

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  11/17/2014
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NAME OF PROVIDER OR SUPPLIER  LINCOLNSHIRE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410
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K010000	<p>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).</p> <p>Survey Date: 11/17/14</p> <p>Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>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 surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>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 hard wired smoke detection in corridors, in spaces open to</p>	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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K010021 SS=D	<p>the corridors and in resident rooms. The facility has a capacity of 100 and had a census of 73 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached storage sheds.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 11/19/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the</p>	K010021		12/05/2014
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	<p>facility failed to ensure 2 of 8 doors to hazardous areas were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice affects staff in the kitchen and service corridor.</p> <p>Findings include:</p> <p>Based on observation on 11/17/14 with the Corporate Properties Manager, the following was noted:</p> <p>a. At 1:00 p.m., the self closing door to the maintenance shop was blocked open by a plastic wedge under the door. The room exceeded 50 square feet and contained 25-50 cardboard boxes.</p> <p>b) At 1:05 p.m., the self closing door to the clean laundry door was blocked open by a metal clothing cart.</p> <p>Based on interview at the time of observations, the Corporate Properties Manager acknowledged the doors were prevented from self closing.</p> <p>3.1-19(b)</p>		<p><b>Lincolshire Health and Rehab</b></p> <p><b>Life Safety Code Survey:</b> <b>11/17/2014</b></p> <p><b>K021 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>Magnetic holder for clean laundry door has been installed. Plastic wedge propping the maintenance shop door open has been discarded.</p> <p><b>How will the facility identify other areas having the potential to be affected by the same deficient</b></p>	

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			<p><b>practice?</b></p> <p>All doors within an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure are at risk of being affected by the same deficient practice.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>All staff have been in-serviced in regards to not propping any doors open throughout the facility. All exits have been inspected to ensure that doors are not propped open by any means.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p> <p>Maintenance Director and/or designee will inspect five doors at random three times a week for three</p>	

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K010029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1		months to ensure that doors are not propped open by any means or that motion of auto closing door mechanisms are not impeded in any way.  Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.  <b>Completion Date: 12/5/2014</b>		

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	<p>Based on observation and interview, the facility failed to ensure 1 of 8 doors to hazardous areas, such as a kitchen closed automatically or upon activation of the fire alarm system. This deficient practice affects staff in the kitchen and service corridor.</p> <p>Findings include:</p> <p>Based on observation on 11/17/14 at 1:10 p.m. with the Corporate Properties Manager, the west kitchen corridor door to the service hall lacked a door closing device. Based on interview at the time of observation, the Corporate Properties Manager acknowledged the west kitchen service hall corridor lacked a self closing device.</p> <p>3.1-19(b)</p>	K010029	<p><b>Lincolnshire Health and Rehab</b></p> <p><b>Life Safety Code Survey:</b> <b>11/17/2014</b></p> <p><b>K029 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>Auto-closing device was installed on west kitchen corridor door to the service hall.</p> <p><b>How will the facility identify other areas having the potential to be affected by the same deficient</b></p>	12/05/2014

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			<p><b>practice?</b></p> <p>All doors equipped with auto-closing devices are potentially at risk of being affected by the same deficient practice.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>Maintenance Director/designee have been in-serviced in regards to ensuring that doors equipped with auto-closing devices function properly and close securely.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p> <p>Maintenance Director and/or designee will inspect three doors equipped with auto-closing devices three times weekly for three months to ensure proper functioning and</p>	

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K010038 SS=E	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, the facility failed to ensure 1 of 9 exit door electromagnetic locks remained unlocked while the fire alarm was activated. Note: Life Safety Code (LSC) 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm	K010038	secure closure.  Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.  <b>Completion Date: 12/5/2014</b>  <b>Lincolnshire Health and Rehab</b>  <b>Life Safety Code Survey:</b> <b>11/17/2014</b>  <b>K038 NFPA 101 Life Safety Code Standard</b>  Please accept the following as the	12/05/2014			

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	<p>system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires that all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice affects at least 10 residents, staff and visitors near the B wing exit #7</p> <p>Findings include:</p> <p>Based on observation on 11/17/14 at 2:15 p.m. with the Corporate Properties Manager, the fire alarm system was activated by a pull station and all magnetically locked doors released but the doors at exit #7 relocked when the fire alarm was silenced. Based on interview during the time of observation, the Corporate Properties Manager acknowledged the magnetically locked doors at exit #7 relocked when the fire alarm system was silenced but not reset.</p> <p>3.1-19(b)</p>		<p>facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>Service provided by outside contractor to magnetically locked door at exit #7 to ensure that emergency exit connected to the fire alarm system unlocks upon receipt of a fire alarm signal by the fire alarm system protecting the premises and remains unlocked until fire alarm system is reset.</p> <p><b>How will the facility identify other areas having the potential to be affected by the same deficient practice?</b></p> <p>All magnetically locked emergency exit doors connected to the fire alarm system are potentially at risk of being affected by the same deficient</p>	

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			<p>practice.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>Maintenance Director/designee have been in-serviced on routine inspection of all magnetically locked emergency exit doors connected to the fire alarm system. All magnetically locked emergency exit doors connected to the fire alarm system will be checked by Maintenance Director/designee for proper functioning monthly during routine fire drills conducted on alternating shifts, at alternating times of the day, for alternating days of the month. Inspections will be documented on NFPA State Inspection Schedule.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p> <p>Maintenance Director and/or designee will inspect all magnetically locked emergency exit doors</p>		

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K010046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.  Based on observation and interview; the facility failed to ensure 1 of 1 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires	K010046	connected to the fire alarm system for proper functioning monthly during routine fire drills. Inspections will be documented on NFPA State Inspection Schedule and signed by Administrator monthly for a duration of three months.  Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.  <b>Completion Date: 12/5/2014</b>  <b>Lincolnshire Health and Rehab</b>  <b>Life Safety Code Survey:</b> <b>11/17/2014</b>	12/05/2014	

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	<p>a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on interview from 9:45 a.m. to 11:30 a.m. on 11/17/14 and observation from 12:30 p.m. to 2:30 p.m., with the Corporate Properties Manager, the facility has one battery operated emergency light at the generator location and lacked documentation for the annual and monthly testing of the battery operated emergency light at the generator.</p> <p>3.1-19(b)</p>		<p><b>K046 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>Facility has ensured that 1 of 1 battery operated emergency light at the generator location has been tested for proper functioning and documented accordingly on NFPA State Inspection Schedule.</p> <p><b>How will the facility identify other areas having the potential to be affected by the same deficient practice?</b></p> <p>Only one battery operated emergency</p>		

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			<p>light is located within the premises.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>Maintenance Director/designee have been in-serviced regarding battery operated emergency light testing. Maintenance Director/designee will test the battery operated emergency light at the generator location for a minimum of 90 seconds monthly and for a minimum of 90 minutes annually. Maintenance Director/designee will ensure that all battery operated emergency light tests are recorded and documented accordingly on NFPA State Inspection Schedule.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p> <p>Maintenance Director and/or designee will test the battery operated emergency light at the generator location for a minimum of 90 seconds monthly and for a</p>		

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K010050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are		<p>minimum of 90 minutes annually. Maintenance Director/designee will ensure that all battery operated emergency light tests are recorded and documented accordingly on NFPA State Inspection Schedule. Administrator will observe testing of battery operated emergency light and sign documentation monthly for a duration of three months.</p> <p>Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> <p><b>Completion Date: 12/5/2014</b></p>		

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	<p>conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 7 of 12 fire drills. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of fire drill report documentation with the Administrator on 11/17/14 at 10:00 a.m., fire drills conducted over the past four quarters on 08/31/14, 06/30/14, 05/31/14, 04/30/14, 03/30/14, 02/28/14 and 01/31/14 were held at or near the end of the month. Based on interview at the exit conference, the Administrator acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p><b>Lincolnshire Health and Rehab</b></p> <p><b>Life Safety Code Survey:</b> <b>11/17/2014</b></p> <p><b>K050 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>Facility has ensured measures are taken to conduct routine fire drills at unexpected times under varying conditions, at least quarterly per shift.</p>	12/05/2014

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			<p><b>How will the facility identify other areas having the potential to be affected by the same deficient practice?</b></p> <p>Fire drills are to be conducted at unexpected times under varying conditions, at least quarterly per shift.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>Maintenance Director/designee have been in-serviced regarding routine fire drills needing to be conducted at unexpected times under varying conditions, at least quarterly per shift and documented accordingly on NFPA State Inspection Schedule.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p>	

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K010062 SS=F	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 record review and interview, the facility failed to ensure 1 of 1	K010062	Maintenance Director and/or designee will conduct routine fire drills at unexpected times under varying conditions, at least quarterly per shift and document drills on NFPA State Inspection Schedule. Administrator will observe fire drills for each shift and sign NFPA State Inspection Schedule monthly for a duration of three months.  Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.  <b>Completion Date: 12/5/2014</b>  <b>Lincolnshire Health and Rehab</b>	12/05/2014

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	<p>automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Service Call Report" documentation during record review with the Administrator and the Corporate Properties Manager from 9:45 a.m. to 11:30 a.m. on 11/17/14, an internal pipe inspection conducted on 03/20/12 for the facility's dry sprinkler system stated, "Removed 2 inch end cap on wing closest to inspectors test port, found significant amount of rust build up. Recommend having dry pipe sprinkler system completely flushed." Based on interview at the exit conference, the Administrator was not able to provide documentation the sprinkler system had been flushed since the 03/20/12 internal pipe inspection.</p> <p>3.1-19(b)</p>		<p><b>Life Safety Code Survey: 11/17/2014</b></p> <p><b>K062 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>Water based fire protection system has been scheduled to be flushed by outside contractor at earliest appointment available. To ensure the structural integrity of water based fire protection system, service has been scheduled for no later than April 15, 2015 in order to prevent freeze-related damage to existing pipes.</p>		

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			<p><b>How will the facility identify other areas having the potential to be affected by the same deficient practice?</b></p> <p>Entire water based fire protection system on premises is potentially affected by this alleged deficient practice.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>Maintenance Director/designee have been in-serviced regarding need for 5 year Internal Pipe Inspection of water based fire protection system and scheduled service for water based fire protection system.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p> <p>Maintenance Director and/or</p>	

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K010067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2  Based on record review and interview, the facility failed to ensure 6 of 124 fire dampers were maintained. Life Safety	K010067	designee will ensure that water based fire protection system is flushed by outside contractor no later than April 15, 2015 to ensure proper functioning of system. Maintenance Director/designee will ensure that 5 year Internal Pipe Inspection of water based fire protection system is conducted accordingly in the future.  Maintenance Director/designee will present a status update summary regarding scheduled water based fire protection system service to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.  <b>Completion Date: 12/5/2014</b>  <b>Lincolnshire Health and Rehab</b>  <b>Life Safety Code Survey:</b>	12/05/2014	

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	<p>Code 4.6.12.1 requires any device required for compliance with the provisions of this Code be continuously maintained. This deficient practice could affect at least 10 residents, staff and/or visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on review, a TLC Construction Fire and Smoke Damper Inspection Report dated 01/09/13, indicated fire dampers in the main lobby (1) supply, PT area(2) supply, maintenance area (1) supply, and main dining area (2) supply had bad fusible links and new damper assemblies were ordered. Based on interview at the exit conference, the Administrator was not able to provide documentation the failed fire dampers had been repaired or replaced since the 01/09/13 fire damper inspection.</p> <p>3.1-19(b)</p>		<p><b>11/17/2014</b></p> <p><b>K067 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>Documentation has been obtained from TLC Construction indicating that all identified concerns have been remedied as of 3/19/13 and will be presented as evidence in lieu of the required plan of correction for K067.</p> <p><b>How will the facility identify other areas having the potential to be affected by the same deficient</b></p>		

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			<p><b>practice?</b></p> <p>No other areas are potentially at risk of being affected by this alleged deficient practice.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>No further measures are required in relation to this alleged deficient practice.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p> <p>No further corrective action is required to ensure that the alleged deficient practice will not recur.</p> <p><b>Completion Date: 12/5/2014</b></p>	

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K010147 SS=E	<p><b>NFPA 101</b> <b>LIFE SAFETY CODE STANDARD</b> Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 pieces of medical equipment and high current draw electrical devices were not plugged into powers strips or extension cords as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 20 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Corporate Properties Manager from 12:30 p.m. to 2:30 p.m. during a tour of the facility on 11/17/14, the following was noted:</p> <p>a) An oxygen concentrator was plugged into a power strip in resident room A22. b) A medical pump and oxygen concentrator were plugged into a power strip under the bed in resident room A25. c) A coffee pot was plugged into a power</p>	K010147	<p><b>Lincolnshire Health and Rehab</b></p> <p><b>Life Safety Code Survey:</b> <b>11/17/2014</b></p> <p><b>K147 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.</p> <p><b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b></p> <p>All identified medical equipment and high current draw electrical devices have been plugged directly into fixed wiring outlets.</p>	12/05/2014
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	<p>strip in the housekeeping office. d) The electric bed was plugged into a powerstrip in resident room B22. Based on interview at the time of observations, the Corporate Properties Manager acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		<p><b>How will the facility identify other areas having the potential to be affected by the same deficient practice?</b></p> <p>All medical equipment and high current draw electrical devices within premises are potentially at risk of being affected by this deficient practice.</p> <p><b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b></p> <p>All staff have been in-serviced regarding the need to plug medical equipment and high current draw electrical devices directly into fixed wiring outlets. Maintenance Director/designee have inspected facility for any further medical equipment and/or high current draw electrical devices that are not plugged directly into fixed wiring outlets.</p> <p><b>How will the corrective action be monitored to ensure that the</b></p>		

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K020000	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: 11/17/14  Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950	K020000	<b>deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b>  Maintenance Director/designee will audit five resident rooms at random three times a week for three months.  Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.  <b>Completion Date: 12/5/2014</b>		

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	<p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>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 2009 addition to the Therapy Room was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>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 hard wired smoke detection in the corridors, in spaces open to the corridors and in resident rooms. The facility has a capacity of 100 and had a census of 73 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage equipment sheds.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor</p>			

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K020050 SS=C	<p>on 11/19/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 7 of 12 fire drills. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of fire drill report documentation with the Administrator on 11/17/14 at 10:00 a.m., fire drills conducted over the past four quarters on 08/31/14, 06/30/14, 05/31/14, 04/30/14, 03/30/14, 02/28/14 and 01/31/14 were held at or near the end of the month. Based on interview at the exit conference, the Administrator</p>	K020050	<p><b>Lincolnshire Health and Rehab</b></p> <p><b>Life Safety Code Survey:</b> <b>11/17/2014</b></p> <p><b>K050 NFPA 101 Life Safety Code Standard</b></p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially</p>	12/05/2014	

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	acknowledged the fire drills were not held randomly.  3.1-19(b) 3.1-51(c)		requests paper compliance for this citation.  <b>What corrective action will be accomplished for those areas found to have been affected by the deficient practice?</b>  Facility has ensured measures are taken to conduct routine fire drills at unexpected times under varying conditions, at least quarterly per shift.  <b>How will the facility identify other areas having the potential to be affected by the same deficient practice?</b>  Fire drills are to be conducted at unexpected times under varying conditions, at least quarterly per shift.  <b>What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?</b>		

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			<p>Maintenance Director/designee have been in-serviced regarding routine fire drills needing to be conducted at unexpected times under varying conditions, at least quarterly per shift and documented accordingly on NFPA State Inspection Schedule.</p> <p><b>How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?</b></p> <p>Maintenance Director and/or designee will conduct routine fire drills at unexpected times under varying conditions, at least quarterly per shift and document drills on NFPA State Inspection Schedule. Administrator will observe fire drills for each shift and sign NFPA State Inspection Schedule monthly for a duration of three months.</p> <p>Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>	

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

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OMB NO. 0938-0391

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  11/17/2014
NAME OF PROVIDER OR SUPPLIER  LINCOLNSHIRE HEALTH & REHABILITATION 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	
			Completion Date: 12/5/2014		