STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/03/12 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 Surveyors: Joe L Brown, Jr., Life Safety Code Specialist and Robert Sutton, Life Safety Code Surveyor Specialist Trainee At this Life Safety Code survey, Lincolnshire Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The 1984 building was	K0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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: 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/03/2012
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410	

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	surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility 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 and spaces open to the corridors with hard wired smoke detectors in the fifty four resident rooms. The facility has a capacity of 100 and had a census of 82 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the metal shed located on the north side of the facility and the wooden shed located on the south side of the facility. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/04/12. The facility was found not in compliance with the aforementioned regulatory			

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NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410	

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	requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/03/2012
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K0021 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 11 doors serving hazardous areas such as a laundry was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice would not directly affect the residents but could affect staff. Findings include: Based on observations on 12/03/12 with the Maintenance Director during the tour at 12:15 p.m., the clean laundry room door was held open by a device, a rack of plastic hangers on top of a card board box, which would not allow the door to close automatically upon activation of the fire alarm system. It was also observed	K0021	**K021** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** **-Device was removed from the doorway.** **2) How the facility identified other residents:** **-No residents were affected.**	12/21/2012

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	again during the tour at 1:36 p.m. on 12/03/12. Based on interview during the times of observation, the Maintenance Director acknowledged the door should not be propped open. 3.1-19(b)		**3) Measures put into place/ System changes:** **-Staff will be inserviced on appropriate storage of equipment and keeping all objects clear of all doors activated by the fire alarm system.** **4) How the corrective actions will be monitored:** **-Facility staff will round weekly to monitor compliance.** **5) Date of compliance: 12/21/12**	

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K0038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 9 of 9 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon	K0038	**K038** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** **-Signs have been put on all exit doors that to indicate that you may push until the alarm sounds and the door will open in 15 seconds.** **2) How the facility identified other residents:** **-No residents have been affected by this practice.** **3) Measures put into place/ System changes:** **- Signs have been installed.** **4) How the corrective actions will be monitored:** **-Monthly during routine**	12/21/2012

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	application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 12/03/12 during the tour from 10:15 a.m. to 2:40 p.m. with the Maintenance Director, all the exit doors where magnetically locked, provided with delayed egress, and opened within 15 seconds by pushing on the door, however, signs saying the door would		**maintenance rounds the signs will be monitored.** **5) Date of compliance: 12/21/12**	

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	open in 15 seconds were not posted. Based on interview during the time of observation, the Maintenance Director acknowledged the signage was not provided. 3.1-19(b)			

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K0062 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads within the floor care room was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition, Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice does not directly affect residents since this area is accessible to only staff members. Findings include: Based on observation on 12/03/12 at 12:48 p.m. with the Maintenance Supervisor, the one sprinkler head in the housekeeping office furnace room was obstructed by air handler ductwork in such a way the spray pattern of the	K0062	**K062** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** **-Sprinkler head has been moved.** **2) How the facility identified other residents:** **-No residents have been affected by this practice.** **3) Measures put into place/ System changes:** **- All other sprinkler head have been observed to be in appropriate locations.** **4) How the corrective actions will be monitored:**	12/21/2012

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	sprinkler head would not provide coverage of the entire room. Based on interview at the time of observation, it was acknowledged by the Maintenance Supervisor, the spray pattern of the sprinkler head would not provide complete coverage of the room. 3.1-19(b)		**-Monthly during routine maintenance rounds the sprinkler heads will be checked.** **5) Date of compliance: 12/21/12**	

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen equipment in 2 of 2 oxygen storage areas. NFPA 99, 8-3.1.11.2(c)2 requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation on 12/03/12 during the tour of the facility with the Maintenance Director from 1:20 p.m. to 1:30 p.m., the following combustible items were stored within five feet of stationary liquid oxygen containers in the	K0076	**K076** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** **-Cardboard boxes and plastic bags have been removed from oxygen storage areas.** **2) How the facility identified other residents:** **-No residents have been affected by this practice.** **3) Measures put into place/**	12/21/2012

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	oxygen storage rooms on A and B wings; cardboard boxes, a crash cart with respiratory supplies wrapped in plastic, and two respiratory regulators wrapped in plastic sitting on the counter in the B wing oxygen storage room. Based on interview at the time of observation, the Maintenance Director acknowledged combustible materials were stored within five feet of stationary liquid oxygen containers. 3.1-19(b)		**System changes:** **-An audit of oxygen storage areas have been completed.** **4) How the corrective actions will be monitored:** **-Weekly during rounds oxygen storage areas will be observed.** **5) Date of compliance: 12/21/12**	

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LINCOLNSHIRE HEALTH CARE CENTER	8380 VIRGINIA ST MERRILLVILLE, IN 46410

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K0130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to remove 1 of 2 annunciators at the A wing nurses station. NFPA 101, 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient could affect all residents and staff. Findings include: Based on observation on 12/03/12 at 11:33 p.m. with the Maintenance Director, there was an abandoned generator annunciator behind the A wing nurses' station that has been disabled and is no longer in use. Based on interview at the time of observation, it was acknowledged by the Maintenance Director, the annunciator has been replaced with a new one and the old annunciator is no longer in use. 3.1-19(b)	K0130	**K130** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** **-Annunciators have been removed from facility.** **2) How the facility identified other residents:** **-No residents have been affected by this practice.** **3) Measures put into place/ System changes:** **-An audit was done to ensure that all disabled annunciators have been removed from the facility.** **4) How the corrective actions will be monitored:** **-An audit was done to ensure that all disabled annunciators have been**	12/21/2012

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			removed from the facility. **5) Date of compliance: 12/21/12**	

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/03/12 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 Surveyor: Joe L. Brown, Jr., Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee At this Life Safety Code survey, Lincolnshire Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The Therapy Room added to	K0000		

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	the original 1984 building in 2009 was surveyed with Chapter 18, New Health Care Occupancies. This one story facility 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 and spaces open to the corridors with hard wired smoke detectors in the fifty four resident rooms. The facility has a capacity of 100 and had a census of 82 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the metal shed located on the north side of the facility and the wooden shed located on the south side of the facility. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the			

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NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to remove 1 of 2 annunciators at the A wing nurses station. NFPA 101, 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient could affect all residents and staff. Findings include: Based on observation on 12/03/12 at 11:33 p.m. with the Maintenance Director, there was an abandoned generator annunciator behind the A wing nurses' station that has been disabled and is no longer in use. Based on interview at the time of observation, it was acknowledged by the Maintenance Director, the annunciator has been replaced with a new one and the old annunciator is no longer in use. 3.1-19(b)	K0130	**K130** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** **-Annunciators have been removed from facility.** **2) How the facility identified other residents:** **-No residents have been affected by this practice.** **3) Measures put into place/ System changes:** **-An audit was done to ensure that all disabled annunciators have been removed from the facility.** **4) How the corrective actions will be monitored:** **-An audit was done to ensure that all disabled annunciators have been**	12/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 12/03/2012
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			removed from the facility. **5) Date of compliance: 12/21/12**	