

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/28/12 and 11/29/12</p> <p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lincoln Centers for Rehabilitation and Healthcare 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 West building was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K0000	Preparation or execution of this plan of correction (POC) doesnot constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forthin the Statement of Deficiencies (SOD). The POC is prepared and executed solely because it is required under law. By this response, Lincoln Centers Rehab acknowledgesreceipt of the SOD and alleges that it is in compliance. Accordingly, the POC is submitted as alleged complianceas of December 21, 2012.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/29/2012
NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331		
(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	
	<p>corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 152 and had a census of 109 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has a detached twenty foot by thirty foot laundry building and a ten foot by twelve foot shed which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/05/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/28/12 and 11/29/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lincoln Centers for Rehabilitation and Healthcare 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 West building was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 152 and had a census of 109 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has a detached twenty foot by thirty foot laundry building and a ten foot by twelve foot shed which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/05/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
K0144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p>	K0144	<p>K 144: It is the policy of this facility to comply with K144 Annual load bank test will be conducted on generator for the West and East buildings on December 19, 2012 by a licensed service provider (Buckeye Power Sales Co) for the Generator set Annual Load bank test will be conducted on Generators for both buildings on an annual basis Maintenance Director re-educated on requirement of Annual load bank testing on generators Maintenance Director or designee will complete a QA check monthly to ensure compliance of annual load bank testing x 4 weeks and then quarterly thereafter. Results of this QA review will be reviewed at the QI/QA meeting. Correction date: 12/21/12</p>	12/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>residents, staff and visitors in the West building.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 11/28/12 at 11:30 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for the West building generator set for each of the past twelve months for thirty minutes, however, there was no indication of a thirty percent nameplate rated test, a measurement of operating temperature, or an annual load bank test conducted for the generator set. Based on an interview with the maintenance supervisor on 11/28/12 at 11:50 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The West building generator set was tested on an annual load bank test, but a load bank test has not been conducted in over a year. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 11/29/12 at 2:40 p.m.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors in the West building.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 11/28/12 at 11:30 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for the West building generator set for each of the past twelve months for thirty minutes, however, there was no indication of a thirty percent nameplate rated test, a measurement of operating temperature, or an annual load bank test conducted for the generator set. Based on an interview with the maintenance supervisor on 11/28/12 at 11:50 a.m., the monthly</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The West building generator set was tested on an annual load bank test, but a load bank test has not been conducted in over a year. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 11/29/12 at 2:40 p.m.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED  11/29/2012	
NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331			
(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	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/28/12 and 11/29/12</p> <p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lincoln Centers for Rehabilitation and Healthcare 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 East building was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the</p>	K0000	Preparation or execution of this plan of correction (POC) doesnot constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forthin the Statement of Deficiencies (SOD). The POC is prepared and executed solely because it is required under law. By this response, Lincoln Centers Rehab acknowledgesreceipt of the SOD and alleges that it is in compliance. Accordingly, the POC is submitted as alleged complianceas of December 21, 2012.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 152 and had a census of 109 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has a detached twenty foot by thirty foot laundry building and a ten foot by twelve foot shed which were not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/28/12 and 11/29/12</p> <p>Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370</p> <p>Surveyor: Mark Bugni, Life Safety Code</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p><b>Specialist</b></p> <p>At this Life Safety Code survey, Lincoln Centers for Rehabilitation and Healthcare 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 East building was surveyed using Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 152 and had a census of 109 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has a detached twenty foot by thirty foot laundry building and a ten foot by twelve foot shed which were not sprinklered.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
K0144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all</p>	K0144	<p>K 144: It is the policy of this facility to comply with K144 Annual load bank test will be conducted on generator for the West and East buildings on December 19, 2012 by a licensed service provider (Buckeye Power Sales Co) for the Generator set Annual Load bank test will be conducted on Generators for both buildings on an annual basis Maintenance Director re-educated on requirement of Annual load bank testing on generators Maintenance Director or designee will complete a QA check monthly to ensure compliance of annual load bank testing x 4 weeks and then quarterly thereafter. Results of this QA review will be reviewed at the QI/QA meeting. Correction date: 12/21/12</p>	12/21/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>residents, staff and visitors in the East building.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 11/28/12 at 11:30 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for the East building generator set for each of the past twelve months for thirty minutes, however, there was no indication of a thirty percent nameplate rated test, a measurement of operating temperature, or an annual load bank test conducted for the generator set. Based on an interview with the maintenance supervisor on 11/28/12 at 11:50 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The East building generator set was tested on an annual load bank test, but a load bank test has not been conducted in over a year. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 11/29/12 at 2:40 p.m.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors in the East building.</p> <p>Findings include:</p> <p>Based on a review of the Generator Testing Log Book on 11/28/12 at 11:30 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for the East building generator set for each of the past twelve months for thirty minutes, however, there was no indication of a thirty percent nameplate rated test, a measurement of operating temperature, or an annual load bank test conducted for the generator set. Based on an interview with the maintenance supervisor on 11/28/12 at 11:50 a.m., the monthly</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  11/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN 47331
---	--

(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
	<p>load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The East building generator set was tested on an annual load bank test, but a load bank test has not been conducted in over a year. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 11/29/12 at 2:40 p.m.</p> <p>3.1-19(b)</p>			