STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 01 B. WING	11/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/28/16 Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in spaces open to the corridors and in resident rooms. The facility has a capacity of 100 and had a census of 80 at the time of this survey.	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached storage sheds. Quality Review completed on 12/01/16 - DA			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 Laundry and 1 of 1 Kitchen doors were only held open by a release device complying with LSC 7.2.1.8.2 that automatically closes such doors upon activation of the fire alarm system. This deficient practice could affect all occupants in the same	K 0223	K223 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. does not*	12/14/2016

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	smoke compartment as the laundry and kitchen. Findings include: Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 11:02 a.m. then again at 11:19 a.m., the Laundry Room contained fuel-fired dryers. One of two corridor doors had a device on the wall to hold the door open. Then again, the Kitchen contained three separate 32 gallon containers of trash. One of the five corridor doors had a device on the wall to hold the door open. Based on interview at the time of each observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged each aforementioned condition and confirmed both hold open devices do not release with the fire alarm. 3.1-19(b)		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **1. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The alleged deficient areas are located in facility common areas where residents, visitors, and facility personnel would have the potential to be affected by this	

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			alleged deficient practice. **2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Door-holding device was removed from: 1) Service hallway kitchen door and 2) Service hallway laundry door, allowing door to remain closed unless being temporarily opened. **3. How the corrective action(s) 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)	

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			ensure no door-holding devices (that aren't connected with the fire system) are used or installed 2) monitor proper usage of door by remaining closed unless passing through aforementioned door. Audit results will be reviewed in monthly QA meetings. - - **4. The date the systemic changes will be completed.** December 14, 2016	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 1. Based on observation, the facility failed to meet 1 of 6 corridors clear width requirement exception per 19.2.3.4(5). LSC 19.2.3.4(5) requires where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture. 19.2.3.4(5)(a) the fixed furniture is	K 0232	K232 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. does not*	12/14/2016

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	securely attached to the floor or to the wall. This deficient practice could affect staff and up to 5 residents from the Activity room. Findings include: Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 10:12 a.m., two chairs were located in the corridor outside of the Administrator's office. When tested, the chair was able to be moved around the corridor. Based on interview at the time of observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged the aforementioned condition and confirmed the chair was not secured. 3.1-19(b) 2. Based on observation, the facility failed to meet 1 of 6 corridors clear width requirement exception per 19.2.3.4(1). LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could affect staff		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The 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.	

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	only. Findings include: Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 11:08 a.m., transport carts were in the service corridor. When measured, the clear width was fourty two inches. Based on interview at the time of observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)		**3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The identified non-anchored chairs in resident-use corridor with less than eight (8) foot width have been moved to a location with greater than eight (8) foot width. Staff in-serviced regarding the correct placement of fixed furniture. Staff in-serviced not to store carts in non-resident-use corridor, as the width from the cart to the corridor wall is only 42 inches. Staff in-serviced regarding minimum width of 44 inches in non-resident-use corridor. **4. How the corrective action(s) 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 ten (10) rounds weekly for one (1) month and, thereafter,	

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			monthly x three (3) months. Audit results will be reviewed in monthly QA meetings. - - **5. The date the systemic changes will be completed.** December 14, 2016	
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler			

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	Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to maintain protection of 1 of 1 Mechanical Room 3 in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing and have no impediments to latching. This deficient practice could affect all occupants in the same smoke compartment as the Main Dining room. Findings include: Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 10:20 a.m., the Mechanical Room 3 contained fuel-fired equipment. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Maintenance Director,	K 0321	K321 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:**	12/14/2016

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	the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged the aforementioned condition. 3.1-19(b)		No residents were identified. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The 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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The identified mechanical room door was repaired by the installation of a self-closure mechanism.	

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			4. How the corrective action(s) 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 two (2) x weekly for one (1) month and, thereafter, monthly x three (3) months to: 1) monitor proper latch/self-closure mechanism function 2) ensure no door impediments. Audit results will be reviewed in monthly QA meetings. - - **5. The date the systemic changes will be completed.** December 14, 2016	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour			

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	period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manage on 11/28/16 at 10:45 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company. Based on an interview record review, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged the aforementioned condition.	K 0346	K346 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified.	12/14/2016

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	3.1-19(b)		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The 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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The fire watch policy was revised and includes contacting the insurance company when the fire alarm system is out of services for more than four (4) hours in a twenty-four (24) hour period. Emergency action plan binders updated with revised policy and staff in-serviced over the revision. **4. How the corrective**	

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			action(s) 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 one (1) in-service weekly for one (1) month and, thereafter, monthly x three (3) months. Audit results will be reviewed in monthly QA meetings. - - **5. The date the systemic changes will be completed.** December 14, 2016	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 9:57 a.m., the sprinkler system was inspected quarterly. No documentation was available for the monthly gauges or control valves inspection. Based on interview at the time of observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate	K 0353	K353 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified.	12/14/2016

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(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
	Properties Manager acknowledged the aforementioned condition. 3.1-19(b)		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The 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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Documentation will be provided for the monthly inspection, and maintenance if necessary, of the sprinkler system. Gauges and control valves will be inspected, and maintained if necessary, monthly. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	155650	A. BUILDING 01 B. WING	11/28/2016

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			assurance program will be put into place: Maintenance Director, or designee, will conduct and document one (1) inspection every (1) month on a log. The Administrator will audit the completion of this log one (1) x every one (1) month for three (3) months. If maintenance is necessary, Maintenance Director will inform Administrator to ensure the issue is resolved. After three (3) months of audits, the facility's Safety Committee will determine if continuing the audits is necessary. - - **5. The date the systemic changes will be completed.** December 14, 2016	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated			

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	representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			
	Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 10:45 a.m., the facility provided fire watch	K 0354	K354 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:**	12/14/2016

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	documentation but it was incomplete. The plan failed to include contacting the insurance company. Based on an interview record review, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged the aforementioned condition. 3.1-19(b)		No residents were identified. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The 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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The fire watch policy was revised and includes contacting the insurance company when the sprinkler system is out of services for more than ten (10) hours in a twenty-four (24) hour period. Emergency action plan binders updated with revised policy and	

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			staff in-serviced over the revision. **4. How the corrective action(s) 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 one (1) in-service weekly for one (1) month and, thereafter, monthly x three (3) months. Audit results will be reviewed in monthly QA meetings. **5. The date the systemic changes will be completed.** December 14, 2016	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10			

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	Based on observation and interview, the facility failed to ensure 1 of 1 Therapy portable fire extinguishers was installed correctly in accordance with 19.3.5.12. NFPA 10, the Standard for Portable Fire Extinguishers, 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 pounds shall be installed so that the top of the fire extinguisher is not more than 5 feet above the floor. This deficient practice could affect staff and at least 5 residents in Therapy. Findings include: Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 11:55 a.m., the Therapy fire extinguisher measured 65 inches from the top of the extinguisher to the floor. Based on interview at the time of observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)	K 0355	K355 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **2. How other residents having the potential to be affected by the same deficient practice will be identified and**	12/14/2016

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			what corrective action(s) will be taken: The 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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The portable fire extinguisher was lowered and is 53.5 inches from the floor. Prior to the Maintenance Director relocating a portable fire extinguisher, the Administrator must be notified to approve of the extinguisher relocation being within 60 inches from the floor. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: Administrator, or designee, will conduct inspect the height of every portable fire extinguisher in the facility one (1) time a week for one (1) month and, thereafter, monthly x three (3) months. Audit results will be reviewed in monthly QA meetings. **5. The date the systemic changes will be completed.** December 14, 2016	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 2 B Wing corridor was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception	K 0361	K361 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible*	12/14/2016

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	per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff and up to 11 residents in the smoke compartment. Findings include: Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 11:33 a.m., the corridor door to resident room B01 was removed. The area was converted into two rooms which both had doors. In between the two room doors and the removed corridor door was a small area that also contained access to the shared bathroom. Furthermore, LSC 19.3.6.1(7) was not met because the room was not protected by an electrically supervised automatic smoke detection		*compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The alleged deficient areas are located in facility common areas where residents, visitors, and facility personnel would have the potential to be affected by this	

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	system. Based on interview at the time of observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged the aforementioned condition. 3.1-19(b)		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:** The identified small corridor outside of resident room without protection of an electrically supervised automatic smoke detection system outside of resident room was resolved by installing an electrically supervised automatic smoke detection system. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** - Administrator will ensure that a visual assessment is made by him/herself and the Maintenance Director after any future renovation to ensure the installation of an electrically supervised automatic smoke detection system, if necessary. If there is a facility renovation in the	

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			future, visual assessment results will be reviewed in monthly QA meetings. - - **5. The date the systemic changes will be completed.** December 14, 2016	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 6 smoke barrier walls were protected to maintain the	K 0372	K372 *The facility requests paper compliance for this citation. This*	12/14/2016

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	smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all occupants in the Main Dining smoke compartment. Findings include: Based on observations with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 12:23 p.m. then again at 12:29 p.m., the A wing resident room 1 smoke barrier lacked a three foot by seven foot piece of drywall in the attic. Then again, above the drop ceiling the B Wing resident room 1 smoke barrier contained a quarter inch unsealed penetration around cables. Additionally, the attic barrier contained a two inch by one inch unsealed penetration. Based on interview at the time of each observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged each aforementioned condition and provided the measurements.		*Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The alleged deficient areas are located in facility common areas where residents, visitors, and	

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	3.1-19(b)		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:** The identified smoke barrier penetrations were corrected by patching the three (3) x seven (7) foot drywall in attic (GA-225-08), sealing the quarter-inch (1/4) penetration around cables in smoke barrier (UL System # W-L-3148), and sealing a two (2) x one (1) inch unsealed penetration in attic barrier (GA-225-08). External vendors will be notified of using an approved UL system to seal any smoke barrier/attic penetrations that were made as a result of their work. Maintenance Director, or designee, will inspect the area that the external vendor worked on to ensure no penetrations are present. **4. How the corrective action(s) will be monitored to ensure the deficient practice**	

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			will not recur, i.e., what quality assurance program will be put into place: Administrator will ensure that a visual assessment is made by the Maintenance Director, or designee, by auditing three (3) smoke/attic barrier locations every one (1) week for one (1) month and five (5) smoke/attic barrier locations every one (1) month for the following three (3) months. Results will be reviewed in monthly QA meetings. **5. The date the systemic changes will be completed.** December 14, 2016	
K 0522 SS=F Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected * takes air for combustion from outside			

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	* provides for a combustion system separate from occupied area atmosphere 18.5.2.2, 19.5.2.2 Based on observation and interview, the facility failed to install 1 of 1 Entrance Lounge Fireplace in accordance with 19.5.2.2. LSC 19.5.2.2(1) any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. This deficient practice could affect all occupants open to the only dining room. Findings include: Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 10:10 a.m., the Main Entrance Lounge had an electric fireplace. Based on interview at the time of observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager confirmed that no documentation was available to prove the heating device does not have anything installed to shut down the equipment in case of excessive temperature or ignition failure. 3.1-19(b)	K 0522	K522 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.* **1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **2. How other residents**	12/14/2016

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			having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The 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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The identified heating element for the main entrance electric fireplace was disconnected. Electric fireplace heating element will not be connected unless further detailed information becomes available regarding the heating device's shut off. **4. How the corrective action(s) will be monitored to**	

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	155650	A. BUILDING 01 B. WING	11/28/2016

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			ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: - Administrator, or designee, will ensure compliance after any future electric fireplace modifications or additions to ensure all documentation is available to show automatic shut off information of the heating device, in case of excessive temperature or ignition failure. Fireplace documentation results will be reviewed in monthly QA meetings. - - **5. The date the systemic changes will be completed.** December 14, 2016	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

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	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 11 residents in the B Wing Nurse's station smoke compartment. Findings include:	K 0920	K920 *The facility requests paper compliance for this citation. This Plan of Correction (P.O.C.) is the center's allegation of credible compliance. Preparation and/or execution of this P.O.C. 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 P.O.C. is prepared and/or executed solely because it is required by the provision of federal and state law.*	12/14/2016

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	Based on observation with the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager on 11/28/16 at 11:25 a.m. then again at 11:42 a.m., a surge protector was powering a refrigerator in the Director of Nursing office. Then again, a surge protector was powering another surge protector in the B Wing Nurse's station. Based on interview at the time of each observation, the Maintenance Director, the Corporate Maintenance Engineer, the Administrator, and the Corporate Properties Manager acknowledged each aforementioned condition. 3.1-19(b)		**1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The 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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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			Surge protector powering refrigerator in office was removed and refrigerator is now plugged directly into outlet. Surge protector powering another surge protector under nurses' station was removed, and only one surge protector is plugged directly into outlet. Staff in-serviced regarding proper surge protector utilization. **4. How the corrective action(s) 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 facility surge protectors for one (1) month and, thereafter, monthly x three (3) months to ensure proper utilization. Audit results will be reviewed in monthly QA meetings. - **5. The date the systemic changes will be completed.**	

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			December 14, 2016	