

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 03/11/2014
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NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410
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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: 03/11/14</p> <p>Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950</p> <p>Surveyors: Bridget Brown, 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		
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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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	<p>the corridors and in resident rooms. The facility has a capacity of 100 and had a census of 79 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/13/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors in 2 of 8 smoke compartments would latch into their door frames and resist the passage of smoke. This deficient practice affects staff, visitors and 10 or more residents in the center A wing and B wing smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the administrator between 11:30 a.m. and 4:00 p.m., the door to the A wing nutrition room was missing a six by 36 inch vision panel. The administrator said at the time of observation, the panel had been removed because there had been a malfunction of the door knob locking</p>	K010018	<p>K018 <i>The facility request paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law. 1) Immediate action taken for those residents identified: No residents were identified 2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken: Alleged deficient areas are located in facility common hallway areas and all</i></p>	03/25/2014	

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	mechanism. The door protecting the corridor opening to the B wing clean linen room failed to latch into the door frame. The administrator acknowledged at the time of observation, the door would not latch. 3.1-19(b)		residents, visitors and facility personnel would have the potential to be affected by this alleged deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Malfunctioning coded door entry handle was repaired on A Wing nutrition door on 3/12/14 and, subsequently, 36" vision panel was reinstalled in A Wing nutrition door on 3/12/14. Door latch repair was completed to: 1) B Wing clean linen room door and 2) south and west therapy door(s) allowing door to correctly latch into door frame. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit ten (10) doors 2 x weekly for one (1) month and, thereafter, monthly x three (3) months to: 1) monitor to proper latch/self closure mechanism function 2) ensuring no impediments and/or 3) correct door coordinator function. Audit results will be reviewed in monthly QA meetings. 5) What date the systematic changes will be completed. March 25th, 2014		

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K010021 SS=E	<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 facility failed to ensure doors to hazardous areas and smoke barriers in 2 of 9 smoke compartments were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 20 or more residents in the dining room and service corridor smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the administrator on 03/11/14 at 3:00 p.m., the kitchen exit door to the service corridor was equipped with a self closer. The door stood wide open, and upon closer inspection the door was found to "catch" on an uneven floor which allowed</p>	K010021	<p>K021</p> <p><i>The facility request paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice</p>	03/25/2014
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	<p>it to remain open unless pulled closed. The administrator acknowledged at the time of observation, the door was prevented from closing.</p> <p>b. Based on observation with the administrator on 03/11/14 between 3:15 p.m. and 4:00 p.m., the self closing doors to the unoccupied laundry and maintenance shop were prevented from closing. The laundry door by a five gallon bucket and the maintenance shop door by a string wound around the door knob and tied to the counter behind it. The administrator acknowledged at the time of observation, the doors were prevented from self closing.</p> <p>c. Based on observation with the administrator on 03/11/14 at 4:00 p.m., the smoke barrier door set separating the main lobby from the dining room swung in the same direction. A door coordinator was attached to the door frame. When the fire alarm was activated on 03/11/14 at 4:00 p.m., one door in the smoke barrier double door set failed to close. It was held open by the door coordinator. The administrator acknowledged at the time of observation, the coordinator was malfunctioning.</p> <p>3.1-19(b)</p>		<p>will be identified and what corrective actions will be taken:</p> <p>Alleged deficient areas are located in facility common areas and all residents, visitors and facility personnel would have the potential to be affected by this alleged deficient practice.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Repair work completed to kitchen door which corrected the alleged issue of door catching on the floor allowing self-closer to properly function.</p> <p>Administrator, or designee, completed in-servicing to laundry, dietary and maintenance personnel regarding impediment(s) to door closure.</p> <p>Facility completed repair work the door coordinator/self closure mechanism(s) on the smoke barrier door(s) separating main lobby/dining room. Following these repairs on-going testing confirmed fire doors functioned correctly upon every closure.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>				

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			<p>Administrator, or designee, will audit ten (10) doors 2 x weekly for one (1) month and, thereafter, monthly x three (3) months to: 1) monitor to proper latch/self closure mechanism function 2) ensuring no impediments and/or 3) correct door coordinator function. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure ceiling and wall smoke barrier penetrations in 2 of 9 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient could affect visitors, staff and 10 or more residents in the service corridor and dining room smoke compartments.</p>	K010025	<p>K025</p> <p><i>The facility request paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p>	03/25/2014
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	<p>Findings include:</p> <p>Based on observation with the administrator between 2:00 p.m. and 4:00 p.m., ceiling and wall penetrations were found:</p> <p>a. Unsealed around wires penetrating the smoke barrier near the dining room and conference room above the lay in ceilings leaving gaps of one half inch;</p> <p>b. In the kitchen cooler, where expandable foam was used to seal the two inch gap around conduit penetrating into the freezer;</p> <p>c. In the electrical and emergency generator transfer switch room where expandable foam was used to seal a three inch gap around conduit supplying power to the emergency generator circuits.</p> <p>The administrator acknowledged the unsealed gaps identified, and the materials in use to seal penetrations, at the time of observations.</p> <p>3.1-19(b)</p>		<p>Alleged area of penetration noted in the smoke barrier near dining and conference room is located in facility common area. All residents, visitors and facility personnel would have the potential to be affected by this alleged deficient practice.</p> <p>Areas where expandable foam was identified in kitchen cooler and electrical room are areas where access is restricted to facility personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Identified penetration noted in the smoke barrier near dining and conference room was repaired 3/12/14.</p> <p>Expandable foam noted in: 1) kitchen cooler and 2) electrical room was removed and repair was completed with approved fire prevention material to seal identified penetration(s).</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will audit facility smoke barrier(s),</p>		

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			<p>offices and mechanical area(s) 2 x weekly for one (1) month and, thereafter, monthly x three (3) months to ensure proper sealant of smoke compartments. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K010029 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure doors to hazardous areas, such as a storage rooms larger than 50 square feet in size, kitchens and storage locations for soiled linen receptacles larger than 32 gallons in 3 of 9 smoke compartments, closed automatically or upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 30 or more residents in the A wing, dining room, and service corridor smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the administrator on 03/11/14 at 3:00 p.m., the self closing corridor door between the</p>	K010029	<p>K029</p> <p><i>The facility request paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be</p>	03/25/2014			

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	<p>kitchen and service corridor failed to latch into the door frame when tested twice. The door could be pushed open. The administrator acknowledged at the time of observation, the latch was not working.</p> <p>b. Based on observation with the administrator on 03/11/14 at 3:45 p.m., the self closing corridor door separating the A wing shower room identified with a red hazard sign and used for the collection of two 50 gallon, half full, soiled linen barrels was tested twice. Each time the door failed to latch into the door frame.</p> <p>c. Based on observation with the administrator on 03/11/14 at 3:10 p.m., the nine by ten foot room used to store 20 or more combustible cardboard cartons containing medical records had no self closer. The administrator said at the time of observation, he was unaware the room needed a self closing door.</p> <p>3.1-19(b)</p>		<p>taken: Alleged deficient areas are located in facility common areas where residents, visitors and facility personnel would have the potential to be affected by this alleged deficient practice.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Door latch and/or self closure mechanism repair was completed to: 1) kitchen/service corridor door and 2) A Wing Soiled utility room allowing door to properly close/latch into door frame.</p> <p>Self closure mechanism was installed in the medical records room connected to the main dining room.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit ten (10) doors 2 x weekly for one (1) month and, thereafter, monthly x three (3) months to: 1) monitor to proper latch/self closure mechanism function 2) ensuring no impediments and/or 3) correct door coordinator function. Audit results will be reviewed in monthly QA</p>	

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K010038 SS=E	<p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 3 kitchen exit doors were provided with the means to readily open the doors under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect 6 or more visitors and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 at 2:50 p.m., two doors providing exit through the dining room from the kitchen were each equipped with dead bolt latches and a lever by which to open the doors. When the dead bolt latches were engaged, two actions were required to open the doors, turning the dead bolt and pushing the</p>	K010038	<p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>Alleged deficient areas are located in facility common/egress areas where all residents, visitors and facility personnel would have the potential to be affected by this alleged deficient practice.</p> <p>3) What measures will be</p>	04/10/2014			

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	<p>lever. The administrator acknowledged at the time of observations, the doors could not be opened with a single action if the dead bolts were engaged.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 exit doors equipped with magnetic locks, were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 says door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects visitors, staff and 20 or more residents on A wing.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 03/11/14 at 3:40 p.m., the emergency exit door from the A wing</p>		<p>put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Door levers and deadbolt mechanism(s) were removed from kitchen door egress door(s). Maintenance shall install "Storage Room Style" door knobs on each door, ensure doors are provided with self-closing mechanism, and the doors upon closing will latch into the frame and lock. This action will provide a positive latching system and ensure a single action motion to open the door as needed, especially in an emergency situation.</p> <p>Egress keypad code was posted on the emergency exit door in the A Wing lounge.</p> <p>Administrator has authorized concrete repair via contracted vendor to repair uneven grade/irregularities to the concrete walking surface in the southwest A Wing emergency egress.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will audit ten (10) doors 2 x weekly for one (1) month and, thereafter, monthly x three (3) months to: 1)</p>	

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	<p>lounge was magnetically locked. The lock would release by entering a code at the keypad located beside the exit door. The code was not posted. The Administrator confirmed at the time of observation, the resident population was not limited to residents with cognitive impairment.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 9 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 20 or more residents on A wing.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 at 4:15 p.m., the concrete exit discharge surface for the southwest A wing was damaged by a uneven crack across the surface of the exit discharge, with pitting and a change of grade of one half to three fourths</p>		<p>monitor proper latch/self closure mechanism function 2) ensuring no impediments 3) emergency egress code posting and/or 4) correct door coordinator function. Audit results will be reviewed in monthly QA meetings.</p> <p>Administrator, or designee, will audit facility emergency egress exits 1 x weekly for three (3) months to monitor for level surfaces. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. April 10th, 2014</p>				

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	<p>inches contributing to irregularities in the walking surface. The administrator acknowledged the damage at the time of observation.</p> <p>3.1-19(b)</p>			

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K010045 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure exit egress lighting for 1 of 9 smoke compartment emergency exit lights was arranged so a failure of any single bulb would not leave the area in darkness. This deficient practice affects visitors, and 20 or more staff in the kitchen and service corridor.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 between 11:30 a.m. and 3:00 p.m., the illuminated exit egress signs in the kitchen and service corridor were designed for use with two bulbs. One exit light in the kitchen was unlit and another had a single bulb burning. Exit egress lighting for each end of the service corridor had a single operating bulb and the second unlit one. The administrator acknowledged the means of egress would be unlit if the remaining bulbs failed.</p> <p>3.1-19(b)</p>	K010045	<p>K045</p> <p><i>The facility request paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>Alleged deficient areas are located in facility egress areas and all residents, visitors and facility personnel would have the potential to be affected by this</p>	03/25/2014			

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			<p>alleged deficient practice.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Identified non-illuminated bulbs within exit egress signs in the kitchen/service corridor have been replaced with higher performance LED bulbs. Systemically, facility will switch all exit egress signage to LED bulbs longer bulb life and brighter exit egress signage illumination.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit ten (10) egress exit signs 2 x weekly for one (1) month and, thereafter, monthly x three (3) months. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>		

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to ensure the diagram of emergency exit routes was consistent with signs posted in the facility. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Emergency Exit Routes diagram provided by the administrator on 03/11/14 at 12:35 p.m., the diagram labeled exits from the dining room and B wing lounge as exits. During a tour with the administrator on 03/11/14 between 2:00 p.m. and 4:15 p.m., the doors at these exits were provided with signs which notified occupants they were not exits. The administrator agreed at the time of record review, the evacuation diagram and posted signs were confusing.</p> <p>3.1-19(b)</p>	K010048	<p>K048</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic</p>	03/25/2014			

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			<p>changes will be made to ensure that the deficient practice does not recur: Administrator revised emergency exit route diagram removing dining room and B wing lounge as posted emergency exit routes. Revisions have been made to both posted emergency egress diagrams and within facility's disaster plan.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit emergency egress signage two (2) x weekly for one (1) month and, thereafter, monthly for three (3) months. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K010050 SS=F	<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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Monthly Fire Drill Reports with the administrator on 03/11/14 at 12:45 p.m., there was no record of a third shift fire drill for the fourth quarter during 2013. The administrator reviewed the reports for a second time and acknowledged fire drill records were not complete.</p> <p>3.1-9(b) 3.1-51(c)</p>	K010050	<p>K050</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p>	03/25/2014			

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			<p>The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Administrator in-serviced facility maintenance director regarding: 1) conducting facility fire drills, at minimum, quarterly on each shift 2) documenting the CST each fire drill is conducted for facility personnel and 3) education of facility shift times.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit fire drill documentation monthly x three (3) months. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K010062 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 9 smoke compartments were free of corrosion. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 20 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 at 3:05 p.m., four sprinkler heads in the kitchen were turning green, usually evidence of corrosion. The administrator acknowledged at the time of observations, the sprinklers were corroding.</p> <p>3.1-19(b)</p>	K010062	<p>K062</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p> <p>3) What measures will be</p>	03/26/2014			

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			<p>put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Contracted fire service provider visited facility 3/20/14 and verified that alleged four (4) deficient sprinkler heads were still in safe and operable condition. As a preventative measure, Administrator authorized contracted fire service provider to not only replace the four (4) alleged deficient sprinkler heads in question, but also all other sprinkler heads located in the kitchen. Fire service provider scheduled to complete kitchen sprinkler head repair work on 3/26/14.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will follow contracted fire service provider quarterly sprinkler reports completing repair/maintenance as identified.</p> <p>5) What date the systematic changes will be completed. March 26th, 2014</p>	

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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to enforce a no smoking policy and ensure cigarette butts were deposited into a noncombustible container in 1 of 1 areas where smoking was obvious. This deficient practice had the potential to affect 10 or more residents utilizing the employee entrance and service corridor.</p> <p>Findings include:</p> <p>Based on observation on 03/11/14 with the administrator at 3:20 p.m., the grass,</p>	K010066	<p>K066</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p>	03/25/2014
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	loading dock and concrete parking area adjacent to the emergency generator and employee entrance were carpeted with cigarette butts. The administrator said at the time of observation, the facility was a "no smoking campus" and acknowledged the facility's employees disposed of cigarette butts on the ground and throughout the grassy area. 3.1-19(b)		<p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken: The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Identified cigarette butts were removed from employee entrance and emergency generator area. Facility personnel re-educated about facility no smoking policy.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will conduct audits of facility grounds weekly x four (4) weeks and, thereafter, monthly x three (3) months to monitor for compliance. Audit results will be</p>		

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			<p>reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 2 of 2 space heaters were equipped with heating elements which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects visitors, staff and 20 or more residents in the A and B wing lounges.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 between 11:30 a.m. and 4:00 p.m., electric fireplaces were observed in the the occupied A and B wing lounges. The administrator said at the time of observation the fireplaces were decorative and had no heating element, however, upon closer inspection the electric installation was encased in a box usually required to contain heat sources. The administrator interviewed the staff at the adjacent nurses station and found the fireplace was operated by a remote which identified a heat feature allowing the temperature to be raised or lowered. There was nothing to indicate</p>	K010070	<p>K070</p> <p><i>The facility request paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p>	03/25/2014			

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	<p>the limit of the heating element. The administrator said at the time of observations, he had no evidence the space heating fireplace elements would not exceed the 212 F degree limit. A review of facility policy and procedures on 03/11/14 at 1:55 p.m. did not produce a policy and procedure for the use of space heaters. The administrator confirmed on 03/11/14 at 4:35 p.m., he had no policy for the use of space heaters.</p> <p>3.1-19(b)</p>		<p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Identified electric fireplaces in A/B Wing lounges were immediately removed and discarded by facility.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will conduct audits of facility weekly x four (4) weeks and, thereafter, monthly x three (3) months to monitor that portable space heating devices are not used within facility. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>		

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure electrical wiring and equipment was in compliance with NFPA 70, National Electrical Code, in 2 of 8 smoke compartments. NFPA 70, 1999 edition, Article 300-11(a) states raceways, cable assemblies, boxes, cabinets and fittings shall be securely fastened in place. This deficient practice could affect 10 or more staff and visitors in the service corridor smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation with the administrator on 03/11/14 at 3:20 p.m., conduit for the HVAC system sensor control box ran to a junction box on the exterior of the vertical duct in the HVAC equipment room. The box hung from the conduit without support. The administrator acknowledged at the time of observation, the conduit was not intended to be used as a hanger for equipment attached to it.</p> <p>b. Based on observation with the administrator on 03/11/14 at 2:00 p.m., flexible metal conduit located near the southwest dining room smoke barrier was</p>	K010147	<p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic</p>	03/25/2014			

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	<p>used as the support for a bundle of wires above the lay in ceiling. The administrator acknowledged at the time of observation, the conduit was not meant to carry the weight of other materials.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 30 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 at 2.00 p.m., a junction box above the lay in ceiling near the southwest dining room smoke barrier was left uncovered with multiple wires exposed. The administrator acknowledged at the time of observation, the box was uncovered.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview,</p>		<p>changes will be made to ensure that the deficient practice does not recur: HVAC sensor unit was securely fastened to HVAC ductwork.</p> <p>Wires running above lay-in ceiling near the southwest dining room smoke barrier were re-rerouted and secured eliminating contact/support with metal conduit and/or sprinkler piping. Additionally, cover for electrical junction box was re-installed.</p> <p>Administrator in-serviced facility maintenance personnel regarding three (3) foot storage clearance of items located within electrical equipment rooms.</p> <p>Extension cords/power strip cords were removed from: 1) admissions office 2) B Wing Pantry 3) resident room #10 and 4) B Wing Unit Manager office. Administrator re-inserviced department manager staff 3/25/14.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will audit facility smoke barrier(s), office and mechanical area(s) 2 x weekly for one (1) month and,</p>	
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	<p>the facility failed to ensure electrical equipment rooms in 1 of 8 smoke compartments were provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects 30 or more staff, and visitors in the service corridor smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 at 3:20 p.m., two electrical rooms housing electrical circuit panels and emergency generator transfer switch equipment were located behind the maintenance shop. Maintenance equipment carts, equipment parts and tools were stored immediately in front of and abutting the electrical equipment in both rooms. The administrator acknowledged at the time of observation, a three foot clearance had not been maintained to allow access to the electrical equipment.</p>		<p>thereafter, monthly x three (3) months to ensure proper use of electrical wiring and electrical equipment. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>				

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	<p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 4 of 8 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, 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 staff, visitors, and 10 or more residents in the west A wing, administrative offices, and two B wing smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the administrator on 03/11/14 between 2:00 p.m. and 4:00 p.m., power strip extension cords were used to supply power to a coffle pot and microwave in the Admissions office, a microwave and refrigerator in the B wing pantry, and an oxygen concentrator in resident room 10.</p> <p>b. Based on observation with the administrator on 03/11/14 at 2:40 p.m., an extension cord was piggybacked to a power strip to supply power to a refrigerator in the B wing unit manager's office. The administrator acknowledged at the time of observation, the flexible</p>			
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	<p>cords which were in use.</p> <p>3.1-19(b)</p>			
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K010154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 79 of 79 residents in the event the automatic sprinkler system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could</p>	K010154	<p>K154</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect</p>	03/25/2014	

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	<p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Procedures (revised 2014) and Fire Watch Policy (undated) provided as evidence of procedures to follow in the event the automatic sprinkler system was out of service with the administrator on 03/11/14 at 12:55 p.m., the policy was not complete and consisted of two documents which were each incomplete. A Fire Watch Policy did not identify the fire watch was required if the sprinkler system system was out of service for four hours in a 24 hour period; it said to initiate the fire watch if the system was out of service "for a period longer than 4 hours." In addition it identified staff in each department to conduct the fire watch without regard for whether they were assigned to other duties as well. The second Facility Fire Watch Procedure included the 24 hour parameter for initiating the fire watch, however there was no mention of notifying ISDH or whether staff assigned to conduct a fire watch had other duties. The administrator acknowledged at the time of record review, each document was incomplete and could be confusing.</p> <p>3.1-19(b)</p>		<p>all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Administrator obtained the revised corporate Facility Fire Plan and Procedures including fire watch procedures whose purpose states: <i>"To establish a plan of action should the Fire Alarm System or Sprinkler System be out of service for more than 4 hours in a 24 hour period or inoperable."</i></p> <p>Item #5 of this revised fire watch procedure states: <i>"if the sprinkler system or fire alarm system is inoperable notify ISDH at: (317)233-7241."</i></p> <p>Additionally, item #7 of this revised fire watch procedure states: <i>"fire watch shall be performed by a person required by the local fire chief who has been certified at the mandatory fire fighting training level."</i></p> <p>Administrator educated all departmental managers of the revised plan and procedures on 3/25/14 and these revised plan and procedures were incorporated into the facility disaster plan.</p> <p>4) How the corrective</p>				

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			<p>actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will ensure revised facility procedures are received timely and implemented via staff education and integration into facility policies and procedures.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K010155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 79 of 79 residents in the event the automatic fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p>	K010155	<p>K155</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect all residents, visitors and facility</p>	03/25/2014

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	<p>Findings include:</p> <p>Based on review of the facility's Fire Watch Procedures (revised 2014) and Fire Watch Policy (undated) provided as evidence of procedures to follow in the event the automatic fire alarm system was out of service with the administrator on 03/11/14 at 12:55 p.m., the policy was not complete and consisted of two documents which were each incomplete. A Fire Watch Policy did not identify the fire watch was required if the fire alarm system was out of service for four hours in a 24 hour period; it said to initiate the fire watch if the system was out of service "for a period longer than 4 hours." In addition it identified staff in each department to conduct the fire watch without regard for whether they were assigned to other duties as well. The second Facility Fire Watch Procedure included the 24 hour parameter for initiating the fire watch, however there was no mention of notifying ISDH or whether staff assigned to conduct a fire watch had other duties. The administrator acknowledged at the time of record review, each document was incomplete and could be confusing.</p> <p>3.1-19(b)</p>		<p>personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Administrator obtained the revised corporate Facility Fire Plan and Procedures including fire watch procedures whose purpose states: "To establish a plan of action should the Fire Alarm System or Sprinkler System be out of service for more than 4 hours in a 24 hour period or inoperable." Item #5 of this revised fire watch procedure states: "if the sprinkler system or fire alarm system is inoperable notify ISDH at: (317)233-7241." Additionally, item #7 of this revised fire watch procedure states: "fire watch shall be performed by a person required by the local fire chief who has been certified at the mandatory fire fighting training level." Administrator educated all departmental managers of the revised plan and procedures on 3/25/14 and these revised plan and procedures were incorporated into the facility disaster plan.</p> <p>4) How the corrective actions will be monitored to</p>		

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			<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will ensure revised facility procedures are received timely and implemented via staff education and integration into facility policies and procedures.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K020000	<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: 03/11/14</p> <p>Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950</p> <p>Surveyor: Bridget Brown, 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</p>	K020000		
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	<p>to the corridors and in resident rooms. The facility has a capacity of 100 and had a census of 79 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>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K020018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure doors in 1 of 1 smoke compartments would latch into their door frames. This deficient practice affects staff, visitors and 10 or more residents in the physical therapy room.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 03/11/14 at 2:10 p.m., the south and west physical therapy access doors each failed to latch into their door frames. The administrator said at the time of observation, the latches appeared to be defective.</p>	K020018	<p>K018<i>The facility request paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law. 1) Immediate action taken for those residents identified: No residents were identified 2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken: Alleged deficient areas are located in facility common hallway areas and all residents, visitors and facility personnel would have the potential to be affected by this alleged deficient practice. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p>	03/25/2014	

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			<p>Malfunctioning coded door entry handle was repaired on A Wing nutrition door on 3/12/14 and, subsequently, 36" vision panel was reinstalled in A Wing nutrition door on 3/12/14. Door latch repair was completed to: 1) B Wing clean linen room door and 2) south and west therapy door(s) allowing door to correctly latch into door frame. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit ten (10) doors 2 x weekly for one (1) month and, thereafter, monthly x three (3) months to: 1) monitor to proper latch/self closure mechanism function 2) ensuring no impediments and/or 3) correct door coordinator function. Audit results will be reviewed in monthly QA meetings. 5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K020048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1</p> <p>Based on record review, observation and interview; the facility failed to ensure the diagram of emergency exit routes was consistent with signs posted in the facility. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Emergency Exit Routes diagram provided by the administrator on 03/11/14 at 12:35 p.m., the diagram labeled exits from the dining room and B wing lounge as exits. During a tour with the administrator on 03/11/14 between 2:00 p.m. and 4:15 p.m., the doors at these exits were provided with signs which notified occupants they were not exits. The administrator agreed at the time of record review, the evacuation diagram and posted signs were confusing.</p> <p>3.1-19(b)</p>	K020048	<p>K048</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic</p>	03/25/2014			

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			<p>changes will be made to ensure that the deficient practice does not recur: Administrator revised emergency exit route diagram removing dining room and B wing lounge as posted emergency exit routes. Revisions have been made to both posted emergency egress diagrams and within facility's disaster plan.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit emergency egress signage two (2) x weekly for one (1) month and, thereafter, monthly for three (3) months. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>		

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K020050 SS=F	<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 ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Monthly Fire Drill Reports with the administrator on 03/11/14 at 12:45 p.m., there was no record of a third shift fire drill for the fourth quarter during 2013. The administrator reviewed the reports for a second time and acknowledged fire drill records were not complete.</p> <p>3.1-9(b) 3.1-51(c)</p>	K020050	<p>K050</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p>	03/25/2014			

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			<p>The alleged deficient practice would have the potential to affect all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Administrator in-serviced facility maintenance director regarding: 1) conducting facility fire drills, at minimum, quarterly on each shift 2) documenting the CST each fire drill is conducted for facility personnel and 3) education of facility shift times.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator, or designee, will audit fire drill documentation monthly x three (3) months. Audit results will be reviewed in monthly QA meetings.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>		

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K020154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 79 of 79 residents in the event the automatic sprinkler system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could</p>	K020154	<p>K154</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect</p>	03/25/2014
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	<p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Watch Procedures (revised 2014) and Fire Watch Policy (undated) provided as evidence of procedures to follow in the event the automatic sprinkler system was out of service with the administrator on 03/11/14 at 12:55 p.m., the policy was not complete and consisted of two documents which were each incomplete. A Fire Watch Policy did not identify the fire watch was required if the sprinkler system was out of service for four hours in a 24 hour period; it said to initiate the fire watch if the system was out of service "for a period longer than 4 hours." In addition it identified staff in each department to conduct the fire watch without regard for whether they were assigned to other duties as well. The second Facility Fire Watch Procedure included the 24 hour parameter for initiating the fire watch, however there was no mention of notifying ISDH or whether staff assigned to conduct a fire watch had other duties. The administrator acknowledged at the time of record review, each document was incomplete and could be confusing.</p> <p>3.1-19(b)</p>		<p>all residents, visitors and facility personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Administrator obtained the revised corporate Facility Fire Plan and Procedures including fire watch procedures whose purpose states: <i>"To establish a plan of action should the Fire Alarm System or Sprinkler System be out of service for more than 4 hours in a 24 hour period or inoperable."</i></p> <p>Item #5 of this revised fire watch procedure states: <i>"if the sprinkler system or fire alarm system is inoperable notify ISDH at: (317)233-7241."</i></p> <p>Additionally, item #7 of this revised fire watch procedure states: <i>"fire watch shall be performed by a person required by the local fire chief who has been certified at the mandatory fire fighting training level."</i></p> <p>Administrator educated all departmental managers of the revised plan and procedures on 3/25/14 and these revised plan and procedures were incorporated into the facility disaster plan.</p> <p>4) How the corrective</p>				

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			<p>actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will ensure revised facility procedures are received timely and implemented via staff education and integration into facility policies and procedures.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	

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K020155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 79 of 79 residents in the event the automatic fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.</p>	K020155	<p>K155</p> <p><i>The facility requests paper compliance for this citation. This Plan of Correction (herein POC) is the center's allegation of credible compliance. Preparation and/or execution of this POC does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p>1) Immediate action taken for those residents identified: No residents were identified</p> <p>2) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken:</p> <p>The alleged deficient practice would have the potential to affect all residents, visitors and facility</p>	03/25/2014
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NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410		
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	<p>Findings include:</p> <p>Based on review of the facility's Fire Watch Procedures (revised 2014) and Fire Watch Policy (undated) provided as evidence of procedures to follow in the event the automatic fire alarm system was out of service with the administrator on 03/11/14 at 12:55 p.m., the policy was not complete and consisted of two documents which were each incomplete. A Fire Watch Policy did not identify the fire watch was required if the fire alarm system was out of service for four hours in a 24 hour period; it said to initiate the fire watch if the system was out of service "for a period longer than 4 hours." In addition it identified staff in each department to conduct the fire watch without regard for whether they were assigned to other duties as well. The second Facility Fire Watch Procedure included the 24 hour parameter for initiating the fire watch, however there was no mention of notifying ISDH or whether staff assigned to conduct a fire watch had other duties. The administrator acknowledged at the time of record review each document was incomplete and could be confusing.</p> <p>3.1-19(b)</p>		<p>personnel.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Administrator obtained the revised corporate Facility Fire Plan and Procedures including fire watch procedures whose purpose states: "To establish a plan of action should the Fire Alarm System or Sprinkler System be out of service for more than 4 hours in a 24 hour period or inoperable." Item #5 of this revised fire watch procedure states: "if the sprinkler system or fire alarm system is inoperable notify ISDH at: (317)233-7241." Additionally, item #7 of this revised fire watch procedure states: "fire watch shall be performed by a person required by the local fire chief who has been certified at the mandatory fire fighting training level." Administrator educated all departmental managers of the revised plan and procedures on 3/25/14 and these revised plan and procedures were incorporated into the facility disaster plan.</p> <p>4) How the corrective actions will be monitored to</p>		

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 03/11/2014
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			<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Administrator, or designee, will ensure revised facility procedures are received timely and implemented via staff education and integration into facility policies and procedures.</p> <p>5) What date the systematic changes will be completed. March 25th, 2014</p>	