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	07/28/2023

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. Survey dates: July 24, 25, 26, 27 and 28, 2023. Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 8 Medicaid: 46 Other: 13 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/1/23.	F 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *The facility respectfully request paper compliance.*	
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rita Gatson	Administrator	08/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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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	manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.			
	Based on observation and interview, the facility failed to ensure residents had access to their personal funds at all times for 1 of 2 residents reviewed for personal funds. (Resident 67) Finding includes: On 7/24/23 at 8:40 a.m., the Resident Trust Banking Hours were observed posted at the front desk. The hours were Monday-Friday 8:00 a.m. to	F 0567	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement*	08/09/2023

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	4:00 p.m. and Saturday-Sunday 9:00 a.m.-5:00 p.m. Interview with Resident 67, on 7/24/23 at 10:22 a.m., indicated she was not able to get money from her personal funds account on the weekends. Interview with the Business Office Manager, on 7/28/23 at 2:47 p.m., indicated the receptionist kept resident funds in a lock box and she would give them money as requested. If the receptionist wasn't there, no one else had access to the lockbox or kept money on hand for the residents. 3.1-6(f)(1)		*by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 67 was notified immediately that resident funds are available 24 hours/7days a week. All residents and families have been notified that resident funds are available 24 hours/days a week. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring that resident funds are available 24 hours/7 days a week **4) How the corrective actions will be monitored:** The Administrator or Designee will	

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			complete an audit of the availability of resident funds after hours 1 time weekly for 4 weeks and then bi-weekly thereafter to ensure compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40			

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	but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to develop and implement comprehensive, resident-centered Care Plans related to activities, antidepressant medications, diabetes and anticoagulant medications for 2 of 17 resident Care Plans reviewed. (Residents 44 and 34) Findings include: 1. On 7/24/23 at 10:00 a.m., 7/25/23 at 11:48,	F 0656	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	08/09/2023

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	7/26/23 at 8:38, 10:00 a.m., and 12:35 p.m., Resident 44 was observed lying in bed with the television on. The resident indicated she liked to get out of bed for an hour sometimes, but she couldn't remember the last time she had been out of bed. The resident's record was reviewed on 7/25/23 at 11:10 a.m. Diagnoses included, but were not limited to, Parkinson's disease, weakness and neuropathy. The Quarterly Minimum Data Set assessment, dated 7/1/23, indicated a cognitive assessment could not be completed, and the resident required extensive one person assistance for transfers and toileting and two person assistance for bed mobility. The Quarterly Activities Evaluation, dated 7/5/23, indicated it was somewhat important to the resident to do things in groups of people, listen to music she liked, do favorite activities, and attend religious services. The evaluation did not specify what the resident's favorite activities were. The current Activity Care Plan indicated the resident may need encouragement and reminders to attend and participate in programs, and to invite, encourage, and assist to programs of interest. The Care Plan lacked any interventions that included specific activities the resident enjoyed or the frequency to attend. Interview with the Activity Director, on 7/27/23 at 9:27 a.m., indicated the Care Plan was incomplete and should include activities and frequencies. 2. Record review for Resident 34 was completed on 7/27/23 at 8:48 a.m. Diagnoses included, but were not limited to, dementia, depression, hypertension, and diabetes mellitus.		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** An individualized activity care plan was put in place for Residents 34 and 44. An audit was completed on all residents to ensure each resident has an individualized care plan for activities. Care plans for the use of antidepressant, anticoagulant, and antidiabetic were put in place for resident 44. An audit was completed on all residents requiring use of antidepressants, anticoagulants, and antidiabetic to ensure care plans are in place. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:**	

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	The Annual Minimum Data Set (MDS) assessment, dated 6/18/23, indicated the resident was moderately cognitively impaired. The preference section indicated it was very important for the resident to listen to music and somewhat important to do things with groups of people. The resident had received an antidepressant and anticoagulant medication. The July 2023 Physician's Order Summary (POS) indicated orders for the following medications: - eliquis (anticoagulant, blood thinner) 5 mg (milligrams) twice a day - citalopram (antidepressant) 10 mg, half tablet every day - tradjenta (antidiabetic medication) 5 mg every day The record lacked any documentation an activity, anticoagulant, antidepressant, or diabetes care plan had been completed. Interview with the Activity Director on 7/27/23 at 11:25 a.m., indicated she could not provide any documentation an activity care plan had been completed. Interview with the MDS Coordinator on 7/27/23 at 12:57 p.m., indicated the care plans had not been completed but should have been. 3.1-35(a)		Facility staff was re-educated on ensuring that all residents receiving antidepressants, anticoagulants, and antidiabetics have a care plan present related to the use of these medications. **4) How the corrective actions will be monitored:** The DON/Designee will audit 5 residents care plans weekly for 4 weeks and then bi-weekly thereafter to ensure compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an			

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	ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for dependent residents for 3 of 4 residents reviewed for activities. (Residents 44, 34 and 40) Findings include: 1. On 7/24/23 at 10:00 a.m., 7/25/23 at 11:48, 7/26/23 at 8:38, 10:00 a.m., and 12:35 p.m., Resident 44 was observed lying in bed with the television on. The resident indicated she liked to get out of bed for an hour sometimes, but she couldn't remember the last time she had been out of bed. The resident's record was reviewed on 7/25/23 at 11:10 a.m. Diagnoses included, but were not limited to, Parkinson's disease, weakness and neuropathy. The Quarterly Minimum Data Set assessment, dated 7/1/23, indicated a cognitive assessment could not be completed, and the resident required extensive one person assistance for transfers and toileting and two person assistance for bed mobility. The Quarterly Activities Evaluation, dated 7/5/23, indicated it was somewhat important to the resident to do things in groups of people, listen to music she liked, do favorite activities and attend	F 0679	**F679 Activities Meet Interest/Needs Each Resident** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** An activity assessment was completed for residents 34, 44, and 50. The activity care plan for residents 34, 44, and 50 have been updated to include the resident's preferences for activities.	08/09/2023

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	religious services. The current Activity Care Plan indicated the resident may need encouragement and reminders to attend and participate in programs, and to invite, encourage and assist to programs of interest. The Activity Participation log for the past 30 days indicated the resident had one on one visits two times, and food and socialize two times. The remaining activities were watching television alone. Interview with the Activity Director, on 7/27/23 at 9:27 a.m., indicated staff would visit her 2-3 times a week for reading or puzzles. She indicated it was not documented as it should be. 2. On 7/24/23 at 9:30 a.m., Resident 34 was observed lying in bed yelling out that she was hungry. The resident's curtain was pulled around the bed. The resident's television or radio was not on. On 7/25/23 at 9:34 a.m., the resident was lying in bed. The curtain was pulled around the bed. The resident's television or radio was not on. On 7/25/23 at 2:02 p.m., the resident was observed lying in bed. The resident's television or radio was not on. There were other residents observed playing bingo in the Main Dining Room (MDR) at that time. On 7/26/23 at 1:56 p.m. and again at 2:57 p.m., the resident was observed lying in bed. The resident's television or radio was not on. There were other residents observed listening to live entertainment in the MDR at that time.		An audit was completed on all residents to ensure each resident has an updated activity assessment and an activity care plan with interventions according to their individualized preference. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring all residents have an updated activity assessment and care plan with interventions according to their personal preferences. **4) How the corrective actions will be monitored:** The Administrator/Designee will audit 5 residents weekly for 4 weeks and then bi-weekly thereafter to ensure residents have an updated activity assessment and each resident has an individualized activity care plan with interventions according to the resident's preference. **The results of these audits will be reviewed in Quality**	

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	Record review for Resident 34 was completed on 7/27/23 at 8:48 a.m. Diagnoses included, but were not limited to, dementia, depression and diabetes mellitus. The Annual Minimum Data Set (MDS) assessment, dated 6/18/23, indicated the resident was moderately cognitively impaired. The resident required an extensive 1 person assistance for transfers and locomotion. The preference section indicated it was very important for the resident to listen to music and somewhat important to do things with groups of people. A Care Plan, dated 6/19/23, indicated the resident's vision had been assessed to be highly impaired. An intervention included to introduce self and others and to orient the resident to her surroundings as needed. An Activity Participation Note, dated 6/19/23 at 12:32 p.m., indicated the resident liked to go to activities and listen to what was going on. The resident's record lacked any documentation an activity care plan or activity assessment had been completed for the resident. Interview with the Activity Director on 7/27/23 at 11:25 a.m., indicated she was unable to find an activity assessment or care plan had been completed for the resident. She indicated staff was supposed to turn the resident's radio on for her daily. There had been some problems with the CNAs not getting some of the residents out of bed and bringing them to activities. She was unable to provide any documentation the resident had been getting any 1 on 1 activities provided in her room.		**Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	3. On 7/25/23 at 9:41 a.m., Resident 40 was observed lying in bed in her room. The residents eyes were open. There was a sign on the wall that indicated to have the radio on. The resident's radio was not turned on. On 7/26/23 at 9:44 a.m., the resident was lying in bed and her radio was not turned on. The resident also had a television by her bed that was also not turned on. The resident was looking towards her roommate's television but the television was angled away from her and the volume was low. On 7/26/23 at 1:58 p.m., the resident was sitting up in bed with her eyes open. Neither the resident's radio nor television was turned on. The resident was looking towards her roommate's television again but the television was angled away from her and the volume was low. There were other residents observed listening to live entertainment in the MDR at that time. Record review for Resident 40 was completed on 7/26/23 at 9:20 a.m. Diagnoses included, but were not limited to, stroke, aphasia (loss of ability to understand or express speech), dementia, depression, and hemiplegia (paralysis of one side of the body). The Annual MDS (Minimum Data Set) assessment, dated 4/24/23, indicated the resident was severely cognitively impaired. The resident required a total 2+ person assist for transfers and an extensive 1 person assist for locomotion. The preference section indicated it was somewhat important for her to listen to music, do things with groups of people, and to do her favorite activities. A Care Plan, dated 6/7/23, indicated the resident			

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	was independently capable of pursuing her own activities of preference without intervention from the care center as identified in the resident's activity assessment. Interventions included to check in on the resident on a daily basis to ensure she had material desired, and invite and encourage to new and available programs. The resident's record lacked any documentation an activity assessment had been completed for the resident that included what her favorites activities were. Interview with the Activity Director on 7/27/23 at 11:25 a.m., indicated she was unable to find an activity assessment had been completed for the resident. She indicated staff was supposed to turn the resident's radio on for her daily. There had been some problems with the CNAs not getting some of the residents out of bed and bringing them to activities. She was unable to provide any documentation the resident had been getting any 1 on 1 activities provided in her room. 3.1-33(a)			
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	F 0684	F684 Quality of Care	08/09/2023

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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
	received the necessary treatment and services related to the monitoring and assessment of a resident with a possible change in condition for 1 of 1 residents reviewed for change in condition, monitoring and assessment of skin discolorations for 1 of 2 residents reviewed for non-pressure related skin conditions, and an improper length of a bed for 1 of 1 residents reviewed for positioning. (Residents 63, 43 and 13) Findings include: 1. On 7/26/23 at 11:50 a.m., RN 2 was observed passing medication to Resident 63. The resident was seated in his wheelchair. His head was tipped forward toward his chest and his eyes were closed. A family member was present and indicated she thought he was "getting worse". She indicated his left side seemed weaker, he was less alert than usual and complained about pain in his stomach. The RN indicated she would get him back to bed after lunch. She indicated she wasn't familiar with the resident and would have to look in his chart. She then exited the room. The resident was drooling onto his shirt and the family member present indicated she wanted a Physician to see him. At 12:03 p.m., the RN was observed at her medication cart. She was still passing medications. The RN was notified the family member was very concerned about the resident and indicated she would check on him. At 12:52 p.m., the resident was observed back in bed. His eyes were closed and his mouth was open. His lunch was on the table in front of him untouched. On 7/27/23 at 8:35 a.m., the resident was observed		The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** An assessment was completed and documented for Residents 63 and 43. Monitoring of bruises was put in place for Resident 43. An assessment was completed for Resident 13 to ensure the bed was extended as far as it could be extended, confirmed by the maintenance director. Resident 13 was repositioned in bed and encouraged to use the trapeze to assist himself with repositioning. **2) How the facility identified other residents:**	

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	155650	A. BUILDING 00 B. WING	07/28/2023

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	in bed. He indicated he didn't feel well yesterday and his legs were hurting him. The resident's record was reviewed on 7/26/23 at 12:56 p.m. Diagnoses included, but were not limited to, cerebral infarction, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) of the right side. The Quarterly Minimum Data Set assessment, dated 6/7/23, indicated the resident had significant cognitive deficits and required extensive assist of one for bed mobility and transfers. There was no assessment or progress note from earlier that day related to the possible change in condition. On 7/27/23 at 8:38 a.m., there was still no assessment or progress note from the previous day. Interview with the Director of Nursing, on 7/27/23 at 10:17 a.m., indicated if a family member was voicing concern about a resident's condition, she would expect to see an assessment completed. She indicated she would contact the RN. 2. On 7/24/23 at 12:40 p.m., Resident 43 was observed seated in her room eating lunch. She had reddish/ purple discolorations on both forearms. On 7/25/23 at 9:12 a.m., the resident was observed in her room. The discolorations to both arms were still present. She indicated it was from scratching her arms and they were getting bigger, and had been there for about a week. The resident's record was reviewed on 7/27/23 at		All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring assessments for a change in residents' condition is completed in a timely manner, skin assessments should be completed weekly on shower days and as needed as well as any findings should be addressed and monitored. Staff was also re-educated on ensuring residents beds are the appropriate length and their feet are not touching the foot board. **4) How the corrective actions will be monitored:** The DON/Designee will audit/observe 5 residents weekly for 4 weeks and then bi-weekly thereafter ensure assessments for a change in residents' condition is completed in a timely manner, skin assessments are completed accordingly and any findings have been documented and monitoring in place, as well as bed lengths are appropriate for the resident. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6**	

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	10:37 a.m. Diagnoses included, but was not limited to, atrial fibrillation and heart failure. The Quarterly Minimum Data Set assessment, dated 5/21/23, indicated the resident was cognitively intact and required extensive assistance of one for bed mobility and transfers. A Physician's Order, dated 5/1/23, indicated to take Eliquis (an anticoagulant drug) 2.5 milligrams twice daily for atria fibrillation. The current Anticoagulant Care Plan indicated the resident was at risk for abnormal bleeding/ bruising related to use of an anticoagulant and to monitor for side effects every shift. The July 2023 Bath and Skin Report indicated the resident's skin was intact on 7/13/23, 7/17/23, 7/20/23 and 7/24/23. On 7/27/23, the Skin Report indicated there was a bruise on the right arm only. There was no progress note or assessment related to the discolorations. Interview with the Director of Nursing, on 7/27/23 at 1:25 p.m., indicated any skin concerns should be documented on the Bath and Skin Reports or weekly skin assessments. A facility policy titled, "Skin Condition Assessment & Monitoring-Pressure and Non-Pressure" and received as current from the Wound Nurse on 7/26/23, indicated, "...At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified..." 3. On 7/24/23 at 1:31 p.m., Resident 13 was observed lying in bed. The resident's head of the bed was raised up and the resident was sitting		**months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	upright. Both of the resident's feet were touching the foot board. The resident had one boot to the left foot in place while lying in the bed. The resident had no boot or protection to the right foot. The right foot was pressed up against the foot board and his knees were slightly bent. The resident indicated he thought the bed was too small for him because he's "a big guy." On 7/27/23 at 9:07 a.m., the resident was observed lying in bed. The head of the bed was elevated while the resident ate his breakfast. The right and left boot were placed on the resident's feet. Both of the resident's feet were resting on the foot board. The resident's knees were also flexed at that time. On 7/27/23 at 2:32 p.m., the resident was observed lying in bed. The resident indicated he was used to being uncomfortable in the bed and he tolerated the short bed. The resident elevated the foot of his mattress, while he lowered the head of the bed. The resident's feet were not touching the footboard, however the resident's head of the bed was positioned less than 30 degrees for this to occur. Record review for Resident 13 was completed on 7/24/23 at 9:15 a.m. Diagnosis included, but were not limited to, legal blindness, chronic obstructive pulmonary disease, pain unspecified ankle and joints of unspecified foot, muscle weakness, unspecified lack of coordination, spastic hemiplegia affecting left dominant side, hemiplegia unspecified affecting left dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 6/15/23, indicated the resident was cognitively intact. The resident required an extensive assist of 1 person for bed mobility. The			

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	resident had spastic hemiplegia (paralysis of one side of the body), which affected the left side of the resident's body. The resident's height was 73 inches tall. A Care Plan, dated 8/26/23, indicated the resident required assistance with activities of daily living, including bed mobility, eating, transfers, toileting and bathing related to legal blindness, chronic obstructive pulmonary disease, diabetes mellitus, and hemiplegia. A Physician's Order, dated 4/25/23, indicated the head of the bed was to be elevated to not less than 30 degrees at all times, due to shortness of breath when lying flat related to a diagnosis of chronic obstructive pulmonary disease. Interview with the Director of Nursing, on 7/27/23 2:01 p.m., indicated the resident's bed should be longer and the beds can be extended. She would have the maintenance man extend the resident's bed. Interview with the Maintenance Director, on 7/27/23 2:08 p.m., indicated he extended the resident's bed as far as it will go and it cannot be extended any further. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing, related to the lack of a timely treatment put into place for 1 of 4 residents reviewed for pressure ulcers. (Resident 40) Finding includes: On 7/26/23 at 9:49 a.m., Resident 40 was observed receiving wound care from the Wound Nurse. The resident had an open area observed to her right ankle. The area was approximately the size of a half dollar coin. The area was red with slough (dead skin tissue) observed to the bed of the wound. Record review for Resident 40 was completed on 7/26/23 at 9:20 a.m. Diagnoses included, but were not limited to, stroke, aphasia (loss of ability to understand or express speech), dementia, depression, and hemiplegia (paralysis of one side of the body). The Quarterly Minimum Data Set (MDS) assessment, dated 6/3/23, indicated the resident was moderately cognitively impaired. The resident required an extensive 1 person assist with bed mobility. The resident did not have any pressure ulcers.	F 0686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** An assessment was completed by the wound nurse for Resident 40. The Physician was notified and a treatment was put in place. **2) How the facility identified**	08/09/2023

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	A Care Plan, dated 6/1/23, indicated the resident was at risk for pressure ulcers. An intervention included to inform the resident, family, and caregivers of any new area of skin breakdown. A Progress Note, dated 6/20/23 at 3:38 p.m., indicated the resident was noted to have open skin on the left ankle outer aspect. The area was cleansed with normal saline, patted dry, and a dressing was applied and properly secured. The resident tolerated the procedure "fairly okay." The left lower extremity was elevated on a soft pillow. There was no documentation of an assessment of the wound that included the size or characteristics of the wound. There was no documentation the Physician or the Wound Nurse was notified of the resident's wound until 6/28/23. A Wound Nurse note, dated 6/28/23 at 5:30 p.m., indicated she was called into the resident's room to show her a wound on the resident's right ankle. The area was assessed and measured 2.5 cm (centimeters) x 2.5 cm. There was 90% slough and 10% granulation (new tissue). The Physician was called. A Physician's Order, dated 6/28/23, indicated to apply Santyl (wound ointment) to the right outer ankle every day. A Physician's Order, dated 6/28/23, indicated to use heel protectors in bed every shift. A Care Plan, dated 6/28/23, indicated the resident had a pressure ulcer. Interventions included to administer treatments as ordered and monitor for effectiveness.		**other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring a resident with a pressure ulcer receive the necessary treatment and services to promote wound healing in a timely manner. **4) How the corrective actions will be monitored:** The DON/Designee will audit 5 residents weekly for 4 weeks and then bi-weekly thereafter to ensure assessments and treatments are place for any newly acquired pressure ulcers. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	Interview with the Wound Nurse on 7/26/23 at 10:08 a.m., indicated the wound was found on 6/20/23. She was not informed the resident had a wound until 6/28/23. The Progress Note, dated 6/20/23, had also indicated the wrong ankle. The resident's wound was on the right ankle and not the left as documented. When she observed the wound on 6/28/23, it was covered with a dry dressing. The wound presented as an unstageable pressure ulcer on the right ankle. The resident's family member was in the room at the time and indicated the wound appeared the same as it did the first time they saw it on 6/20/23. She was unsure why, when the nurse discovered the wound, that she did not call the Physician to receive an order for a treatment for the wound or why no one notified her about the wound until 6/28/23. A facility policy titled, "Skin Condition Assessment & Monitoring-Pressure and Non-Pressure" and received as current from the Wound Nurse on 7/26/23, indicated, "...At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified..." 3.1-40(a)(2) 3.1-40(a)(3)			
F 0690 SS=C Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident with abnormal urine in the indwelling catheter was assessed timely and a resident with a colostomy received daily colostomy care for 2 of 2 residents reviewed for urinary catheters, bowel and bladder care. (Residents 66 and 12) Findings include: 1. On 7/24/23 at 11:41 a.m., 7/26/23 at 8:40 a.m., and	F 0690	F690 Bowel/Bladder Incontinence, Catheter, UTI The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	08/09/2023

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	7/28/23 at 8:40 a.m., Resident 66 was observed laying in her bed. There was an indwelling catheter bag hanging on the side of the bed. In the tubing, the urine was very cloudy with a large amount of sediment present. The resident's record was reviewed on 7/26/23 at 9:22 a.m. Diagnoses included, but were not limited to, sacral pressure ulcer and spina bifida. The Quarterly Minimum Data Set assessment, dated 5/23/23, indicated the resident was cognitively intact, required extensive assistance for bed mobility and had an indwelling catheter. The current Catheter Care Plan indicated the resident required a catheter related to her pressure ulcer. Interventions included to monitor, record and report to Physician any sign of a urinary infection such as pain, burning, cloudiness, no output, increased pulse and temperature. On 7/28/23 at 11:51, RN 1 indicated she was not aware the residents urine was cloudy or had sediment present. She then observed the urine in the catheter and indicated it was cloudy and she would notify the Physician at that time. 2. On 7/24/23 at 2:15 p.m., Resident 12 was observed lying in bed. There was an odor of bowel movement in the room. The resident indicated the nursing staff were not emptying his colostomy (opening from the large intestine to the outside of the body so stool can pass through) like they were supposed to. Record review for Resident 12 was completed on 7/28/23 at 9:32 a.m. Diagnoses included, but were not limited to, anxiety, anemia, and depression. The Quarterly Minimum Data Set (MDS)		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** An assessment was completed for Resident 66. The Physician was notified and an order was received for a U/A C&S. Colostomy care was provided for Resident 12. An order was placed on the TAR for nursing staff to document colostomy care every shift. An assessment was completed on residents with indwelling catheters to ensure urine output is not cloudy with sediment. An audit was completed on all residents with colostomies to ensure an order is in place on the TAR for nursing staff to document colostomy care provided every shift. **2) How the facility identified other residents:** All the residents have the	

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	assessment, dated 5/16/23, indicated the resident was cognitively intact. The resident required required an extensive 2+ person assistance for bed mobility. The resident required an extensive 1 person assistance for toilet use. The resident had an ostomy (surgery to create an opening from an area inside the body to the outside). A Care Plan, dated 5/17/23, indicated the resident had a colostomy. Interventions included to empty, irrigate, and cleanse ostomy pouch on a routine basis using the appropriate equipment. The July 2023 Physician's Order Summary indicated orders for the following: - Colostomy care every shift. - Colostomy: Change the wafer and the pouch daily and when necessary The July 2023 Medication Administration Record (MAR) or Treatment Administration Record (TAR) did not include any documentation the colostomy care or changing of the pouch was completed. Interview with the Director of Nursing (DON) on 7/28/23 at 11:30 a.m., indicated she was unsure why the orders for the colostomy were not on the TAR for the nursing staff to check off they were doing care. She could not provide any documentation the colostomy care was completed every shift or the colostomy wafer and pouch was changed daily. 3.1-41(a)(2)		potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring residents with indwelling catheters are assessed for cloudy, sediment urine and notifying the Physician of any abnormal findings. Staff was also re-educated on ensuring those residents with colostomies have an order in place on the TAR to provide colostomy care every shift. **4) How the corrective actions will be monitored:** The DON/Designee will observe 5 residents weekly for 4 weeks and bi-weekly thereafter to ensure residents urine is not cloudy with sediment and if so an assessment has been completed; and those with colostomies, there is an order in place on the TAR to provide colostomy care every shift. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the			

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	155650	A. BUILDING 00 B. WING	07/28/2023

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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	posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to have accurate and complete daily nurse staffing postings. This had the potential to affect all 67 residents residing in the facility. Finding includes: On 7/24/23 at 8:44 a.m., the nursing staffing posting was observed on the wall near the main entrance. The nursing staffing posting was dated 7/21/23 and did not have any hours documented under the actual hours worked column. On 7/24/23 at 12:01 p.m., the nursing staffing posting was observed on the wall near the main entrance. The nursing staffing posting was dated 7/21/23 and did not have any hours documented under the actual hours worked column. On 7/24/23 at 2:00 p.m., the nursing staffing posting was observed on the wall near the main entrance. The nursing staffing posting was still dated 7/21/23 and did not have any hours documented under the actual hours worked column. Review of the nursing staffing postings, dated 6/24/23 through 7/24/23, lacked any documentation under actual hours worked columns. The columns were left blank. Interview with the Director of Nursing (DON) on 7/24/23 at 2:01 p.m., indicated she was not aware the incorrect date was posted or that the postings were not complete. She would update the posting.	F 0732	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The Posted Nurse Staffing sheet was posted immediately. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring that the Daily Posted	08/09/2023

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			Nurse Staffing sheet is posted daily and the actual hours worked column has been completed. **4) How the corrective actions will be monitored:** The Administrator/Designee will observe the Daily Posted Nurse Staffing sheet 3 times weekly for 4 weeks and the bi-weekly thereafter to ensure compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted			

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	upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, record review, and interview, the facility failed to identify or act on an irregularity in a resident's medication regimen related to an unnamed medication being administered for 1 of 5 residents reviewed during medication pass. (Resident 1) Finding includes:	F 0756	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	08/09/2023

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	On 7/27/23 at 9:00 a.m., LPN 1 was observed giving Resident 1 medication during medication pass observation. The July 2023 Medication Administration Record (MAR) included a medication called "drug" to be applied to the left side of the resident's neck twice daily. The LPN indicated she did not know what that medication was. She looked through the medication and treatment carts and was unable to locate a topical medication for the resident. She then looked at the Physician Orders, and indicated the medication was called "drug". She indicated she would have to call the Physician to clarify the order. A Physician's Order, dated 5/12/23, indicated to apply "drug" twice daily to the left side of neck for redness, itching and swelling. The July 2023 MAR indicated the medication "drug" was administered 44 times that month. Interview with the Director of Nursing, on 7/27/23 at 9:52 a.m., indicated the Unit Managers and Pharmacist reviewed all residents' medications monthly and should have caught the discrepancy and corrected it. 3.1-25(i)		*constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** The Physician was notified and the order was clarified for Resident 1. The order was put on the TAR correctly as Hydrocortisone Cream. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on ensuring that all orders placed on the MAR's and TAR's have the correct name listed for the medication **4) How the corrective actions will be monitored:** The DON/Designee will audit 5 residents orders weekly for 4	

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			weeks and the bi-weekly thereafter to ensure compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
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	F 0802	**What corrective action(s) will be accomplished for those**	08/09/2023

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	serve meals in a timely manner. This had the potential to affect 65 residents who received meals from the kitchen. (Main Kitchen) Finding includes: On 7/24/23 at 9:30 a.m., Resident 34, who resided on the A Unit, was observed lying in bed yelling out that she was hungry. Interview with QMA 1 at that time indicated the breakfast trays had not been brought to the unit yet and the resident "always says she's hungry". The QMA didn't indicate he would check on the room trays or offer to get the resident something to eat. A breakfast room tray cart was observed to arrive to the A Unit at 10:00 a.m. Review on 7/28/23 at 10:00 a.m. of the Resident Council Follow-Up, indicated that on 7/3/23, it was brought to the facility's attention the residents had a concern that meals were very late on the weekends. The Dietary Manager (DM) response, dated 7/7/23, indicated, "Apologize for tardiness of meals on weekends! Often have call-offs and do our very best to get meals out in timely manner!" Interview with Resident 16 on 7/24/23 at 10:12 a.m., indicated the food was served late all the time. Interview with Resident 48 on 7/24/23 at 10:45 a.m., indicated the food was always late. Interview with the DM on 7/27/23 at 11:45 a.m., indicated the breakfast room carts were served late on 7/24/23 because one kitchen staff member called off that morning and another one had quit that morning. No one came into the kitchen to		**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 non-dietary staff availability to	

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	help her get the trays out in a timely manner. She was finally able to get someone to come into work to help her get the rest of the meals out on time that day. The breakfast room trays usually start to go out at 8:00 a.m. On the 24th, the B wing breakfast cart went out around 9:00 a.m. - 9:15 a.m., and the A Wing 10:00 a.m.-10:15 a.m. Interview with the Administrator on 7/28/23 at 10:07 a.m., indicated the QMA should have offered the resident something to eat. They have hired another cook for the evenings to have more help in the kitchen. 3.1-20(h)		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 4 weekly then bi-weekly thereafter to ensure compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0921 SS=E 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 dirty floors, damaged walls, peeling non-skin strips, a running toilet, and broken furniture on 2 of 2 units. (The A and B Units)	F 0921	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	08/09/2023

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	Findings include: During the environmental tour, on 7/28/23 at 9:20 a.m., with the Maintenance Director and the Administrator, the following was observed: 1. A Unit a. The A unit common area carpet was dirty, there was debris under the chairs and the end table was missing the drawer. 31 residents resided on the A Unit. b. Room A05: the bathroom floor was dirty and the non-skid strips were peeling off the floor. Two residents resided in the room. c. Room A07: there was a build up of dirt on the bathroom floor. Two residents resided in the room. d. Room A17: there was a buildup of dirt around the bathroom baseboards. Two residents resided in the room. e. Room A19: the non-skid strips in the bathroom were peeling off the floor and the call light cord was only about three inches long. One resident resided in that room. 2. B Unit- a. Room B16: the toilet was running nonstop. Two residents resided in the room. b. Room B18: there was a large plastered area on the bathroom wall that was painted a different color than the rest of the room. One resident resided in the room.		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** A unit common area debris under the chairs and the end table that was missing a drawer was removed. The carpet has been cleaned. A5, the bathroom floor was cleaned and the non-skid strips were replaced. A7, the bathroom floor was cleaned. A17, the bathroom baseboards were cleaned. A19, the non-skid strips in the bathroom were replaced and a longer call light cord was added. B16, the running toilet has been repaired. B18, the wall in the bathroom has	

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	c. Room B23: there were gouges in the wall behind bed 1. Two residents resided in the room. Interview with the Administrator at that time, indicated the above items were in need of cleaning or repair. 3.1-19(f)		been repainted. B23, the gouges in the wall behind bed 1 has been repaired. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on cleanliness of the facility including; ensuring debris is not under furniture, replacing non-skid strips that are beginning to peel, ensuring residents bathroom are cleaned thoroughly including the floors, fixing gouges in the walls when they become noticeable, and repairing running toilets as soon as possible. **4) How the corrective actions will be monitored:** The Administrator/Designee will observe 5 rooms including the common areas weekly for 4 weeks and the bi-weekly thereafter to ensure compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6**	

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