STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING -- B. WING	08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/16/23 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 At this Emergency Preparedness survey, Lincolnshire 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 68. Quality Review completed on 08/18/23	E 0000	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 respectfully request paper compliance.	
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: 08/16/23 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 At this Life Safety Code survey, Lincolnshire	K 0000	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 respectfully request paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rita Gatson	Administrator	09/18/2023

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.

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	Health and 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 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 the corridors and in resident rooms. The facility has a capacity of 100 and had a census of 68 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for one detached storage shed. Quality Review completed on 08/18/23			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of 10 exit signs were continuously illuminated. This deficient practice could affect approximately 20 residents and staff.	K 0293	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	08/28/2023

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	Findings include: Based on observations on 08/16/23 during a tour of the facility from 09:15 a.m. to 11:51 a.m. with the Maintenance Director, VP of Operations and Administrator, the Activity Hall exit sign above the exit door and the exit sign near resident room 19 above the exit door were not illuminated. Based on an interview with the Maintenance Director at the time of observation, it was stated the exit sign light bulbs are burned out. Findings were discussed with the Maintenance Director, Administrator and VP of Operations at exit conference. 3.1.19(b)		submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The bulbs were replaced in the Activity Hall exit sign and the exit sign near Room 19.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance Director was educated on ensuring all exit signs are continuously illuminated. An audit will be completed once a month for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meetings monthly. Any deficient practice will be corrected upon occurrence.*	

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K 0761 SS=F Bldg. 01	Based on records review and interview, the facility failed to ensure annual inspection and testing of 11 of 11 fire door 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.	K 0761	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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *Fire/Smoke Door Inspection & Testing completed with written record of inspection on the 11 fire/smoke doors.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *The Maintenance Director was trained on completing an annual written record of inspection and testing of the 11 fire/smoke doors. A monthly audit*	09/07/2023

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	(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. (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. Findings include: Based on record review with the Maintenance Director and VP of Operations on 08/16/23 between 09:15 a.m. and 11:51 a.m., no documentation of an annual inspection for the (11) fire door assemblies was available for review from the last 12 months. The last documented fire door inspections were completed on 04/13/22. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspection was not completed within the last year and stated there was a change in management and could have been missing when the inspections were due. Findings were discussed with the Maintenance Director, VP of Operations and Administrator at exit conference. 3.1.19(b)		*of smoke/fire door testing logs will be conducted by the Administrator/designee to ensure compliance.* How will the corrective action be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meetings monthly for 3 months. Any deficient practice will be corrected upon occurrence.*	

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to document the transfer time to the	K 0918	Please accept the following as	08/28/2023

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	alternate power source on the monthly load tests for 11 of the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/16/23 between 09:15 a.m. and 11:51 a.m. with the VP of Operations and Maintenance Director, the Weekly Generator Checklist was reviewed over the past 11 months and lacked the transfer time from normal power to emergency power. Based on interview at the time of record review, the Maintenance Director indicated that the generator runs under load weekly and does transfer power, however it is not documented on the testing sheets. Findings were discussed with the Maintenance Director and VP of Operations at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator for 11 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of		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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The Facility started logging transfer time for emergency generator.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in the event the generator failed to transfer in a power outage.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur** *The Maintenance Director was in-serviced on logging transfer times and recording the percentage of load on the monthly emergency diesel generator test form for the monthly emergency generator load test. A monthly audit of generator logs will be conducted by the Administrator to ensure compliance.*	

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	8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on review of generator load testing documentation with the VP of Operations and Maintenance Director from 09:15 a.m. to 11:51 a.m. on 08/16/23, the load information to show the actual load percentage for the diesel powered generator was not documented. Based on interview at the time of record review, the Maintenance Director stated that he was unaware what the generator load percentage usually is, but he should be able to check on the generator. This finding was reviewed with the VP of Operations and Maintenance Director at the exit conference. 3.1-19(b)		How will the corrective action be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meetings monthly for 3 months. Any deficient practice will be corrected upon occurrence.*	
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			

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	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 2 of 2 flexible cords were not used 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. This deficient practice could affect approximately 10 staff and residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and VP of Operations on 08/16/23 between 11:56 a.m. and 1:17 p.m., a medicine dispensing unit was plugged into and was being supplied power by an extension cord in the B-wing med room. Furthermore, a coffee pot was plugged into and had power supplied by an extension cord. Based on interview at the time of observation, the Maintenance Director acknowledged the extension cords and agreed both were in use	K 0920	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. Facility cordially requests paper compliance in regards to this plan of correction. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The extension cord was removed from the B-wing med room.* *The extension cord was removed that supplying the coffee pot.*	08/28/2023

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	The finding was reviewed with the Maintenance Director, Administrator and VP of Operations at exit conference. 3.1-19(b)		**How will the facility identify other residents having the potential to be affected by the same deficient practice?** *All residents are potentially at risk of the same alleged deficient practice. Maintenance Director and Maintenance Assistant have inspected all resident rooms, med rooms, and offices to ensure flexible cords were not used as a substitute for fixed wiring, no further concerns identified.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Staff in-serviced on ensuring extension cords are not being used in med rooms and offices.* How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *Maintenance Director/designee to inspect offices and med rooms weekly to ensure flexible cords were not used as a substitute for fixed wiring for 3 months. Copy of audit will be reviewed at safety committee meetings monthly for 3 months. Any deficient practice will be corrected upon occurrence.*	

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