		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/04/2024	
	PROVIDER OR SUPPLIER			5025 M	ADDRESS, CITY, STATE, ZIP COD CCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
E 0000 Bldg	conducted by the In accordance with 42  Survey Date: 09/04  Facility Number: 00  Provider Number: 1 1002  At this Emergency Health & Rehab wa Emergency Prepare Medicare and Mediand Suppliers, 42 Co.  The facility has 106 for Medicare and M survey, the census was accordance of the survey of the s	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.  Survey Date: 09/04/2024  Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410  At this Emergency Preparedness survey, Harbor Health & Rehab was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73  The facility has 106 beds which are dually certified for Medicare and Medicaid. At the time of the urvey, the census was 58.  Quality Review completed on 09/10/24		000			
E 0039 SS=F Bldg	Based on record reversal failed to provide confirst and second executes Emergency Prepare The LTC facility m (i) Participate in an is community-based a. When a communaccessible, conduct facility-based function. If the LTC facility	view and interview, the facility implete documentation for the ercises of choice to test the dness Plan (EPP). ust do the following: annual full-scale exercise that it; or ity-based exercise is not an annual individual,	E 00	)39	E039 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the	of on of not f	09/20/2024

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

(X6) DATE

TITLE

Craig Clemons Administrator 09/22/2024

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5YDM21 Facility ID: 000108 If continuation sheet Page 1 of 18

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155653	B. W	ING		09/04/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			CCOOK AVE		
HARBOF	R HEALTH & REHA	В			CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		lan, the LTC facility is exempt			statement of deficiencies. T	he .	
		ext required full-scale in a			plan of correction is prepare		
		or individual, facility-based			and/or executed solely beca		
	1	l exercise for 1 year following			it is required by the provisio		
	the onset of the actual event.				of federal and state law.		
	(ii) Conduct an additional exercise that may				1)Immediate actions taken for	or	
	include, but is not limited to the following:				those residents identified:	•	
	a. A second full-scale exercise that is				Maintenance Director		
	community-based or an individual, facility-based				participated in Full Scale		
	functional exercise.				Exercise on 5/21/2024. Ful		
	b. A mock disaster drill; or				Scale Exercise & After Action	n	
	c. A tabletop exercise or workshop that is led by a				Report was reviewed with ID		
	facilitator that includes a group discussion, using				and additional staff members		
		y-relevant emergency scenario,			on 9/16/2024. Facility is in	_	
		n statements, directed			compliance with emergency		
	_	red questions designed to			preparedness		
	challenge an emerg	-			Facility enacted emergency		
		CC facility's response to and			response plan to a real even	t	
		ation of all drills, tabletop			that occurred on 7/15/2024.	•	
		gency events, and revise the			Facility response and after		
		gency plan, as needed in			action report was reviewed		
		CFR 483.73(d)(2). This			with IDT and additional staff		
		ould affect all occupants.			members on 9/12/2024. Facil		
	1	•			is in compliance with	,	
	Findings include:				emergency preparedness.		
					2) How the facility identified		
	Based on record rev	view with the Maintenance			other residents:		
	Director on 09/04/2	4 between 09:08 a.m. and at			Staff, and residents that		
	12:07 p.m., docume	entation for a full-scale tornado			reside at the facility have the	)	
	_	within the past 12 months was			potential to be affected by th		
	_	the exercise did not include			alleged deficient practice.		
	l *	rt nor included all staff. The			3) Measures put into place/		
		sted of the Maintenance			System changes:		
	I	ore, no second exercise of			The Maintenance Director or		
		ast 12 months could be located			Designee will complete		
	_	Based on interview at the time			generator monthly 30 minute	es	
		e Maintenance Director			under load testing and will		
		ack of documentation and			document on the Preventativ	/e	
		ne facility is in the process of			Maintenance Worksheet. Th	-	
		vergise for a disaster in the	1		Maintonance Director will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155653	A. BUILL B. WING		<del></del>	09/04/2	
		133033				09/04/	2024
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
HARBOR	R HEALTH & REHAI	В		EAST CHICAGO, IN 46312			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION ne missing one, however he	T	AG			DATE
		e was lack of documentation.			re-educated on emergency preparedness requirements.		
	commined that there	was fack of documentation.			The Maintenance Director is		
	This finding was rev	viewed with the Maintenance			responsible for compliance.		
	-	ministrator during the exit			4 )How the corrective action	s	
	conference.				will be monitored:		
					The Administrator/Designee		
					will review the emergency		
					preparedness binder annuall	У	
					to ensure facility is in		
					compliance with emergency preparedness for full scale a	nd	
					tabletop exercises. The resul		
					of these audits will be		
					reviewed in Quality Assurance	ce	
					Meeting monthly until 100%		
					compliance is achieved. The		
					QA Committee will identify a	ny	
					trends or patterns and make		
					recommendations to revise t plan of correction as indicate	-	
E 0044	400 45( ) 400 70	/			plan of correction as indicate	iu.	
E 0041 SS=F		(e), 485.542(e), 485.62 LTC Emergency Power					
Bldg	Hospital CAH and	LTC Emergency Power					
Diag	Based on records re	view and interview, the facility	E 0041	1	E 041- Hospital CAH and LTC	;	09/20/2024
		the emergency power system			Emergency Power		07/20/2021
	-	in the Health Care Facilities			g ,		
	Code, NFPA 110, a	nd Life Safety Code in			The facility requests paper		
	accordance with 42	CFR 483.73(e)(2). This			compliance for this citation.		
	deficient practice co	ould affect all occupants.			This Plan of Correction is the		
					center's credible allegation of	)f	
	Findings include:				compliance.		
	Based on record rev	view with the Administrator			Preparation and/or execution this plan of correction does		
		irector on 09/04/24 between			constitute admission or	101	
		7 p.m., the generator lacked			agreement by the provider of	<sub>f</sub>	
		g required by LSC and NFPA			the truth of the facts alleged		
		view at the time of record			conclusions set forth in the		
	review, the Mainten	ance Director acknowledged			statement of deficiencies. The	he	

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

Event ID:

5YDM21 Facility ID: 000108

If continuation sheet Page 3 of 18

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ENT OF DEFICIENCIES  N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(x3) date survey completed 09/04/2024
	F PROVIDER OR SUPPLIE		5025 N	ADDRESS, CITY, STATE, ZIP COD MCCOOK 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)	(X5) COMPLETION DATE
	was unaware wher as that was before	entation and further stated he e the documentation could be his time at the facility.		plan of correction is prepare and/or executed solely becau it is required by the provision of federal and state law.	use
	_	viewed with the Administrator Director at the exit conference.		1) Immediate actions taker for those residents identified Facility unable to locate missing documentation.  Monthly generator load testing is occurring and documentation completed.  2) How the facility identified other residents  Visitors, staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.  2) Measures put into place System changes:  Maintenance Director will complete monthly load testing and will document and keep current log of testing. The Maintenance Director will be re-educated on the Preventative Maintenance Program.  The Maintenance Director is responsible for compliance.  4) How the corrective actions will be monitored:  The Administrator will reviet the Preventative Maintenance Worksheets monthly.  The results of these audits we be reviewed in Quality  Assurance Meeting monthly  6 months or until 100%	e g w e

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/04/2024	
	PROVIDER OR SUPPLIER		5025 M	ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
				compliance is achieved. QA Committee will identify trends or patterns and ma recommendations to revision of correction as indicated to the commendation of correction as indicated to the complex contraction as indicated to the complex correction as indicated to the correction as	y any ke se the
K 0000					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a)  Survey Date: 09/04.  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety 0 Rehab was found no Requirements for Po Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I	200108 55653 267410 Code Survey, Harbor Health & ot in compliance with	K 0000		
	(222) construction of facility has a fire also smoke detection in opened to the corridetectors are install rooms. The building diesel powered eme has 106 beds which	ity determined to be of Type II was fully sprinklered. The arm system with hard wired the corridors and in areas lors. Battery operated smoke ed in all resident sleeping g is partially protected by a ergency generator. The facility are dually certified for caid and a census of 58 at the			

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

Event ID:

5YDM21

Facility ID: 000108

08

If continuation sheet Page

Page 5 of 18

	AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COM		COMPL	ATE SURVEY OMPLETED 0/04/2024			
	ROVIDER OR SUPPLIER  CHEALTH & REHA			5025 M	CCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	тE	(X5) COMPLETION DATE
K 0300	were sprinklered. A services were sprinklered storage sheds.  Quality Review con	dents have customary access ll areas providing facility clered except two detached upleted on 09/10/24					
K 0300 SS=E Bldg. 01	failed to ensure 1 of smoke alarms instal were not over ten you NFPA 72. NFPA 72 states unless otherwing manufacturer's publimultiple-station smowhen they fail to reshall not remain in a from the date of ma practice could affect and staff.  Findings include:  Based on observation Director on 09/04/2 from 12:16 p.m. to documentation affix smoke alarm install sleeping room 217 respectively. Based observation, the Ma aforementioned smoold and further states.	on and interview, the facility Fover 30 battery operated led in resident sleeping rooms ears old in accordance with 2, 2010 Edition, Section 14.4.8.1 rise recommended by the ished instructions, single- and oke alarms shall be replaced spond to operability tests but service longer than 10 years nufacture. This deficient t approximately 20 residents  ons with the Maintenance 4 during a tour of the facility 1:32 p.m., manufacturer's ted to the battery operated ed above the door in resident was listed as 05/23/2006 on interview at the time of intenance Director agreed the oke alarm was over 10 years and he was aware of two other in were the same type.	K 0	300	K 300 The facility requests paper compliance for this citation.  This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaute it is required by the provision of federal and state law.  1) Immediate actions taken for those residents identified the maintenance director completed audit & testing all battery operated smoke detectors in facility. 3 smoked detectors were replaced as they exceeded 10 year	of n of not f or the ed use ns	09/20/2024
	This finding were re	eviewed with the Administrator			manufacture date. 2) How the facility identified.		

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

Event ID:

5YDM21 Facility ID: 000108

If continuation sheet Page 6 of 18

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 09/04/2024	
	PROVIDER OR SUPPLIER R HEALTH & REHAB	5025 M	ADDRESS, CITY, STATE, ZIP COD ICCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  and Maintenance Director during the exit  conference.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)  other residents  Visitors, staff, and residents that reside at the facility have	DATE	
K 0324	3.1-19(b) NFPA 101		the potential to be affected by the alleged deficient practice.  2) Measures put into place System changes: Maintenance Director will complete quarterly inspection and will document and keep current log of inspections. A battery operated smoke detector that fail operability tests or exceeds 10 year manufacture date will be immediately replaced. The Maintenance Director will be re-educated on the Preventative Maintenance Program.  The Maintenance Director is responsible for compliance.  4) How the corrective actions will be monitored: Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assuran Meeting monthly for 6 mont or until 100% compliance is achieved. The QA Committe will identify any trends or patterns and make recommendations to revise plan of correction as indicated.	de/ ons Any  s  file e  the  the  the  the  the	
SS=F	NFPA 101 Cooking Facilities				

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

Event ID:

5YDM21

Facility ID: 000108

If continuation sheet

Page 7 of 18

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPL	ETED
		155653	B. WI	NG		09/04/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			5025 M	CCOOK AVE		
HARBOR	HEALTH & REHA	3		EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01							
		riew, observation and	K 0	324	K 324		09/20/2024
	·	ty failed to ensure 1 of 1			The facility requests paper		
		sion system was inspected			compliance for this citation.		
	semiannually. NFPA 96, 2011 Edition, Standard for				This Plan of Correction is th		
	Ventilation Control and Fire Protection of				center's credible allegation of	f	
	Commercial Cooking Operations, Section 11.2.1				compliance.		
	states Maintenance of the fire-extinguishing				Preparation and/or execution		
	•	xhaust hoods containing a			this plan of correction does i	not	
		vated water system that is			constitute admission or		
	listed to extinguish a fire in the grease removal				agreement by the provider of		
	devices. Hood exhaust plenums, and the exhaust				the truth of the facts alleged	or	
	ducts shall be made by properly trained, qualified,				conclusions set forth in the		
	and certified person(s) acceptable to the authority				statement of deficiencies. The		
		at lease every six months. This			plan of correction is prepare		
	-	ould affect staff in the kitchen		and/or executed solely because			
		15 residents who use the			it is required by the provision	ns	
	adjoining dining roo	om.			of federal and state law.		
	E. 1 1 1				1) Immediate actions take		
	Findings include:				for those residents identified	:	
	D 1 1	to the desired to			Facility unable to locate		
		riew with the Maintenance			missing documentation.	.	
		histrator on 09/04/24 between			Contracted vendor conducte	a	
		7 p.m., the only documentation			repairs and inspection on		
		en suppression system			kitchen fire suppression syst		
	_	for review was dated documentation could be			on 9/3/24. Kitchen fire systen		
		e the system has been			has been inspected and is in		
	-	s after 08/29/23. Based on			compliance.		
	_	e of record review, the			2) How the facility identified other residents		
		or acknowledged the lack of				4.	
		further stated that the kitchen			Staff, and residents that residents	Je	
		had been inspected the night			at the facility have the	_	
		nentation had been missing to			potential to be affected by the alleged deficient practice.	-	
	-	suppression system had been			2) Measures put into place	,	
	inspected semiannua				System changes:	'	
	mopeoco somaniu				Maintenance Director will		
	The finding was dis-	cussed with the Maintenance			ensure that kitchen fire		
	-	istrator at exit conference.			suppression is inspected		
	Director and Admini	institutor at Cart Comprehence.			semi-annually and that recor	de	
			1		i sonii-annuany and machecur	uJ	

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

Event ID:

5YDM21 Facility ID: 000108

If continuation sheet Page 8 of 18

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ľ í	(x2) multiple construction  a. building 01			(X3) DATE SURVEY COMPLETED	
		155653	B. WI	NG		09/04/2	2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0353 SS=F Bldg. 01	3.1-19(b)  NFPA 101 Sprinkler System	· Maintenance and Testing			of inspections are completed and retained. The Maintenand Director will be re-educated of the Preventative Maintenance Program. The Maintenance Director is responsible for compliance.  4) How the corrective actions will be monitored: The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 month or until 100% compliance is achieved. The QA Committe will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	ce on e w e ce is e		
Diag. 01	failed to maintain 1 systems in accordar requires all sprinkle tested, and maintain 25, Standard for the Maintenance of Wa Systems. NFPA 25 states the property or representative shall or impairments that inspection, test and standard. Correctio performed by qualif	riew and interview, the facility of 1 automatic sprinkler use with NFPA 25. LSC 9.7.5 or systems shall be inspected, used in accordance with NFPA Inspection, Testing, and ter-Based Fire Protection, 2011 Edition, Section 4.1.4.1 owner or designated correct or repair deficiencies are found during the maintenance required by this use and repairs shall be used maintenance personnel or or. NFPA 25, 4.3.1 requires	K 03	353	K353 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. To plan of correction is prepare and/or executed solely because.	of n of not f or he	09/20/2024	

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

Event ID:

5YDM21

Facility ID: 000108

If continuation sheet

Page 9 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/04/2024	
NAME OF I	PROVIDER OR SUPPLIEF	R	-		ADDRESS, CITY, STATE, ZIP COD		
HARBOF	R HEALTH & REHA	В		5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
		de for all inspections, tests,			it is required by the provision	ns	
		f the system components and			of federal and state law.		
		able to the authority having			1) Immediate actions take		
	jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.  Findings include:				for those residents identified	l:	
					Sprinkler system inspection		
					documentation obtained		
					indicating type of antifreeze		
					sprinkler system. Facility ha	S	
					contracted with vendor to		
	Based on record review of with Maintenance Director on 02/13/19 between 09:08 a.m. to 12:17 p.m., the annual sprinkler report dated 07/16/24 under the deficiencies section on page one of the				perform 5-year internal inspection that includes		
					replacement of antifreeze.		
					2) How the facility identified		
	report; indicated that "tested at the interface (-10)				other residents		
	glycerine and (-47) glycol. No signs or placards				Staff, visitors, and residents		
	1	solution in question is a			that reside at the facility hav		
	_	ition." Also, the report			the potential to be affected by		
		records onsite indicating that			the alleged deficient practice	-	
		stion is a factory premix			2) Measures put into place		
	_	and recharging with the proper			System changes:		
	"listed" solution and	d add signs and placards."			Maintenance Director will		
	Based on interview	at the time of record review,			ensure that sprinkler syster	n is	
		irector acknowledged the			inspected, tested, and		
	*	I further stated that the work			maintained. Records will be		
		pleted by the time of the			completed, maintained, and		
	_	ey could not provide			made readily available. The		
	documentation duri	ing the time of the survey.			Maintenance Director will be		
					re-educated on the		
		scussed with the Maintenance			Preventative Maintenance		
	Director and Admii	nistrator at exit conference.			Program. The Maintenance		
	2.1.10(1.)				Director is responsible for		
	3.1-19(b)				compliance.		
					4) How the corrective		
					actions will be monitored: The Administrator will revie		
					the Preventative Maintenance	C	
					Worksheets monthly. The results of these audits will b	•	
					reviewed in Quality Assuran		
					Meeting monthly for 6 month		
	1		i i				I

OF 1 TO 1	TO OF PERIODS	TALL DE CLARE GLESS AND	G. T. C. T	THE STREET STREET	ON LOTTING TO A LO	(T/2) 5 : 5=	CLIDATEN
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì ′		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155653	B. W	ING		09/04	/2024
				CTDEET	ADDRESS CITY STATE ZIB COD	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
114000		В					
HAKBOF	R HEALTH & REHA	ND		EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	\TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\L	DATE
					or until 100% compliance is		
					achieved. The QA Committee	e	
					will identify any trends or		
					patterns and make		
					recommendations to revise	the	
					plan of correction as indicat		
						ou.	
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01							
J	1. Based on observ	ation and interview, the facility	K 0	363	K363		09/20/2024
		of 30 resident room corridor	100	303	The facility requests paper		09/20/2021
	doors on the second	d floor was provided with a			compliance for this citation.		
		keeping the door closed, had			compliance for the citation.		
		closing, latching and would			This Plan of Correction is the	1	
	-	of smoke. This deficient			center's credible allegation of		
		ct approximately three residents			compliance.		
	and staff.	et approximately unce residents			Compliance.		
	ana starr.						
	Findings include:						
	i manigs metade.				Preparation and/or execution	of	
	Rased on observati	on with the Maintenance			this plan of correction does no		
		24 between 09:08 a.m. and 12:07			1		
		loor to resident room 210			constitute admission or agree		
	-	me, however the door took			by the provider of the truth of facts alleged or conclusions s		
					_	eı	
		inally properly latch. After			forth in the statement of		
		ain after it latched, the door			deficiencies. The plan of		
		hing. Based on interview at the			correction is prepared and/or		
		n, the Maintenance Director			executed solely because it is		
		door had issues latching and			required by the provisions of		
	would try and fix the	he latching hardware.			federal and state law.		
	TE1 (* 1'						
		viewed with the Administrator					
		ce Director during the exit					
	conference.				1)Immediate actions taken for	-	
					those residents identified:		
	3.1-19(b)						
					The corridor door to resident		
		ation and interview, the facility			210 was adjusted to ensure p	roper	
	failed to ensure 2 o	of 2 doors to the corridor from			closure.		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155653	r í	JILDING	onstruction 01	(X3) DATE COMPL 09/04/	ETED
	PROVIDER OR SUPPLIEF			5025 M	ADDRESS, CITY, STATE, ZIP COD CCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
	room would comple smoke. Doors prote other than required openings, exits, or l passage of smoke a solid-bonded core v of resisiting fire for fully sprinklered sn	rk office and 2nd floor med etely resist the passage of cting corridor openings in enclosures of vertical nazardous areas resist the nd are made of 1 3/4 inch wood or other material capable at least 20 minutes. Doors in noke compartments are only e passage of smoke. Corridor			Penetrations in doors were se for MDS/Social Services office 2nd floor med room  2) How the facility identified oresidents:  Staff, and residents that reside the facility have the potential to	and ther	
	doors and doors to a combustible materi- hardware. Roller la regulation. These re auxiliary spaces tha combustible materi-	rooms containing flammable or als have positive latching teches are prohibited by CMS equirements do not apply to at do not contain flammable or al. Clearance between bottom overing is not exceeding 1 inch.			affected by the alleged deficie practice.  3) Measures put into place/ System changes:		
	Powered doors compermissible if provikeeping the door clapplied. There is not the doors. Hold ope the door is pushed a Nonrated protective are permitted. Dutc	aplying with 7.2.1.9 are ded with a device capable of osed when a force of 5 lbf is impediment for the closing of on devices that release when or pulled are permitted. e plates of unlimited height h doors meeting 19.3.6.3.6 are mes shall be labeled and made			The Maintenance Director or Designee will complete month visual inspection of doors to ensure proper operation and t there is no penetration. Findin will be documented on the Preventative Maintenance Worksheet. The Maintenance	hat gs	
	of steel or other ma unless the smoke co Fixed fire window a In sprinklered comp restrictions in area flames in window a	terials in compliance with 8.3, ompartment is sprinklered. assemblies are allowed per 8.3. partments there are no or fire resistance of glass or ssemblies. This deficient approximately 40 residents,			Director will be re-educated or Preventative Maintenance Proby the Administrator /designed  The Maintenance Director is responsible for compliance.  4)How the corrective actions	gram e.	
	p.m. and 1:32 p.m.	on on 09/04/24 between 12:16 during a tour of the facility with rector, the MDS/Social Service			be monitored:  The Administrator will review t Preventative Maintenance Worksheets monthly.	he	

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

Event ID:

5YDM21 Facility ID: 000108

If continuation sheet Page 12 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X:		X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CC			COMPL	COMPLETED	
155653		155653	B. WING			09/04/	09/04/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					CCOOK 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 REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG				TAG			DATE	
	office located on the first floor contained a circular				The results of these audits will			
	door penetration that was approximately 1/4" in				reviewed in Quality Assurance			
	diameter. Furthermore, the 2nd floor med room,				Meeting monthly for 6 months	or		
		esk, the door to the room			until 100% compliance is	•11		
		on shaped penetration above			achieved. The QA Committee			
		suring approximately 1/4".			identify any trends or patterns			
	Based on interview at the time of observations,				make recommendations to rev the plan of correction as indica			
	the Maintenance Director confirmed that the				the plan of correction as indica	itea.		
	doors contained penetrations and would get those taken care of.							
	those taken care of.							
	The finding was reviewed with the Maintenance							
	Director and Administrator at exit conference.							
	3.1-19(b)							
K 0741	NFPA 101							
SS=E	Smoking Regulation	ons						
Bldg. 01								
		on and interview; the facility	K 0	741	K741		09/20/2024	
	failed to ensure 1 of 1 smoking areas were				The facility requests paper			
	maintained by disposing cigarette butts in a metal				compliance for this citation.			
	or noncombustible container with self-closing				This Plan of Correction is th			
	cover devices. This deficient practice could affect				center's credible allegation o	)†		
	approximately 5 staff and an unknown number of residents.				compliance.			
					Preparation and/or execution			
	Findings include:  Based on observation during a tour of the facility				this plan of correction does i	ΙΟΙ		
					constitute admission or	F		
					agreement by the provider of the truth of the facts alleged			
	with the Maintenance Director on 09/04/24				conclusions set forth in the	OI .		
		and 12:07 p.m., in the staff			statement of deficiencies. The	he		
		-			plan of correction is prepare			
	smoking area on the first floor, approximately 20 cigarette butts were discovered on the ground,				and/or executed solely becau			
	improperly discarded, around the smoking area in				it is required by the provision			
	the grass. Based on interview at the time of				of federal and state law.			
	_	intenance Director confirmed			Immediate actions take	n		
	·	tts were not properly			for those residents identified			
	-	d get that taken care of.			Cigarette butts were cleaned			
					and properly discarded in			

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

Event ID:

5YDM21 Facility ID: 000108

If continuation sheet Page 13 of 18

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		ľ í	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/04/2024	
		B. WING	<u> </u>		
NAME OF			STR 502	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROV	09/04/2024  (X5) COMPLETION DATE  ed  ints ave d by cice. ace/
K 0761 SS=F Bldg. 01		pection & Testing - Doors		weekly for 6 months to en that cigarette butts are discarded properly into the noncombustible container is provided in the smoking area.  4) How the corrective actions will be monitored: The Administrator will revented the Preventative Maintena Worksheets monthly. The results of these audits will reviewed in Quality Assur Meeting monthly for 6 moor until 100% compliance achieved. The QA Commi will identify any trends or patterns and make recommendations to revisible plan of correction as indicated.	r that g view unce I be ance nths is ittee
	interview, the facil inspection and test assemblies in two	on, records review, and ity failed to ensure annual ing of 4 of 4 fire door stairwells were completed in 19.1.1.4.1.1 communicating	K 0761	K761 The facility requests pape compliance for this citation This Plan of Correction is center's credible allegation	on. s the

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

Event ID:

5YDM21 Facility ID: 000108

If continuation sheet

Page 14 of 18

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/04/2024			
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
TAG	openings in dividing 19.1.1.4.1 shall be protected by door assemblies. (S. 8.3.3.1 Openings researched by Table 8.3. approved, listed, late fire window assembly hardware, including anchorage, and sills requirements of NF and Other Opening otherwise specified states fire door asset tested not less than of the inspection by the A door assemblies shall both sides to assess assembly. NFPA 80 the following items (1) No open holes of either the door or from the door, frame noncombustible throad in working orded damage.  (4) No parts are missed in 4.8.4 and 6.0 The self-closing the active door comfrom the full open processes before the accordinator closes before the accordinator closes before the accordinator.	g fire barriers required by permitted only in corridors and y approved self-closing fire ee also Section 8.3.) LSC quired to have a fire protection 4.2 shall be protected by peled fire door assemblies and olies and their accompanying g all frames, closing devices, in accordance with the PA 80, Standard for Fire Doors Protectives, except as in this Code. NFPA 80 5.2.1 mblies shall be inspected and annually, and a written record all be signed and kept for HJ. NFPA 80, 5.2.4.1 states fire all be visually inspected from the overall condition of door 10, 5.2.4.2 states as a minimum, shall be verified: r breaks exist in surfaces of ame. Bight frames, and glazing beads ely fastened in place, if so 1.5. single of the signs of 1.5. device is operational; that is, pletely closes when operated to sition. In the secure of the situation of the signs of 1.5. single of the situation of the signs of 1.5. single of the situation of the signs of 1.5. single of 1.5. sing	TAG	compliance.  Preparation and/or executive this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. In plan of correction is preparation and/or executed solely become it is required by the provision of federal and state law.  1) Immediate actions taken the those residents identified: 4 missing fire door inspect were completed. Fire door inspection currently in compliance. 2) How the facility identified other residents: Staff, visitors and residents that reside at the facility has the potential to be affected the alleged deficient practical.  3) Measures put into place/System changes: The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator/designee The Maintenance Director is responsible for compliance.	on of snot of dor The ed ause ons of or ions of six or ions or		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION				JILDING	01	COMPLETED		
155653			B. W	B. WING 09/			/2024	
NAME OF	DDOVIDED OF GUIDN TEX			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				5025 M	CCOOK 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 APPROPRIA DEFICIENCY)	ATE	COMPLETION	
IAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION  (9) Auxiliary hardware items that interfere or			TAG			DATE	
	•	are not installed on the door or			4)How the corrective actions will be monitored:	5		
	frame.	are not histaired on the door of			The Administrator will revie			
		fications to the door assembly			the Preventative Maintenance			
	1 1	ed that void the label.			worksheets annually.	· <b>C</b>		
	_	edge seals, where required, are			The results of these audits v	vill		
		their presence and integrity.			be reviewed in Quality	<b>*</b>		
		ice could affect all residents.			Assurance Meeting monthly	for		
					6 months or until 100%			
	Findings include:				compliance is achieved. The			
					QA Committee will identify a			
	Based on record rev	view with the Administrator			trends or patterns and make			
	and Maintenance D	firector on 09/04/24 between			recommendations to revise	the		
	09:08 a.m. and 12:07 p.m., documentation had been				plan of correction as indicat	ed.		
	_	that annual fire door						
	_	en completed in June of 2024,						
		or inspections were missing						
		ll doors. Based on observation						
	_	facility, the facility contained						
		a total of four fire doors. Based						
		time of observation and record						
		nance Director confirmed that						
		s were missing and further						
		visually check them everyday						
		n, however he does not						
	document the inspe	ctions on an annual basis.						
	The finding was dis	scussed with the Administrator						
		birector at exit conference.						
	and Mannenaerie D	nector at Cart conference.						
	3.1-19(b)							
K 0918	NFPA 101							
SS=F Bldg. 01		s - Essential Electric Syste						
	Based on record rev	view and interview, the facility	K 0	918	K918		09/20/2024	
		complete written record of		,10	The facility requests paper		07/20/2027	
		load testing for 5 of the last 12			compliance for this citation.			
		4.4.1.1.4(a) of 2012 NFPA 99			This Plan of Correction is the	ne		
		sting of the generator serving			center's credible allegation			

PRINTED: 09/25/2024 FORM APPROVED

CENTERS FO	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155653  NAME OF PROVIDER OR SUPPLIER  HARBOR HEALTH & REHAB			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/04/2024	
			5025 M EAST (	ADDRESS, CITY, STATE, ZIP COD MCCOOK 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	the emergency electric accordance with N Emergency and State 8. NFPA 110 8.4.2 service to be exercised in the service to be exercised in the service and service as written performance, exercised in the service and service as written performance, exercised in the service and service was a service	ctrical system to be in FPA 110, the Standard for andby Powers Systems, Chapter requires diesel generator sets in ised at least once monthly, for a nutes. Chapter 6.4.4.2 of NFPA en record of inspection, cising period, and repairs for the ularly maintained and available the authority having leficient practice could affect all view with the Maintenance 24 between 09:08 a.m. and 12:07 ation for the months of grough January 2024 were we to show the diesel generator exercised under load at least a minimum of 30 minutes. Based the time of record review, the stor confirmed that the serior confirmed that the serior shad been completed.  Eviewed with the Administrator Director during the exit		compliance.  Preparation and/or execution this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.  1) Immediate actions taken for those residents identified: Facility unable to locate documentation from September through January 2024. Generator load testing being completed monthly and in compliance with documentation post January 2024.  2) How the facility identified other residents: Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.  3) Measures put into place/System changes: The Maintenance Director or Designee will complete generator monthly 30 minute under load testing and will	n of not  f or he d use ns or  d	
				document on the Preventativ	e	

re-educated on the

**Maintenance Worksheet. The** Maintenance Director will be

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/25/2024
FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
155653		B. WING			09/04/2024		
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTH & REHAB				5025 M EAST C	ADDRESS, CITY, STATE, ZIP COD CCOOK AVE CHICAGO, IN 46312		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Preventative Maintenance		
					Program by the Administrato	r	
					/designee.		
					The Maintenance Director is		
					responsible for compliance.		
					4 )How the corrective actions will be monitored: The Administrator will review the Preventative Maintenance worksheets monthly. 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	v e e s	
					recommendations to revise the	he	

plan of correction as indicated.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5YDM21 Facility ID: 000108 If continuation sheet Page 18 of 18