreer	nent	
	Administrator durir	ng a tour of the facility at on			by the provider of the truth of t	he	
		.m., a sprinkler in the kitchen			facts alleged or conclusions se	et .	
	had a missing escut	cheon, leaving a one-inch			forth in the statement of		
	_	nd the sprinkler. Based on			deficiencies. The plan of		
		e of observation, the			correction is prepared and/or		
	_	ed an escutcheon was missing			executed solely because it is		
		aken care of as soon as					
	possible.				Immediate actions take for those residents identified		
	This finding was #0	viewed with the Administrator			for those residents identified	١.	
	at the exit conferen				· Kitchen sprinkler		
	at the CAR COMETEN				escutcheon was installed. The	ırα	
	3.1-19(b)				were no residents cited in rega		
	J.1 17(0)				to this regulation.	ai u	
					to ano rogalation.		

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CENTERS FOR	R MEDICARE & MEDIC						B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED	
		155653	B. WING		-	10/11/2022	
			2			13/11/	
NAME OF E	PROVIDER OR SUPPLIER		ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	NO VIDER OR SUPPLIER		50)25 M(CCOOK AVE		
HARBOF	R HEALTH & REHA	3	E/	AST C	HICAGO, IN 46312		
	T			- 1			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	λG	DEFICIENCY)		DATE
					2) How the facility identified	ed	
					other residents:		
					· Staff and residents have	the	
					potential to be affected by the		
					· ·	thor	
					alleged deficient practice. All o		
					sprinklers were assessed, and	110	
					further issues were identified.		
					3) Measures put into place/		
					System changes:		
					 Sprinkler heads inspecti 	ons	
					are completed weekly and		
					documented on the Preventati	ve	
					Maintenance Worksheet Log b		
						'y	
					the Maintenance Department.		
					The Maintenant D'		
					The Maintenance Direct	Of	
					will be re-educated on the		
					Preventative Maintenance Pro	gram	
					by the Executive		
					Director/designee by 10/13/22		
					· The Maintenance Direct	or	
					is responsible for compliance.		
					•		
					4. How the corrective		
					actions will be monitored:		
					· The Sprinkler Check Log	a is	
					part of the Preventative	9 10	
					-		
					Maintenance Manual. The		
					Administrator will review the		
					Preventative Maintenance Mar	nual	
					weekly for four weeks, and		
					monthly thereafter to ensure		
					compliance.		

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			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155653			COMPL 10/11/		
		100000	J		ADDRESS, CITY, STATE, ZIP COD	10/11/	
NAME OF I	PROVIDER OR SUPPLIEI	R			CCOOK AVE		
HARBOF	R HEALTH & REHA	В		EAST C	CHICAGO, IN 46312		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, and the second	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					The results of these aud will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliar is achieved. The QA Committ will identify any trends or patter and make recommendations to revise the plan of correction as indicated 5. Compliance Date: 10/13/22	or 6 nce ee erns	
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that in Nonrated protectivare permitted. Do fixed fire window are self-closing or require latching, as in the direction of provides a minimum for swinging or ho 19.3.7.6, 19.3.7.8 Based on observative failed to ensure 1 of would restrict the in 20 minutes. LSC 19 barriers shall comp 8.5.4.1 requires door		K 03	74	K374 NFPA 101 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER The facility requests paper compliance for this citation.	N	10/13/2022

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	OF CORRECTION	IDENTIFICATION NUMBER 155653	A. BUILDING <u>01</u> COMPI		COMPLETED 10/11/2022
	PROVIDER OR SUPPLIER		5025 N	ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE
		r operation. This deficient t as many as 35 residents, staff		This Plan of Correction is the center's credible allegation compliance.	
	10/11/22 at 12:05 p doors by resident ro completely leaving three separate occas the time of observat the smoke barrier de leaving a two-inch g fullest.	g a tour of the facility on .m., the set of smoke barrier om 203 did not close a two-inch gap when tested on sions. Based on interview at .ion, the Administrator agreed oors did not close completely gap when closed at their		Preparation and/or execution this plan of correction does constitute admission or agric by the provider of the truth of facts alleged or conclusions forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it required by the provisions of federal and state law. 1) Immediate actions that for those residents identify. There were no resident cited in regard to this regulated in regard to this regulated in regard to this regulated in regard to the provisions of the smoke barrier do near room 203 was inspect is closing properly. 2) How the facility identified other residents: Residents, staff, and visitors have the potential to affected by the alleged defining practice. All other smoke barried doors were assessed follow directly after survey and no issues were identified. 3) Measures put into place.	not eement of the s set or is of ken ied: ents ation. oor ed and o be cient er ring further

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
155653 B. WING					/2022		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					CCOOK AVE		
HARBOR HEALTH & REHAB				EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Smoke barrier door inspections are completed we and documented on the Preventative Maintenance Worksheet Log by the Maintenance Department. The Maintenance Direct will be re-educated on the Preventative Maintenance Proby the Administrator/designee 10/13/22. The Maintenance Direct is responsible for compliance. How the corrective actions will be monitored: The Smoke Barrier Door Inspection Log is part of the Preventative Maintenance Manual. The Administrator wireview the Preventative Maintenance Manual weekly four weeks, and monthly there to ensure compliance. The results of these aud will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliants achieved. The QA Committively and make recommendations to the preventation of the pattern of the pat	ekly tor gram by tor if or eafter dits or 6 nce eee	DATE
					revise the plan of correction as indicated		

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5) Date of compliance:

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155653	B. WI	NG		10/11/	2022	
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
					10/13/22			

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