## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					<del></del>	С	
		14G181	B. WING			12/	22/2015
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELLMED	TERRACE			8	801 MARKET STREET		
ELLNER	IERRACE			E	EVANSVILLE, IL 62242		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		W 000				
	COMPLAINT INVE	ESTIGATION SURVEY					
W 104	COMPLAINT #1549 483.410(a)(1) GOV		W 1	104			1/22/16
		y must exercise general policy, ing direction over the facility.					
	Based on observation review, the facility's exercise general dithey failed to ensure documented and are	s not met as evidenced by: tion, interview and record governing body has failed to rection over the facility when e that needed repairs are re completed within a timely potential to affect 14 of 14 cility (R1-R14).					
	Findings include:						
		e facility were completed on P.M 2:2:05 P.M. with the					
	through the middle portion which appearock coming throug lawnmower. The g starting spidering a The left window's lo	bedroom window had a hole of the screen and the glass ared to be consistent with a h the window, shot from a lass around the hole had cross the entire window pane. ocking mechanism was broken low from locking and/or					
LABORATO TO	and the outer scree	edroom window was open on was bent, allowing for DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE

Any deficiency statement ending with an actorick (\*) denotes a deficiency which the institution may be excused from correcting providing

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.

12/28/2015

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		14G181	B. WING				C <b>22/2015</b>
NAME OF PROVIDER OR SUPPLIER  ELLNER TERRACE				8	STREET ADDRESS, CITY, STATE, ZIP CODE 801 MARKET STREET EVANSVILLE, IL 62242		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 104	between the screen air was felt coming R5's and R6's bedr curtain up. The cur the left side allowin see into the bedrood At 4:45 P.M., E1 (Fobserved R1 - R6's E1 stated, "Staff ar daily. If anything is write this in the may was asked if these and addressed, she maintenance book' The maintenance book' The maintenance book' The maintenance book' R2's and R3's wind in their screen on 0 The last dated entry There were no entry window latch in R2's bedroom screen in and/or the curtain the R6's bedroom. When E1 was asked done to address the 08/04/15, she state measure the windo ordered". On 11/16 window's glass was	a room. No storm window was an and the glass pane and cold through the window; and room window had a full length tain was off track of the rod on g anyone from the outside to om.  Residential Services Director) bedrooms with the surveyor. The to check the environment broken, they (staff) are to intenance book. When E1 issues had been documented the stated, "We can check the colow was reviewed with E1 at following documentation was show was "shattered" with a hole	<b>W</b> 1	104			

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	14G181 B. WING				C <b>12/22/2015</b>		
NAME OF PROVIDER OR SUPPLIER  ELLNER TERRACE				STREET ADDRESS, CITY, STATE, ZIP CO 801 MARKET STREET EVANSVILLE, IL 62242		1/22/2010	
(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 COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 104		ld come out on 11/18/15 to	W 1				