| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155650 | A. BUILDING **01**<br>B. WING _____ | R<br>**02/06/2018** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {E 000} | Initial Comments<br><br>.<br>Paper compliance to the Emergency Preparedness Survey conducted on 01/17/18 was completed on 02/06/18.<br><br>Review Date: 02/06/18<br><br>Facility Number: 000577<br>Provider Number: 155650<br>AIM Number: 100266950<br><br>Lincolnshire Health & Rehabiliation Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.73, Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. | {E 000} | | |
| {K 000} | INITIAL COMMENTS<br><br>Paper compliance to the Life Safety Code Recertification and State Licensure Survey conducted on 01/17/18 was completed on 02/06/18.<br><br>Review Date: 02/06/18<br><br>Facility Number: 000577<br>Provider Number: 155650<br>AIM Number: 100266950<br><br>Lincolnshire Health & Rehabiliation Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies | {K 000} | | |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| {K 000} | Continued From page 1<br>and 410 IAC 16.2. | {K 000} | | |