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	05/02/2024

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: 05/02/24 Facility Number: 000235 Provider Number: 155343 AIM Number: 100267740 At this Emergency Preparedness Survey, Life Care Center of LaGrange was found not 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 completed on 05/08/24	E 0000	K 000 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 it 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.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Thompson	Administrator	05/20/2024

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

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	155343	A. BUILDING -- B. WING	05/02/2024

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	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	155343	A. BUILDING -- B. WING	05/02/2024

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	. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least once every year in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Maintenance Director and Administrator on 05/02/24 at 10:00 a.m., the facility failed to review and update the EPP once every year. No documentation was available for review to show when the EPP was last reviewed and updated. Based on an interview during records review, the Maintenance Director stated no other documentation available to show the EPP was reviewed and updated within the last year. The finding was reviewed with the Maintenance Director and Administrator during the exit conference.	E 0004	**E 004 Develop EP Plan, Review and Update Annually.** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: The Administrator and QAPI team reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. The administrator verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at each nurse's station and the following locations: 1 Administration Office's 2 Environmental/Maintenance Offices 3 Director of Nursing Office 4 Dietary Manager Office 5 Therapy Office 6 Social Service Office. **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 of being affected. The revised or updated materials have been included in the existing training module for new hires. The Administrator or designee will review the EEP no less then	05/20/2024

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			monthly. Aspects of the EEP will be shared with employees during monthly ALL Staff Meetings. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Present employees will be educated on the revised or updated materials. They will also be included in the existing training module for new hires. **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 will review aspects of the EMP based on the time of the year and or issues that arise related to the EEP during “All Staff” meetings monthly. The Administrator will review the EEP at the monthly QAPI meeting each month for 6 months.. The EEP will be updated no less then annually thereafter. **By what date the systemic changes for reach deficiency will be completed**. 05/20/2024	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b),			

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	§441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policy and Procedures at least once every year in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Maintenance Director and Administrator on 05/02/24 at 10:00 a.m., the facility failed to review and update the EPP Policy and Procedures once every year. No documentation was available for review to show when the EPP Policy and	E 0013	**E 013 Development of EP Policies and Procedures** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: The Administrator reviewed and updated the emergency plan including policies and procedures, based community risk assessment and communication plan utilizing an all hazards approach, including missing residents. The Administrator	05/20/2024

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	Procedures were last reviewed and updated. Based on an interview during records review, the Maintenance Director stated no other documentation available to show the EPP Policy and Procedures were reviewed and updated within the last year. The finding was reviewed with the Maintenance Director and Administrator during the exit conference.		verified all disaster preparedness manuals are current, updated, and accessible. Manuals are located at nurse station and the following locations: 1 **Administrator Office** 2 **Environmental Service Director's office** 3 **Director of Nursing office** 4 **Dietary manager Office** 5 **Therapy Office** 6 **Social Service office** **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. Employees have been educated on the revised or updated materials. They have also been included in the existing training module for new hires. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Life Care Centers, compliance office will continue to send the annual reminder to review the Policies and Procedures. QAPI to review EEP. **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 will review aspects of	

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			the EP based on the time of the year or issues arise related to EEP. The information will be shared during monthly “All Staff” meetings. The Administrator will review the EEP at the monthly QAPI meeting each month for 6 months. The EEP will be updated no less then annually thereafter. **By what date the systemic changes for reach deficiency will be completed**. Policy will be updated by May 20, 2024	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communications Plan at	E 0029	**E 029 Development of Communication Plan** **What correction will be**	05/20/2024

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	least once every year in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Maintenance Director and Administrator on 05/02/24 at 10:00 a.m., the facility failed to review and update the EPP Communications Plan once every year. No documentation was available for review to show when the EPP Communications Plan was last reviewed and updated. Based on an interview during records review, the Maintenance Director stated no other documentation available to show the EPP Communications Plan was reviewed and updated within the last year. The finding was reviewed with the Maintenance Director and Administrator during the exit conference.		**accomplished for those residents found to have been affected by this deficient practice**: The Administrator and QAPI Team reviewed and updated the emergency Plan that including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all hazards approach, including missing residents. The Administrator verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at each nurse's station and the following locations: 1 Administrative Offices 2 Environmental Services Office 3 Director of Nursing Office 4 Social Service Office 5 Dietary Manager Office 6 Therapy Office. **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 of being affected. The revised or updated materials heave been included in the existing training modules for new hires. The Administrator or designee will review the EEP no less then monthly. Aspects of the EEP will be shared with employees during	

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			monthly All Staff Meetings. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Present employees will be educated on the revised or updated materials. They will also be included in th existing training module for new hires. **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 will review aspects of the EEP during "ALL Staff" meetings monthly. The Administrator will review the EEP at the monthly QAPI meeting each month for 6 months and annually thereafter. **By what date the systemic changes for reach deficiency will be completed**. This change will be implemented by May 20, 2024	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d),			

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	§485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of			

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	this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training Plan at least once every year in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Maintenance Director and Administrator on 05/02/24 at 10:00 a.m., the facility failed to review and update the EPP Training Plan once every year. No documentation was available for review to show when the EPP Training Plan was last reviewed and updated. Based on an interview during records review, the Maintenance Director	E 0036	**E 036 EP Training and Testing** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: The Administrator and QAPI Team reviewed and updated the EEP including the Training and testing, **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. Maintenance Director	05/20/2024

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	stated no other documentation available to show the EPP Training Plan was reviewed and updated within the last year. The finding was reviewed with the Maintenance Director and Administrator during the exit conference.		will modify Training and testing schedule and ensure staff are in-serviced on the dates. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Present employees will be educated on the revised or updated materials Testing and Training dates will be provided to all employees as part of the EEP training. **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 will review aspects of the EEP based on the time of the year and or issues that arise related to the EEP during "All Staff" meetings monthly. The Administrator will review the EEP at the monthly QAPI meeting each month for 6 months and annually thereafter. **By what date the systemic changes for reach deficiency will be completed**. May 20, 2024	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)			

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	05/02/2024

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
	EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

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	*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]			

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	(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per			

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	year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual			

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	individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or			

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	prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of	E 0039	**E 039 – EP Testing Requirements** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: The Administrator and QAPI Team reviewed and updated the emergency plan including policies and procedures on testing requirements.	05/20/2024

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	emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and the Maintenance Director on 05/02/24 at 12:45 p.m., documentation of annual EPP training was past due. The provided EEP training had a completion date of 05/16/22. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated the EPP training was not conducted within the last year. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**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. The revised or updated materials have been included in the existing training module for new hires. The Administrator or designee will review the EEP no less then monthly. Aspects of the EEP will be shared with employees during the monthly "All Staff" meeting. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Present employees will be educated one revised or updated material. They will also be included in the existing training module for new hires. Education provided to Maintenance Director to ensure compliance with this annual requirement. **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 will review aspects like Testing of the EEP based on the time of the year and or issues that arise related to the EEP. This	

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			information will be shared with staff monthly at "All Staff" meetings. The Administrator will review the EEP at the monthly QAPI meeting each month for 6 months then annually therafter. **By what date the systemic changes for reach deficiency will be completed**. May 20, 2024	
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: 05/02/24 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 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.	K 0000	K 000 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 it 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	

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	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 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 completed on 05/08/24		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 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 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			

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	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 1 of 1 rooms greater than 50 square feet and being used for storage of large amounts of combustibles was protected as a hazardous area. This deficient practice could affect 20 residents and staff in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 05/02/24 at 2:05 p.m., the Central Supply room containing over 50 boxes of combustible material, was greater than 50 square feet, therefore making the room a hazardous area. The Central Supply room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the Central Supply room room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.	K 0321	**K 321 Hazardous areas-Enclosure** **What correction will be accomplished for those residents found to have been affected by this deficient practice:** The self-closing door to the storage room has been repaired. **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. An audit has been created and all doors with self -closers have been inspected and are working correctly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Maintenance will continue to inspect doors per the PM Program. An audit will be	05/20/2024

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	3.1-19(b)		conducted 1x weekly for 6 months and monthly thereafter. **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**: Audits on self-closing doors will be conducted 1x weekly for 6 months and monthly thereafter. Findings will be addressed upon discovery. Results of audits will be reviewed during the monthly QAPI meeting. **By what date the systemic changes for reach deficiency will be completed**. 05/20/2024	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler			

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	Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) (1) Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 6 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect up to 25 residents in 1 smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 05/02/24 between 1:00 p.m. and 2:30 p.m., the kitchen pantry contained one quick response and one standard response sprinkler heads in the same location. Based on an interview at the time of observations, the Maintenance Director agreed there were a mix of quick response and standard response sprinklers in the kitchen pantry. (2) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 corridors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff	K 0351	**K 351 Sprinkler System-Installation** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: 1 Our Sprinkler System Vendor, Shambaugh and Sons will replace standard with a with a quick - response. Both Sprinkler heads will be the same. 2 The escutcheon is now on the Sprinkler in corridor outside room 405. **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. Maintenance will continue to inspect during preventive maintenance. Maintenance completed an Audit of existing sprinkler heads. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: A log in our TELS system has been created that includes the sprinkler head inspections. Maintenance will check these on a weekly basis.	05/20/2024

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	and up to 20 residents in the smoke compartment. Findings include: Based on observation with the Maintenance Director on 05/02/24 at 2:11 p.m., the sprinkler in the corridor outside room 405 had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheon was missing. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**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 will use audit tool to inspect sprinklers 1x weekly for 6 months and monthly thereafter. Results of Audits will be dealt with immediately as needed and reviewed during monthly QAPI meetings. Vendor will continue Quarterly inspections per regulations. **By what date the systemic changes for reach deficiency will be completed**. Policy will be updated by May 20, 2024	
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			

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	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 Based on observation and interview, the facility failed to replace 1 of 30 sprinkler heads in areas with moisture 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 three smoke compartments. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 5/2/24 at 1:14 p.m. a sprinkler head located in the laundry room by the washers showed signs of corrosion. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler head showed signs of greening and corrosion. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0353	**K 353 Sprinkler System-Maintenance and Testing** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: Corroded sprinkler head has been replaced. **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 of being affected. Maintenance will use an Audit as part of the PM Program. An audit of all sprinkler heads has been conducted. This audit will continue to be used. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: An audit form has been created and will be used to audit sprinkler heads. This will be a part of the PM Program. Action will be taken when an issue arises. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	05/20/2024

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			recur, i.e., what quality assurance program will be put into place: The audit will be conducted 1x weekly for 6 months, then monthly thereafter. Findings will be dealt with immediately and data reviewed during monthly QAPI meeting. **By what date the systemic changes for reach deficiency will be completed**. This change will be implemen	
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 Based on observation and interview, the facility failed to ensure 9 of 24 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observation with the Maintenance Director on 05/02/24 between 1:00 p.m. and 2:30 p.m., the portable fire extinguishers located in main hall, near laundry room, next to room 102, next to the staff development office, next to the	K 0355	**K 355 Portable Fire Extinguishers** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: The Portable Fire extinguishers in main hall, near laundry room, next to room 102, next to the staff development office, next to the employee time clock, next to the social service office next to room 405, and next to room 310 have been re-positioned. The aforementioned extinguishers are not at regulation height. **How other residents having the**	05/20/2024

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	employee time clock, next to the social services office, next to the medical records office, next to room 405, and next to room 310, were mounted on the wall with the top of the extinguisher between 5 feet 5 inches to 5 feet 6 inches above the floor. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned fire extinguishers were mounted with the top of the extinguisher greater than five feet above the floor. This finding was reviewed with the Maintenance Director and Administrator at the exit conference. 3.1-19(b)		**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. Administrator will notify Maintenance of any changes in regulations and appropriate action will be taken to ensure compliance. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Portable Extinguisher inspections will continue to be a part of the PM Program and audits conducted weekly and monthly. **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**: An audit of the extinguishers will be conducted 1x weekly for 6 months and 1x monthly thereafter. Findings will be reviewed during at the monthly QAPI and action taken based on the findings. **By what date the systemic changes for reach deficiency will be completed**. May 20, 2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the attic above room 401 was protected according to LSC 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect up to 20 residents in the smoke compartment. Findings include: Based on observations with the Maintenance Director on 05/02/24 at 2:29 p.m., in the attic above room 401 an electrical receptacle did not contain a faceplate. Based on interview at the time of observation, the Maintenance Director agreed the outlet was not covered with a faceplate. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0511	**K 511 Utilities- Gas and Electric** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: The Cover Plate to Electrical outlet in the attic above room 401 has been replaced. Maintenance will counsel with Vendors on need to check these at the time **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. An Audit has been created that will be used to periodically check cover plates. **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 to ensure compliance with this requirement. Audit will be conducted as part of PM Program to ensure compliance. **How the corrective action(s) will be monitored to ensure the**	05/20/2024

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			deficient practice will not recur, i.e., what quality assurance program will be put into place: Audit will be conducted 1x weekly for 6 months and monthly thereafter. Finding will be reviewed at monthly QAPI meeting and additional recommendations provided as needed. **By what date the systemic changes for reach deficiency will be completed**. May 20, 2024	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.			

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	(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 2 smoking areas were maintained by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect staff outside the service exit. Findings include: Based on observation during a tour of the facility with Maintenance Director on 05/02/24 at 1:43 p.m., In the staff smoking area outside by the service hall exit there were over 10 cigarette butts disposed in a trash can containing combustible materials. Based on interview at the time of observation, the Maintenance Director agree the cigarette butts were in a plastic trash can. This finding was reviewed with the Maintenance Director and Administrator at time of exit. 3.1-19(b)	K 0741	**K 741 Smoking Regulations** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: The cigarette butts have been removed and Signage has been placed on non-smoking trash cans to alert anyone from using in to place smoking material. An approved smoking ash tray has been placed by the trash can as well to steer smokers form placing cigarette in non-smoking trash can. All employees have been re-educated regarding the smoking policy. **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 of being affected. The non-smoking trash cans now have Signage on them to alert smokers not use the can for smoking materials. An ashtray has been placed by the	05/20/2024

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			trash cans to steer smokers from using the non-smoking trash can. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Maintenance or designee will audit the trash can and ashtrays as part of daily PM. program. **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 will audit trash/smoking area 3x weekly for 4 weeks. Then 2x weekly for 3 months and 1x weekly thereafter. The findings of the audits will be addressed immediately. Monthly findings will bew reviewed by QAPI Team with additional action taken as needed. **By what date the systemic changes for reach deficiency will be completed**. 05/20/2024	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling			

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	to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) (1) Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect all resident. Findings include: Based on records review Maintenance Director and Administrator on 05/02/24 at 12:30 p.m., an oxygen trans-filling policy was provided for review, but no documentation to indicate if staff were properly trained on trans-filling liquid oxygen was available for review. Based on interview at the time of observation, the Administrator stated the oxygen trans-filling training paperwork could not be found. (2) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one-hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations with the Maintenance	K 0927	**K 927 Gas Equipment- Trans filling Cylinders** **What correction will be accomplished for those residents found to have been affected by this deficient practice**: 1 Employees have been in-serviced on oxygen trans-filling liquid oxygen. The annual requirement has been re-implemented and is scheduled to be reviewed by the QAPI Team annually. 2 Maintenance has repaired the hole in door to oxygen. This door and all similar doors will be inspected weekly. **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. 1. Employees have been in-serviced on trans-filling oxygen and this in-service will be completed annually. 2. Maintenance inspected all doors for repairs. **What measures will be put into place and what systemic changes will be made to**	05/20/2024

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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
	Director on 05/02/24 at 1:40 p.m., the oxygen trans-filling room was not protected with a one-hour fire-resistive construction due to a 2-inch by 3/4 inch hole in the wall. Based on an interview at the time of observation, the Maintenance Director agreed there was an unsealed hole in the wall of the oxygen trans-filling room. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur**: This annual requirement is now a part of the QAPI agenda to be reviewed by QAPI team annually. Maintenance will inspect doors as part on PM Program. **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**: 1 Each month for the next 12 months, the Facility Administrator will send a copy of the QAPI minutes to the Regional Vice President for their review to ensure compliance. Findings will be presented in the QAPI and plan developed to remedy when necessary. 2 Door to Oxygen room will be audited 1x weekly for 6 months and 1x weekly thereafter. **By what date the systemic changes for reach deficiency will be completed**. Policy will be updated by May 20, 2024	