STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/17/2018	
NAME OF PROVIDER		REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
TAG REG	ACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 0000 Bldg An Er condu of Hea 483.75 Surve Facility Provide AIM I Linco was for Emergy Medica Provide The fatime of Quality DA The results of the provide the provided	mergency Facted by the alth in account of the Number of the Survey Prepare and Moders and Survey Review of the sur	Preparedness Survey was e Indiana State Department ordance with 42 CFR /17/18 : 000577 r: 155650	E 00		DEFICIENCE		DATE

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ľ		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	A. BUILDING			COMPL	(3) DATE SURVEY COMPLETED 01/17/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	RECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE		
E 0039 SS=C Bldg							DATE	
	facility failed to emergency plan unannounced sta	review and interview, the conduct exercises to test the at least annually, including ff drills using the emergency LTC facility must do all of	E 00)39	Lincolnshire Annual Life Safety Cod Survey, 1/17/18 E 039	le	01/26/2018	
	the following: (i) exercise that is c community-base an individual, fac	oparticipate in a full-scale ommunity-based or when a d exercise is not accessible, cility-based. If the LTC	a EP Testing Requirements		its			
	man-made emergactivation of the facility is exemp community-based facility-based ful following the on conduct an additinclude, but is not	Il-scale exercise for 1 year set of the actual event; (ii) ional exercise that may of limited to the following: -scale exercise that is			Please accept the following as facility's plan of correction. The plan of correction does not constitute an admission of guil liability by the facility and is submitted only in response to regulatory requirement. Facilic cordially requests paper compliance in regards to this profice of correction.	is It or the ty		
	facility-based. (E includes a group facilitator, using clinically-relevan	3) a tabletop exercise that discussion led by a			What corrective action will be accomplished for those reside found to have been affected b deficient practice?			
	to challenge an e the LTC facility' documentation o	pared questions designed mergency plan; (iii) analyze s response to and maintain f all drills, tabletop nergency events, and revise			A tabletop exercise focusing of fire emergency as the clinically-relevant emergency scenario was completed on 1/19/18. The interdisciplinary			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP COD IRGINIA ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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
	needed in accord			discussion was facilitated by the Administrator and reviewed curifire safety policy and procedure Staff in-serviced in regards to facility fire safety policy and procedures.	urrent
	Engineer, the Ma 01/17/18 betwee	review with the ne Corporate Facilities nintenance Director on n 9:56 a.m. and 11:02 ty-based drill was		How will the facility identify other residents having the potential to be affected by the same deficient practice?	e
	been performed. time of record re Corporate Facility Maintenance Din	Based on interview at the eview, the Administrator, the ties Engineer, the ector confirmed a fill was not performed.		All residents are potentially at of the same alleged deficient practice. Tabletop exercise completed on 1/19/18 during facility's interdisciplinary Safet Meeting.	
				What measures will the facilitake or what systems will the facility alter to ensure that the problem will be corrected an will not recur?	e ne
				Facility Safety Meeting continued to be held monthly to review applicable policy/procedure, in suggestions as applicable, an adjust facility practice accordingly. Facility will condexercises to test the emergen	nake d uct

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X:	O1/17/2018
	ROVIDER OR SUPPLIER SHIRE HEALTH &	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP COD /IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				plan annually hereafter.	
				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?	t
				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.	g ,
				Date of Completion:	
				1/26/18	
K 0000					
Bldg. 01					

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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 01/17/2018				
		155650	B. W	ING		01/17/	/2018
NAME OF F	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP COD		
					RGINIA ST		
LINCOLI	NSHIRE HEALTH &	REHABILITATION CENTER		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		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	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	K 0	TAG	DEFICIENC 17		DATE
	1	ode Recertification and	K 0	000			
		Survey was conducted by					
		Department of Health in					
	accordance with	42 CFR 483.90(a).					
		4540					
	Survey Date: 01	./1//18					
	Table N	. 000577					
	Facility Number						
	Provider Number: 155650						
	AIM Number: 100266950						
	At this Life Safe	ty Code survey					
		alth & Rehabiliation Center					
		compliance with					
	^	r Participation in					
		aid, 42 CFR Subpart					
	` , , .	Safety from Fire and the					
		the National Fire Protection					
	`	PA) 101, Life Safety Code					
		19, Existing Health Care					
	Occupancies and	1410 IAC 16.2.					
	This one story for	acility was determined to be					
		construction and was fully					
		e facility has a fire alarm					
	_	-					
	· ·	d wired smoke detection in					
	_	ces open to the corridors					
		ooms. The facility has a					
		and had a census of 84 at					
	the time of this s	survey.					
	A 11 a 1						
	All areas where	residents have customary					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		A. BUILDII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/17/2018	
		155650	B. WING			01/17/	/2018
NAME OF P	ROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD RGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
	access were sprin	nklered. All areas					
	providing facility services were sprinklered,						
	except two detac	thed storage sheds.					
	.						
	Ouality Review	completed on 01/19/18 -					
	DA	omprova on 01/19/10					
	DA						
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
	_	d means of egress shall not					
	be equipped with	a latch or a lock that					
	requires the use o	f a tool or key from the					
	egress side unless	s using one of the following					
	special locking arr	•					
		OR SECURITY THREAT					
	LOCKING						
	•	king arrangements for the					
	_	eds of the patient are					
		king device shall be					
		door and provisions shall apid removal of occupants					
		of locks; keying of all					
	_	ed by staff at all times; or					
		e means available to the					
	staff at all times.						
	18.2.2.2.5.1, 18.2.	2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENTS						
		king arrangements for the					
	-	e patient are used, all of					
		curity Locking requirements					
	-	addition, the locks must be					
		at fail safely so as to					
	•	of power to the device; the ed by a supervised					
		er system and the locked					
	automatic sprinkle	a system and the locked	1				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/17/2018	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 VI	ADDRESS, CITY, STATE, ZIP COD IRGINIA ST LLVILLE, 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	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	detection system (at an attended loc space); and both the systems are arran upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRESARRANGEMENTSAPPROVED, listed do systems installed for 7.2.1.6.1 shall be assemblies serving contents in building an approved, superdetection system automatic sprinkled 18.2.2.2.4, 19.2.2. ACCESS-CONTRACC	elayed-egress locking in accordance with permitted on door glow and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised r system. 2.4 OLLED EGRESS IGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS IGEMENTS I access door locking in .2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an seed automatic sprinkler				
	Based on observ	ation and interview, the ensure the means of egress	K 0222	Lincolnshire	01/26/2018	
	through 1 of 11 of	exits were readily accessible		Annual Life Safety Coo Survey, 1/17/18	de	
		is deficient practice could p to 16 residents.		K 222		
1	1		I	I	l	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	ľ í	JILDING	onstruction 01	(X3) DATE : COMPL 01/17/	ETED
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		8380 VI	ADDRESS, CITY, STATE, ZIP COD RGINIA ST LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
	Findings include	:			Egress Doors		
	Facilities Engine Director, and the on 01/17/18 at 1 door near residen two inches befor and would not op interview at the to Corporate Facility Maintenance Dir Assistant #1 ack aforementioned of cement pad was	ation with the Corporate eer, the Maintenance e Maintenance Assistant #1 1:38 a.m., the exterior exit int room 25 opened about re catching on the cement pen any further. Based on time of the observation, the ties Engineer, the rector, and the Maintenance nowledged the condition and confirmed the raised high enough to from fully opening.			Please accept the following as facility's plan of correction. The plan of correction does not constitute an admission of gui liability by the facility and is submitted only in response to regulatory requirement. Facility cordially requests paper compliance in regards to this post of correction. What corrective action will be accomplished for those reside found to have been affected by deficient practice? The cement pad outside the facility exit door near resident room 25 was grinded to allow 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 ar close.	is It or the ty blan ints y the	
					How will the facility identify		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	(X5) COMPLETION DATE	
				other residents having the potential to be affected by the same deficient practice?	he	
				All residents are potentially at of the same alleged deficient practice. Maintenance Direct has tested all exit doors to en complete opening and closing possible, no further concerns identified.	or Isure g is	
				What measures will the facil take or what systems will th facility alter to ensure that the problem will be corrected an will not recur?	e he	
				All exit doors are included in a monthly preventative mainten schedule to ensure proper, fu opening and closing of doors.	nance III	
				How will the corrective action monitored to ensure the defic practice will not recur, i.e., wh quality assurance program will put into place?	ient nat	
				Maintenance Director/designe	ee to	

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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	COMI	E SURVEY PLETED 7/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP IRGINIA ST ILLVILLE, IN 46410	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
				inspect 5 facility exit of to ensure proper oper closing for 3 months. Administrator/designer present a summary of to the Quality Assurar Committee monthly for Thereafter, if determinecessary by the QA auditing and monitoring done quarterly and properties of the QA meeting Monitoring will be ong Date of Completion:	ee will f the audits nce or 3 months. ned Committee, ng will be esented ng.	
K 0321 SS=F Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire exti- accordance with 8 approved automat option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system e areas shall be separated by smoke resisting rs in accordance with 8.4.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155650	A. BUILDING <u>01</u> COMPLETED B. WING 01/17/2018		
		133030	_		01/17/2010
NAME OF P	PROVIDER OR SUPPLIEF	8		FADDRESS, CITY, STATE, ZIP COD VIRGINIA ST	
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER		RILLVILLE, IN 46410	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION inches from the bottom of	TAG	DEFICIENCE	DATE
	the door.	inches from the bottom of			
		and zone locations of			
	hazardous areas t	that are deficient in			
	REMARKS.				
	19.3.2.1, 19.3.5.9				
	Area	Automatic Sprinkler			
	Separation	-			
		-Fired Heater Rooms			
	b. Laundries (larger than 100 square feet)				
c. Repair, Maintenance, and Paint Shops					
	d. Soiled Linen Rooms (exceeding 64 gallons)				
	e. Trash Collection	n Rooms			
	(exceeding 64 gal	lons)			
		orage Rooms/Spaces			
	(over 50 square fe				
	g. Laboratories (if Hazard - see K32	classified as Severe			
	i	ration and interview, the	K 0321	Lincolnshire	01/26/2018
		maintain protection of 1 of 1			
	1	rdance of 19.3.2. LSC		Annual Life Safety Coo Survey, 1/17/18	de
	19.3.2, Protectio	n from Hazards, requires		Guivey, Intinio	
	doors to be self-	closing or automatic		K 321	
	_	ficient practice could affect		Hazardous Areas - Enclo	sure
	all occupants op	en to the Main Dining		114241 40 40 7 11 040 211010	
	Room.				
	Findings include	•			
	Findings include	··		Please accept the following as	s the
	Događ on abar	eation with the Company		facility's plan of correction. Th	is
		ration with the Corporate		plan of correction does not	ilt or
		eer, the Maintenance		constitute an admission of gui	III OI
	Director, and the Maintenance Assistant #1		submitted only in response to	the	
		1:55 a.m., the Laundry		regulatory requirement. Facil	•
contained fuel-fire equipment. When the			cordially requests paper		

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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> B. WING			COMPLETED 01/17/2018	
		155650	B. W	ING		01/17/	/2018	
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD			
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER	8380 VIRGINIA ST MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		.TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	compliance in regards to this		DATE	
		ns tested, the door			of correction.	лап		
		lid not latch into the frame.						
		ew at the time of						
		Corporate Facilities						
	Engineer, the Maintenance Director, and the Maintenance Assistant #1 acknowledged				What corrective action will be accomplished for those residents found to have been affected by the			
	the door did not	latch into the frame.			deficient practice?			
	3.1-19(b)							
					The speed and strength of the	<u>.</u>		
					auto-closer for the Laundry ro			
					corridor door was adjusted to			
					ensure proper latching into the	•		
					frame.			
					How will the facility identify			
					other residents having the			
					potential to be affected by the same deficient practice?	e		
					Same dencient practice?			
					Maintenance Director and			
					Maintenance Assistant have tested all doors equipped with			
					auto-closing devices to ensure			
					proper latching into frame, no			
					further concerns identified.			
					What measures will the facili	itv		
					take or what systems will the			
					facility alter to ensure that th	ne		
					problem will be corrected an	d		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	E CONSTRUCTION X3		X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED		
155650		B. WING 01/17/2018				2018		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		8380 VI	DDRESS, CITY, STATE, ZIP COD RGINIA ST LVILLE, IN 46410			
(X4) ID	SHMMARV	STATEMENT OF DEFICIENCIE	<u> </u>	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	,	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	'	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
-					will not recur?			
					Maintenance Director and Maintenance Assistant have be educated on the need to have doors equipped with auto-clos devices latch into frames. All doors equipped with auto-clos devices are included in the monthly preventative maintena schedule to ensure proper late into frame. How will the corrective action of monitored to ensure the deficie practice will not recur, i.e., who	ing ing ance ching be ent at		
					quality assurance program will put into place? Maintenance Director/designe inspect 5 facility doors equippe with auto-closing devices wee to ensure proper latching into frame for 3 months. Administrator/designee will present a summary of the aud to the Quality Assurance Committee monthly for 3 month Thereafter, if determined necessary by the QA Committen auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing.	e to ed kly its ths.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155650		A. B	A. BUILDING <u>01</u> COI			DATE SURVEY OMPLETED 1/17/2018			
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
					Date of Completion:				
					1/26/18				
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of a the patient care vi non-PCREE (e.g. except in long-terr do not use PCREI meet UL 1363A o for non-PCREE in (outside of vicinity non-patient care r other UL standard used with general cords are not used wiring of a structu temporarily are re completion of the installed and mee 10.2.3.6 (NFPA 98)	ent - Power Cords and ent - Power Cords and ent - Power Cords and catient care vicinity are only ents of movable ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for personal electronics), m care resident rooms that E. Power strips for PCREE T UL 60601-1. Power strips the patient care rooms b) meet UL 1363. In coms, power strips meet ls. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. e), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2018	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER		8380 V	ADDRESS, CITY, STATE, ZIP COD IRGINIA ST LLVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Based on observation and interview, the	K 0920	Lincolnshire	01/26/2018	
	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		Annual Life Safety Coo Survey, 1/17/18	le	
	electrical wiring and equipment shall be in		K 920		
	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		Electrical Equipment – Po Cords and Extension Co		
	fixed wiring of a structure. This deficient		Please accept the following as	s the	
	practice affects staff and up to 13 residents.		facility's plan of correction. Th	is	
	Findings include:		plan of correction does not constitute an admission of gui liability by the facility and is		
	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		submitted only in response to regulatory requirement. Facili cordially requests paper compliance in regards to this profit of correction.	ty	
	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.		What corrective action will be accomplished for those reside found to have been affected b deficient practice?		
	3.1-19(b)		The extension cord was remore from resident room 13.	ved	
			How will the facility identify other residents having the		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction g	X3) DATE SURVEY COMPLETED 01/17/2018
	ROVIDER OR SUPPLIE SHIRE HEALTH &	R R REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP COD IRGINIA ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				potential to be affected by the same deficient practice?	
				All residents are potentially at ri of the same alleged deficient practice. Maintenance Director and Maintenance Assistant hav inspected all resident rooms to ensure flexible cords were not used as a substitute for fixed wiring, no further concerns identified.	
				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?	,
				Staff in-serviced on ensuring residents are not using extension cords in resident rooms.	on
				How will the corrective action be monitored to ensure the deficie practice will not recur, i.e., what quality assurance program will put into place?	nt t
				Maintenance Director/designee	to

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COMP	ESURVEY LETED 7/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP ((IRGINIA ST ILLVILLE, IN 46410	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				inspect 5 resident room to ensure flexible cord used as a substitute for wiring for 3 months. Administrator/designe present a summary of to the Quality Assurant Committee monthly for Thereafter, if determing necessary by the QA of auditing and monitoring done quarterly and prequarterly at QA meeting Monitoring will be ongoing. Date of Completion:	s were not or fixed e will the audits ace or 3 months. aed Committee, ag will be essented ag.	
K 0923 SS=D Bldg. 01	Storag Gas Equipment - Storage Greater than or ec Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or within space of non- or li construction, with that can be secure	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 qubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and Oxidizing gases are not ables, and are separated				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUME		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
155650		B. WING 01/17/2018				2018	
NAME OF F	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					RGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER		MERRII	LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s by 20 feet (5 feet if					
		closed in a cabinet of onstruction having a					
		re protection rating.					
		Il to 300 cubic feet					
		compartment, individual					
	-	e for immediate use in					
	•	with an aggregate volume					
		ual to 300 cubic feet are not					
	*	red in an enclosure.					
	•	handled with precautions					
	as specified in 11.	ign readable from 5 feet is					
		ate of a cylinder storage					
	-	ign includes the wording as					
		ΓΙΟΝ: OXIDIZING GAS(ES)					
	STORED WITHIN	• • •					
	Storage is planned	d so cylinders are used in					
		y are received from the					
		ylinders are segregated					
		When facility employs					
	-	gral pressure gauge, a					
	•	e considered empty is ty cylinders are marked to					
	·	Cylinders are marked to					
	are protected from						
		.3.3, 11.3.4, 11.6.5 (NFPA					
	99)						
	Based on observ	ation and interview, the	K 09	23	Lincolnshire		01/26/2018
	facility failed to	ensure 2 of 2 oxygen transfill			Annual Life Octob O	-	
	rooms were prot	ected in accordance with			Annual Life Safety Cod Survey, 1/17/18	е	
	-	IFPA 99 11.3.2.3 requires			Juivey, 1/11/10		
	oxidizing gases such as oxygen and nitrous				K 923		
		parated 5 feet from					
		materials. This deficient			Gas Equipment – Cylinder	and	
	practice could af				Container Storage		
	practice could at	iect stair only.					
	Finding 1 1 1						
	Findings include	:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2018			
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ΓE	(X5) COMPLETION DATE
	Facilities Engine Director, and the on 01/17/18 at 1 12:28 a.m., the A contained liquid of five cardboard wing oxygen tra oxygen stored w cardboard boxes time of each obs Facilities Engine Director, and the	ation with the Corporate eer, the Maintenance e Maintenance Assistant #1 1:30 a.m. then again at A wing oxygen transfill room oxygen stored within 5 feet d boxes. Then again, the B insfill room contained liquid ithin 5 feet of two Based on interview at the ervation, the Corporate eer, the Maintenance e Maintenance Assistant #1 ombustible storage was			Please accept the following as facility's plan of correction. Thi plan of correction does not constitute an admission of guil liability by the facility and is submitted only in response to regulatory requirement. Facilit cordially requests paper compliance in regards to this pof correction. What corrective action will be accomplished for those reside found to have been affected by deficient practice?	s t or the ty olan	
	3.1-19(b)	of liquid oxygen containers.			Cardboard boxes removed from and B wing oxygen transfill room		
					How will the facility identify other residents having the potential to be affected by the same deficient practice?	e	
					Only facility staff could be affer by the same alleged deficient practice.	cted	
					What measures will the facili	ty	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	f '		NSTRUCTION	(X3) DATE SURVEY	
and Plan of Correction identification number 155650		A. BUILDING <u>01</u> COMPLETED B. WING 01/17/2018					
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	0.1.1.20.10	
NAME OF F	PROVIDER OR SUPPLIER				RGINIA ST		
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER			LVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	1
1110	independent of			0	take or what systems will the		
					facility alter to ensure that th		
					problem will be corrected an	d	
					will not recur?		
					Staff educated on not storing	,	
					combustible materials in A and unit oxygen transfill rooms.) B	
					driit oxygeri tidrioiiii rooms.		
					How will the corrective action I monitored to ensure the deficient		
					practice will not recur, i.e., what		
					quality assurance program wil		
					put into place?		
					Maintenance Director/designe	e to	
					inspect the A and B unit oxyge		
					transfill rooms 3 times weekly		
					3 months to ensure combustib materials are not stored within		
					feet of oxidizing gases.		
					Administrator/designee will		
					present a summary of the aud	its	
					to the Quality Assurance Committee monthly for 3 month	the	
					Thereafter, if determined	110.	
					necessary by the QA Committ	ee,	
					auditing and monitoring will be	:	
					done quarterly and presented		
					quarterly at QA meeting. Monitoring will be ongoing.		

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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 01/17/2018		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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	TC	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	16	DATE	
				Date of Completion: 1/26/18			

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