STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155343	A. BUILDING -- B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF LAGRANGE	0770 NORTH 075 EAST LAGRANGE, IN 46761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/11/22 Facility Number: 000235 Provider Number: 155343 AIM Number: 100267740 At this Emergency Preparedness Survey, Life Care Center of LaGrange was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 44. Quality Review on 08/12/22.	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/11/22 Facility Number: 000235 Provider Number: 155343 AIM Number: 100267740 At this Life Safety Code Survey, Life Care Center of LaGrange was found not in compliance with	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of LaGrange agrees with the allegations and citations listed. Life Care Center of LaGrange maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility built in 1987 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors with exception of the business office and battery-operated smoke detectors in all resident rooms. The building is partially protected by a propane powered 30 kW emergency generator. The facility has a capacity of 100 and had a census of 44 at the time of this survey. All areas where the residents have customary access and all areas providing facility services were sprinklered. Quality Review on 08/12/22.		accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 corridor mechanical room exit door leaf met the open with requirement of 28 inches. LSC 19.2.2.1 states doors complying with	K 0211	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life	08/17/2022

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	7.2.1 shall be permitted. 7.2.1.2.3.2 (4) states in existing buildings, the existing door leaf width shall be not less than 28 in. (710 mm). This deficient practice could affect staff. Findings include: Based on observation with the Maintenance Director and the Administrator on 08/11/22 at 12:28 p.m., the exit door from the Kitchen Mechanical room would not fully open due to pipes blocking the path of the door. The measurement of the door opening was 20 inches. Based on interview at the time of observation, the Maintenance Director and the Administrator agreed the door opening was only 20 inches wide. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b)		Care Center of LaGrange agrees with the allegations and citations listed. Life Care Center of LaGrange maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is if of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K – 211** Means of Egress - General **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice**: · The Maintenance Director completed a thorough inspection of the facility's corridors on 8/11/22 and no other deficiencies were noted **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents has the potential to be affected by this deficient practice. · The Maintenance Director	

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			moved the pipe to the mechanical room on 8/13/22 so the door can open fully. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** · The maintenance director will do a weekly audits of the egress corridors to ensure the can fully open for one month, and then a monthly audit for five months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** · The results of these audits will be managed by the Quality Assurance Performance Improvement Committee monthly with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Completion date systemic changes will be completed: 8/17/22	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system			

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	option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of 2 storage rooms on the 500-hall with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 20 residents in the 500-hall. Findings include: Based on observation with the Administrator and the Maintenance Director on 08/11/22 at 1:00 p.m., rooms 507 and 508 were used as storage rooms, contained over 20 cardboard boxes, and was greater than 50 square feet making the rooms	K 0321	**K – 321** Hazardous Areas - Enclosure **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice**: · The combustible items were immediately removed from 507 and 508 on 8/11/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/12/2022

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	hazardous areas. The rooms were not protected as a hazardous areas because the corridor doors to the rooms were not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the rooms contained large amount of combustible storage, was larger than 50 square feet, and the corridor doors to the room were not self-closing. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b)		**action(s) will be taken:** · All residents had the potential to be affected by this deficient practice. · 8/11/22 the Maintenance Director inspected all rooms and no other deficiencies were noted. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** · Education was provided to the Maintenance Director by the Executive Director on combustible storage · The Maintenance Director or designee will complete an audit of storage areas 1 x per week for 3 month, and 1 x per month for 3 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** · The results of these audits will be managed by the Quality Assurance Performance Improvement Committee monthly with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Completion date systemic changes will be completed: 8/12/22	

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Director on 08/11/22 at 10:20 a.m. and at 2:00 p.m., no current documentation for a smoke detector sensitivity testing was available for review. The only sensitivity testing located had a date of February 2018. Based on interview	K 0345	**K – 345** Fire Alarm System - Testing and Maintenance **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice**: · No residents have been affected by this deficiency. · An annual smoke detector sensitivity testing was added to our agreement with our Fire monitoring company. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents had the potential to be affected by this deficient practice. · An annual smoke detector sensitivity test was completed on 8/25/22. **What measures and what systemic changes will be made to ensure that the deficient**	08/25/2022

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	at the time of record review, the Maintenance Director stated a current sensitivity report could not be found. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b)		**practice doesn't recur:** · The Maintenance Director was educated regarding Policy and sensitivity testing requirements. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** · The results of these audits will be managed by the Quality Assurance Performance Improvement Committee monthly with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Completion date systemic changes will be completed: 8/25/22	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 4 of 10 sprinkler heads in the kitchen were not loaded and covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 25 residents in one smoke compartment. Findings include: Based on observation with the Administrator and the Maintenance Director on 08/11/22 at 12:10 p.m., four sprinkler heads in the kitchen were loaded with dirt and grease. Based on interview at the time of observation, the Maintenance Director confirmed four sprinkler heads in the kitchen were loaded with dirt and grease. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b)	K 0353	**K – 353** Sprinkler System - Maintenance and Testing **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice**: · No residents were affected by the deficient practice **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the ability to be affected. · The Maintenance Director removed the debris from the sprinkler heads · Safe Care is scheduled to replace the 4 sprinkler head on 9/5/22 **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** · The maintenance director will do a weekly audit to ensure sprinkler heads are free from debris for one month, and then a monthly audit for five months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality**	08/17/2022

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			assurance program will be put in place: · The results of these audits will be managed by the Quality Assurance Performance Improvement Committee monthly with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Completion date systemic changes will be completed: 8/17/22	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 2 of 3 offices with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LSC 19.3.6.5.1 states miscellaneous	K 0361	**K – 361** Corridors - Areas Open to Corridor **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice**: · Safe Care is scheduled to install a smoke detectors in the 2 offices with the deficiencies that is tied into the Fire Alarm System on 8/29/2022. **How other residents having the potential to be affected by the same deficient practice will be**	08/29/2022

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	openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up to 20 residents in one smoke compartments. Findings include: Based on observation during a tour of the facility with the Administrator and the Maintenance Director on 08/11/22 at 12:00 p.m., the Staff Development office and the Rehab Manager office had a pass-through window with an opening of 114 square inches and the offices were not protected by an electrically supervised automatic smoke detection. Based on interview at the time of observation, the Administrator and the Maintenance Director agreed the windows were greater than 20 square inches and the offices did not contain electrically supervised automatic smoke detection. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b)		**identified and what corrective action(s) will be taken:** · All residents had the potential to be affected by this deficient practice. · Safe Care is scheduled to install a smoke detectors in the 2 offices with the deficiencies that is tied into the Fire Alarm System on 8/29/2022. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** · The maintenance director will do monthly audits to the hard wired smoke detectors for 6 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** · The results of these audits will be managed by the Quality Assurance Performance Improvement Committee monthly with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Completion date systemic changes will be completed: 8/29/22	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills			

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	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Administrator and the Maintenance Director on 08/11/22 at 10:20 a.m., no documentation was available to show a third shift fire drill for the fourth quarter of 2021 was conducted. Based on interview at the time of record review, the Maintenance Director stated the forementioned drill was not conducted due to the previous Maintenance Director did two second shift drills. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	**K – 712** Fire Drills **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice**: · All residents had the potential to be affected by this deficient practice. · A schedule for the drills insuring all shifts, (one drill on every shift each quarter for a total of 12 drills) was put into place **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · Maintenance supervisor to ensure that fire drills are held monthly on each shift per quarter via our electronic tracking system. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** · Maintenance Director will	08/17/2022

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			complete an audit to ensure that fire drills are held monthly on each shift per quarter for 6 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:** · The results of these audits will be managed by the Quality Assurance Performance Improvement Committee monthly with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Completion date systemic changes will be completed: 8/17/22	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155343	A. BUILDING 01 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 residents. Findings include: Based on observation with the Administrator and the Maintenance Director on 08/11/22 at 12:38 p.m., room 211 contained a multi-plug adaptor powering electrical equipment. Based on interview at the time of observation, the Maintenance Director and Administrator agreed a multi-plug adaptor was in use in room 211. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b)	K 0920	**K – 920** **What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice**: · All residents had the potential to be affected by this deficient practice. · The multi-plug adaptor was replace immediately on 8/11/22 with an approved powerstrip **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · Education was provided to the Maintenance Director by the Executive Director on power cord safety. **What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:** · The maintenance director will do a weekly audit to ensure there are no multi-plug adaptors are in use for one month, and then a monthly audit for five months.	08/17/2022

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: · The results of these audits will be managed by the Quality Assurance Performance Improvement Committee monthly with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits. Completion date systemic changes will be completed: 8/17/22	