PRINTED: 01/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650			r í	JILDING	onstruction 01	(X3) DATE COMPL 11/28	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		8380 VI	ADDRESS, CITY, STATE, ZIP CODE RGINIA ST LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0000 Bldg. 01	State Licensure of the Indiana State accordance with Survey Date: 11 Facility Number Provider Number AIM Number: 1 At this Life Safe Lincolnshire Heat found not in come Requirements for Medicare/Medi	: 000577 r: 155650 00266950 ty Code survey, alth Care Center was appliance with r Participation in aid, 42 CFR Subpart Safety from Fire and the	K 0	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER NSHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	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. T Plan of Correction (P.O.C.) is center's allegation of credible compliance. Preparation and execution of this P.O.C. does	the 'or

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	8380	ET ADDRESS, CITY, STATE, ZIP CODE O VIRGINIA ST BRILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON END (X5) DE COMPLETION DATE
	smoke comparting kitchen. Findings included Based on observe Maintenance Distriction Maintenance En Administrator, at Properties Manata.m. then again at Laundry Room of device on the water Then again, the separate 32 galled One of the five of device on the water Based on intervi	ration with the rector, the Corporate gineer, the nd the Corporate ger on 11/28/16 at 11:02 at 11:19 a.m., the contained fuel-fired wo corridor doors had a all to hold the door open. Kitchen containers of trash. corridor doors had a all to hold the door open. eva the time of each		constitute admission or agreement by the provider truth of the facts alleged or conclusions set forth in the statement of deficiencies. P.O.C. is prepared and/or executed solely because it required by the provision of federal and state law. 1. Corrective action(s) accomplished for those residents found to have be affected by the deficient practice: No residents were identified.	The is f
	the Corporate M Administrator, a Properties Mana aforementioned	Maintenance Director, aintenance Engineer, the nd the Corporate ger acknowledged each condition and confirmed devices do not release m.		1. How other residents having the potential to be affected by the same deficient practice will be identified what corrective action(s) be taken: The alleged deficient areas located in facility common where residents, visitors, a facility personnel would hapotential to be affected by	cient and will s are areas and we the

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	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUILDING B. WING	01	COMPLETED 11/28/2016
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE I'IRGINIA ST ILLVILLE, IN 46410	l
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
				2. What measures will put into place or what syschanges will be made to ensure that the deficient practice does not recur:	
				Door-holding device was removed from: 1) Service I kitchen door and 2) Servic hallway laundry door, allov door to remain closed unle being temporarily opened.	e ving
				3. How the corrective action(s) will be monitore ensure the deficient practive will not recur, i.e., what question assurance program will be into place: - Administrator, or designee audit ten (10) doors 2 x we one (1) month and, theream monthly x three (3) months	tice uality ee put , will eekly for fter,

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY
OF CORRECTION			<u>U1</u>	COMPLETED 11/28/2016
	100000			11/20/2010
ROVIDER OR SUPPLIER				
ISHIRE HEALTH &	REHABILITATION CENTER			
SUMMARY S	FATEMENT OF DEFICIENCIES	ID	DROWIDEBIG BY AN OF CORRECTION	(X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
			ensure no door-holding device (that aren't connected with the system) are used or installed monitor proper usage of door remaining closed unless pass through aforementioned door. Audit results will be reviewed monthly QA meetings. - - 4. The date the systemic changes will be completed. December 14, 2016	e fire 2) by ing
Aisle, Corridor or R 2012 EXISTING The width of aisles unobstructed) serve be at least 4 feet at the convenient ren patients on stretch 19.2.3.4, exception 19.2.3.4, 19.2.3.5 1. Based on obset failed to meet 1 or requirement excert LSC 19.2.3.4(5) corridor width is projections into the	Ramp Width s or corridors (clear or ving as exit access shall and maintained to provide moval of nonambulatory lers, except as modified by the state of 6 corridors clear width exption per 19.2.3.4(5). The requires where the at least 8 feet, the required width shall fixed furniture.	K 0232	K232 The facility requests paper compliance for this citation. The plan of Correction (P.O.C.) is center's allegation of credible compliance. Preparation and execution of this P.O.C. does	the /or
	NFPA 101 Aisle, Corridor or F 2012 EXISTING The width of aisles unobstructed) serv be at least 4 feet at the convenient rer patients on stretch 19.2.3.4, exception 19.2.4, exception 19.2.4, exception 19.2.4, exception 19.2.4,	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Wi	NFPA 101 Aisle, Corridor or Ramp Width Aisle, Corridor or Ramp Wid	ROYIDER OR SUPPLIER ISHIRE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Alsie, Corridor, or Ramp Width Alsie, Corridor, or Ramp Width Alsie, Corridor, or Ramp Width Alsie, Corridor or Ramp Width Alsie, Corridor,

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPLETED	
		155650	B. WI	ING		11/28/2016	
NAME OF 1	PROVIDER OR SUPPLIER	R	-		ADDRESS, CITY, STATE, ZIP CODE		
					IRGINIA ST		
LINCOLI	NSHIRE HEALTH &	REHABILITATION CENTER		MERRI	ILLVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATE	
	1	d to the floor or to the			constitute admission or agreement by the provider of	: the	
		ent practice could affect			truth of the facts alleged or	inc	
	staff and up to 5	residents from the			conclusions set forth in the		
	Activity room.				statement of deficiencies. Th	ne	
					P.O.C. is prepared and/or		
	Findings include	2 :			executed solely because it is		
					required by the provision of federal and state law.		
	Based on observ	vation with the			rederal and state law.		
	Maintenance Di	rector, the Corporate					
	Maintenance En	-					
		and the Corporate					
	1	ager on 11/28/16 at 10:12			1		
	_	were located in the			Corrective action(s) accomplished for those		
	· ·	of the Administrator's			residents found to have bee	an .	
					affected by the deficient	,,,,	
		sted, the chair was able to			practice:		
		d the corridor. Based on					
		time of observation, the					
		rector, the Corporate					
	Maintenance En	-			No residents were identified.		
		and the Corporate					
	Properties Mana	iger acknowledged the					
	aforementioned	condition and confirmed			2. How other residents		
	the chair was no	ot secured.			having the potential to be		
					affected by the same deficie		
	3.1-19(b)				practice will be identified an		
	` ´	ervation, the facility			what corrective action(s) wi be taken:	"	
		of 6 corridors clear width			- Committee		
		eption per 19.2.3.4(1).					
	LSC 19.2.3.4(1)						
	` ′	imps in adjunct areas not			The alleged deficient areas a		
	•				located in facility common are		
		housing, treatment, or			where residents, visitors, and facility personnel would have		
	_	s shall not be less than 44			potential to be affected by this		
	inches in clear a	nd unobstructed width.			alleged deficient practice.	-	

This deficient practice could affect staff

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	PROVIDER OR SUPPLIE	R REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Er Administrator, a Properties Mana a.m., transport of corridor. When was fourty two interview at the Maintenance Di Maintenance Er Administrator, a Properties Mana	vation with the crector, the Corporate agineer, the and the Corporate ager on 11/28/16 at 11:08 carts were in the service measured, the clear width inches. Based on time of observation, the crector, the Corporate agineer, the and the Corporate ager acknowledged the condition and provided		3. What measures will be put into place or what system 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 with have been moved to a location with greater than eight (8) foot width. Staff in-serviced regard the correct placement of fixed furniture. Staff in-serviced not store carts in non-resident-use corridor, as the width from the cart to the corridor wall is only inches. Staff in-serviced regarding minimum width of 4 inches in non-resident-use corridor.	dth n ding to
				4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place: - Administrator, or designee, wi conduct ten (10) rounds week for one (1) month and, thereaf	ty ut

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	nstruction 01	(X3) DATE COMPL		
		155650	B. W		<u>01</u>	11/28/	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	<u> </u>	8380 VI	NDDRESS, CITY, STATE, ZIP CODE RGINIA ST LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
K 0321 SS=F Bldg. 01	barrier having 1-hd (with 3/4-hour fire automatic fire extir accordance with 8 automatic fire extir used, the areas shother spaces by srand doors in accorshall be self-closin and permitted to h field-applied protection.	are protected by a fire our fire resistance rating rated doors) or an anguishing system in arranguishing system option is shall be separated from moke resisting partitions radance with 8.4. Doors g or automatic-closing ave nonrated or cive plates that do not from the bottom of the			monthly x three (3) months. A results will be reviewed in mon QA meetings. 5. The date the systemic changes will be completed. December 14, 2016		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 01 COMPLETE B. WING 11/28/20			
		155650	B. W.	ING		11/28/	2016
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Seperation a. Boiler and Fuel- b. Laundries (large c. Repair, Mainten d. Soiled Linen Ro gallons) e. Trash Collection (exceeding 64 gal f. Combustible Sto (over 50 square fe g. Laboratories (if Hazard - see K322 Based on observ facility failed to of 1 Mechanical of 19.3.2. LSC 1 Hazards, require or automatic clos impediments to l practice could af same smoke com Dining room. Findings include Based on observ Maintenance Din Maintenance En Administrator, a Properties Mana a.m., the Mechan fuel-fired equipm	N/A -Fired Heater Rooms er than 100 square feet) lance, and Paint Shops froms (exceeding 64 In Rooms lons) orage Rooms/Spaces eet) classified as Severe 20) ation and interview, the maintain protection of 1 Room 3 in accordance 9.3.2, Protection from s doors to be self-closing sing and have no latching. This deficient effect all occupants in the inpartment as the Main Exaction with the rector, the Corporate gineer, the	K 0		The facility requests paper compliance for this citation. The Plan of Correction (P.O.C.) is to center's allegation of credible compliance. Preparation and/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	the or not he	12/14/2016
		on interview at the time he Maintenance Director,			affected by the deficient practice:		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE /IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Administrator, a	aintenance Engineer, the nd the Corporate ger acknowledged the condition.		No residents were identified.	
	3.1-19(b)			2. How other residents having the potential to be affected by the same deficie practice will be identified an what corrective action(s) will be taken:	d
				The alleged deficient areas are located in facility common are where residents, visitors, and facility personnel would have potential to be affected by this alleged deficient practice.	the
				3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur:	mic
				The identified mechanical roo door was repaired by the installation of a self-closure mechanism.	m

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	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	ROVIDER OR SUPPLIER ISHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST ILLVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0346	NFPA 101		4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be pinto place: - Administrator, or designee, wi 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 wireviewed in monthly QA meetings. 5. The date the systemic changes will be completed. December 14, 2016	ity out
SS=C Bldg. 01	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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	01	COMPL	
III. I I I I I I I I I I I I I I I I I	155650	B. WI		<u>01</u>	11/28/	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & F	REHABILITATION CENTER	<u> </u>	8380 VI	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN 46410	l	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
period, the authority be notified, and the evacuated or an appearance be provided for all puthe shutdown until the shutdown unt	review with the ector, the Corporate gineer, the did the Corporate ge on 11/28/16 at 10:45 provided fire watch at it was incomplete. The view and interview, to provide a complete 1 sy for the protection of the procedures to be a service for the procedures to be a service for the in a twenty four hour and the Corporate ge on 11/28/16 at 10:45 provided fire watch at it was incomplete. The view with the ector, the Corporate ge on 11/28/16 at 10:45 provided fire watch at it was incomplete. The view with the end the Corporate ge on 11/28/16 at 10:45 provided fire watch at it was incomplete. The view with the end the Corporate ge on 11/28/16 at 10:45 provided fire watch at it was incomplete. The view with the end the Corporate watch and the ties Maintenance ministrator, and the ties Manager	K 0		The facility requests paper compliance for this citation. The Plan of Correction (P.O.C.) is center's allegation of credible compliance. Preparation and execution of this P.O.C. does constitute admission or agreement by the provider of 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.	the /or not the	12/14/2016

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155650		· ·	01	COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER SHIRE HEALTH & REHABILITATION CE	8380 V	ADDRESS, CITY, STATE, ZIP CO I'IRGINIA ST ILLVILLE, IN 46410	ODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCII (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION (X5) OULD BE PPROPRIATE DATE
	3.1-19(b)		2. How other reside having the potential to affected by the same of practice will be identification what corrective action be taken:	b be deficient ied and
			The alleged deficient ar located in facility comm where residents, visitor facility personnel would potential to be affected alleged deficient practic	non areas rs, and I have the by this
			3. What measures we put into place or what changes will be made ensure that the deficie practice does not recu	systemic to ent
			The fire watch policy wa and includes contacting insurance company wh alarm system is out of s for more than four (4) h twenty-four (24) hour pol Emergency action plan updated with revised pol staff in-serviced over the	g the en the fire services sours in a eriod. binders blicy and
			4. How the corrective	ve

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	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUILDING B. WING	01	COMPLETED 11/28/2016
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	8380	T ADDRESS, CITY, STATE, ZIP CODE VIRGINIA ST RILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
				action(s) will be monitored ensure the deficient practic will not recur, i.e., what qua assurance program will be into place:	e Ility
				Administrator, or designee, v conduct one (1) in-service w for one (1) month and, there monthly x three (3) months. results will be reviewed in me QA meetings.	eekly after, Audit
				5. The date the systemic changes will be completed.	
				December 14, 2016	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with I Inspection, Testin Water-based Fire Records of syster inspection and tes secure location ar	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a and readily available. The system last checked			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		l í	JILDING	onstruction 01	(X3) DATE S COMPL 11/28/	ETED	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER			8380 VI	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) SUPPLY SOURCE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8. Based on record the facility failed sprinkler system 9.7.5. LSC 9.7.5 sprinkler system maintained in ac Standard for the Maintenance of Protection Systeedition, Table 5. required frequen	RKS information on non-required or partial r system. and NFPA 25 review and interview, I to maintain 1 of 1 in accordance with LSC requires all automatic s shall be inspected and cordance with NFPA 25, Inspection, Testing, and Water-Based Fire ms. NFPA 25, 2011 1.1.2 indicates the cy of inspection and cient practice could nts.	K 0	353	K353 The facility requests paper compliance for this citation. T Plan of Correction (P.O.C.) is center's allegation of credible compliance. Preparation and execution of this P.O.C. does constitute admission or agreement by the provider of 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.	the 'or not the	12/14/2016
	Maintenance En Administrator, a Properties Mana a.m., the sprinkle quarterly. No do available for the control valves in interview at the	rector, the Corporate gineer, the and the Corporate ger on 11/28/16 at 9:57 er system was inspected cumentation was monthly gauges or spection. Based on time of observation, the rector, the Corporate gineer, the			1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: No residents were identified.	n	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER NSHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST ILLVILLE, 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	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI 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 deficie practice will be identified ar what corrective action(s) wi be taken:	nd
			The alleged deficient areas a located in facility common are where residents, visitors, and facility personnel would have potential to be affected by thi alleged deficient practice.	eas I the
			3. What measures will be put into place or what syste changes will be made to ensure that the deficient practice does not recur:	
			Documentation will be provid for the monthly inspection, ar maintenance if necessary, of sprinkler system. Gauges an control valves will be inspecte and maintained if necessary, monthly.	nd the nd ed,
			4. How the corrective action(s) will be monitored to ensure the deficient practic will not recur, i.e., what qua	e

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	ROVIDER OR SUPPLIER ISHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, 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 APPROPRIA DEFICIENCY)	DATE
			assurance program will be p into place:	ut
			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) every one (1) month for three months. If maintenance is necessary, Maintenance Direct will inform Administrator to ensure the issue is resolved. After three (3) months of audit the facility's Safety Committee determine if continuing the au is necessary. - - 5. The date the systemic changes will be completed. December 14, 2016	x (3) ctor s,
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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i '			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>01</u>		COMPLETED 11/28/2016	
		155650	B. W.	B. WING			2016
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER				8380 VI	ADDRESS, CITY, STATE, ZIP CODE RGINIA ST LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	other authorities heen notified. Whout of service for r 24-hour period, the building affected a approved fire water sprinkler system here. 18.3.5.1, 19.3.5.1, Based on record the facility failed written policy concepts for failed written policy concepts for failed written failed	r 10 hours or more in a n accordance with LSC, SC 9.7.5 requires ment procedures comply 2011 Edition, the Inspection, Testing and Water-Based Fire ms. NFPA 25, 15.5.2 peedures that the dinator shall follow. This e could affect all	K 0	354	K354 The facility requests paper compliance for this citation. The Plan of Correction (P.O.C.) is to center's allegation of credible compliance. Preparation and/execution of this P.O.C. does a 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.	the or not he	12/14/2016
	Maintenance En Administrator, a Properties Mana	review with the rector, the Corporate gineer, the			1. Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:	1	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE I'IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	The plan failed to insurance comparinterview record Director, the Cornel Engineer, the Accorporate Property	review, the Maintenance rporate Maintenance dministrator, and the		2. How other residents having the potential to be affected by the same deficie practice will be identified at what corrective action(s) will be taken: The alleged deficient areas a located in facility common ar where residents, visitors, and	nd ill are eas
				facility personnel would have potential to be affected by thi alleged deficient practice. 3. What measures will be put into place or what syste changes will be made to ensure that the deficient practice does not recur: The fire watch policy was revand includes contacting the insurance company when the sprinkler system is out of ser for more than ten (10) hours twenty-four (24) hour period. Emergency action plan binde updated with revised policy a	emic rised evices in a

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE /IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place: - Administrator, or designee, wi conduct one (1) in-service were for one (1) month and, thereat monthly x three (3) months. A	ion. p ity ut Il ekly fter,
				results will be reviewed in mor QA meetings. - 5. The date the systemic changes will be completed.	
K 0355 SS=E Bldg. 01	installed, inspecte	nguishers guishers are selected, ed, and maintained in NFPA 10, Standard for nguishers.		December 14, 2016	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE C		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u> COM		COMPLETED
	155650	B. WING	11/28/2016	
		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		IRGINIA ST	
LINCOL	NSHIRE HEALTH & REHABILITATION CENTER		LLVILLE, IN 46410	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Based on observation and interview, the	K 0355	K355	12/14/2016
	facility failed to ensure 1 of 1 Therapy			
	portable fire extinguishers was installed			
	correctly in accordance with 19.3.5.12.		The facility requests paper	
	NFPA 10, the Standard for Portable Fire		compliance for this citation. T	his l
	Extinguishers, 6.1.3.8.1 Fire		Plan of Correction (P.O.C.) is	the
	extinguishers having a gross weight not		center's allegation of credible	/o.r
	exceeding 40 pounds shall be installed so		compliance. Preparation and/ execution of this P.O.C. does	
	that the top of the fire extinguisher is not		constitute admission or	
	more than 5 feet above the floor. This		agreement by the provider of t	the
	deficient practice could affect staff and at		truth of the facts alleged or	
	least 5 residents in Therapy.		conclusions set forth in the	
	least 3 residents in Therapy.		statement of deficiencies. The	9
			P.O.C. is prepared and/or executed solely because it is	
	Findings include:		required by the provision of	
			federal and state law.	
	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		1. Corrective action(s)	
	a.m., the Therapy fire extinguisher		accomplished for those	
	measured 65 inches from the top of the		residents found to have been	ո
	extinguisher to the floor. Based on		affected by the deficient	
	interview at the time of observation, the		practice:	
	Maintenance Director, the Corporate			
	Maintenance Engineer, the			
	Administrator, and the Corporate		No residents were identified.	
	Properties Manager acknowledged the			
	aforementioned condition and provided			
	the measurement.			
	3.1-19(b)		2. How other residents	
	5.1 17(0)		having the potential to be	
			affected by the same deficien	nt
			practice will be identified and	d

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURV	VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	A. BUILDING <u>01</u>		COMPLETED	
		155650	B. W	ING		11/28/2016	
****	.n.o.v.n.n. o	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER	L			RGINIA ST		
		REHABILITATION CENTER	_	MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	what corrective action(s) will		DATE
					be taken:		
					be taken.		
					The alleged deficient areas are		
					located in facility common are where residents, visitors, and	as	
					facility personnel would have t	he	
					potential to be affected by this		
					alleged deficient practice.		
					3. What measures will be		
					put into place or what system	nic	
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					The portable fire extinguisher	was	
					lowered and is 53.5 inches fro		
					the floor. Prior to the		
					Maintenance Director relocatir	ng a	
					portable fire extinguisher, the	to	
					Administrator must be notified approve of the extinguisher	ιο	
					relocation being within 60 inch	es	
					from the floor.		
					4. How the corrective		
					action(s) will be monitored to	,	
					ensure the deficient practice		
					will not recur, i.e., what quali		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/28/2016
LINCOLN		REHABILITATION CENTER	8380 V MERRI	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				assurance program will be pinto place: - Administrator, or designee, wiconduct inspect the height of every portable fire extinguished the facility one (1) time a weed one (1) month and, thereafter monthly x three (3) months. A results will be reviewed in mo QA meetings. - 5. The date the systemic changes will be completed. December 14, 2016	er in k for Audit
K 0361 SS=E Bldg. 01	treatment rooms a waiting areas, nur and cooking facilit are in accordance 18.3.6.1 and 19.3. 18.3.6.1, 19.3.6.1 Based on observ facility failed to corridor was sep by a partition cap passage of smok	Open to Corridor n patient sleeping rooms, and hazardous areas), se's stations, gift shops, ies, open to the corridor with the criteria under	K 0361	K361 The facility requests paper compliance for this citation. The plan of Correction (P.O.C.) is center's allegation of credible	•

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	838	EET ADDRESS, CITY, STATE, ZIP CODE 80 VIRGINIA ST ERRILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE APPRO	ON (X5) DBE COMPLETION DATE
	that spaces other rooms, treatment areas shall be op unlimited in area and corridors whin the same smol protected by an eautomatic smoke accordance with space is protecte sprinklers, and (cobstruct access to	than patient sleeping arooms, and hazardous en to the corridor and approvided: (a) The space eich the space opens onto are compartment are electrically supervised edetection system in 19.3.4, and (b) Each d by an automatic e) The space does not to be required exits. This e could affect staff and is in the smoke		compliance. Preparation a execution of this P.O.C. do constitute admission or agreement by the provider truth of the facts alleged or conclusions set forth in the statement of deficiencies. P.O.C. is prepared and/or executed solely because it required by the provision of federal and state law. 1. Corrective action(s) accomplished for those residents found to have the constitution of the statement of the statem	oes not of the r the The
	compartment. Findings include	:		affected by the deficient practice:	
	Maintenance Eng	ector, the Corporate gineer, the		No residents were identified.	
	a.m., the corridor B01 was remove converted into tw doors. In betwee and the removed	ger on 11/28/16 at 11:33 r door to resident room		2. How other residents having the potential to be affected by the same defi practice will be identified what corrective action(s) be taken:	cient and
	19.3.6.1(7) was it	oom. Furthermore, LSC not met because the room d by an electrically natic smoke detection		The alleged deficient areas located in facility common where residents, visitors, a facility personnel would ha potential to be affected by	areas and ve the

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER NSHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST ILLVILLE, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	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)		3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur:	iic
			The identified small corridor outside of resident room withou 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 qualit assurance program will be puinto place:	у
			Administrator will ensure that a visual assessment is made by him/herself and the Maintenand Director after any future renovation to ensure the installation of an electrically supervised automatic smoke detection system, if necessary, there is a facility renovation in the	ce

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/28/2016
LINCOLN	ROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 VI	ADDRESS, CITY, STATE, ZIP CODE RGINIA ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 0372	NFPA 101			future, visual assessment resi will be reviewed in monthly Qumeetings. - 5. The date the systemic changes will be completed. December 14, 2016	
SS=F Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers sh 1/2-hour fire resist Smoke barriers sh terminate at an att are not required in ducted HVAC syst sprinkler system is compartments adj barrier. 19.3.7.3, 8.6.7.1(1) Describe any med system in REMAR Based on observ facility failed to	pall be constructed to a sance rating per 8.5. pall be permitted to rium wall. Smoke dampers a duct penetrations in fully tems where an approved installed for smoke acent to the smoke had be constructed to a sance and a s	K 0372	K372	12/14/2016
	conduit through	2 of 6 smoke barrier cted to maintain the		The facility requests paper compliance for this citation. T	This

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u> COMPLETED B. WING 11/28/2016					
	155650			_		11/28/2	2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LINICOLA	ICLUDE LIEALTIL O	DELIADII ITATIONI CENTED			IRGINIA ST		
		REHABILITATION CENTER		WERRI	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG		e of each smoke barrier.		IAG	Plan of Correction (P.O.C.) is a	the	DATE
		3.7.5 requires smoke			center's allegation of credible		
		nstructed in accordance			compliance. Preparation and/		
		n 8.5 and shall have a			execution of this P.O.C. does	not	
					constitute admission or agreement by the provider of t	ho	
		r fire resistive rating.			truth of the facts alleged or		
	•	actice could affect all Main Dining smoke			conclusions set forth in the		
	•	Main Dining Shoke			statement of deficiencies. The	•	
	compartment.				P.O.C. is prepared and/or		
	Eindings include				executed solely because it is required by the provision of		
	Findings include				federal and state law.		
	Based on observ	-4ii4l- 4l					
		rector, the Corporate					
	Maintenance En	•					
	· ·	nd the Corporate			1. Corrective action(s)		
		ger on 11/28/16 at 12:23			accomplished for those		
		at 12:29 p.m., the A wing			residents found to have been	1	
		smoke barrier lacked a			affected by the deficient practice:		
	_	en foot piece of drywall			practice.		
		again, above the drop					
	_	ng resident room 1					
		ntained a quarter inch			No residents were identified.		
	*	tion around cables.					
		e attic barrier contained a					
	two inch by one				2. How other residents		
	*	ed on interview at the			having the potential to be	_	
	time of each obs	·			affected by the same deficier practice will be identified and		
		rector, the Corporate			what corrective action(s) will		
	Maintenance En	•			be taken:		
	Administrator, a	•					
	•	ger acknowledged each					
		condition and provided			The alleged deficient areas are	_	
	the measurement	ts.			located in facility common area where residents, visitors, and		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE VIRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	3.1-19(b)			facility personnel would have potential to be affected by this alleged deficient practice.	
				3. What measures will be put into place or what syste 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 sever foot drywall in attic (GA-225-0 sealing the quarter-inch (1/4) penetration around cables in smoke barrier (UL System #W-L-3148), and sealing a two x one (1) inch unsealed penetration in attic barrier (GA-225-08). External vendo will be notified of using an approved UL system to seal a smoke barrier/attic penetration that were made as a result of their work. Maintenance Dire or designee, will inspect the atthat the external vendor work on to ensure no penetrations present.	ors any ector, area ed
				4. How the corrective action(s) will be monitored to ensure the deficient practice.	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER NSHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, 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 APPROPRIA DEFICIENCY)	DATE
			will not recur, i.e., what quali assurance program will be p into place:	-
			Administrator will ensure that visual assessment is made by 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 (months. Results will be review in monthly QA meetings. - 5. The date the systemic changes will be completed.	the))) 3)
			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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	ONSTRUCTION 01	(X3) DATE S COMPLE		
		155650	B. W		* '	11/28/2	
NAME OF PROVIDER O		REHABILITATION CENTER	<u> </u>	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN 46410		
PREFIX (EAC	H DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
PREFIX TAG REGULT * provide from occ 18.5.2.2 Based of facility Lounge 19.5.2.2 device simmedi shut do excessir This de occupant Finding Based of Mainten Mainten Admini Propert a.m., the electric the time Directo Engine Corpora that no prove the anythin	es for a coupied are, 19.5.2.2 on observe failed to a Fireplace. LSC 19 shall have ately stop with the economic failed to a Fireplace on observe failed to a Fireplace. LSC 19 shall have ately stop with the economic failed to a fireplace of observe failed for observe failed failed for observe failed failed for observe failed failed for observe failed	ombustion system separate atmosphere ation and interview, the install 1 of 1 Entrance in accordance with 0.5.2.2(1) any heating a safety features to pethe flow of fuel and quipment in case of either rature or ignition failure. The actice could affect all to the only dining room.	K 0	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	This the Vor not the	COMPLETION
_ ^ ^	ature or iş	gnition failure.			2. How other residents		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUILDING B. WING	01	COMPLETED 11/28/2016
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				having the potential to be affected by the same deficie practice will be identified an what corrective action(s) wi be taken:	nd
				The alleged deficient areas a located in facility common are where residents, visitors, and facility personnel would have potential to be affected by thi alleged deficient practice.	eas I the
				3. What measures will be put into place or what syste changes will be made to ensure that the deficient practice does not recur:	
				The identified heating elemer the main entrance electric fireplace was disconnected. Electric fireplace heating eler will not be connected unless further detailed information becomes available regarding heating device's shut off.	ment
				4. How the corrective action(s) will be monitored to	to

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER		ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, 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 APPROPRIA DEFICIENCY)	DATE
			ensure the deficient practice will not recur, i.e., what qual assurance program will be p into place:	ity
			Administrator, or designee, wi ensure compliance after any future electric fireplace modifications or additions to ensure all documentation is available to show automatic s off information of the heating device, in case of excessive temperature or ignition failure. Fireplace documentation resu will be reviewed in monthly Qumeetings.	hut Its
			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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		r í	JILDING	onstruction 01	(X3) DATE COMPL 11/28/	ETED	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		8380 VI	ADDRESS, CITY, STATE, ZIP CODE RGINIA ST LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	assembled by quathe conditions of 1 the patient care vinon-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or strips for non-PCF rooms (outside of non-patient care nother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99, 400-8 (NFPA 70), 12-5 Based on observing facility failed to cords were not unfixed wiring accords were not unfixed wiring according to the unit of the unit of the unit of the used as a wiring of a structure affects structure affects structure according to the unit of the unit	le cords and cables shall substitute for fixed ture. This deficient staff and up to 11 3 Wing Nurse's station nent.	K 0	920	K920 The facility requests paper compliance for this citation. T Plan of Correction (P.O.C.) is center's allegation of credible compliance. Preparation and execution of this P.O.C. does constitute admission or agreement by the provider of 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.	the for not the	12/14/2016

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	PROVIDER OR SUPPLIER NSHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	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 bee affected by the deficient practice: No residents were identified. 2. How other residents having the potential to be affected by the same deficie practice will be identified an what corrective action(s) will be taken: The alleged deficient areas ar located in facility common are where residents, visitors, and facility personnel would have	nt d I e as
			potential to be affected by this alleged deficient practice. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recur:	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/28/2016
	ROVIDER OR SUPPLIER ISHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			Surge protector powering refrigerator in office was remo and refrigerator is now plugge directly into outlet. Surge protector powering another su protector under nurses' station was removed, and only one su protector is plugged directly in outlet. Staff in-serviced regard proper surge protector utilizati	d Irge n urge to ding
			4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place:	ity
			Administrator, or designee, wi audit facility surge protectors to one (1) month and, thereafter, monthly x three (3) months to ensure proper utilization. Audiresults will be reviewed in mor QA meetings.	for
			5. The date the systemic changes will be completed.	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155650	B. WING		11/28/2016		
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER			8380 V	ADDRESS, CITY, STATE, ZIP CODE I'IRGINIA ST ILLVILLE, IN 46410			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
				December 14, 2016			

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