| 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 | 10/09/2024 |

| 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 |
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| E 0000<br><br>Bldg. -- | A Post Survey Revisit (PSR) for the Emergency Prepardness Survey that exited on 09/04/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73<br><br>Survey Date: 10/09/2024<br><br>Facility Number: 000108<br>Provider Number: 155653<br>AIM Number: 100267410<br><br>At this Emergency Preparedness PSR, Harbor Health & Rehab was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 106 beds which are dually certified for Medicare and Medicaid. At the time of the survey, the census was 61.<br><br>Quality Review completed on 10/15/24 | E 0000 | | |
| K 0000<br><br>Bldg. 01 | A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/04/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).<br><br>Survey Date: 10/09/2024<br><br>Facility Number: 000108<br>Provider Number: 155653<br>AIM Number: 100267410 | K 0000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Craig Clemons | Administrator | 10/31/2024 |

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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| | 155653 | A. BUILDING 01<br>B. WING | 10/09/2024 |

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| | At this Life Safety Code PSR, 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<br><br>This two story facility determined to be of Type II (222) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in areas opened to the corridors. Battery operated smoke detectors are installed in all resident sleeping rooms. The building is partially protected by a diesel powered emergency generator. The facility has 106 beds which are dually certified for Medicare and Medicaid and a census of 61 at the time of this survey<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage sheds.<br><br>Quality Review completed on 10/15/24 | | | |
| K 0324<br>SS=E<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br><br>Based on record review and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated | K 0324 | **The facility requests paper compliance for this citation.**<br>*This Plan of Correction is the center's credible allegation of compliance.*<br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement* | 10/28/2024 |

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| | water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and approximately 15 residents who use the adjoining dining room.<br><br>Findings include:<br><br>Based on record review with the Maintenance Director on 10/09/24 between 11:49 a.m. and 12:28 p.m., the only documentation of semiannual kitchen suppression system inspection available for review was dated 08/29/23. No other documentation could be presented to indicate the system has been inspected six months after 08/29/23. During record review, an invoice for work completed was given to the surveyor. The work indicated that multiple items had been repaired/service for the kitchen suppression system. However, the invoice was not an inspection report. Based on interview at the time of record review, the Maintenance Director stated that the day before the first survey, the kitchen suppression inspection company came in and did repairs, so the company never completed any inspections since 2023. Furthermore, he was unaware if the inspection company created an inspection report when they did the work in the previous month. He acknowledged the lack of documentation presented at the time of the revisit.<br><br>The finding was discussed with the Maintenance Director at the exit conference. This deficiency was cited on 09/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. | | *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.*<br>**1) Immediate actions taken for those residents identified:**<br>Facility unable to locate missing documentation. Semi-annual fire suppression system inspection was completed on 9/3/24. Kitchen fire system has been inspected and is in compliance.<br>**2) How the facility identified other residents**<br>Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.<br>**2) Measures put into place/ System changes:**<br>Maintenance Director will ensure that kitchen fire suppression is inspected semi-annually and that records of inspections are completed and retained. The Maintenance Director was educated on the Preventative Maintenance Program. The Maintenance Director is responsible for compliance.<br>**4) How the corrective actions will be monitored:**<br>The Administrator will review the Preventative Maintenance Worksheets 2x monthly. The results of these audits will be | |

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| | 3.1-19(b) | | 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. | |
| K 0353 SS=F Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.<br><br>Findings include:<br><br>Based on record review of with Maintenance Director on 10/09/24 between 11:49 a.m. to 12:28 p.m., the annual sprinkler report dated 07/16/24 under the deficiencies section on page one of the | K 0353 | **The facility requests paper compliance for this citation.**<br>***This Plan of Correction is the center's credible allegation of compliance.***<br>*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.*<br>**1) Immediate actions taken for those residents identified:**<br>Sprinkler system inspection documentation obtained indicating type of antifreeze in sprinkler system. Facility has contracted with vendor to perform 5-year internal inspection that includes replacement of antifreeze. Work scheduled to begin on November 8th 2024.<br>**2) How the facility identified** | 11/08/2024 |

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| | report; indicated that "tested at the interface (-10) glycerine and (-47) glycol. No signs or placards indicating that the solution in question is a factory premix solution." Also, the report indicated that "No records onsite indicating that the solution in question is a factory premix solution. Recommend recharging with the proper "listed" solution and add signs and placards." During record review, documentation of a quote from the sprinkler inspection company was provided which was dated 08/22/24. Based on interview at the time of record review, the Maintenance Director confirmed that the work has not been completed yet as they were waiting for the approval to pay for the work. At the time of the survey, the Maintenance Director stated that parts had been ordered and payment had been completed, however there was not a designated time as to when the repairs were supposed to be completed.<br><br>The finding was discussed with the Maintenance Director and Administrator at the exit conference. This deficiency was cited on 09/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-19(b) | | **other residents**<br>Staff, visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.<br>**2) Measures put into place/ System changes:**<br>Maintenance Director will ensure that sprinkler system is inspected, tested, and maintained. Records will be completed, maintained, and made readily available. The Maintenance Director was educated on the Preventative Maintenance Program. The Maintenance Director is responsible for compliance.<br>**4) How the corrective actions will be monitored:**<br>The Administrator will review the Preventative Maintenance Worksheets 2x 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 recommendations to revise the plan of correction as indicated. | |