| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155650 | A. BUILDING 01<br>B. WING | 10/14/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LINCOLNSHIRE HEALTH & REHABILITATION CENTER | 8380 VIRGINIA ST<br>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 |
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| K 0000<br><br>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).<br><br>Survey Date: 10/14/15<br><br>Facility Number: 000577<br>Provider Number: 155650<br>AIM Number: 100266950<br><br>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.<br><br>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 | K 0000 | Lincolnshire Healthcare and Rehab Center 8380 Virginia ST Merrillville, IN 46410-6231 Provider#: 155650 AIM Number: 100266950 Facility ID: 000577 Life Safety Code Survey 10/14/15 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility formally request paper compliance for all citations identified regarding annual survey 10/14/15. Please feel free to contact me, Kenan Weekley, Administrator, with any questions or concerns. Thank you in advance. KENAN WEEKLEY | |

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

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| | 155650 | A. BUILDING 01<br>B. WING | 10/14/2015 |

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| | census of 80 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached storage sheds.<br><br>Quality Review completed 10/20/15 - DA | | | |
| K 0025<br>SS=B<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>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<br>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 6 smoke barrier walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff and 11 residents.<br><br>Findings include: | K 0025 | **Lincolnshire Health and Rehab**<br><br>**Life Safety Code Survey: 10/14/2015**<br><br>**K025 NFPA 101 Life Safety Code Standard**<br><br>Please accept the following as the | 10/21/2015 |

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| | 155650 | A. BUILDING 01<br>B. WING | 10/14/2015 |

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| | Based on observations with the Corporate Properties Manager and the Maintenance Director on 10/14/15 at 11:15 p.m. then again at 12:35 p.m., the ceiling had a two inch circle cut out of the drywall in the Medical Records Office. Then again the smoke barrier wall in B Wing B Hall had a quarter inch gap around a cable. Based on interview at the time of each observation, the Corporate Properties Manager and the Maintenance Director acknowledged each aforementioned condition and provided the measurements for each unsealed penetration.<br><br>3.1-19(b) | | facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.<br><br>**What corrective action will be accomplished for those areas found to have been affected by the deficient practice?**<br><br>The 2 inch cut out on drywall in the medical records office ceiling was repaired. Also the quarter inch gap around the cable in the B wing B hall has been fire caulked and repaired. Please see attached evidence and pictures.<br><br>**How will the facility identify other areas having the potential to be affected by the same deficient practice?**<br><br>All ceiling smoke barriers and smoke barrier walls are potentially at risk of being affected by the same deficient practice. | |

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| | | | **What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?**<br><br>Maintenance Director/designee have been in-serviced in regards to ensuring that all smoke barrier areas in the facility are maintained to provide a one hour fire resistance rating and are in functioning condition according to regulation.<br><br>**How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?**<br><br>Maintenance Director and/or designee will inspect three identified smoke barrier areas in the facility weekly for three months to ensure proper functioning.<br><br>Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee | |

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| | | | if further monitoring should continue and for what time period.<br><br>**Completion Date: 10/21/2015** | |
| K 0029<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>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<br>Based on observation and interview, the facility failed to ensure 1 of 2 doors serving hazardous areas in A Wing C Hall, such as the Hazardous Storage, closed and latched to prevent the passage of smoke. This deficient practice could affect staff and up to 9 residents.<br><br>Findings include: | K 0029 | **Lincolnshire Health and Rehab**<br><br>**Life Safety Code Survey: 10/14/2015**<br><br>**K029 NFPA 101 Life Safety Code Standard** | 10/30/2015 |

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| | Based on observations with Corporate Properties Manager and the Maintenance Director on 10/14/15 at 10:49 a.m., the Shower Room in A Wing C Hall contained a 32 gallon storage container of soiled linen and three separate 12 gallon storage of trash. When the door was self tested to positively self-latch, there was a one and one half inch by four inch gap in the door shining light through from the hallway. Based on interview at the time of observation, the Corporate Properties Manager and the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure the attic door to 1 of 6 attic spaces, was provided with self closer and would latch into the frame. This deficient practice could affect staff and 18 residents in A Wing A Hall.<br><br>Findings include:<br><br>Based on observation with Corporate Properties Manager and the Maintenance Director on 10/14/15 at 12:38 p.m., the attic space above Resident Room 8 contained 23 cardboard boxes containing medical records. Based on interview at | | Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.<br><br>**What corrective action will be accomplished for those areas found to have been affected by the deficient practice?**<br><br>The shower room door for A wing C hall has been repaired and no longer yields the gap noted. Linen and trash containers have been removed. All cardboard boxes containing medical records were removed from Resident room 8 so that now this area is not identified as hazardous storage area.<br><br>**How will the facility identify other areas having the potential to be affected by the same deficient practice?**<br><br>All doors servicing hazardous areas are potentially at risk of being affected by the same deficient practice. | |

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| | the time of observation, the Corporate Properties Manager and the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | | **What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?**<br><br>Maintenance Director/designee have been in-serviced in regards to ensuring that doors equipped with auto-closing devices function properly and close securely as well as are in functioning condition according to regulation.<br><br>**How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?**<br><br>Maintenance Director and/or designee will inspect three doors equipped with auto-closing devices three times weekly for three months to ensure proper functioning and secure closure.<br><br>Maintenance Director/designee will present a summary of audits to the | |

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| | | | QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.<br><br>**Completion Date: 10/30/2015** | |
| K 0062<br>SS=D<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>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<br>Based on observation and interview, the facility failed to ensure the spray pattern for 2 of 2 sprinkler heads in the Pantry was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as | K 0062 | **Lincolnshire Health and Rehab**<br><br>**Life Safety Code Survey: 10/14/2015**<br><br>**K062 NFPA 101 Life Safety Code Standard**<br><br>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in | 10/30/2015 |

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| | 155650 | A. BUILDING 01<br>B. WING | 10/14/2015 |

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| | defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation the Corporate Properties Manager and the Maintenance Director on 10/14//15 at 10:19 a.m., two separate sprinkler heads were both next to two separate ceiling box lights. The two light boxes were three inches away and three inches lower than the sprinkler head deflector. Based on interview at the time of observation, the Corporate Properties Manager and the Maintenance Director acknowledge the aforementioned condition and provided the measurements.<br><br>3.1-19(b) | | response to the regulatory requirement. The facility cordially requests paper compliance for this citation.<br><br>**What corrective action will be accomplished for those areas found to have been affected by the deficient practice?**<br><br>Sprinkler System Co. was contacted and has scheduled a visit for 10/27/15 to drop the sprinkler heads in the pantry so that they will be unobstructed to spray patterns according to regulation.<br><br>**How will the facility identify other areas having the potential to be affected by the same deficient practice?**<br><br>All sprinkler heads in the sprinkler system on premises is potentially affected by this alleged deficient practice.<br><br>**What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?** | |

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| | | | Maintenance Director/designee have been in-serviced regarding inspection of all sprinkler heads in facility to ensure they are unobstructed.<br><br>**How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?**<br><br>Maintenance Director and/or designee will ensure that all sprinkler heads in the facility are not obstructed by any objects that can alter the appropriate spray patterns according to regulation via weekly maintenance rounds.<br><br>Maintenance Director/designee will present a status update summary regarding sprinkler heads to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. | |

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| K 0147 SS=B Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 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 5 residents were in the area at the time of observation..<br><br>Findings include:<br><br>Based on observation with Corporate Properties Manager and the Maintenance Director on 10/14/15 at 11:36 a.m., a surge protector was powering a refrigerator in the B Wing Nurse's Station. Based on interview at the time of observation, the Corporate Properties Manager and the Maintenance Director acknowledged the aforementioned condition.<br><br>3.1-19(b) | K 0147 | **Completion Date: 10/30/2015**<br><br>**Lincolnshire Health and Rehab**<br><br>**Life Safety Code Survey: 10/14/2015**<br><br>**K147 NFPA 101 Life Safety Code Standard**<br><br>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility cordially requests paper compliance for this citation.<br><br>**What corrective action will be accomplished for those areas found to have been affected by the deficient practice?**<br><br>All identified medical equipment and high current draw electrical devices | 10/16/2015 |

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| | | | have been plugged directly into fixed wiring outlets.<br><br>**How will the facility identify other areas having the potential to be affected by the same deficient practice?**<br><br>All medical equipment and high current draw electrical devices within premises are potentially at risk of being affected by this deficient practice.<br><br>**What measures will the facility take, or systems the facility will alter, to ensure that the problem is corrected and will not recur?**<br><br>All staff have been in-serviced regarding the need to plug medical equipment and high current draw electrical devices directly into fixed wiring outlets. Maintenance Director/designee have inspected facility for any further medical equipment and/or high current draw electrical devices that are not plugged directly into fixed wiring outlets. | |

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| | | | **How will the corrective action be monitored to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?**<br><br>Maintenance Director/designee will audit resident rooms and common areas at random three times a week for three months.<br><br>Maintenance Director/designee will present a summary of audits to the QA committee monthly x 3 months. After 3 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.<br><br>**Completion Date: 10/16/2015** | |
| K 0000<br><br>Bldg. 02 | 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).<br><br>Survey Date: 10/14/15 | K 0000 | Lincolnshire Healthcare and Rehab Center 8380 Virginia ST Merrillville, IN 46410-6231 Provider#: 155650 AIM Number: 100266950 Facility ID: 000577 Life Safety Code Survey 10/14/15 Please accept the following as the facility's plan of | |

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| | 155650 | A. BUILDING 02<br>B. WING | 10/14/2015 |

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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 |
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| | Facility Number: 000577<br>Provider Number: 155650<br>AIM Number: 100266950<br><br>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.<br><br>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 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.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage equipment sheds.<br><br>Quality Review completed 10/20/15 - DA | | correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility formally request paper compliance for all citations identified regarding annual survey 10/14/15. Please feel free to contact me, Kenan Weekley, Administrator, with any questions or concerns. Thank you in advance. KENAN WEEKLEY | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155650 | A. BUILDING 02<br>B. WING | 10/14/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNSHIRE HEALTH & REHABILITATION CENTER | 8380 VIRGINIA ST<br>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 |
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