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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155269	A. BUILDING -- B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST LAKE NURSING & REHABILITATION CENTER	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 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: 12/14/22 Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100 At this Emergency Preparedness survey, East Lake Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 152 and had a census of 81 at the time of this survey. Quality Review completed on 12/15/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/14/22 Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100 At this Life Safety Code survey, East Lake Nursing and Rehabilitation was found not in compliance with Requirements for Participation in	K 0000	A Life Safety Code Recertification and Emergency Preparedness Survey was conducted on December 14, 2022. Please find the enclosed plan of correction that is respectfully submitted as a remedy to the deficiencies that were cited. All systemic changes and in-servicing will be completed on or by January 13, 2023. I would like to formally request your consideration in granting this facility Paper Compliance due to the nature and low scope and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
McKenzie Hojara	Executive Director	12/29/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a monitored fire alarm system with hard-wire smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 152 and had a census of 81 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/15/22		severity of the deficiencies found. If you have any questions or require additional information, please contact me by phone at 574-264-1133.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted			

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 exit doors from the housekeeping storage only contained one latching mechanism to release the door and open. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect staff that use the storage room. Findings include: Based on observation with the Maintenance Director and Executive Director on 12/14/22 at 1:48 p.m., the housekeeping storage room door near the family lounge was equipped with two latching devices, a latching door turn handle and a separate deadbolt lock. Based on interview at the time of observation, the Executive Director agreed the housekeeping storage room door was equipped with two latching devices. This finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)	K 0222	It is the practice of the facility to ensure means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless utilized in special locking arrangements. The housekeeping storage room door latches were changed. All staff who utilize that storage room could be affected by the deficient practice. A facility audit was completed to ensure no other egress doors are affected by this deficient practice. Maintenance Director/designee will complete a facility wide audit on or before 1/13/23 to ensure no other egress doors are affected by this deficient practice. Staff to be inserviced on egress door latching devices on or before 1/13/23. 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” daily for 1 week, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2	01/13/2023

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			quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
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 __________________________ 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 1. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in laundry were not loaded or 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)	K 0353	It is the practice of the facility to ensure means of ensure sprinkler heads are not loaded or covered with foreign materials, sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe, and all sprinkler systems should be inspected, tested, and maintained. The loaded sprinkler head in laundry was cleaned, the electrical wires on the sprinkler pipes were removed, and the	01/13/2023

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	Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect all laundry staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Executive Director on 12/14/22 between 12:47 p.m. and 2:00 p.m., a sprinkler head in the back laundry area of the dryers was loaded with dirt and lint. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed dirt accumulation and loading. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Executive Director on 12/14/22 at 1:57 p.m., the attic space		backflow device was scheduled to be repaired on or before 1/13/23. All residents, staff, and visitors in the facility have the potential to be impacted by this deficient practice. A facility audit was completed to ensure no other sprinkler heads were loaded, no wires are resting on sprinkler piping and the backflow system is in working condition. Maintenance Director/designee will complete a facility audit on or before 1/13/23 to ensure no other sprinkler heads were loaded, no wires are resting on sprinkler piping and the backflow system is in working condition. Staff to be inserviced on or before 1/13/23. 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” daily for 1 week, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	next to the Social Services office contained electrical wires being supported across the sprinkler pipe. Based on interview at the time of observation, the Maintenance Director agreed there were wires across and around a sprinkler line in the attic. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to maintain 1 of 2 backflow devices for the automatic sprinkler system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review of "Form for Inspection, Testing, and Maintenance of dry sprinkler systems" documentation dated 06/20/22 with			

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	Maintenance Director on 12/14/22 between 10:15 a.m. and 12:45 p.m., under the deficiencies section on page one of the report; one backflow device failed inspection and listed: "Backflow device failed due to not being able to shut off without wrench, shutoff valve (2) is pinned against the bypass backflow device, both shutoff valves need to be rotated 90 degrees so the handle can be properly installed" Based on interview at the time of record review, the Maintenance Director acknowledged that the backflow device had failed and was in the process of fixing it at the time of survey. The Maintenance Director made contact with the contracted entity and had a set date for the backflow to be fixed later this month. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)			
K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the kitchen were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect all kitchen staff. Findings include:	K 0355	It is the practice of the facility to ensure portable fire extinguishers are not obstructed, are inspected monthly and are secured appropriately according to NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.4. The kitchen carts were moved from obstructing the portable fire extinguisher. The	01/13/2023

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	Based on observations during a tour of the facility with the Maintenance Director and the Executive Director on 12/14/22 at 1:10 p.m., one ABC portable fire extinguisher located in the kitchen next to the dining room doors were blocked by two large service carts. Based on interview at the time of observation, the Executive Director acknowledged the blocked fire extinguisher and would train kitchen staff. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to inspect 3 of 15 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to		K-Class extinguisher in the kitchen, ABC extinguisher in the Maintenance Office, and the ABC extinguisher in salon room were inspected. The ABC extinguisher in the Maintenance Office was removed from the floor and secured appropriately. All staff and/or residents who utilize these areas could be affected by the deficient practice. A facility audit was completed to ensure no other portable fire extinguishers are obstructed, missing monthly inspection, and secured appropriately. Maintenance Director/designee will complete a facility wide audit on or before 1/13/23 to ensure no other portable fire extinguishers are obstructed, missing monthly inspection, and secured appropriately. Staff to be inserviced on or before 1/13/23. 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” daily for 1 week, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee	

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	require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff in the kitchen. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Executive Director on 12/14/22 between 12:47 p.m and 2:00 p.m., the following deficiencies were noted: a) The K-Class extinguisher in the kitchen was missing monthly inspections for October and November 2022 b) The ABC extinguisher in the Maintenance Office was missing the last 12 months worth of monthly inspections c) The ABC extinguisher in the salon room near activities was missing monthly checks from August to November 2022. Based on interview at the time of observation, the Maintenance Director confirmed the three extinguishers were missing monthly inspections. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility		for review and follow up.	

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	failed to ensure 1 of 1 portable fire extinguishers in the maintenance shop were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff in the maintenance shop. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 12/14/22 at 1:35 p.m., an ABC portable fire extinguisher in the maintenance office was sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the floor and stated it is a spare extinguisher. Findings were discussed withe the Maintenance Director and Executive Director at exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20			

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	minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 25 resident room corridor doors on the 300 hall and 600 hall wings were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke.	K 0363	It is the practice of the facility to ensure corridor doors are provided with a means suitable for keeping the door closed, have no impediment to closing, latching and resist the passage of smoke.	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155269	A. BUILDING 01 B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAST LAKE NURSING & REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficient practice could affect 4 residents in rooms 602 and 304. Findings include: Based on observation with the Maintenance Director and Executive Director on 12/14/22 between 12:47 p.m. and 2:00 p.m., the corridor doors to resident rooms 602 and 304 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director stated the corridor doors would not latch into the door frame and would make the necessary adjustments. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		The door closures on rooms 602 and 304 were repaired to ensure proper closer. All staff and/or residents could be affected by the deficient practice. A facility audit was completed to ensure no other corridor doors are affected by this deficient practice. Maintenance Director/designee will complete a facility wide audit on or before 1/13/23 to ensure no other corridor doors are affected by this deficient practice. Staff to be inserviced on or before 1/13/23. 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” daily for 1 week, weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	