STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING -- B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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 completed by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/10/2023 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 At this Emergency Preparedness survey, South Shore Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 80. Quality Review completed on 07/13/23	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: 07/10/2023 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 At this Life Safety Code survey, South Shore	K 0000		

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

Philip M. Birn | Administrator | 07/27/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	Health & Rehabilitation Center 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. This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The building is fully protected by a 200 kW diesel-powered generator. The facility has a capacity of 100 with a census of 80 at the time of the survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage. Quality Review completed on 07/13/23			
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 07/10/23 between 09:34 a.m. and 1:24 p.m., the semi-annual fire alarm report did not show if all listed devices passed or failed testing. The only documentation provided was from the "TELS" system listed as "Fire Alarm System: Conduct routine test of fire alarm system" that showed a monthly visual inspection of the fire alarm system. However, the documentation did not itemize the list of all devices inspected nor if they had passed/failed and only showed that the inspection was completed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned issue. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)	K 0345	K345 – NFPA 101 *This plan of Correction is the facility's credible allegation of compliance.* *The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Facility has put together a report to be documented by maintenance staff that documents that there was a monthly visual inspection of the fire alarm system with an itemized list of all devices inspected and if they passed/filed. Maintenance staff were in-serviced on the regulations of maintaining the fire alarm system in	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
			accordance with 9.6.1.3 LSC 9.6.1.3 requiring a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70 fire alarm code. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A log sheet was developed for maintenance to summarize the semi- annual fire alarm report and if it listed all devices passed or failed testing. This log sheet will be presented to the QAPI committee each month for review and recommendations. **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 present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2023**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	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			
	Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems 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:	K 0353	K353– NFPA 101 *This plan of Correction is the facility's credible allegation of compliance.* *The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. The	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	Based on records review of "Form for Inspection, Testing, and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 02/07/23 with Maintenance Director on 07/10/23 between 09:34 a.m. and 1:24 p.m., under the deficiencies section on page one of the report; The sprinkler company listed an "open" deficiency listed as "critical" due to "WFD reports to fire panel, 10" bell outside does not ring when WFD is activated." The inspection report listed that all electrical waterflow alarm devices passed test as "no." Based on interview at the time of observation, the Maintenance Director stated that he was aware of the problem with the sprinkler report and that the deficiency has not been fixed as of the time of the survey. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		10 inch bell outside was identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Facility contacted Ryan Fire Protection to correct the deficiency so that the 10 inch bell outside does ring during testing of all electrical waterflow alarm devices and passes the tests during inspection. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance will be in service on the importance of getting inspection reports and will report all deficiencies reports to administrator so that the administrator can contact and correct any deficiencies with vendors immediately. **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 present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
			the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2023**	
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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	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 47 resident room corridor doors in the facility were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 4 residents. Findings include: Based on observation with the Maintenance Director and Administrator on 07/10/23 between 1:33 p.m. and 3:42 p.m., the corridor doors to resident rooms 401 and 306 did not latch into the frame when tested. Based on interview at the time of observation, the Administrator acknowledged both resident room doors would not latch into the frame when tested three times. The door to room 401 was fixed upon observation. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	K363– NFPA 101 *This plan of Correction is the facility's credible allegation of compliance.* *The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. Rooms 401 and 306 were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
			residents have the potential to be affected by this alleged deficient practice. Room 401 door was brought back into compliance upon observation with surveyor and room 306 door has been brought back into compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance will track and inspect and audit all doors in the facility to be sure that all doors latch into the frame when tested. Maintenance was in serviced on to track and inspect all doors and are in compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance will present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2023**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and approximately 30 residents and staff in one smoke compartment. Findings include:	K 0372	K372– NFPA 101 *This plan of Correction is the facility's credible allegation of compliance.* *The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be**	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	Based on observations during a tour of the facility with the Maintenance Director on 07/10/23 between 1:33 p.m. and 3:42 p.m., above the drop ceiling near the 400-hall smoke wall near the nurses station, there was an approximately 6 inch penetration in the barrier around metal piping. Based on interview at the time of observation, the Maintenance Director acknowledged the barrier penetration and the hole would have to be resealed. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. The approximate 6 inch hole penetration in the barrier wall around the metal pipping was sealed and the areas have been fire stopped. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur :Whole** Facility inspection was done and no other penetrations were found. Maintenance was in serviced on the importance of track and inspect and audit areas in the facility that have penetrations in the ceiling and seal and firestop these areas. **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 present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2023**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 07/10/23 between 09:34 a.m. and 1:24 p.m., the following shifts were missing documentation of a completed fire drill: a) A third shift fire drill in the second quarter of 2023. b) A third shift fire drill in the fourth quarter of 2022. Based on interview at the time of record review, the Maintenance Director stated that 12 fire drills were completed over the past 12 months, however the way he conducted the drills did not include third shift for the two quarters and did multiple	K 0712	K712– NFPA 101 *This plan of Correction is the facility's credible allegation of compliance.* *The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. Facility will follow fire drill schedule	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	second shift drills and acknowledged that the two shifts were missing. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 3.1-51(c)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Facility has a fire drill schedule that alternates the time between each drill to make sure that all shifts have a fire drill so that they are familiar with the procedures and is aware that the drills are part of established routine. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility will follow fire drill schedule and will audit with a check off sheet that the drills are done in a timely and correct manner. This check off sheet will be presented to the QAPI committee each month for review and recommendations. Maintenance director was in service on the importance of following the fire drill schedule. **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 present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
			consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2023**	
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. (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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	Based on observation and interview; the facility failed to ensure 2 of 2 facility areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 07/10/23 between 1:33 p.m. and 3:42 p.m., outside of the kitchen exit door there were over 50 cigarette butts disposed on the ground in and around the area. That area was not a designated smoking area. Furthermore, in the patio sitting area next to the Activities Room had approximately over 100 cigarette butts disposed on the ground. The patio area is the designated smoking area for residents. Based on interview at the time of observations, the Maintenance Director and Administrator agreed there were cigarette butts on the ground in the aforementioned locations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0741	K741– NFPA 101 *This plan of Correction is the facility's credible allegation of compliance.* *The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Facility during scheduled smoking times, will ensure that smoking areas are maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices.. **What measures will be put into place or what systemic changes will be made to**	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
			ensure that the deficient practice does not recur: Facility will check daily the two facility smoking areas to make sure that the smoking areas are free of cigarette butts and have the correct cigarette butt disposable containers. This check off sheet will be presented to the QAPI committee each month for review and recommendations. In service of Staff and resident on the importance of disposing of cigarette butts in the approved noncombustible approved containers. **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 present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2023**	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 3 of 5 fire door	K 0761	K761– NFPA 101 *This plan of Correction is the facility's credible allegation of*	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf.		*compliance.* *The facility requests paper compliance for this citation. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. Doors near 200 Hall, separation door between 300 and 400 hall and oxygen storage/transfilling room door will be inspected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. All fire doors will be inspected annually and documented. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance was in serviced on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	(8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents and staff. Findings include: Based on record review with the Maintenance Director on 07/10/23 between 9:34 a.m. and 1:24 p.m., documentation for fire door inspections were provided and confirmed two doors were inspected annually. Later during a tour of the facility with the Maintenance Director between 1:33 p.m. and 3:42 p.m., the following doors were observed without an annual inspection: a) The separation door located next to the dining room near 200 Hall was rated as a 3-hour fire door b) The separation door located in between 300 and 400-hall was rated as a 3-hour fire door c) The oxygen storage/transfilling room was rated as a 45 minute fire door. Based on interview at the time of record review and observation, the Maintenance Director stated that the three fire doors were not inspected annually and agreed that all three doors were rated fire doors. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		the importance of tracking and inspecting all fire doors to be sure that they are functioning properly and in compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance will present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2023**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 4 staff and 15 residents. Findings include:	K 0920	K920 – NFPA 101 – Electrical Equipment – power cords and extension cords The facility requests paper compliance for this citation. *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	08/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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
	Based on observations during a tour of the facility with the Maintenance Director and Administrator on 07/10/23 between 1:33 p.m. and 3:42 p.m., the employee break room contained a power strip that supplied power to a microwave. Based on interview at the time of observation, the Administrator acknowledged the power strip and removed the power strip upon observation. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 07/10/23 between 1:33 p.m. and 3:42 p.m., within the 200-Hall nurses station desk was a power strip plugged into and supplied power to another power strip for a printer and computer supplies. Based on interview at the time of observation, the Administrator agreed two powerstrips were daisy chained and removed one power strip at observation. Findings were discussed with the Maintenance		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. The power strip was removed from the employee break room that supplied power to the microwave and the microwave was plugged directly into the outlet. The power strip that was plugged into another power strip for a printer and computer supplies were unplugged and all cords were appropriately plugged in. The power strip that was dangling in the Storage/It room will be mounted or set on the floor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A walk through of facility was completed with no other multi-plug outlets or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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 and Administrator at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Maintenance Director and Administrator on 07/10/23 between 1:33 p.m. and 3:42 p.m., in the Storage/IT room next to the Unit 4 nurse's station, there was a power strip used to power equipment, was not secured, and was dangling from the outlet on the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director and Administrator agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		surge protectors used out of compliance. Facility staff, Department Supervisors and Therapy were in-serviced on the regulations involving extension cords, multi-plug outlets and surge protectors in the Long-Term Care facility. Staff will continue to observe all areas for non-compliance and note any concerns on a Maintenance request form so proper electrical needs are addressed. Maintenance request logs will be presented to the QAPI committee for review. **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 present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 8/11/2022**	