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	06/26/2023

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: 06/26/23 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 45. Quality Review completed on 06/27/23	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: 06/26/23 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 cittions listed. Life Care Center of LaGrange maintains that the alleged deficiencies do not jeopardize the health and safety of the ressidents nor is it of such character to limit our capabilities to render adequate care. Please	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Stanley	Interim Executive Director	07/13/2023

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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, 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 45 at the time of this survey. All areas where the residents have customary access and all areas providing facility services were sprinklered. Quality Review completed on 06/27/23		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 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 maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101	K 0345	**What correction will be accomplished for those residents found to have been**	07/30/2023

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	Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals. b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director on 06/26/23 at 10:05 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 08/25/22. Based on interview at the time of records review, the Maintenance Director stated a visual inspection of the fire alarm system six months after the annual fire alarm inspection was not conducted. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**affected by this deficient practice**: The Fire Protection Division of S & S has been contracted to provide the semi-annual inspection by July 30, 2023. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken**: All residents have the potential to be affected by this practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: **The faciity will continue to contract with Fire Protection Division of S&S for semi-annual inspection. Maintenance Director** will monitor compliance through TELS, and upload S&S documentation upon completion of this task. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director to complete audit of TELS to ensure documentation of completion of semi-annual fire alarm inspection is conducted. **By what date the systemic**	

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			changes for reach deficiency will be completed. Facility has requested of S&S to conduct semi-annual visual inspection of the fire alarm system no later than July 30, 2023.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Maintenance Director and Administrator on 06/26/23 at 11:25 a.m., the fire watch plan stated to contact the state agency but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by	K 0346	**What correction will be accomplished for those residents found to have been affected by this deficient practice**: The facility has added the verbiage to its policy “to contact the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov.” **How other residents having the potential to be affected by**	07/30/2023

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	completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the state agency but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**the same deficient practice be identified and what corrective action will be taken**: All residents are covered under the fire alarm system. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Should an event occur, the facility will utilize the Gateway or by emailing the Incident Reporting form. Education has been provided to all Department Heads at monthly QAPI meeting. Policy has also been updated to include "to contact the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov." **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**: ED/designee will ensure all reportable outages are reported thorugh the Gateway as the primary method or by the secondary method when the IDOH	

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			Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. **By what date the systemic changes for reach deficiency will be completed**. Policy will be updated by July 13, 2023.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall	K 0354	**What correction will be accomplished for those residents found to have been affected by this deficient practice**: The facility has added the verbiage to its policy “to contact the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the	07/30/2023

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	follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Maintenance Director and Administrator on 06/26/23 at 11:25 a.m., the fire watch plan stated to contact the state agency but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the state agency but not via the IDOH Gateway link or at the e-mail address listed above. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov." **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken**: All residents are covered under the fire alarm system. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Should an event occur, the facility will utilize the Gateway or by emailing the Incident Reporting form. Education has been provided to all Department Heads at monthly QAPI meeting. Policy has also been updated to include "to contact the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov." **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place: ED/designee will ensure all reportable outages are reported thorugh the Gateway as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@health.in.gov. **By what date the systemic changes for reach deficiency will be completed**. Policy will be updated by July 13, 2023.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills 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	K 0712	**What correction will be accomplished for those residents found to have been affected by this deficient practice**: The Maintenance Director will	07/30/2023

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	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 06/26/23 at 09:30 a.m., no documentation was available to show a third shift fire drill for the fourth quarter of 2022 was conducted. Based on interview at the time of record review, the Maintenance Director agreed one fire drill was not conducted. This finding was reviewed by the Administrator and the Maintained Director during the exit conference. 3.1-19(b) 3.1-51(c)		follows tasks as outlined in TELS. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken**: Timely completion of fire drills will affect all residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Maintenance Director will provide fire drill report on a monthly basis for six months to ED to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**: Maintenance Director will identify completed fire drill at QAPI on a monthly basis for six months to ensure compliance. **By what date the systemic changes for reach deficiency will be completed**. Audit of monthly fire drills for six months will begin by July 30, 2023.	

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K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 55 of 55 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each	K 0914	**What correction will be accomplished for those residents found to have been affected by this deficient practice**: Receptacle testing to be completed by July 30, 2023. **How other residents having the potential to be affected by the same deficient practice be identified and what corrective**	07/30/2023

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	receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 06/26/23 between 11:30 a.m. and 1:00 p.m., the facility's 55 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review at 11:15 a.m., no documentation was available to show the electrical receptacles in resident sleeping rooms were tested within the past 12 months. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated the pervious Maintenance Director completed the testing in October 2022 but could not locate the paperwork. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**action will be taken**: All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Education provided to Maintenance Director r/t non-hospital grade electrical receptacle testing requirements. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**: Maintenance Director to provide documentation of required tasks and their completion to QAPI meeting monthly for a six-month period.. **By what date the systemic changes for reach deficiency will be completed**. The Receptacle Testing will be completed by July 30, 2023.	