STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00370366 and IN00373423. Complaint IN00370366 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00373423 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: July 18, 19, 20, 21, and 22, 2022. Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 9 Medicaid: 56 Other: 10 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/26/22.	F 0000	Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully request paper compliance.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable			

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

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	accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review and interview, the facility failed to accommodate the needs of a dependent resident related to the call light being out of reach for 1 of 18 residents observed for call lights. (Resident 22) Finding includes: On 7/18/22 at 1:05 p.m., Resident 22 was observed awake in bed. The call light was on the floor next to the resident's bed. On 7/21/22 at 2:27 p.m., Resident 22 was observed awake in bed. The call light was on the floor next to the resident's bed. The resident's record was reviewed on 7/21/22 at 3:30 p.m. Diagnoses included, but were not limited to, anemia, heart failure, high blood pressure, and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 7/13/22, indicated the resident was cognitively intact and required extensive one person assistance with bed mobility and toileting. Interview with the Environmental Services Director, on 7/21/22 at 2:27 p.m., indicated the call light should have been in reach for the resident. 3.1-3(v)(1)	F 0558	**F 558 Reasonable Accommodations Needs/Preferences** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 22's call light was immediately retuned in reach. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Facility staff were in-serviced on ensuring residents call lights are in reach. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility managers/Guardian Angles will audit 20 residents weekly to ensure the residents	08/03/2022

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			call light is in reach. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 2 of 5 residents reviewed for non-pressure related skin conditions and an improper length of a bed for 1 of 1 residents reviewed for positioning. (Residents 44, 13, and 60) Findings include: 1. On 7/19/22 at 9:03 a.m., Resident 44 was observed lying in bed. Large dark purple discolorations were observed to both forearms and his left elbow.	F 0684	**F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 44's skin was assessed, and the physician and family were updated on the findings. The bruising to both forearms is being monitored. Resident 60's skin was assessed and the physician and family were updated. The bruise to the right wrist is being monitored. Resident 13's bed was extended.	08/03/2022

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	On 7/21/22 at 9:23 a.m., Resident 44 was observed lying in bed. The dark purple discolorations were still observed to both arms. Record review for Resident 44 was completed on 7/20/22 at 2:48 p.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, hypertension, and dementia. The Admission Minimum Data Set (MDS) assessment, dated 6/9/22, indicated the resident was moderately cognitively impaired. The resident required an extensive assist of 1 person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident had received an anticoagulant medication (blood thinning medication). A Care Plan, dated 6/7/22, indicated the resident was at risk for abnormal bleeding/bruising related to the use of Eliquis (blood thinning medication). An intervention included to report signs of active bleeding which included ecchymotic areas (bruising). The July 2022 Physician's Order Summary indicated an order for Eliquis 2.5 mg (milligrams) twice a day. Bath Sheets, dated 7/2, 7/6, 7/9, 7/13, and 7/16/22, did not have any bruises or discolored areas marked. The record lacked any documentation to indicate his skin discolorations were being monitored. Interview with LPN 1 on 7/21/22 at 9:28 a.m., indicated she was unaware the resident had any discolorations. The staff should have noticed the		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were in-serviced on documenting clinical assessments in the medical record. Nurse Managers were in-serviced on monitoring clinical documentation. Nurses and Nurse Managers were in-serviced on observing resident's environment for needed adjustments and ensure adjustments are carried out. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers/designee will observe 10 residents weekly for skin discolorations to ensure monitoring and assessments are complete for any resident observed with skin discolorations.	

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	discolorations during his daily care and reported it to the nurse. Interview with B Wing Unit Manager on 7/21/22 at 10:15 a.m., indicated the resident's discolorations should have been monitored until they were gone, especially when the resident was on an anticoagulant medication. A facility policy, titled "Orders For Anticoagulants," and received as current from the Administrator, indicated, "...4. Nursing must notify the physician if the resident has any signs or symptoms of internal bleeding such as hematuria or excessive bruising..." 2. On 7/19/22 at 11:04 a.m., Resident 13 was observed lying in bed. The resident's head of bed was raised up and the resident was sitting up right. His legs were observed with a slight bend in the knees and his feet were in a flexed position up against the foot board of the bed. The resident indicated the bed was too small for him and he was uncomfortable. He further indicated he was unable to completely stretch his legs out unless he bent his knees some but his feet would still be up against the foot board. On 7/20/22 at 9:00 a.m., the resident was observed lying in bed. The head of bed was raised slightly up and he was still observed with his feet flexed up against the foot board. On 7/21/22 at 2:36 p.m., the resident was observed lying in bed. The head of bed was raised slightly and the resident's knees were raised slightly. His feet were still observed flexed up against the foot board. Record review for Resident 13 was completed on		Nurse Managers/designee will observe resident's environment upon rounds weekly for needed adjustments and ensure adjustments are carried out. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	7/20/22 at 9:05 a.m. Diagnoses included, but were not limited to, anemia, orthostatic hypotension, dementia, and hemiplegia (paralysis of one side of the body). The Significant Change MDS assessment, dated 4/26/22, indicated the resident was cognitively intact. The resident required an extensive assist of 1 person for bed mobility. The resident had impairment on both sides of his upper and lower extremities for functional limitation in range of motion. The resident was 73 inches tall. A Care Plan, dated 1/18/22, indicated the resident was limited in functional status in regards to the ability to independently change positions in bed, in example as to turn, sit up, or move to head of bed. An intervention included to maintain body in functional alignment when at rest and to provide assist with bed mobility as needed. Interview with Environmental Services Director on 7/21/22 at 2:36 p.m., indicated he was unaware that the resident's feet reached the foot board. There was no order for a bigger bed or additional placement of bolsters. He indicated he would extend the foot board further and add a bolster.3. On 7/18/22 at 12:49 p.m., Resident 60 was observed in the hallway propelling herself in her wheelchair. There was a purple discoloration to her right wrist. She indicated she was not sure how it happened. On 7/20/22 at 9:56 a.m., Resident 60 was observed lying in bed watching television. The purple discoloration remained to her right wrist. Record review for Resident 60 was completed on 7/20/22 at 2:19 p.m. Diagnoses included, but were not limited to, multiple sclerosis, hypothyroidism,			

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	and anxiety disorder. The Quarterly MDS assessment, dated 6/17/22, indicated the resident was cognitively intact. The resident required an extensive 1 person assist for personal hygiene and was totally dependent on staff for bathing. The Bath and Skin Report sheet, dated 7/2022, indicated the resident received a shower on 7/4, 7/7, 7/11, 7/14, and 7/18. There were no areas of bruising or discoloration documented. Interview with LPN 1 on 7/20/22 at 10:29 a.m., indicated she was not aware of any skin discolorations or bruising and would go assess the resident. A facility policy, titled "Measurement of Alterations in Skin Integrity," indicated "...1. At first observation of any skin condition, the charge nurse or treatment nurse is responsible to measure and/or describe skin condition in the clinical record...Skin conditions such as bruises, skin tears, abrasion, rashes, and moisture/incontinence associated dermatitis will be described upon initial observation and documented in the clinical record. Weekly measurements of these areas are not required..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 5 residents reviewed for accidents. (Resident 60) Finding includes: On 7/20/22 at 9:56 a.m., Resident 60 was observed lying in bed watching television. There were no non-skid strips observed to the floor anywhere in her room or bathroom. On 7/21/22 at 10:15 a.m., Resident 60 was observed seated in her wheelchair propelling herself toward the activity room. There were no non-skid strips observed to the floor anywhere in her room or bathroom. Record review for Resident 60 was completed on 7/20/22 at 2:19 p.m. Diagnoses included, but were not limited to, multiple sclerosis, hypothyroidism, and anxiety disorder. The Quarterly MDS (Minimum Data Set) assessment, dated 6/17/22, indicated the resident was cognitively intact. The resident required an extensive 1 person assist with bed mobility and transfers. She had impairment of the functional range of motion to the lower extremity on one side. A Fall Investigation, dated 3/11/22, indicated the resident had attempted to stand up from her wheelchair to reach her belongings in her closet, lost her balance, and fell to the floor on her right	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 60's fall interventions were reviewed and are in place. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who have fall interventions have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were in-serviced on ensuring fall interventions are in place. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will review 5 residents with fall interventions weekly to ensure fall interventions are in place.	08/03/2022

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	side. She was sent to the hospital and was discovered to have a right femur fracture. She returned to the facility on 3/18/22. A Physician's Order, dated 3/21/22, indicated "anti skid strips in bathroom and next to bed." A Care Plan, updated 7/8/22, indicated the resident was at risk for falls. The interventions included, non skid strips in front of the closet, next to the bed, and in the bathroom. Interview with the Director of Nursing and Nurse Consultant on 7/21/22 at 11:09 a.m., indicated they would review the fall interventions. A facility policy, titled "Falls-Clinical Protocol," indicated, "...Treatment/Management 1. Based on preceding assessment, the staff and Physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling...2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling..." 3.1-45(a)		The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interview, the facility failed to ensure a dependent, non-verbal resident received pain medication prior	F 0697	F 697 Pain Management **What corrective action(s) will be accomplished for those**	08/03/2022

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	to a dressing change for a stage 4 pressure ulcer for 1 of 4 residents reviewed for pain. (Resident 37) Finding includes: On 7/20/22 at 8:50 a.m., Resident 37's wound care was observed with the Wound Nurse and Hospice Aide. The Wound Nurse indicated the resident had been given a pain pill prior to the treatment. The resident was turned onto her left side, she began to whine, furrow her brows, and grimace. The Wound Nurse removed the old dressing to her sacrum. There was a large, irregular shaped pressure ulcer and bone exposed. The resident was whimpering and continued to have facial grimacing. The Hospice Aide patted her on the arm and attempted to reassure her. The wound was cleansed with saline and gauze, then packed with medicated gauze. The resident continued to whimper and grimace. When the treatment was completed, the resident was positioned on her back. Her face relaxed, she was no longer crying out and she was staring at the wall. When asked if she was having pain, she was unable to answer and continued to stare at the wall. The resident's record was reviewed on 7/19/22 at 1:39 p.m. Diagnoses included, but were not limited to, osteomyelitis (bone infection), unspecified dementia, stage 4 pressure ulcer and aphasia (inability to express self). The resident was receiving hospice services. The Quarterly Minimum Data Set assessment, dated 5/31/22, indicated the resident had severe cognitive impairment and required extensive one person assist for bed mobility and extensive two person assist for transferring.		**residents found to have been affected by the deficient practice?** R37's medications were reviewed and new orders were received. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents receiving wound care treatments. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff were in-serviced on ensuring residents pain is managed prior to wound care treatments. The IDT team met to review residents receiving wound care treatments and their pain medications. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will review 5 residents with orders for wound care treatments weekly to ensure pain is managed prior to wound care treatments. DON/designee will	

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	A Pain Assessment for Cognitively Impaired was completed on 7/7/22. The assessment indicated the resident exhibited signs of pain such as crying, groaning, whimpering, whining and moaning. She would exhibit resistance to certain movements, would occasionally grimace or frown, and be withdrawn. The interpretation was the resident experienced moderate pain and was provided analgesics and rest. A Physician's Order indicated the resident had a Fentanyl patch (narcotic pain medication) for pain. The dosage had been changed from 50 micrograms (mcg) to 75 mcg on 7/11/22 due to increased signs of pain. The Physician's Order Summary, dated 7/2022, indicated the resident could have Norco (narcotic pain medication) 10/325 milligrams (mg) every 8 hours as needed (PRN) for pain, and Morphine 10 mg/ 5 milliliters (ml) give .25 ml every 2 hours as needed for pain. A Physician's Order, dated 7/11/22, indicated the resident was to have dressing changes to the sacrum wound on Mondays, Wednesdays and Fridays, and as needed if dislodged or soiled. The Medication Administration Record, dated 7/2022, lacked documentation that Norco or Morphine had been given on 7/20/22 prior to the dressing change. There was no PRN pain medication given on 7/11 or 7/14/22 when dressing changes had been completed previously. Interview with LPN 1 on 7/20/21 at 10:18 a.m., indicated she had not given the resident any pain medication that morning, but she would do so now.		present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring period will be extended. Monitoring will be on-going.	

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	Interview with the Director of Nursing (DON) on 7/22/22 at 10:09 a.m., indicated the resident was monitored for pain every hour or two. She would grunt or cry out but had pain medications available as needed. She indicated she should have been medicated prior to wound care but there was not an order to do so. During a follow up interview at 10:24 a.m., the DON indicated she had contacted hospice about scheduling pain medication prior to dressing changes and would discuss during the next IDT (interdisciplinary team) meeting. 3.1-37(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use			

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	155650	A. BUILDING 00 B. WING	07/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure an AIMS (Abnormal Involuntary Movement Scale) assessment was completed for a resident taking antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 11) Finding includes: Resident 11's record was reviewed on 7/22/22 at 9:27 a.m. The resident was admitted to the facility on 11/8/17. Diagnoses included, but were not limited to, Parkinson's disease and cognitive communication deficit.	F 0758	**F 758 Unnecessary Psychotropic Meds** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 11's AIMS observation was updated and resident is not exhibiting any abnormal movements. **How the facility will identify other residents having the potential to be affected by the**	08/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	The Quarterly Minimum Data Set (MDS) assessment, dated 7/18/22, indicated the resident had severe cognitive impairment. The Physician's Order Summary, dated 7/2022, indicated the resident received risperidone (an antipsychotic medication), 0.5 milligrams twice daily. The record lacked a recent AIMS assessment. The last assessment was completed on 2/8/21. Interview with the Nurse Consultant on 7/22/22 at 1:55 p.m., indicated 2/8/21 was the last AIMS assessment completed. The AIMS was to be completed every six months. She indicated Social Services would update the assessment. 3.1-48(a)(3)		**same deficient practice and what corrective action will be taken;** All residents with orders for psychotropic medications have the potential to be affected by the same alleged deficient practice. An audit of all residents receiving psychotropic medications was compiled and their AIMS observation was updated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nursing staff were in serviced on ensuring residents with orders for psychotropic medications have an AIMS observation quarterly at minimum. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Social Services /designee will randomly audit 5 residents with orders for psychotropic medications weekly to ensure they have a AIMS observation quarterly at minimum. Social Services /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

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			extended. Monitoring will be on going.	
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, record review, and interview, the facility failed to ensure residents' food preferences were assessed and honored and education was given related to their diet for 2 of 2 residents reviewed for food. (Residents 12 and 324) Findings include: 1. On 7/18/22 at 1:55 p.m., Resident 12 was observed sitting in her wheelchair in her room eating lunch. The resident had chicken and stuffing with gravy on both of them. The resident had eaten just a little bit of the chicken. The resident indicated she had told the facility she did not like gravy or rice and they still served it to her all the time. On 7/19/22 at 1:59 p.m., the resident was observed propelling herself down the hallway in her wheelchair. She indicated she was served a pork chop at lunch with gravy on it and rice. On 7/20/22 at 8:54 a.m., the resident was observed sitting in her wheelchair in her room eating breakfast. The resident indicated, "no bacon again today". The resident had a diet card on her tray that indicated, Dislikes: no bacon, sausage,	F 0800	**F 800 Provided Diet Meets Needs of Each Resident** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R 12 was interviewed by the Dietary Manger and Dietician to assess and honor food preferences as well as, provide education to resident. R 324 was interviewed by the Dietary Manger and Dietician to assess and honor food preferences as well as, provide education to resident. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the	08/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ham, hot dogs, bologna, salami, gravy, tomatoes/tomato products, bratwurst, fish, and rice. The resident indicated that she had never told anyone she disliked any of those food items except for the gravy and rice. She was unsure why the food items were written on the diet card. On 7/21/22 at 12:10 p.m., the residents lunch tray was delivered to her room. The food on the plate consisted of beef and potatoes with gravy on it and green beans. Record review for Resident 12 was completed on 7/21/22 at 10:32 a.m. Diagnoses included, but were not limited to, heart failure, end stage renal disease, and hyperkalemia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/3/22, indicated the resident was cognitively intact. The resident received a therapeutic diet. A Dietary Note completed by the Registered Dietician, dated 5/26/22 at 2:19 p.m., indicated the Nurse Practitioner had requested the resident watch her intake of sodium. She would recommend her diet order be amended to include: "no bacon, sausage, ham, salami, bologna, hot dogs, or soup". The record lacked any documentation the resident was told and educated about her diet being changed to omit those foods. Interview with the Dietary Manager (DM) on 7/21/22 at 1:57 p.m., indicated she had not spoken to the resident about not being able to have specific foods. She further indicated the resident should not have been served gravy on her food or the rice.		potential to affect all facility residents. An audit was completed on all residents admitted within the last 6 months to ensure food preferences have been assessed and honored as well as education provided. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Dietary Manger educated on completing assessment of food preferences for residents and ensuring their preferences are being honored as well as, education provided. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Dietary Manager/ designee will audit all newly admitted resident's food preferences weekly x 6 months to ensure food preferences are being honored and resident has been educated. A summary of the audits will be presented to the Quality Assurance committee monthly for 6 months or until compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Interview with the Registered Dietician on 7/21/22 at 1:59 p.m., indicated she was unsure if anyone had spoken to the resident about why it was recommended to not have the foods listed as "dislikes" on her diet card. The diet card said, "dislikes" because they could not edit it to say anything else. The resident should not have been served the gravy on her food or the rice. She further indicated she would talk to the DM about paying closer attention to the diet cards. 2. On 7/18/22 at 2:53 p.m., Resident 324 was observed sitting in his room. He indicated he was new to the facility and had never received a menu for meals. He indicated no one had ever asked him what foods he liked or disliked. On 7/22/22 at 1:04 p.m., the resident was observed sitting in a wheelchair in his room. The resident indicated he had told the staff he disliked eggs and oatmeal and was still being served those items for breakfast. He further indicated he was unaware of what alternatives they had to offer and had asked for a menu but had never received one. Record review for Resident 324 was completed on 7/20/22 at 11:15 a.m. Diagnoses included, but were not limited to, end stage renal disease, heart failure, and diabetes mellitus. The resident was admitted to the facility on 7/11/22. The 5 Day MDS assessment, dated 7/18/22, indicated the resident was cognitively intact. The resident did not have a specific diet marked on the assessment. The record lacked any documentation to indicate the resident's food preferences had been reviewed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with the DM on 7/22/22 at 1:16 p.m., indicated she had not yet spoken to the resident about his food preferences of what he liked or disliked. She relied a lot on the CNAs to ask the residents. She would normally talk with the residents within 3 days of their admission but had not spoken to him yet because she had not had the time. She was unaware that he didn't like eggs or oatmeal or that he didn't know about the menu alternatives. 3.1-21(a)(4)			
F 0802 SS=E Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation, record review, and interview, the facility failed to ensure there was sufficient dietary staff available to effectively serve meals in a timely manner. This had the	F 0802	F 802 Sufficient Dietary Support Personnel **What corrective action(s) will**	08/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

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	potential to affect 69 residents who received meals from the kitchen. (Main Kitchen) Finding includes: On 7/18/22 at 8:55 a.m., the initial kitchen observation was completed. The Dietary Manager (DM) was plating breakfast trays. The DM indicated there had been two call offs, and she was trying to get breakfast served. The normal kitchen staff consisted of a dishwasher, an aide, and a cook. On 7/19/22 at 9:30 a.m., the DM was again observed plating breakfast trays. There was one other staff member in the kitchen. On 7/19/22 at 9:55 a.m., the breakfast trays were taken to the A wing to be served to residents. The Meal Schedule indicated breakfast was to be served on the A wing between 7:45 and 8:00 a.m. Interview with the DM on 7/19/22 at 9:30 a.m., indicated there was a call off again that day and another staff member was on vacation. She indicated the backup plan in the event of call offs was for herself to assist. Administrative staff would assist if she had asked, but she had not notified them as the call off occurred at 2:00 a.m. Interview with the Administrator on 7/22/22 at 9:52 a.m., she indicated she had just been notified there was an issue getting breakfast to the units and a staff member had been sent to assist. 3.1-20(h)		**be accomplished for those residents found to have been affected by the deficient practice?** The dietary manager provided training for non-dietary facility staff to provide assistance to the dietary department to ensure meal service is timely. The dietary manager was educated on immediate notification to facility administrator and DON in the event dietary staffing is insufficient for timely meal service. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** The Dietary Manager provided training to multiple non-dietary staff related to food service in the kitchen. The facility has developed a rotation and schedule for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

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			non-dietary staff availability to assist with meal preparation and food service if dietary staff is unavailable. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Dietary Manager/ designee will observe and audit alternating meal serving times 3 x week for 6 months to ensure there is adequate staff and meals are being served timely. A summary of the observations/audits will be presented to the Quality Assurance committee monthly for 6 months or until compliance is met.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

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	applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure a safe and sanitary kitchen related to improper food storage in the refrigerator and freezer, expired food, improper drying of bowls and improper handling of food during food service. This had the potential to affect the 69 residents who received meals from the kitchen. (Main Kitchen) Findings include: 1. During the initial tour of the kitchen on 7/18/22 at 9:15 a.m. with the Dietary Manager (DM), the following was observed: a. In the freezer: -There were boxes and containers stacked on shelves touching the ceiling. -There was a covered foil container of chili dated 5/9/22 with a use by date of 7/9/22. b. In the refrigerator: - There were two boxes of lettuce sitting directly on the floor. Interview with the DM on 7/20/22 at 10:40 a.m. indicated her stock person was a new hire and was still in training. A facility policy, titled "Storage of Food and Supplies, received as current, indicated "...2. Food and supplies will be stored six (6) inches above the floor on clean racks or shelves and at	F 0812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Food storage in the freezer higher than 18 inches was corrected. Food in foil covered container dated for 5/9/22 was discarded. The boxes of lettuce were removed from the floor and placed on shelving. Ultra-liner shelf liners were placed on the trays to assist with the drying of dishes. Dietary staff member immediately received a teachable moment related to touching food and other items or areas with the same gloves being used to prepare meal servings. **How will facility identify other**	08/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	least eighteen (18) inches from sprinkler heads...5. Food stored in refrigerators or freezers will be stored on shelves, racks, dollies, or other surfaces that facilitate cleaning..." 2. On a follow-up visit to the kitchen on 7/20/22 at 10:40 a.m., there were bowls observed drying in the dishwasher areas. The bowls were upside down resting directly on trays, with no air able to circulate around them. There was water pooled around the bowls. Interview with the DM on 7/20/22 at 10:40 a.m., indicated she was instructed not to use netted drying mats as they were unnecessary. She had instructed staff that if they pulled out a wet bowl they should use a single paper towel, wipe once, throw it away, then use more if needed to dry it. A facility policy titled, "Dishwashing Procedure," received as current, indicated " ...11. Allow dishes to air dry before stacking ..." 3. On 7/20/22 at 11:45 a.m., Dietary Aide (DA) 1 was observed plating lunch trays. She was wearing disposable gloves. She reached into a bag of buns and placed one on the plate, then used tongs to place beef on a scale then onto the bun. She reached down to a storage shelf under the steam table, then pulled the service cart closer to her with her gloved hand. She then used a scoop to serve waffle fries and reached into the bag and retrieved another bun with her same gloved hand. She had not changed her gloves. She proceeded to prepare the next plate. Interview with the DM on 7/20/22 at 11:55 a.m., indicated the DA should not be touching food and non food items with the same gloved hands, and she would talk to her immediately.		**residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Dietary staff educated on ensuring food is being stored according to the facility policy. Dietary staff educated on the use of ultra-liner shelf liners to assist with the drying of the dishes. Dietary staff educated on the need and importance of changing gloves as necessary when preparing and serving meal trays. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Dietary Manager/ designee will audit dietary staff performance 5 x a week for 6 months to ensure food is being stored accordingly, ultra-liner shelf liners are being used to assist with dish drying, and dietary staff are changing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-21(i)(3)		gloves as needed during meal preparation and servings. A summary of the audits will be presented to the Quality Assurance committee monthly for 6 months or until compliance is met.	
F 0921 SS=B Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to keep the residents' environment clean and in good repair related to peeling paint and scuffed walls, running toilet, and bed control cords in need of repair for 1 of 2 units. (The B Wing) Findings include: During the Environmental tour on 7/21/22 at 2:27 p.m., the following was observed: 1. B Wing, B Hall a. Room B12: There was peeling paint and scuffed walls behind and above the headboard of the bed. One resident resided in the room. b. Room B16: The toilet tank was running and making a constant noise. Two residents resided in the room. 2. B Wing, C Hall a. Room B20: The cord for the bed controls on bed 1 were wrapped around the bed side railing. The	F 0921	F 921 Safe/Functional/Sanitary/Comfortable Environment **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The peeling paint in room B13-1 was corrected immediately by the Maintenance Department. The running toilet in room B16 was corrected immediately by the Maintenance Department. The bed controller and cord in room B20-1 was replaced. **How will facility identify other residents who have the potential to be affected by the same alleged deficient**	08/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

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	cord was wrapped in black tape that was peeling away from the cord. The bed side railing had black markings across it. Interview with the Environmental Services Director on 7/21/22 at 2:36 p.m., indicated he was unaware of the needed repairs observed on the tour, but they would be corrected immediately. 3.1-19(f)		**practice?** The deficient practice has the potential to affect all facility residents. An audit was completed on all resident rooms to ensure there was no peeling of paint, running toilets, nor bed controllers needing replacement. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** The Maintenance Director and Assistant Maintenance educated on making daily rounds to ensure rooms do not have peeling paint, running toilets, nor bed controllers that need replacement. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Maintenance Director/ designee will audit 5 rooms weekly for 6 months to ensure there is no peeling of paint, running toilets, nor bed controllers that need replacement. A summary of the audits will be presented to the Quality Assurance committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	07/22/2022

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

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			monthly for 6 months or until compliance is met.	
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an environment free of pests, related to ants on a resident's bed and floor during a random observation of a resident's room. (Resident 42) Finding includes: On 7/18/22 at 1:14 p.m., Resident 42 requested a Surveyor come to her room. She pointed to an ant on her bed. There were 6-7 ants observed crawling on the sheet at the head of her bed, a few more on the bed railing, and several observed on the floor. Interview with Resident 42 at that time indicated there had been ants on her sheets the previous night and the staff had changed her sheets. The Maintenance Director was brought into the room at 1:19 p.m. He observed the ants and indicated they needed to remove the resident from her bed immediately. During an interview with the Maintenance Director at that time, he indicated an exterminator came into the building twice a month, mostly for ants. If there were ants seen in between visits, he used a bleach solution to treat the area. He indicated they would take care of the concern right away. 3.1-19(f)(4)	F 0925	**F 925 Maintain Effective Pest Control Program** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R 42 was assessed and removed from her bed/room while the room was being deep cleaned and treated for pest. Contributing factors were removed from the room. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. An audit was completed on all resident rooms to ensure there were no observation of pest throughout the resident rooms and	08/03/2022

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			environment. Sentry Pest control came out to the facility, treated room A5 and surrounding rooms as well as an observation of all resident rooms in the facility for pest. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** All staff educated on ensuring residents environment is free of pest and to notify maintenance immediately if pest is observed in the environment. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Maintenance Director/ designee will audit 5 rooms weekly for 6 months to ensure there is no observation of pest noted in the environment. A summary of the audits will be presented to the Quality Assurance committee monthly for 6 months or until compliance is met.	