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

FORM APPROVED
OMB NO. 0938-0391

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	06/17/2021

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/17/21 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 76. Quality Review on 06/22/21	E 0000	The facility respectfully ask for 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: 06/17/21 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 At this Life Safety Code survey, Lincolnshire	K 0000	The facility respectfully ask for paper compliance.	

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.

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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 76 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 on 06/22/21			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 3 of 3 battery backup lights were tested monthly for 30 seconds over the past year to ensure the lights would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests,	K 0291	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**	06/24/2021

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	for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) 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 as many as 14 residents, 6 staff, and 1 visitor in the facility. Findings include: Based on record review on 06/18/21 at 10:09 a.m. with the Maintenance Director, the documentation entitled "Emergency Light Monthly Checklist" for 2021 indicated three battery operated lights located in the facility. During review of the documentation provided by the Maintenance Director, the testing of the three battery-operated emergency lights was completed for the past ten months but stopped on 03/04/2021. Based on observations during a tour of the facility with the Maintenance Director on 06/18/21 from 11:46 a.m. to 1:35 p.m., the facility had three battery operated exit lights located throughout the facility. Based on an interview at the time of the observations, the Maintenance Director acknowledged that he must have forgotten to test or document the battery-operated emergency light testing in both the April and May of 2021. During the exit conference with the facility Administrator and the Maintenance Director on 06/17/2021 at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice?** *The Facility tested all emergency lights to ensure working condition. The Facility will proceed with monthly testing and recording of emergency lights 30 seconds for 11 months and 90 minutes for 1 month.* **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 if facility lost power and emergency lights failed in an evacuation.* **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 monthly testing of all emergency lights. The emergency lights will be audited weekly 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 for 3 months.*	

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			Any deficient practice will be corrected upon occurrence.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ 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 document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all	K 0353	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?** *The Facility will proceed with weekly gauge readings of the fire sprinkler system.*	06/24/2021

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	inspections, tests, and maintenance of the system and its 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: Based on record review of the facilities vendor for sprinkler system inspections entitled "Sprinkler: Report of inspection" documentation for the most recent twelve-month period with the Maintenance Director during record review at 10:12 a.m. on 04/17/17, weekly dry sprinkler system gauge inspection documentation for 2 weeks of the most recent 52-week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 1 month of the most recent 12-month period was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review. During the exit conference with the facility Administrator and the Maintenance Director on 06/17/2021 at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**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 if sprinkler system pressure failed and gauges were not checked.* **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 weekly reading and recording of sprinkler gauges. The weekly gauge reading will be audited 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 for 3 months. Any deficient practice will be corrected upon occurrence.*	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas			

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	Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, National Electric Code, 2011 edition states energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 06/17/21 at 12:52 p.m., the electric junction box located in the corridor immediately outside Resident Room #22 was not locked or secured and could be opened by pushing on the latching mechanism. Based on interview at the time of the observation, the Maintenance Director agreed the aforementioned electrical panel in the corridor was not secured from non-authorized personnel. During the exit conference with the facility Administrator and the Maintenance	K 0511	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?** *The breaker box located in A-wing C-hall was corrected and is now locked.* **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 A-wing C-hall.* **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 electrical safety practices. A weekly random audit of electrical breaker boxes in facility will be*	06/24/2021

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	Director on 06/17/2021 at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		*conducted for 3 months.* 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 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 ensure 2 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include:	K 0712	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?** *The Facility will*	06/24/2021

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	Based on record review of the document titled "Fire Drill Report" with the Maintenance Director on 07/17/21 at 9:17 a.m., the following was noted: a) the documentation for the drill conducted on 05/21/2021 at 3:18 p.m. failed to include the verification of transmission of the fire alarm signal to the monitoring station. b) the documentation for the drill conducted on 12/31/2020 at 5:30 p.m. failed to include the verification of transmission of the fire alarm signal to the monitoring station. This drill was conducted as a silent drill, but the verification of transmission of the fire alarm signal to the monitoring station was not conducted later the next day. Based on interview at the time of record review, the Maintenance Director stated that he must have forgotten to ask or document the information on above listed fire drills. During the exit conference with the facility Administrator and the Maintenance Director on 06/17/2021 at 2:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		*proceed with monthly fire drills with emphasis on recording of the transmission of the signal documentation.* **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 if transmission of the signal failed to occur.* **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 proper recording of transmission of the fire alarm signal. Fire drill documentation will be audited 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 for 3 months. Any deficient practice will be corrected upon occurrence.*	