STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155269		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/27/2025	
NAME OF P	PROVIDER OR SUPPLIEF	<u>. </u>		ADDRESS, CITY, STATE, ZIP COD	•
EAST LA	KE NURSING & RE	EHABILITATION CENTER		EANWOOD DR RT, IN 46514	
(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)	(X5) COMPLETION DATE
E 0000	REGULATORT OF	CESC IDENTIFY TING INFORMATION	IAG		DATE
Bldg	conducted by the Irraccordance with 42 Survey Date: 02/27 Facility Number: 00 Provider Number: 1002 At this Emergency Lake Nursing and Fcompliance with Erracquirements for Marticipating Provides 483.73. The facility has a care	/2025 00169 .55269	E 0000		
	Quality Review cor	npleted on 02/28/25			
K 0000					
Bldg. 01	Licensure Survey w Department of Head 483.90(a). Survey Date: 02/27 Facility Number: 00 Provider Number: 1	00169 55269	K 0000		
	At this Life Safety	Code survey, East Lake			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

McKenzie Hojara **Executive Director** 03/13/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8XHB21 Facility ID: 000169 If continuation sheet Page 1 of 19

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/27/2025
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1900 J	ADDRESS, CITY, STATE, ZIP COD EANWOOD DR ART, IN 46514	
(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)	(X5) COMPLETION DATE
K 0281	compliance with Re Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (I Health Care Occupation This one-story facil Type V (111) const sprinklered. The fasystem with hard-wedge corridors, areas open hardwired smoke do The facility has a casensus of 101 at the All areas where the access were sprinkle facility services were	dilitation was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. A sty was determined to be of ruction and was fully etility has a monitored fire alarm ire smoke detection in the n to the corridors and etectors in the resident rooms. Apacity of 152 and had a time of this survey. The residents have customary ered. All areas providing re sprinklered. A style of 102/28/25			
SS=E Bldg. 01	Illumination of Me	ans of Egress			
	facility failed to ens lighting for 1 of 9 e requirement, exit di designated stairs, ai escalators, walkway leading to a public could affect residen hall. Findings include: Based on observation	ration and interview, the sure continuity of egress xits. For the purposes of this scharge shall include only sles, corridors, ramps, vs and exit passageways way. This deficient practice tts, staff and visitors in the 500 on and interview with the Administrator-In-Training, and	K 0281	It is the practice of the facility to ensure continuity of egress lighting for exits. The exit discharge sidewalk leading to public way from the 500 hall he exit lighting added to ensure adequate illumination. Egress lighting of the identified of exit include multiple lights per sign All residents, staff and visitors the 500 hall have the potential be affected by this deficient practice. A facility audit will be conducted on exit discharge	the ad to in to

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet

Page 2 of 19

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	UILDING	onstruction 01	(X3) DATE COMPL 02/27 /	ETED
PROVIDER OR SUPPLIER	EHABILITATION CENTER	1900 JE	ADDRESS, CITY, STATE, ZIP COD EANWOOD DR RT, IN 46514		
SUMMARY (EACH DEFICIENT REGULATORY OF The Maintenance Dip.m. on 02/27/25, the leading to a public single egress light a and again at the exit based on interview Maintenance Direct approximately 80 fth Based on interview Maintenance Direct were on generator and the dilluminate of the did not illuminate the sexification of the	STATEMENT OF DEFICIENCIE STATEMENT OF DEFIC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) lighting to ensure adequate illumination on or before 3/27/3 A facility audit was conducted ensure egress lighting sign ha multiple lights. Maintenance Director/designe will complete a facility wide au on or before 3/27/25 to ensure other exit lighting pathways are improperly illuminated and exit signs are appropriately illuminated. All staff to be in-service on adequate exterior lighting on pathways on or beformation on pathways on or beformation on pathways on or beformation on pathways on the surface of the facility Quality. Assurance and Performance Improvement Program (QAPI) The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety Coweekly for 4 weeks, monthly for months and quarterly thereafte at least 2 quarters. If the thres	25. to s e dit no e i r ore	(X5) COMPLETION DATE
Executive Director, the Maintenance Dip.m. on 02/27/25, the 500 hall exit, w fixture with only or acknowledged by the of each observ. These findings were	Administrator-In-Training, and irector from 11:47 a.m. to 2:45 the exit means of egress outside as equipped with one light the bulb. This was the Maintenance Director at the ration. The reviewed with the Executive rator-In-Training, and the tor		of 90% is not met, an action pl will be developed. Findings wil submitted to the QAPI Commit for review and follow up.	l be	

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 3 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155269		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/27/2025		
	OVIDER OR SUPPLIER	EHABILITATION CENTER	<u> </u>	1900 JE	ADDRESS, CITY, STATE, ZIP COD EANWOOD DR RT, IN 46514		
(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 0293 SS=E Bldg. 01	3.1-19(b) NFPA 101 Exit Signage Based on observation failed to install exit	on and interview; the facility signage in the 2 corridors and in the facility in accordance	K 02	293	It is the practice of the facility to ensure exit and directional siguare displayed in accordance w	ns	03/27/2025
	with LSC 7.10. LSC exterior exit doors the identifiable as exits, approved sign that is direction of exit acchorizontal compone an exit enclosure shor directional exit sit the egress path is not states any door, passeneither an exit nor a located or arranged mistaken for an exit that reads as follows sign shall have the whigh, with a stroke word EXIT below this an approved exist practice could affect in 2 of 7 smoke companies. Based on observation Executive Director, the Maintenance Dip.m. on 02/27/25, 1.) the corridor exit	2.7.10.1.2.1 exits, other than main hat obviously and clearly are shall be marked by an seradily visible from any ess. LSC 7.10.1.2.2 states into the egress path within all be marked by approved exit gns where the continuation of to obvious. LSC 7.10.8.3.1 stage, or stairway that is away of exit access and that is so that it is likely to be shall be identified by a sign so that it is likely			are displayed in accordance with 7.10 with continuous illuminatinals also served by the emergency lighting system. Exit signage wadded to the corridor exit near vending machines. Exit signage was added to the corridor betwithe corridor smoke barrier doo and the unit corridor separatio doors, between rooms 101 and 102. The door leading from the memory care unit to an enclose courtyard had signage added indicating no exit. All residents, staff and visitors the facility have the potential to affected by this deficient pract. A facility audit will be conducted on or before 3/27/25 to ensure proper exit signage is present. Maintenance Director/designe will complete a facility audit to ensure proper exit signage on or be 3/27/25. Ongoing compliance with this corrective action will be monitor through the facility Quality Assurance and Performance Improvement Program (QAPI)	on vas the ge veen rs n d e ed in o be ice. ed e	

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 4 of 19

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	(X2) MUI A. BUII B. WIN	LDING	<u>01</u> COMI		survey eted 2025
	ROVIDER OR SUPPLIER KE NURSING & RE	EHABILITATION CENTER		1900 JE	DDRESS, CITY, STATE, ZIP COD ANWOOD DR RT, IN 46514		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	between rooms 101 unit had no exit sign 3.) the door leading an enclosed courtya NO EXIT. Based on interview Maintenance Direct confirmed that the p and contained no ex exits and no signage memory care unit d was not an exit. This finding was re-	from the memory care unit to and had no signage indicating at the time of observation, the for acknowledged and both of egress was not obvious at signage for the 2 corridor to indicating the door from the ining room to the courtyard wiewed with the Executive ator-In-Training, and the for			Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety Coweekly for 4 weeks, monthly for months and quarterly thereafte at least 2 quarters. If the threst of 90% is not met, an action plwill be developed. Findings will submitted to the QAPI Commit for review and follow up.	or 6 er for nold an I be	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities						
	facility failed to ma extinguishing syster 96, Standard for Ve Commercial Cookin states A readily acce activation shall be le in. above the floor, fire, be located in a identify the hazard p 101, Life Safety Co life safety features of required by the code	ration and interview, the intain 1 of 1 kitchen m in accordance with NFPA ntilation and Fire Protection of a Operations, Section 10.5.1 essible means for manual ocated between 42 in. and 48 be accessible in the event of a path of egress, and clearly protected. Additionally, NFPA de, 4.6.12.3 states that existing obvious to the public, if not e, shall be either maintained or scient practice could affect	K 032	24	It is the practice of the facility to maintain the kitchen extinguish system. The pull station was moved to a height between 42 and 48 in. The kitchen range hozzle was moved to be proper positioned. All kitchen staff have the potent to be affected by this deficient practice. A facility audit will be conducted on or before 3/27/2 ensure pull stations are proper maintained and kitchen range hood nozzles are properly positioned. The Maintenance	ing in ood rly tial	03/27/2025

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 5 of 19

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

PRINTED: 03/14/2025 FORM APPROVED OMB NO. 0938-039

	EMENT OF DEFICIENCI LAN OF CORRECTION	ES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2025
	E OF PROVIDER OR SUP T LAKE NURSING	PLIER & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 1900 JEANWOOD DR ELKHART, IN 46514	D
(X4) I PREF TAG	X (EACH DEF G REGULATO	IARY STATEMENT OF DEFICIENCIE ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION	ID PROVIDERS PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5) ULLD BE COMPLETION PROPRIATE DATE
	Findings inclu Based on obse Executive Dire the Maintenan p.m. on 02/27/ suppression sy 61 1/2 inches a leading out of the time of obse observed the m measure and a mounted with at 61 ½ inches 2.) Based on of facility failed the extinguishing working order 10.1.2 requires grease-laden w ignition of gree device, or duct fire-extinguish cooking equip fire-extinguish non-operations practice could Findings inclu Based on obse Executive Dire the Maintenan p.m. on 02/27/ extinguishing positioned over hood. 1 of 3 m the cooking extinguishing	rvation and interview with the ector, Administrator-In-Training, and ce Director from 11:47 a.m. to 2:45 (25, the kitchen hood fire estem "Pull Station" was mounted above the floor near the door the kitchen. Based on interview at servation, the Maintenance Director neasurement taken with a tape ecknowledged the pull station was the center of the pull station handle above the floor. In the servation and interview, the sto ensure 1 of 1 kitchen range hood systems was maintained in proper and in the produces aports and that might be a source of ase in the hood, grease removal the shall be protected by sing equipment. Section 11.1.6 states ment shall not be operated while its sing system or exhaust system is all or impaired. This deficient affect kitchen staff only.	Director/designee will corfacility audit to ensure postations are properly mand kitchen range hood are properly positioned. be in-service on pull statichen range hood nozibefore 3/27/25. Ongoing compliance with corrective action will be through the facility Qual Assurance and Perform Improvement Program (The Maintenance Supervisor/designee will responsible for completity QAPI Audit tool "Life Saweekly for 4 weeks, mon months and quarterly that least 2 quarters. If the of 90% is not met, an acwill be developed. Finding submitted to the QAPI Cofor review and follow up	ull intained nozzles All staff to tions and zles on or th this monitored ity ance QAPI). I be ng the fety Code" nthly for 6 ereafter for e threshold ction plan ngs will be committee

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 6 of 19

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/27/2025
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1900 J	ADDRESS, CITY, STATE, ZIP COD EANWOOD DR ART, IN 46514	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
me	over the cooking eq shelf above the equi These findings were	uipment but pointed to the ipment. e reviewed with the Executive ator-In-Training, and the or	no		DATE
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System	า - Installation			
5	failed to ensure 1 of were protected. LSG occupancies shall be system in accordance states a fire alarm syshall be installed, to accordance with the NFPA 70, National National Fire Alarm Section 10.10.1 stat activated alarm not permitted only if it 10.10.7. Section 10 key-operated or locarranged to provide unauthorized use. The affect all residents, Findings include: Based on observation Executive Director, the Maintenance Director,	on and interview with the Administrator-In-Training, and rector from 11:47 a.m. to 2:45 are control annunciator panels	K 0341	It is the practice of the facility to ensure the fire alarm control panels are protected. The keys the fire annunciator panels were removed. All residents, staff and visitors have the potential to be affected by this deficient practice. A fact audit will be conducted on or before 3/27/25 to ensure the fire control panels were properly secured with no keys present. The Maintenance Director/designee will complete facility audit to ensure the fire control panels were properly secured with no keys present. staff to be in-service on the fire control panels being properly secured with no keys present or before 3/27/25. Ongoing compliance with this corrective action will be monited through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance	s in re ed ility re e a All e

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet

Page 7 of 19

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/27/2025
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	1900 J	ADDRESS, CITY, STATE, ZIP COD EANWOOD DR ART, IN 46514	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F	cabinets, but the doclocked with the key does not protect the unauthorized use. But of observations, the cabinet door to the properly secured be of the door. This finding was reduced by the door. This finding was reduced by the door. This finding was reduced by the door. 3.1-19(b) NFPA 101	station. I annunciator panels were in ors to the cabinets were in the lock. This condition fire alarm system against ased on interview at the time. House Manager agreed the care control panel was not cause the key was in the lock wiewed with the Executive ator-In-Training, and the or		Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety C weekly for 4 weeks, monthly for months and quarterly thereafter at least 2 quarters. If the three of 90% is not met, an action p will be developed. Findings wis submitted to the QAPI Commit for review and follow up.	ode" or 6 er for shold lan ill be
Bldg. 01	facility failed to ens not loaded or covered accordance with LS at 5.2.1.1.1 sprinkle leakage; shall be fre materials, paint, and be installed in the coup-right, pendent, o 5.2.1.1.2 any sprink the following shall be Corrosion (3) Physi the glass bulb heat in Loading (6) Painting sprinkler manufactures	ation and interview, the ure all sprinkler heads were ed with foreign material in C 9.7.5. NFPA 25, 2011 edition, rs shall not show signs of se of corrosion, foreign I physical damage; and shall correct orientation (e.g., r sidewall). Furthermore, at ler that shows signs of any of se replaced: (1) Leakage (2) cal Damage (4) Loss of fluid in responsive element (5) g unless painted by the urer. This deficient practice dents, staff, and visitors.	K 0353	It is the practice of the facility ensure all sprinkler heads are loaded or covered with foreign materials and paint and to ensure sprinkler cabinet has quick response sprinkler present. Sprinkler head located in mair dining room was changed to ensure no paint on deflector. spare sprinklers in the spare sprinkler cabinet were update include quick response sprink All staff, residents and visitors have the potential to be affect by this deficient practice. A facuatit will be conducted on or before 3/27/25 to ensure sprinkleads are not loaded or cover	not n sure The d to lers. ed cility

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet

Page 8 of 19

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

PRINTED: 03/14/2025 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (FORE). The APPROPRIATE DATE OF DATE (COMPLETION SIGNICIPAL APPROPRIATE DATE OF DATE OF THE PROPRIATE DATE DATE OF THE PROPRIATE DATE OF THE PROPRIATE DATE OF THE PROPRIAT		MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	ì	UILDING	ONSTRUCTION 01	(X3) DATE COMPL 02/27	LETED
REFIX TAG REQUATORY OR ISC IDENTIFYING INFORMATION Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, one sprinkler head located in the main dining room outside of the kitchen entrance had paint on the deflector. Based on interview the Maintenance Director acknowledged the paint on the sprinkler deflector but could not explain the reason for the paint. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4.1 states the sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. Section 5.4.1.4.1 states the sprinklers and staff in the facility. Based on observation and interview with the Executive Director Administrator-In-Training, and the Maintenance Director Administrator-In-Training, and the Maintenance Director/designee will complete a facility audit to ensure sprinkler heads are not loaded or covered in foreign material, no paint is present and quick response sprinklers are in sprinkler cabinet. All staff to be in-service on sprinkler heads are not being loaded or covered in foreign material, no paint is present and quick response sprinklers are in sprinkler cabinet. All staff to be in-service on sprinkler are in sprinkler cabinet on the foreign material, no paint is present and quick response sprinklers are in sprinkler to being loaded or covered in foreign material, no paint is present and quick response sprinklers are in sprinkler cabinet. All staff to be in-service on sprinkler whench with the covered with the corrective action will be monitored through the facility Quality Assurance and Performance Improvement P				1900 JEANWOOD DR				
Based on observation and interview with the Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, one sprinkler head located in the main dining room outside of the kitchen entrance had paint on the deflector. Based on interview the Maintenance Director acknowledged the paint on the sprinkler deflector but could not explain the reason for the paint. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinkler systems was maintained with spare sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. Section 5.4.1.4.1 states the sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property. This deficient practice could affect all residents and staff in the facility. present and quick response sprinklers are in sprinkler a facility audit to ensure sprinkler heads are not loaded or covered in foreign material, no paint is present and quick response sprinkler cabinet. All staff to be in-service on sprinkler cabinet. All staff to be in-service on sprinkler cabinet and quick response sprinklers are in sprinkler share heads are not loaded or covered in foreign material, no paint is present and quick response sprinklers are in sprinklers dienter. All staff to be in-service on sprinkler cabinet. All staff to be in-service on sprinkler cabinet. All staff to be in-service on sprinkler cabinet and a sprinkler share present and quick response sprinklers are in sprinkler share present and quick response sprinklers are in sprinkler share in premises. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
Executive Director, Administrator-In-Training, and the Maintenance Director from 11:47 a.m. to 2:45 p.m. on 02/27/25, there were spare standard response sprinkler heads available but there were no spare quick response sprinklers in the cabinet. Based on observation throughout the facility most of the facility had standard response sprinkler heads, but the kitchen contained quick response sprinkler heads. Based on interview at		Executive Director the Maintenance D p.m. on 02/27/25, of main dining room of had paint on the de Maintenance Direct the sprinkler deflect reason for the paint 2.) Based on observations of the paint 2.) Based on observations are premises. NFPA 2 Testing, and Maint Protection Systems states a supply of stan six) shall be not that any sprinklers damaged in any was Section 5.4.1.4.1 standard correspond to the tyof the sprinklers in practice could affect facility. Findings include: Based on observation Executive Director the Maintenance D p.m. on 02/27/25, the response sprinkler no spare quick response of the facility sprinkler heads, but the distribution of the facility sprinkler heads, b	Administrator-In-Training, and irector from 11:47 a.m. to 2:45 one sprinkler head located in the outside of the kitchen entrance flector. Based on interview the tor acknowledged the paint on tor but could not explain the sure 1 of 1 sprinkler systems the spare sprinklers, a spare and a sprinkler wrench on the 5, Standard for the Inspection, enance of Water-Based Fire 1, 2011 Edition, Section 5.4.1.4 pare sprinklers (never fewer maintained on the premises so that have been operated or may can be promptly replaced. Sure and temperature ratings the property. This deficient et all residents and staff in the specific on the sprinklers in the cabinet. On throughout the facility had standard response the kitchen contained quick			present and quick response sprinklers are in sprinkler cate. The Maintenance Director/designee will complete facility audit to ensure sprinkle heads are not loaded or cover foreign material, no paint is present and quick response sprinklers are in sprinkler cate. All staff to be in-service on sprinkler heads are not being loaded or covered in foreign material, no paint is present a quick response sprinklers are sprinkler cabinet on or before 3/27/25. Ongoing compliance with this corrective action will be monithrough the facility Quality Assurance and Performance Improvement Program (QAP). The Maintenance Supervisor/designee will be responsible for completing th QAPI Audit tool "Life Safety (weekly for 4 weeks, monthly months and quarterly thereaf at least 2 quarters. If the threof 90% is not met, an action will be developed. Findings we submitted to the QAPI Commendation of the part of the pa	ete a er ered in inet. and in in tored Code" for 6 ter for shold olan vill be	

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 9 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155269 B. WING 02/27/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1900 JEANWOOD DR EAST LAKE NURSING & REHABILITATION CENTER ELKHART. IN 46514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE the time of the observation, the Maintenance Director acknowledged the spare sprinkler cabinet contained all the same type of sprinkler heads These findings were reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)K 0355 **NFPA 101** SS=E Portable Fire Extinguishers Bldg. 01 Based on observation and interview, the facility K 0355 It is the practice of the facility to 03/27/2025 failed to ensure 1 of 3 portable fire extinguishers in ensure all portable fire the kitchen were installed in accordance with extinguishers are selected, NFPA 10. NFPA 10, Standard for Portable Fire installed, inspected, and Extinguishers, 2010 Edition, Section 6.1.3.8.1 maintained in accordance with states fire extinguishers having a gross weight not NFPA 10, Standard for Portable exceeding 40 lb. shall be installed so that the top Fire Extinguishers. The deficient of the fire extinguisher is not more than five feet portable fire extinguisher affecting above the floor. This deficient practice could kitchen staff was installed so that affect kitchen staff. the top of the fire extinguisher is not more than five feet above the Findings include: floor All staff and residents have the Based on observation and interview with the potential to be affected by this Executive Director, Administrator-In-Training, and deficient practice. A facility audit the Maintenance Director from 11:47 a.m. to 2:45 will be conducted on or before p.m. on 02/27/25, the ABC dry chemical type 3/27/25 to ensure all portable fire portable fire extinguisher located in the kitchen extinguishers are installed to be was located inside a cabinet that was surface no more than five feet above the mounted to the wall with the top of the floor extinguisher 5 feet 8 inches above the floor. The Maintenance Based on interview at the time of observation, the Director/designee will complete a Maintenance Director observed the measurement facility audit to ensure that all taken with a tape measure and acknowledged the portable fire extinguishers are fire extinguisher was mounted with the top of the installed to be no more than five extinguisher greater than five feet above the floor. feet above the floor. All staff to be

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

Event ID:

8XHB21

Facility ID: 000169

If continuation sheet

Page 10 of 19

PRINTED: 03/14/2025 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155269	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/27/2025
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1900 J	ADDRESS, CITY, STATE, ZIP COD EANWOOD DR ART, IN 46514	
(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)	(X5) COMPLETION DATE
	_			in-service on the portable fire extinguishers heights on or be 3/27/25. Ongoing compliance with this corrective action will be monitor through the facility Quality Assurance and Performance Improvement Program (QAPI) The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety Coweekly for 4 weeks, monthly for months and quarterly thereafter at least 2 quarters. If the threes of 90% is not met, an action provided will be developed. Findings with submitted to the QAPI Commit for review and follow up.	ored
K 0363 SS=E Bldg. 01	facility failed to end doors in 1 of 7 smo maintained in according 19.3.6.3. Section 19 doors shall be provided the door closed. See doors shall not be he than those that release or pulled. This defines idents, staff, and compartments. Findings include:	vation and interview, the sure 3 of 12 resident room ke compartments were redance with LSC Section 0.3.6.3.5 states that corridor ided with a means for keeping ection 19.3.6.3.10 states that reld open by devices other ase when the door is pushed cient practice could affect visitors in 1 of 7 smoke	K 0363	It is the practice of the facility to ensure the resident room door are maintained. Room 301, 30 and 305 were fixed to ensure proper latching. The ½-1/2 included above the door in room 5 was fixed to ensure no hole present. All staff and residents have the potential to be affected by this deficient practice. A facility auwill be conducted on or before 3/27/25 to ensure all doors maintain proper latching and the proper in the potential to be single fire doors.	e dit
	Based on observation	on and interview with the		The Maintenance	

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

Event ID:

Executive Director, Administrator-In-Training, and

8XHB21

Facility ID: 000169

If continuation sheet

Director/designee will complete a

Page 11 of 19

ì ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155269	B. WI	NG		02/27/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			EANWOOD DR		
EAST LA	KE NURSING & RE	EHABILITATION CENTER			RT, IN 46514		
			1		·		QUE:
(X4) ID		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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION irector from 11:47 a.m. to 2:45	-	TAG			DATE
		he corridor doors to resident			facility audit to ensure all door		
	*				maintain proper latching and t		
		1 305 failed to latch after the			are no holes in fire doors. All		
		tor made several attempts to			to be in-service on the all door		
		doors. The Maintenance			maintain proper latching and t		
		tive Director removed tissue			are no holes in fire doors on o	I	
		r latch from resident room door			before 3/27/25.		
		loor failed to latch after they al. Based on interview at the			Ongoing compliance with this	arad	
		, the Maintenance Director			corrective action will be monito	neu	
	acknowledged the				through the facility Quality		
	acknowledged the C	10015 did liot fatcii			Assurance and Performance		
	2) Based on observ	vation and interview the			Improvement Program (QAPI) The Maintenance		
	2.) Based on observation and interview, the facility failed to ensure 1 of 1 door to the corridor				Supervisor/designee will be		
	•	esist the passage of smoke.			responsible for completing the		
		orridor openings in other than			QAPI Audit tool "Life Safety C		
		of vertical openings, exits, or			weekly for 4 weeks, monthly for		
	-	ist the passage of smoke and			months and quarterly thereafte		
		nch solid-bonded core wood or			at least 2 quarters. If the thres		
		ble of resisting fire for at least			of 90% is not met, an action p		
	_	eficient practice could affect			will be developed. Findings wi		
		visitors in 1 of 7 smoke			submitted to the QAPI Commi		
	compartments.	Visitors in 1 or / smoke			for review and follow up.	liee	
	compartments.				lor review and rollow up.		
	Findings include:						
		on and interview with the					
		Administrator-In-Training, and					
		rector from 11:47 a.m. to 2:45					
	-	he door to room 512 had					
		inch hole above the door					
		nance Director observed the					
		with a tape measurement and					
	stated the hole was	about ½ inch.					
	TTI: (* 1:	i i Mai E e					
	_	viewed with the Executive					
		rator-In-Training, and the					
	Maintenance Direct						
	at the exit conferen	ce.					

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 12 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155269		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/27/2025	
	PROVIDER OR SUPPLIER	L EHABILITATION CENTER	<u> </u>	1900 JE	ADDRESS, CITY, STATE, ZIP COD EANWOOD DR RT, IN 46514	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110	3.1-19(b)						2.112
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Bui Barrie Based on observation failed to ensure the passage of wire and smoke barrier walls smoke resistance of Section 19.3.7.5 requestions are sistens and shall have a min rating. This deficient residents, staff and compartments. Findings include: Based on observation Executive Director, the Maintenance Dipp.m. on 02/27/25, and approximately 3 includes above the smoke based between the MDS of Maintenance Direct penetration and stating 3 inches. This finding was residued.		K 0	372	It is the practice of the facility ensure penetration of the smobarrier wall by wire and/or combe protected to maintain smok resistance. Two of seven smocompartments were found deficient in the practice, unseapenetration areas have been sealed in accordance with LSG Section 8.5. All residents, staff and visitors the two of seven smoke compartments have the potento be affected by this deficient practice. A facility audit will be conducted on smoke barrier penetrations to ensure the penetrations caused by the passage of wire and/or conduit protected to maintain smoke resistance of each smoke barrion or before 3/27/25. Maintenance Director/designe will complete a facility wide auto ensure penetrations caused the passage of wire and/or cordare protected to maintain smoresistance of each smoke barrier penetrations on or before 3/27/25. Ongoing compliance with this corrective action will be monitor through the facility Quality Assurance and Performance	ke duit ke ke aled C in tial it are rier e dit by nduit ke rier. looke ore	03/27/2025

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 13 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155269		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/27/2025				
NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING & REHABILITATION CENTER		1900 JI ELKHA	STREET ADDRESS, CITY, STATE, ZIP COD 1900 JEANWOOD DR ELKHART, IN 46514					
(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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE			
K 0511				Improvement Program (QAF The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety weekly for 4 weeks, monthly months and quarterly therea at least 2 quarters. If the threat of 90% is not met, an action will be developed. Findings submitted to the QAPI Comfor review and follow up.	ne Code" r for 6 ifter for eshold plan will be			
SS=E Bldg. 01	NFPA 101 Utilities - Gas and	Electric						
	facility failed to ensite restroom located in location in the active ground fault circuit against electric show utilities comply with requires electrical with NFPA 70, Nat 70, NEC 2011 Edition Circuit-Interrupter 1 states, ground-fault personnel shall be perso	ation and interview, the ture 1 of 1 wet location in the the kitchen and 1 of 1 wet lity room was provided with interrupter (GFCI) protection ek. LSC 19.5.1.1 requires the Section 9.1. LSC 9.1.2 Wring and equipment to comply ional Electrical Code. NFPA on at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for provided as required in C). The ground-fault thall be installed in a readily welling Units. All 125-volt, and 20-ampere receptacles tions specified in 210.8(B)(1) we ground-fault rotection for personnel.	K 0511	It is the practice of the facility ensure equipment using gas related piping complies with 54, National Fuel Gas Code electrical wiring and equipmed complies with NFPA 70, Nat Electric Code. The wet locat restroom in kitchen was replay with GFCI protection outlet. Outlet receptacle faceplate to in unit 2 med room was replay all kitchen staff and unit 2 st could be affected by this definity practice. A facility audit will be conducted on ensuring propelectrical receptacles are maintained and outlet receptacles are maintained on before 3/27/25. Maintenance Director/design will complete a facility wide at to ensure proper electrical receptacles are maintained outlet receptacles a	s or NFPA , ent cional cion in faced The cocated aced. caff ficient be er tacle n or nee audit			

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 14 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155269		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/27/2025					
NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING & REHABILITATION CENTER			1900 .	STREET ADDRESS, CITY, STATE, ZIP COD 1900 JEANWOOD DR ELKHART, IN 46514					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION				
	not readily accessible branch circuit dedicing, or pipeline shall be permitted to with 426.28 or 427. Exception No. 2 to only, where the consupervision ensured are involved, an asseconductor program shall be permitted froutlets used to supporteate a greater hazhaving a design that protection. (5) Sinks - where real the substitution of the exception No. 1 to receptacles used to removal of power with hazard shall be permitted from the exception No. 2 to patient bed location care areas of health covered under 210.8(B)(1), GFCI (6) Indoor wet local (7) Locker rooms with facilities (8) Garages, service electrical diagnostic tools, or portable ligused.	(4): In industrial establishments ditions of maintenance and that only qualified personnel ured equipment grounding as specified in 590.6(B)(2) or only those receptacle by equipment that would ard if power is interrupted or to is not compatible with GFCI exceptacles are installed within putside edge of the sink. (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without (5): For receptacles located in sof general care or critical care facilities other than those protection shall not be required.		maintained. All staff to be in-service on ensuring prop electrical receptacles are maintained and outlet receptaceplates are maintained of before 3/27/25. Ongoing compliance with the corrective action will be more through the facility Quality. Assurance and Performance Improvement Program (QAI The Maintenance Supervisor/designee will be responsible for completing to QAPI Audit tool "Life Safety weekly for 4 weeks, monthly months and quarterly there at least 2 quarters. If the throf 90% is not met, an action will be developed. Findings submitted to the QAPI Comfor review and follow up.	otacle on or ais nitored e PI). the Code" y for 6 after for eshold n plan will be				
	receptacles and fixe	d equipment within the area of nave ground-fault circuit							

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet

Page 15 of 19

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155269		ì í	UILDING	nstruction <u>01</u>	(X3) DATE COMPL 02/27 /	ETED		
NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1900 JEANWOOD DR ELKHART, IN 46514					
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	reduce the contact in electrical insulation	protection. Note: Moisture can resistance of the body, and a is more subject to failure. ice could affect staff in the						
	Findings include:							
	Executive Director, the Maintenance Dip.m. on 02/27/25, 1 inches of the sink in kitchen. The electr with ground fault celectrical receptacte when tested failed to tested. Based on into Director stated he dowork since the electrocated on it. 2. interrupter (GFCI)	on and interview with the Administrator-In-Training, and irector from 11:47 a.m. to 2:45 a.) one electrical receptacle 10 in the restroom located in the ic receptacle was not provided ircuit interrupter (GFCI). The ewas a standard type and to interrupt service when the erview the Maintenance with the Maintenance with the maintenance of the maintenance o						
	facility failed to ensure was protected. NFP 406.6, Receptacle Frequires receptacle as to completely coagainst the mounting	vation and interview, the sure 1 of 1 electrical receptacles PA 70, 2011 Edition. Article Faceplates (Cover Plates), faceplates shall be installed so ver the opening and seating surface. This deficient et staff in the Unit 2 med room.						
	Findings include:							
	Executive Director, the Maintenance Di	on and interview with the Administrator-In-Training, and irector from 11:47 a.m. to 2:45 the receptacle cover in the med						

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

Event ID:

8XHB21

Facility ID: 000169

If continuation sheet

Page 16 of 19

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155269				02/27/	02/27/2025	
				CED FIRE	A PARTICIO CITTA OTA TEL TIR COR			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
EAST LAKE NURSING & REHABILITATION CENTER					EANWOOD DR			
EASTLA	KE NURSING & RE	EHABILITATION CENTER		ELKHA	RT, IN 46514			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	CTION SHOULD BE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	room located at Uni	t 2 nurses station was missing.						
	Based on observation	on a refrigerator was plugged						
	into the receptacle a	at the time. Based on interview,						
	the Maintenance Di	rector acknowledged the						
	missing cover and e	exposed wiring.						
	_							
	This finding was rev	viewed with the Executive						
	_	ator-In-Training, and the						
	Maintenance Direct	_						
	at the exit conference	ce.						
	3.1-19(b)							
K 0522	0522 NFPA 101							
SS=E								
Bldg. 01	TIVAO - Ally Ficati	ing Device						
Diag. 01	Based on observation	on and interview, the facility	K 0	522	It is the practice of the facility to		03/27/2025	
		f 1 laundry rooms were	K U.	322	ensure any heating device, oth		03/21/2023	
		e combustion air from the			than a central heating plant, is			
	_	ontaining fuel fired equipment.			designed and installed so			
		ice could create an atmosphere			combustible materials cannot	he		
	_	onoxide which could cause			ignited by device and has a sa			
		or all staff in the laundry room.			feature to stop fuel and shut de	-		
	physical problems i	or all start in the laundry room.			equipment if there is excessive			
	Findings include:				temperature or ignition failure.			
	i mamgs merade.				facility was deficient in providir			
	Based on observation	on and interview with the			of 1 laundry rooms containing	-		
		Administrator-In-Training, and			fired equipment with intake	1401		
		rector from 11:47 a.m. to 2:45			combustion air from outside.			
		ne laundry room had a natural			Facility contracted with service	or.		
	_	heater without a fresh air			-			
					resulting in installation of air in vent to deliver outside air to	lane		
	intake. The water heater was located in the soiled side of the laundry room which was separated					rad		
		of the laundry room by a			laundry room containing fuel fi	ıeu		
		included a door. This			equipment.	atial		
	_				All laundry staff have the poter			
		allow fresh air to completely ed on an interview at the time			to be affected by this deficient			
					practice. A facility audit will be			
		e ceiling vents were present;			conducted reviewing all fuel fir	ea		
		enance Director stated he did			equipment to ensure proper			
	not know if any of the three ceiling vents		1		outside ventilation is in place a	and		

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 17 of 19

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

PRINTED: 03/14/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155269	A. BUILDING <u>01</u> B. WING		<u>01</u>	02/27/2025	
13333			<u> </u>		PRESIDENCE CONTROL CON	OZIZII	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP COD		
EAST LAKE NURSING & REHABILITATION CENTER			ELKHART, IN 46514				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	SHOULD BE COMPL APPROPRIATE	
IAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG			DATE
	provided fresh air . This finding was reviewed with the Executive Director, Administrator-In-Training, and the Maintenance Director at the exit conference. 3.1-19(b)		functional on or before 3/27/25. Maintenance Director/designee will complete a facility wide audit to ensure proper outside ventilation is in place and functional on or before 3/27/25. All staff to be in-service on proper fuel fired equipment ventilation practices on or before 3/27/25. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety Code" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee		dit 5. All r fuel . ored or 6 er for hold an ll be		
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure flex not used as a substitus smoke compartmen wiring and equipment NFPA 70, National Edition, Article 400 specifically permitted shall not be used as a structure. This definition of the second structure of the second	ent - Power Cords and on and interview, the facility tible cords and adapters were tute for fixed wiring in 2 of 7 ts. LSC 9.1.2 requires electrical ent shall be in accordance with Electrical Code. NFPA 70, 2011 0.8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of ficient practice could affect in 1 of 7 smoke compartments.	K 092	20	It is the practice of the facility to ensure power strips utilized in patient care rooms are compliated with National Electrical Code. It deficient practice identified in 27 smoke compartments was corrected by removing the power strips with an unknown rating. All residents, staff and visitors the 2 of 7 smoke compartment have the potential to be affected.	ant The 2 of ver in ts	03/27/2025

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

Event ID:

8XHB21 Facility ID: 000169

If continuation sheet Page 18 of 19

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

PRINTED: 03/14/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
		155269	B. WING			02/27/2025		
NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1900 JEANWOOD DR ELKHART, IN 46514					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
	Findings include: Based on observation Executive Director, the Maintenance Dip.m. on 02/27/25, a rating was supplyin monitor, a fan, and This finding was re	on and interview with the Administrator-In-Training, and frector from 11:47 a.m. to 2:45 power strip with an unknown g power to Pace Maker a night light. viewed with the Executive rator-In-Training, and the			by this deficient practice. A fact audit will be conducted review all power strips ensuring compliance with National Electrical Code on or before 3/27/25. Power strips with unknown ratings will be remove Maintenance Director/designe will complete a facility wide aut to ensure all power strips in utilization are compliance rate accordance with National Electrical Code. All staff to be in-service on proper power strutilization compliance with National Electrical Code on or before 3/27/25. Ongoing compliance with this corrective action will be monitor through the facility Quality Assurance and Performance Improvement Program (QAPI) The Maintenance Supervisor/designee will be responsible for completing the QAPI Audit tool "Life Safety Coweekly for 4 weeks, monthly for months and quarterly thereafter at least 2 quarters. If the threst of 90% is not met, an action plice will be developed. Findings wisubmitted to the QAPI Commit for review and follow up.	red. e dit in ip ored . code" or 6 er for hold lan II be		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8XHB21 Facility ID: 000169 If continuation sheet Page 19 of 19