

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/31/2014
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NAME OF PROVIDER OR SUPPLIER  LINCOLNSHIRE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 27, 28, 29, 30, and 31, 2014</p> <p>Facility number: 000577 Provider number: 155650 AIM number: 100266950</p> <p>Survey team: Julie Ferguson, RN-TC Caitlyn Doyle, RN Jennifer Redlin, RN (October 28, 29, 30 and 31, 2014) Heather Hite, RN Regina Sanders, RN (October 27 and 28, 2014) Janelyn Kulik, RN (October 27, 28 and 31, 2014)</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census Payor type: Medicare: 18 Medicaid: 37 Other: 23 Total: 78</p> <p>These deficiencies reflect state findings</p>	F000000		
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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.

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F000167 SS=C	<p>cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on November 3, 2014, by Janelyn Kulik, RN.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on record review and interview, the facility failed to ensure the residents were aware the State Inspections were available to read and where they were located. This had the potential to affect 78 residents in the facility. (Resident #28 and #20)</p> <p>Findings include:</p> <p>Interview with Resident #28 on 10/28/14 at 9:15 a.m., indicated she was not sure where the survey results were and she did not recall discussing them in the Resident Council meetings.</p> <p>The record for Resident #28 was reviewed on 10/28/14 at 11:00 a.m. The</p>	F000167	<p><b>Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F 167 Right to Survey Results</b></p> <p>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. <b>The facility requests paper compliance for this citation. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> A sign remains posted above the state survey binder located in the front lobby of the facility. Both residents that stated they were unaware of the location of the survey results</p>	11/26/2014

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	<p>discharge Minimum Data Set (MDS) assessment dated 10/15/14 indicated the resident had modified decision making-some difficulty with new situations. Her 14-Day MDS assessment dated 9/8/14 indicated a BIMS (Brief Interview of Mental Status) score of 15, which indicated she was cognitively intact.</p> <p>Interview with Resident #20 on 10/28/14 at 10:02 a.m., indicated she had lived at the facility a few years. She attended Resident Council meetings and she was not aware where to find the survey results and did not recall them being discussed in the Resident Council meetings.</p> <p>The record for Resident #20 was reviewed on 10/28/14 at 11:05 a.m. The annual MDS assessment dated 8/21/14 indicated the resident had a BIMS score of 15. This indicated the resident was cognitively intact.</p> <p>Review of the the Resident Council meeting Minutes from August 2014 to October 2014 on 10/28/14 at 9:45 a.m., indicated there was no discussion about the past survey results or where the results were located in the facility for the residents to review.</p> <p>Interview with the Activity Director on</p>		<p>have been informed of the location of the results. Resident council meeting was held on 11/3/2014 with the local Ombudsman. The location of the survey inspection results was reviewed with the resident council at that time. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.</b> Location of survey inspection results and documentation found therein will be reviewed at the resident council meetings monthly. All residents who were not in attendance at the 11/3/14 Resident Council Meeting have been informed by the Activity staff of the location of the state inspection results. Activity Staff will be in-serviced on the need to review the location of the survey inspection results every month at the resident council meeting. All residents shall be informed upon admission and quarterly thereafter of the location of survey inspection results.</p> <p><b>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?</b></p>		

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	<p>10/28/14 at 9:50 a.m., indicated the Ombudsman did come to some of the meetings and she would see if there was any documentation of discussion of the annual survey results.</p> <p>Interview with the Activity Director on 10/28/14 at 10:51 a.m., indicated she was not here but after the last survey in January 2014, the Resident Council discussed the survey findings at the February 3, 2014 meeting. This also included the discussion of why a survey was conducted. At this time, the Activity Director presented the meeting minutes of the February 3, 2014 meeting. She further indicated the Ombudsman would be attending the November meeting and the survey results were on the agenda to be discussed. The Activity Director also provided information indicating that all residents were informed about the survey results in their admission packets.</p> <p>3.1-3(b)(1)</p>		<p>Activities Director/designee will randomly audit 3 residents a week to ensure those residents are aware of the location of state inspection results. Activities Director/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>	

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to provide resident choices related to type of bathing for 2 of 3 residents reviewed for choices of the 3 who met the criteria. (Residents #7 and #71)</p> <p>Findings include:</p> <p>1. During an interview with Resident #7 on 10/27/2014 at 9:58 a.m., she indicated she did not have a choice on her method of bathing; she currently received showers but would prefer a bath. She further indicated she was not asked what she preferred.</p> <p>During an interview on 10/28/2014 at 2:45 p.m. with the Director of Nursing (DON) and Activities Director regarding choices, the Activities Director indicated she was in charge of asking residents about choices. She further indicated the choices questions, including type of bathing, should be asked of each resident</p>	F000242	<p><b>Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F242 Self-Determination – Right to make choices</b> 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. <b>The facility requests paper compliance for this citation. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> The 2 residents found to have been affected have had their preferences acknowledged and care plans updated accordingly. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures the facility will take or systems the facility</b></p>	11/26/2014

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	<p>upon admission/ readmission and with quarterly assessments. At this time, the DON was unsure if the facility had a bath tub to offer for a bathing choice.</p> <p>During a follow up interview on 10/28/2014 at 3:20 p.m., the DON indicated the facility does in fact have a tub and several residents currently receive baths per the B wing Unit Manager.</p> <p>On 10/28/14 at 3:30 p.m., the Administrator and Activities Director indicated current resident preferences were incomplete and a new form would be used from now on for preferences to capture more complete information for resident preference.</p> <p>Resident #7's record was reviewed on 10/29/2014 at 10:20 a.m.. Diagnoses included, but were not limited to, closed fracture of pubis, closed fracture of clavicle, history of personal fall, difficulty walking, muscle weakness, malaise and fatigue, diabetes mellitus, and polyarthropathy/polyarthritis lower leg.</p> <p>An Admission/ 5 day Minimum Data Set (MDS) assessment dated 9/23/14, the section titled Preferences indicated Resident #7 felt it was "Very Important"</p>		<p><b>will alter to ensure that the problem will be corrected and will not recur.</b> All residents and/or responsible party have completed a Resident Personal Preferences Questionnaire that indicates resident bathing preferences. This Resident Personal Preferences Questionnaire will be completed at the time of initial admission and quarterly thereafter. Nursing staff and department heads have been in-serviced on adhering to resident's preferences for bathing and the Resident Personal Preferences Questionnaire.</p> <p><b>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?</b></p> <p>Administrator/designee will randomly interview 3 residents weekly to ensure that bathing preferences are being adhered to. Administrator/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>		

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	<p>to choose between a tub bath, shower, bed bath, or sponge bath.</p> <p>Review of the Activity Interest Survey dated 9/19/14 indicated bathing preference was not addressed.</p> <p>There was no documentation in the progress notes or clinical record for Resident #7 to indicate the resident was asked her bathing preference.</p> <p>2. During an interview on 10/27/14 at 11:00 a.m., Resident #71 indicated she did not get to choose between a tub bath and a shower. She indicated she received showers but would prefer baths. She further indicated the facility had a whirlpool tub and she was not asked her bathing preference.</p> <p>During an interview on 10/28/2014 at 2:45 p.m. with the Director of Nursing (DON) and Activities Director regarding choices, the Activities Director indicated she was in charge of asking residents about choices. She further indicated the choices questions, including type of bathing, should be asked of each resident upon admission/ readmission and with quarterly assessments. At this time, the DON was unsure if the facility had a bath tub to offer for a bathing choice.</p>			

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	<p>During a follow up interview on 10/28/2014 at 3:20 p.m., the DON indicated the facility does in fact have a tub and several residents do currently receive baths per the B wing Unit Manager.</p> <p>On 10/28/14 at 3:30 p.m., the Administrator and Activities Director indicated current resident preferences were incomplete and a new form would be used from now on for preferences to capture more complete information for resident preference.</p> <p>On 10/30/2014 at 2:20 p.m., the DON indicated the MDS preferences section was only asked for comprehensive and significant change assessments and the current comprehensive annual assessment was currently in progress.</p> <p>Resident #71's record was reviewed on 10/29/2014 at 9:45 a.m. Diagnoses included, but were not limited to, syncope and collapse, anemia, muscle weakness, shortness of breath, renal failure, depressive disorder, end stage renal disease, insomnia, diabetes mellitus and arthropathy.</p> <p>The last significant change MDS assessment for which preferences was discussed was dated 11/8/13.</p>			

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F000279 SS=D	<p>There was no documentation in the progress notes or clinical record for Resident #71 to indicate the resident was asked her bathing preference.</p> <p>3.1-3(u)(3)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop resident care</p>	F000279	Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F279 Develop Comprehensive Care Plans Please accept the	11/26/2014

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	<p>plans related to a medication which can thin the blood (Aspirin), for 1 of 5 residents reviewed for unnecessary medications. (Resident #2)</p> <p>Findings include:</p> <p>Resident #2's record was reviewed on 10/28/14 at 11:00 a.m. The resident's diagnoses included, but were not limited to esophageal reflux, vascular dementia, dementia, diabetes mellitus, seizures, and cerebrovascular disease.</p> <p>The current Physician's Orders, indicated an order for a Aspirin 81 mg (milligrams) give one tablet by mouth one time a day for anticoagulation.</p> <p>Review of the October 2014 Medication Administration Record (MAR) indicated the resident had received the aspirin medication daily since the order date.</p> <p>There was a lack of documentation to indicate the resident had a care plan and/or interventions related to the aspirin usage and risk for bleeding and bruising.</p> <p>An interview with the Director of Nursing (DON) on 10/28/2014 at 2:50 p.m., indicated when a medication was changed or added, the Unit Manager was</p>		<p>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.</p> <p><b>The facility requests paper compliance for this citation. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> An anticoagulant care plan was initiated for the affected resident <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All potentially affected residents on anticoagulant therapy have had their care plans reviewed and care plans updated accordingly.</p> <p><b>What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.</b> Anticoagulant care plans will be updated or initiated during the morning clinical review meeting. Nursing administration will be in-serviced in regards to identifying and initiating anticoagulant therapy care plans for residents receiving anticoagulant therapy. <b>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</b></p>		

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F000282 SS=D	<p>responsible for updating the residents' care plans and should be doing so.</p> <p>During a follow up interview on 10/28/2014 at 3:17 p.m., the DON indicated, "We missed the care plan for aspirin for [Resident #2]. That should have been put into place when the aspirin was started. We did just added that to her care plan now."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure Physician Orders and Care plans were followed as written related to the removal of a dressing to a fistula site used for dialysis for 1 of 1 residents reviewed for dialysis and for non-pharmacological interventions not attempted for pain management for 1 of 3 residents reviewed of the 3 who met the criteria for pain management. (Resident #59 and #77)</p>	F000282	<p><b>program will be put into place?</b> DON/designee will audit 3 residents on anticoagulant therapy 3 times per week to ensure accuracy of care plans. DON/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p> <p><b>Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F282 Services by Qualified Persons per Care Plan</b> 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. <b>What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> The affected resident #</p>	11/26/2014

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	<p>Findings include:</p> <p>1. During an observation on 10/30/14 at 1:45 p.m., Resident #59 had a bandage noted to his right arm. Interview with the resident at the time of the observation indicated he still had his bandage on from dialysis the previous day. He further indicated nursing never removed his bandage from dialysis and he takes it off himself the day after he returns from dialysis.</p> <p>Record review for Resident #59 was completed on 10/29/14 at 9:22 a.m., The Admission Minimum Data Set (MDS) Assessment dated 8/9/14, indicated the resident was cognitively intact. The residents diagnoses included, but were not limited to, hypertension and renal insufficiency.</p> <p>The October 2014 Physician Orders indicated to remove dressing from dialysis fistula 4 hours after return from dialysis every Monday, Wednesday, and Friday.</p> <p>Interview with the B wing Unit Manager on 10/30/14 at 2:00 p.m., indicated nursing was to remove the dialysis bandage 4 hours after dialysis and check the site.</p>		<p>59, expressed his preference of having his dressing removed at next dialysis visit. Physician was notified of resident's preference; new order was received to leave dressing in place until next dialysis visit. The care plan for affected resident #77 has been updated to reflect the residents preferred pain management regimen <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All residents with dialysis fistulas are at risk for the same alleged deficient practice. All residents with the potential for pain have the potential to be affected by the same alleged deficient practice. <b>What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.</b> Clinical records for dialysis residents have been audited to ensure that physician orders are present on the treatment record regarding dialysis fistula dressings and care plans updated accordingly. Nursing staff will be in-serviced regarding treatment of dialysis fistula dressings. All residents with care plans for pain have been reviewed to ensure that interventions for pain management regimen are appropriate to each individual resident. Nursing staff will be in-serviced on pain management. <b>How will the corrective action</b></p>				

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(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			
	<p>Interview with the DON on 10/31/14 at 11:14 a.m., indicated the resident has never let nursing take his dressing off after dialysis and would prefer to have it taken off at dialysis.</p> <p>2. Resident #77's record was reviewed on 10/29/14 at 3:17 p.m. The resident's diagnoses included, but were not limited to hypertension and alcoholic polyneuropathy.</p> <p>Review of the 10/2014 Physician's Order Summary, indicated an order for Norco (a narcotic pain medication) 5-325 mg (milligrams), one tablet every 4 hours as needed for pain 6-10.</p> <p>Review of the Medication Administration Record (MAR), dated 10/2014, indicated there was no indication of interventions attempted prior to the administration of the Norco on 10/1/14, 10/5/14, 10/6/14, 10/9/14, twice on 10/10/4, 10/11/14, 10/12/14, 10/14/14, 10/15/14, and 10/26/14.</p> <p>Review of the Progress Notes and eMAR (electronic medication administration record) notes dated 10/1/2014 through 10/30/2014 indicated there was no indication of interventions attempted prior to the administration of the Norco on 10/1/14, 10/5/14, 10/6/14, 10/9/14, twice on 10/10/14, 10/11/14, 10/12/14,</p>		<p><b>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>DON/Designee will randomly audit 2 dialysis residents 2 x/week to ensure removal of dressing and proper documentation in clinical record. DON/Designee will randomly audit 5 residents 3x/week to ensure pain management is properly followed according to physician orders and care plan to reflect the same. DON/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>				

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	<p>10/14/14, 10/15/14, and 10/26/14.</p> <p>Resident #77 had a care plan for risk for pain secondary to polyneuropathy. The nursing interventions included, "...Provide non-pharmacological interventions such as repositioning, activity of choice, distraction..."</p> <p>During an interview with the DON on 10/31/14 at 10:50 a.m., she indicated any non-pharmacological interventions attempted prior to giving the pain medication should have been documented in the progress notes or eMAR notes.</p> <p>A facility policy, dated 8/2008, titled, "Pain-Clinical Protocol," received from the DON as current on 10/31/14 at 11:14 a.m., indicated, "...Treatment/Management...4. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain..."</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>                      Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment and services related to the removal of a dressing to a fistula site used for dialysis for 1 of 1 residents reviewed for dialysis. (Resident #59)</p> <p>Findings include:</p> <p>1. During an observation on 10/30/14 at 1:45 p.m., Resident #59 had a bandage noted to his right arm. Interview with the resident at the time of the observation indicated he still had his bandage on from dialysis the previous day. He further indicated nursing never removed his bandage from dialysis and that he takes it off himself the day after he returns from dialysis.</p> <p>Record review for Resident #59 was completed on 10/29/14 at 9:22 a.m., The Admission Minimum Data Set (MDS) Assessment dated 8/9/14, indicated the</p>	F000309	<p><b>Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F309 Provide Care and Services for Highest Well-being</b>                      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. <b>The facility requests paper compliance for this citation. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> The affected resident expressed his preference of having his dressing removed at next dialysis visit. Physician was notified of resident's preference; new order was received to leave dressing in place until next dialysis visit. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All residents with dialysis fistulas are at risk for the same alleged deficient practice.</p>	11/26/2014

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F000364 SS=E	<p>resident was cognitively intact. The residents diagnoses included, but were not limited to, hypertension and renal insufficiency.</p> <p>The October 2014 Physician Orders indicated to remove dressing from dialysis fistula 4 hours after return from dialysis every Monday, Wednesday, and Friday.</p> <p>Interview with the B wing Unit Manager on 10/30/14 at 2:00 p.m., indicated nursing was to remove the dialysis bandage 4 hours after dialysis and check the site.</p> <p>Interview with the DON on 10/31/14 at 11:14 a.m., indicated the resident has never let nursing take his dressing off after dialysis and would prefer to have it taken off at dialysis.</p> <p>3.1-37(a)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that</p>		<p><b>What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.</b> Clinical records for dialysis residents have been audited to ensure that physician orders are present on the treatment record regarding dialysis fistula dressings and care plans updated accordingly. Nursing staff will be in-serviced regarding treatment of dialysis fistula dressings. <b>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?</b></p> <p>DON/Designee will randomly audit 2 dialysis residents 2 x/week to ensure removal of dressing and proper documentation in clinical record. DON/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>	

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	<p>conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to serve food at the proper temperature, related to hot food served cold and cold food served warm, for 1 of 2 dining rooms observed, which had the potential to affect 5 residents who received their tray from the unheated tray cart.</p> <p>Findings include:</p> <p>During an observation on 10/27/14 at 7:49 a.m., three carts of breakfast trays were sitting in and outside of the Rehabilitation Dining Room. The tray cart in the Dining room contained five breakfast trays. The food was covered and the cart was covered with a clear plastic cover.</p> <p>Further observation on 10/27/14 at 8:13 a.m., indicated the staff began to deliver the breakfast trays to the residents sitting in the dining room from the clear plastic covered tray cart.</p> <p>Cook #1 was observed taking the temperature of the foods being served. The temperature of the grits was 85.8 F (degrees Fahrenheit), the ham and egg casserole was 106.3 F, and the milk was</p>	F000364	<p><b>Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F364 Nutritive Value-Appear, palatable/prefer temp</b> 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. <b>The facility requests paper compliance for this citation. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> New meal trays were immediately provided for affected residents. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.</b> Resident trays and pleasure feed trays will be transported in metal carts to maximize heat retention. Nursing personnel will be in-serviced on proper staffing levels in dining areas, prompt arrival of staff in dining areas, and</p>	11/26/2014

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F000431 SS=D	<p>64.9 F. The grits were taste tested and were cold to taste.</p> <p>During an interview at the time of the observation, Cook #1 indicated the grits should be 165 degrees, casserole 135 degrees, and the milk no higher than 40 degrees.</p> <p>A facility policy, dated 06/12, titled, "Nutritional Services Policy and Procedure Manual", received from the Administrator as current, indicated, "...The minimum acceptable holding temperature for hot food is 135 degrees F (Fahrenheit) or above. The maximum acceptable temperatures for cold food is 41 degrees F or below..."</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>		<p>timely tray distribution to all residents in the dining room.</p> <p><b>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?</b></p> <p>DON/Designee will randomly audit time of tray distribution to ensure meal pass for breakfast, lunch, and dinner is starting timely for 5 meals weekly. Dietary Manager/designee will randomly audit breakfast, lunch, and dinner food temps for 3 trays on delivery carts 3 days per week. DON/Designee and Dietary Manager/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>		

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	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure a medication was destroyed safely, related to the destruction of a nicotine transdermal patch for 1 of 1 residents observed with a transdermal patch during eight medication pass observations. (Resident #124)</p> <p>Findings include:</p> <p>During a medication administration observation on 10/28/14 at 9:15 a.m., LPN #2 prepared Resident #124's</p>	F000431	<p><b>Lincolnshire Health &amp; Rehabilitation Center Annual Survey 10/31/2014 INFORMAL DISPUTE RESOLUTION F431</b></p> <p>It is the position of Lincolnshire Health &amp; Rehabilitation Center that the findings reported in the Annual Survey are incomplete and in places inaccurate. The facility is presenting compelling information to dispute the deficiency of F431 and respectfully requests the tag be deleted. On 10/31/2014 ISDH completed an annual survey citing the facility F431 at a 'D' level alleging the facility failed to:</p> <ul style="list-style-type: none"> <li>·Ensure a medication was</li> </ul>	11/26/2014

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	<p>medication which included a nicotine transdermal patch 21 mg (milligrams).</p> <p>LPN #2 applied gloves, placed the nicotine patch on the residents upper chest. LPN #2 then removed the prior days patch, she then folded the patch in half and placed the patch into the residents remaining cup of water. The LPN then discarded the cup into the residents garbage can.</p> <p>During an interview on 10/28/14 at 9:18 a.m., LPN #2 indicated she normally throws nicotine patches into the garbage can. She further indicated Resident #124 was confused.</p> <p>Record review for Resident #124 on 10/28/14 at 3:05 p.m., indicated the resident had a chronic/progressive decline in intellectual functioning characterized by deficit in memory, judgement, decision making and thought process related to a diagnosis of dementia. The residents diagnoses included, but were not limited to, dementia with behavioral disturbances, delusional disorder, anxiety, and hypertension.</p> <p>Review of the nicotine transdermal</p>		<p>destroyed safely, related to the destruction of a nicotine transdermal patch.</p> <p>Lincolnshire Health &amp; Rehabilitation Center contends they properly destroyed the nicotine transdermal patch. As mentioned in the 2567, LPN#2 did fold the prior patch in half after removal. She placed the used patch in the resident's remaining cup of water and then <u>temporarily</u> discarded the cup with the patch in it into the resident's garbage can. The 2567 fails to mention the important fact that the nurse brought the resident up to the nurse station after giving them their medications, and then <u>immediately</u> went back to the room and removed the garbage bag containing the used patch. She then properly disposed of the resident's garbage bag into the soiled utility room garbage container. Also, the resident room was in close proximity to the nurse's station and was in the visual field of the nurse. The facility has shown compelling evidence that the facility did properly destroy the nicotine transdermal patch. In conclusion, after review of the all the facts, the facility respectfully requests that F431 be eliminated from the statement of deficiencies or <i>at a minimum the scope in severity be reduced</i> as no degree of harm or potential for harm could have resulted. <b>Lincolnshire Health</b></p>	

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	<p>patch instructions on 10/29/14 at 10:35 a.m., indicated to dispose of the used patches by folding the sticky ends together and placing the used patch into the pouch.</p> <p>Interview with the Director of Nursing (DON) on 10/29/14 at 10:59 a.m., indicated the disposal of the nicotine transdermal patch should be according to the manufacturers instructions.</p> <p>3.1-25(o)</p>		<p><b>and Rehab ANNUAL SURVEY: 10/31/2014 F431 Drug Records, Labels/Store Drugs and Biologicals</b> 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. <b>The facility requests paper compliance for this citation. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> The nurse immediately went back to the room and removed the garbage bag containing the used patch. She then properly disposed of the resident's garbage bag into the soiled utility room garbage container. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.</b> Licensed nurses and QMAs have been in-serviced on the proper disposal of nicotine patches <b>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality</b></p>		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with</p>		<p><b>assurance program will be put into place?</b> DON/designee will observe the administration and removal of nicotine patches for 2 residents 3 times weekly to ensure proper disposal of the patch. DON/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>				

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	<p>a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to implement complete contact isolation precautions to prevent the spread of infection related to not posting signs to notify staff and visitors to check with the nurse before entering a resident's room. (Resident #76)</p> <p>Findings include:</p> <p>During a room observation for Resident #76 on 10/27/14 at 11:25 a.m., a storage container with gloves and gowns was noted hanging on the wide open room door for A wing room 24. There was no sign or indication for visitors to see the nurse before entering the room.</p> <p>During an interview with the A wing Unit Manager on 10/27/2014 at 11:49 a.m. regarding isolation precautions, she indicated visitors would be made aware</p>	F000441	<p><b>Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F441 Infection Control</b> 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. <b>The facility requests paper compliance for this citation. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</b> The affected resident had an isolation sign posted on the room door <b>How the facility will identify other residents having the potential to be affected by the same deficient practice</b> All residents on isolation have the potential to be affected by the same alleged deficient practice. <b>What measures will the facility take or systems the facility will alter</b></p>	11/26/2014

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NAME OF PROVIDER OR SUPPLIER  LINCOLNSHIRE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410
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	<p>of any isolation precautions by a sign posted on a resident's door telling them to report to the nurse before entering. She further indicated Resident #76 in room 24-1 was in contact isolation for ESBL (a bacterial infection) in her urine and room 24 should have a sign on the door to make all staff and visitors aware.</p> <p>Resident #76's record was reviewed on 10/30/2014 at 8:25 a.m. Diagnoses included, but were not limited to, urinary tract infection (ESBL).</p> <p>A policy titled "Isolation - Categories of Transmission - based Precautions" was provided by the Administrator on 10/29/14 at 9:45 a.m. and deemed as current. The policy indicated, "... Contact Precautions: In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment ... g. Signs - Use signs and/ or other measures to alert staff of the implementation of Transmission - based Precautions, while respecting the privacy of the resident. 1) Place a sign at the doorway instructing visitors to report to the nurses' station before entering the</p>		<p><b>to ensure that the problem will be corrected and will not recur.</b></p> <p>Upon becoming aware of an isolation concern, nursing administration will ensure that notification of isolation precautions are conspicuously posted on the room door. Nursing staff will be in-serviced on proper isolation room signage. Extra Isolation signs are readily available and have been distributed to both nursing stations. <b>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?</b> DON/Designee will complete audit of all isolation rooms 3 times per week to ensure that an Isolation sign is in place. DON/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>	

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F000463 SS=D	<p>room."</p> <p>3.1-18(j)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to ensure residents were provided a functioning call system device at the bedside and in the bathroom for 2 of 35 residents whose call lights were observed. (Resident #9 and Resident #15)</p> <p>Findings include:</p> <p>1. On 10/28/14 at 8:50 a.m., an observation was made in A Wing Room 17-2 with Resident #9. The bathroom call light system failed to function properly after several attempts. When the call light cord was pulled the light failed to illuminate; the call light also failed to alert at the Nurse's station.</p> <p>Interview with LPN #1 on 10/28/14 at 8:53 a.m., indicated staff was not aware Resident #9's call light system was not working properly. Maintenance was immediately called to replace the call light.</p>	F000463	<p><b>Lincolnshire Health and Rehab ANNUAL SURVEY: 10/31/2014 F463 Resident Call System</b></p> <p>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. <b>The facility requests paper compliance for this citation. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b> The call lights for the affected residents have been repaired. <b>How will the facility identify other residents having the potential to be affected by the same deficient practice?</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected</b></p>	11/26/2014

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F000465 SS=E	<p>Interview with Maintenance #1 on 10/28/14 at 8:56 a.m., indicated Nursing staff usually checked the call lights and let him know if any were not working. He further indicated there was no specific schedule he followed to check call lights.</p> <p>2. On 10/27/14 at 10:25 a.m., an observation was made in A Wing Room 22-2 with Resident #15. The bedside call light system failed to function properly after several attempts. When the call light was pressed the light failed to illuminate; the call light also failed to alert at the Nurse's station.</p> <p>Staff was not aware Resident #15's call light system was not working properly. Maintenance was immediately called to replace the call light.</p> <p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the</p>	F000465	<p><b>and will not recur?</b> All call lights have been checked to ensure proper functioning. Maintenance personnel have been in-serviced regarding call light inspections. Nursing Staff have been in-serviced on call lights and to report any functioning issues to the appropriate department. <b>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?</b></p> <p>Maintenance Director/designee will complete 25 room inspections monthly to ensure proper call light functioning. Administrator/designee will complete an audit of call lights for 5 rooms 3 times per week to ensure lights are working properly. Administrator/designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>	11/26/2014

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	<p>facility failed to maintain a functional and safe environment related to marred walls and doors, gouged walls, dirty walls and floors, and stained privacy curtains on 2 of 2 units throughout the facility. (A Wing and B Wing)</p> <p>Findings include:</p> <p>During an environmental tour with the Administrator and the Director of Housekeeping on 10/28/14 at 1:22 p.m. through 1:59 p.m., the following was observed:</p> <p>1. A Wing</p> <p>a. Room 1-2: The bathroom walls and the inside of the bathroom door were marred. One resident resided in the room.</p> <p>b. Room 2-2: The bathroom walls were marred. The bed sheet had red stains on it and was dirty. One resident resided in the room.</p> <p>c. Room 3-2: The bathroom walls were marred. The corner of the room door was gouged. Two residents resided in the room.</p> <p>d. Room 5-1: The inside of the bathroom door was gouged. One resident</p>		<p><b>ANNUAL SURVEY: 10/31/2014 F465</b></p> <p><b>Safe/Functional/Sanitary/Comfortable Environment</b> 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. <b>The facility requests paper compliance for this citation. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</b> Identified areas of concern that potentially placed residents at risk of harm were repaired and remedied. Identified areas were thoroughly cleaned and returned to functional status.</p> <p><b>How will the facility identify other residents having the potential to be affected by the same deficient practice?</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur?</b> Privacy curtains for resident rooms will be taken down and laundered routinely. Proper completion of privacy curtain laundering will be tracked on a privacy curtain cleaning schedule. Maintenance Director/designee</p>	

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	<p>resided in the room.</p> <p>e. Room 11-1: The bathroom walls were marred. There were drops of dried tube feeding on the wall behind the bed and on the floor. Two residents resided in the room.</p> <p>f. Room 14-2: The bathroom walls were marred. Two residents resided in the room.</p> <p>g. Room 16-1: The wall next to the nightstand was marred. The wall on the side of the bed was dirty. The bathroom walls were marred. The bathroom wall behind the hand rail was gouged. One resident resided in the room.</p> <p>h. Room 17-2: The bathroom walls were marred. The kick plate inside the bathroom door had a piece missing. Two residents resided in the room.</p> <p>i. Room 21-2: There were black marks on the wall behind the chair. The bathroom walls were marred. Two residents resided in the room.</p> <p>j. Room 22-2: The bathroom walls were marred. The wall paper behind the bed had dark stains on it. One resident resided in the room.</p>		<p>will conduct weekly room checks to identify environmental concerns and track progression of resolution. Housekeeping will initiate room cleaning checklist to identify and document cleaning needs and resultant resolution. Painting, wall plastering, and other structural repairs have been identified and will be expediently resolved. Maintenance Director/Designee have been in-serviced regarding weekly room checks; Housekeeping Director/Designee has been in-serviced regarding room cleaning checklist. <b>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?</b></p> <p>Administrator/designee will complete an audit of 5 resident rooms, 3 times a week to ensure that structural integrity and sanitary conditions of facility are properly maintained. Administrator/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>				

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	<p>k. Room 23-1: The inside of the bathroom door was peeling at the bottom. Two residents resided in the room.</p> <p>l. Room 24-1: There was debris on the floor in the room and bathroom. There was garbage on the toilet seat. The top of the toilet tank was dirty. There was no bag in the trash can. The sink was dirty. The desk and dresser were dirty. The privacy curtain was coming unhooked from the ceiling hooks. There were stains on the privacy curtain. One resident resided in the room.</p> <p>2. B-Wing</p> <p>a. Room 16-1: The wall behind the head of the bed was scraped. One resident resided in the room.</p> <p>b. Room 19-1: The bathroom sink was discolored. The wall behind the head of the bed was gouged. The cove base behind the head of bed was loose. The tube feeding pole had dried drops of tube feeding on the base and pole. The wall behind the head of the bed had dried drops of tube feeding on it. The outside of the room door was gouged. Two residents resided in the room.</p> <p>c. Room 20-1: The mat of the floor was cracked and dirty. There were scuffs on</p>			

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	<p>the wall behind the recliner. The outside of the room door was gouged. One resident resided in the room.</p> <p>d. Room 21-2: The bathroom door and the room door were marred. The wall behind the bed was stained. The floor mats were dirty. The floor by bed 2 was marred and dirty. There was debris on the floor. Two residents resided in the room.</p> <p>e. Room 23-2: The privacy curtain was stained. Two residents resided in the room.</p> <p>f. Room 24-1: The privacy curtain was stained with dark black spots. Two residents resided in the room.</p> <p>g. Room 25-2: The wall behind the head of bed was gouged. The bathroom sink was stained. There was dried tube feeding on the feeding pole and base. Two residents resided in the room.</p> <p>Interview with the Administrator and the Director of Housekeeping at the time of the tour indicated all above areas were in need of repair or cleaning.</p> <p>3.1-19(f)</p>			

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