| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155650 | A. BUILDING -- B. WING | 01/17/2018 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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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| E 0000<br><br>Bldg. -- | .<br>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 01/17/18<br><br>Facility Number: 000577<br>Provider Number: 155650<br>AIM Number: 100266950<br><br>At this Emergency Preparedness survey, Lincolnshire Health & Rehabiliation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 100 certified beds. At the time of the survey, the census was 84.<br><br>Quality Review completed on 01/19/18 - DA<br><br>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: | E 0000 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155650 | A. BUILDING -- B. WING | 01/17/2018 |

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| E 0039 SS=C Bldg. -- | Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise | E 0039 | **Lincolnshire**<br><br>**Annual Life Safety Code Survey, 1/17/18**<br><br>**E 039**<br><br>**EP Testing Requirements**<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. Facility cordially requests paper compliance in regards to this plan of correction.<br><br>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>A tabletop exercise focusing on a fire emergency as the clinically-relevant emergency scenario was completed on 1/19/18. The interdisciplinary | 01/26/2018 |

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| | the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Administrator, the Corporate Facilities Engineer, the Maintenance Director on 01/17/18 between 9:56 a.m. and 11:02 a.m., a community-based drill was performed but no facility-based drill had been performed. Based on interview at the time of record review, the Administrator, the Corporate Facilities Engineer, the Maintenance Director confirmed a facility-based drill was not performed. | | discussion was facilitated by the Administrator and reviewed current fire safety policy and procedures. Staff in-serviced in regards to facility fire safety policy and procedures.<br><br>**How will the facility identify other residents having the potential to be affected by the same deficient practice?**<br><br>All residents are potentially at risk of the same alleged deficient practice. Tabletop exercise completed on 1/19/18 during facility's interdisciplinary Safety Meeting.<br><br>**What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?**<br><br>Facility Safety Meeting continues to be held monthly to review applicable policy/procedure, make suggestions as applicable, and adjust facility practice accordingly. Facility will conduct exercises to test the emergency | |

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| | | | plan annually hereafter.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>Maintenance Director/designee to interview 5 staff weekly regarding fire safety policy/procedure for 3 months. Administrator/designee will present a summary of the audits to the Quality Assurance Committee monthly for 3 months. Thereafter, if determined necessary by the QA Committee, staff interviews will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing.<br><br>**Date of Completion:**<br><br>1/26/18 | |
| K 0000<br><br>Bldg. 01 | | | | |

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| | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 01/17/18<br><br>Facility Number: 000577<br>Provider Number: 155650<br>AIM Number: 100266950<br><br>At this Life Safety Code survey, Lincolnshire Health & Rehabiliation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<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 census of 84 at the time of this survey.<br><br>All areas where residents have customary | K 0000 | | |

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| | access were sprinklered. All areas providing facility services were sprinklered, except two detached storage sheds.<br><br>Quality Review completed on 01/19/18 - DA | | | |
| K 0222 SS=E Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked | | | |

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| | space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4 | | | |
| | Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 exits were readily accessible for residents. This deficient practice could affect staff and up to 16 residents. | K 0222 | **Lincolnshire**<br><br>**Annual Life Safety Code Survey, 1/17/18**<br><br>**K 222** | 01/26/2018 |

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| | Findings include:<br><br>Based on observation with the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 on 01/17/18 at 11:38 a.m., the exterior exit door near resident room 25 opened about two inches before catching on the cement and would not open any further. Based on interview at the time of the observation, the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 acknowledged the aforementioned condition and confirmed the cement pad was raised high enough to prevent the door from fully opening.<br><br>3.1-19(b) | | **Egress Doors**<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. Facility cordially requests paper compliance in regards to this plan of correction.<br><br>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The cement pad outside the facility exit door near resident room 25 was grinded to allow full opening and closing of the aforementioned exit door. Maintenance Director and Maintenance staff have been educated on ensuring all exit doors are able to fully open and close.<br><br>**How will the facility identify** | |

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| | | | **other residents having the potential to be affected by the same deficient practice?**<br><br>All residents are potentially at risk of the same alleged deficient practice. Maintenance Director has tested all exit doors to ensure complete opening and closing is possible, no further concerns identified.<br><br>**What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?**<br><br>All exit doors are included in the monthly preventative maintenance schedule to ensure proper, full opening and closing of doors.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>Maintenance Director/designee to | |

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| | | | inspect 5 facility exit doors weekly to ensure proper opening and closing for 3 months. Administrator/designee will present a summary of the audits to the Quality Assurance Committee monthly for 3 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing.<br><br>**Date of Completion:**<br><br>1/26/18 | |
| K 0321 SS=F Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>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 or 19.3.5.9. 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 | | | |

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| | do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322) | | | |
| | Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect all occupants open to the Main Dining Room.<br><br>Findings include:<br><br>Based on observation with the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 on 01/17/18 at 11:55 a.m., the Laundry contained fuel-fire equipment. When the | K 0321 | **Lincolnshire**<br><br>**Annual Life Safety Code Survey, 1/17/18**<br><br>**K 321**<br><br>**Hazardous Areas - Enclosure**<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. Facility cordially requests paper | 01/26/2018 |

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| | corridor door was tested, the door self-closed but did not latch into the frame. Based on interview at the time of observation, the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 acknowledged the door did not latch into the frame.<br><br>3.1-19(b) | | compliance in regards to this plan of correction.<br><br>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The speed and strength of the auto-closer for the Laundry room corridor door was adjusted to ensure proper latching into the frame.<br><br>**How will the facility identify other residents having the potential to be affected by the same deficient practice?**<br><br>Maintenance Director and Maintenance Assistant have tested all doors equipped with auto-closing devices to ensure proper latching into frame, no further concerns identified.<br><br>**What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and** | |

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| | | | **will not recur?**<br><br>Maintenance Director and Maintenance Assistant have been educated on the need to have doors equipped with auto-closing devices latch into frames. All doors equipped with auto-closing devices are included in the monthly preventative maintenance schedule to ensure proper latching into frame.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>Maintenance Director/designee to inspect 5 facility doors equipped with auto-closing devices weekly to ensure proper latching into frame for 3 months. Administrator/designee will present a summary of the audits to the Quality Assurance Committee monthly for 3 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. | |

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| | | | **Date of Completion:**<br><br>1/26/18 | |
| K 0920<br>SS=E<br>Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (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 | | | |

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| | 155650 | A. BUILDING 01<br>B. WING | 01/17/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| LINCOLNSHIRE HEALTH & REHABILITATION CENTER | 8380 VIRGINIA ST<br>MERRILLVILLE, IN 46410 |

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| | Based on observation and interview, the facility failed to ensure 1 of 1 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 13 residents.<br><br>Findings include:<br><br>Based on observation with the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 on 01/17/18 at 12:21 p.m., an extension cord was powering a nebulizer in resident room 13. Based on interview at the time of each observation, the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 confirmed the extension cord was being used to power a nebulizer.<br><br>3.1-19(b) | K 0920 | **Lincolnshire**<br><br>**Annual Life Safety Code Survey, 1/17/18**<br><br>**K 920**<br><br>**Electrical Equipment – Power Cords and Extension Cords**<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. Facility cordially requests paper compliance in regards to this plan of correction.<br><br>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>The extension cord was removed from resident room 13.<br><br>**How will the facility identify other residents having the** | 01/26/2018 |

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| | | | **potential to be affected by the same deficient practice?**<br><br>All residents are potentially at risk of the same alleged deficient practice. Maintenance Director and Maintenance Assistant have inspected all resident rooms to ensure flexible cords were not used as a substitute for fixed wiring, no further concerns identified.<br><br>**What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?**<br><br>Staff in-serviced on ensuring residents are not using extension cords in resident rooms.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>Maintenance Director/designee to | |

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| | | | inspect 5 resident rooms weekly to ensure flexible cords were not used as a substitute for fixed wiring for 3 months. Administrator/designee will present a summary of the audits to the Quality Assurance Committee monthly for 3 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing.<br><br>**Date of Completion:**<br><br>1/26/18 | |
| K 0923<br>SS=D<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag<br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated | | | |

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| | from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure.<br>Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) | | | |
| | Based on observation and interview, the facility failed to ensure 2 of 2 oxygen transfill rooms were protected in accordance with 11.2.3.2. 2012 NFPA 99 11.3.2.3 requires oxidizing gases such as oxygen and nitrous oxide shall be separated 5 feet from combustibles or materials. This deficient practice could affect staff only.<br><br>Findings include: | K 0923 | **Lincolnshire**<br><br>**Annual Life Safety Code Survey, 1/17/18**<br><br>**K 923**<br><br>**Gas Equipment – Cylinder and Container Storage** | 01/26/2018 |

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| | Based on observation with the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 on 01/17/18 at 11:30 a.m. then again at 12:28 a.m., the A wing oxygen transfill room contained liquid oxygen stored within 5 feet of five cardboard boxes. Then again, the B wing oxygen transfill room contained liquid oxygen stored within 5 feet of two cardboard boxes. Based on interview at the time of each observation, the Corporate Facilities Engineer, the Maintenance Director, and the Maintenance Assistant #1 confirmed the combustible storage was within five feet of liquid oxygen containers.<br><br>3.1-19(b) | | 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. Facility cordially requests paper compliance in regards to this plan of correction.<br><br>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?<br><br>Cardboard boxes removed from A and B wing oxygen transfill rooms.<br><br>**How will the facility identify other residents having the potential to be affected by the same deficient practice?**<br><br>Only facility staff could be affected by the same alleged deficient practice.<br><br>**What measures will the facility** | |

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| | | | **take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?**<br><br>Staff educated on not storing any combustible materials in A and B unit oxygen transfill rooms.<br><br>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br><br>Maintenance Director/designee to inspect the A and B unit oxygen transfill rooms 3 times weekly for 3 months to ensure combustible materials are not stored within 5 feet of oxidizing gases. Administrator/designee will present a summary of the audits to the Quality Assurance Committee monthly for 3 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. | |

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| | | | **Date of Completion:**<br><br>1/26/18 | |