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

FORM APPROVED
OMB NO. 0938-039

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	06/07/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00352057. Complaint IN00352057 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: June 1, 2, 3, 4, and 7, 2021. Facility number: 000577 Provider number: 133650 AIM number: 100266950 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 20 Medicaid: 43 Other: 5 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/9/21.	F 0000	Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully request paper compliance.	
F 0656 SS=D Bldg. 00	483.21(b)(1) 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			

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

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.

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	06/07/2021

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
	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 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.			
	Based on observation, record review and interview, the facility failed to initiate Care Plans	F 0656	What corrective action will be accomplished for those residents found to have been affected by the	06/14/2021

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	06/07/2021

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
	related to respiratory services for 1 of 17 residents whose Care Plans were reviewed. (Resident 61) Finding includes: On 6/1/21 at 11:02 a.m., Resident 61 was observed lying in bed wearing oxygen with a flow rate set at 3 lpm (liters per minute). On 6/3/21 at 9:04 a.m., Resident 61 was observed lying in bed with her oxygen on, with a flow rate set at 3 lpm. On 6/4/21 at 10:00 a.m., Resident 61 was observed laying in bed with her oxygen on, with a flow rate set at 3 lpm. Resident 61's record was reviewed on 6/3/21 at 9:04 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident was on oxygen therapy, was not interviewable, and totally dependent on staff for transfers and all activities of daily living. The current Physician Order Summary (POS), indicated oxygen at 3 lpm as needed for oxygen saturations below 90%. The record lacked any indication that the resident's oxygen saturation dropped below 90% requiring the initiation of oxygen and a there was no Care Plan for oxygen. Interview with the Director of Nursing, on 6/4/21		deficient practice? Oxygen care plan was added for Resident 61. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents using oxygen are potentially at risk of the same alleged deficient practice. What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur? Nursing staff were in-serviced on ensuring all residents with existing oxygen orders have a care plan in place. An audit was completed on all resident's care plans to ensure a care plan is in place for residents identified with existing oxygen orders. The facility will ensure care plans are in place of residents for all areas indicated by their MDS. 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?	

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	06/07/2021

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
	at 10:40 a.m., indicated the oxygen should have been care planned. Interview with MDS 1 and MDS 2, on 6/4/21 at 10:47 a.m., indicated they were unsure if "as needed" oxygen needed a care plan. 3.1-35 (a)(B)(1)		The DON/Designee will audit 5 residents care plans weekly for 6 months to ensure residents have a comprehensive care plan that are driven by the residents' MDS assessment. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. ="" p="">	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents were provided the assistance with activities of daily living (ADL's) they needed related to not assisting a resident out of bed and not providing hair care for 3 of 5 residents reviewed for ADL's. (Residents E, D, and H) Findings include: 1. On 6/1/21 at 1:07 p.m., Resident E was observed in her bed. The resident was also observed in bed on 6/3/21 at 2:25 p.m., 6/3/21 at 10:10 a.m., 6/3/21 at 11:58 a.m., 6/4/21 at 8:50 a.m. and 6/4/21 at 12:00 p.m. The resident was not observed out of her bed, and there was not a wheelchair or recliner in	F 0677	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** ·Residents E was provided with a recliner and assisted out of bed by staff. ·Order obtained for bed rest for Resident D. ·Resident D was assisted with a dry shampoo for hair care. ·Order obtained and carried out for Resident H for ammonium	06/14/2021

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	06/07/2021

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
	her room. The resident's record was reviewed on 6/3/21 at 2:00 p.m. She was admitted on 5/29/21. Diagnoses included, but were not limited to, encephalopathy (A broad term for any brain disease that alters brain function or structure), weakness and chronic obstructive pulmonary disease. The Admission Minimum Data Set assessment, dated 5/31/21, indicated she had severe cognitive impairment and needed extensive, one person assistance for bed mobility and transfers. An ADL/Transfer Care plan, dated 6/2/21, indicated the resident had limited functional status in regards to transferring self. Approaches included to ensure wheelchair was locked and secure prior to transfer and follow therapy recommendations for transfers. Interview with LPN 3 on 6/4/21 at 11:45 a.m., indicated they did not get the resident out of bed and there was not a wheelchair in her room. During an interview with the Director of Nursing (DON), on 6/4/21 at 1:19 p.m., she indicated she had spoken with therapy and the resident needed a recliner. They were going to get one for her at that time and get her out of bed. 2. On 6/1/21 at 12:44 p.m., Resident D was observed in her bed. Her hair appeared greasy and uncombed. The resident was observed again on 6/2/21 at 2:20 p.m., 6/3/21 at 10:19 a.m. and 1:00 p.m., her hair appeared greasy and uncombed. The resident's record was reviewed on 6/2/21 at 2:55 p.m. She was admitted on 5/7/21. Diagnoses included, but were not limited to, aortic aneurysm,		lactate cream to applied to face and scalp as scheduled. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents who are dependent on staff for their ADLS are at risk of the same alleged deficient practice. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Nursing staff were in-serviced on providing assistance and ADL care to resident's that are dependent. This included: ·Assisting residents out of bed. ·Providing assistance with hair care. 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? The DON/Designee will visualize 10 residents dependent on staff for ADL care weekly for 6 months on alternating shifts to ensure ADL's are met. The DON/designee will present a summary of the audits to the Quality Assurance	

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	06/07/2021

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
	altered mental status, weakness and heart failure. The Significant Change Minimum Data Set assessment, dated 5/13/21, indicated she had moderate cognitive deficit and needed one person assistance for bed mobility. There were no Physician's Orders for bed rest. The shower book was reviewed on 6/3/21 and indicated the resident had received a bed bath that morning. The point of care (POC) computer charting did not indicate the resident had a shower since admission, only bed baths or partial bed baths. Interview with CNA 1 on 6/3/21 at 2:00 p.m., indicated he had given the resident a bed bath that morning but hadn't touched her hair. He indicated hair was washed on shower days, but he did not know when the resident had a shower, and it should be documented in POC. Interview with the DON on 6/4/21 at 1:19 p.m., indicated the resident should be on bed rest because of her medical condition, but they had a dry shampoo they could use for her hair. 3. Resident H was observed lying in bed on 6/1/21 at 8:42 a.m. Her hair was unkempt and had visible multiple dry flakes on her scalp. On 6/2/21 at 2:47 p.m., Resident H was lying in bed with her eyes closed. Her hair was unkempt and had visible multiple dry flakes on her scalp. On 6/3/21 at 9:07 a.m., Resident H was lying awake in her bed. Her hair was unkempt and had visible multiple dry flakes on her scalp. Resident H's record was reviewed on 6/2/21 at 3:29 p.m. Diagnoses included, but were not limited to,		committee monthly for 6 months. Thereafter, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.	

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	06/07/2021

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
	Parkinson's disease, diabetes mellitus and dementia. The Quarterly Minimum Data Set assessment, dated 5/10/21, indicated the resident was not interviewable and was totally dependent on staff for bathing. The May 2021 "Bath and Skin Report" indicated the resident was showered on 5/1/21, 5/5/21, 5/8/21, 5/12/21, 5/15/21, 5/19/21, 5/22/21, 5/26/21, and 5/29/21. The June 2021 "Bath and Skin Report," indicated the resident was showered on 6/2/21. The record lacked any indication the resident refused shampooing or had an issue with a dry scalp. Interview with CNA 2, on 6/3/21 at 2:50 p.m., indicated when staff washed her hair, her scalp would get more flaky. She has always had the dry, flaky scalp and there used to be a special lotion that was put on her head, but not any more. Interview with Director of Nursing, on 6/3/21 at 4:38 p.m., indicated hair washes should be included in the shower or a refusal documented. The resident had dry, flaky scalp in the past and there had been a prescribed medication lotion for that issue. This Federal tag relates to Complaint IN00352057. 3.1-38(a)(3)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration.			

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	06/07/2021

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
	(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to provide acceptable parameters of nutrition related to not completing a nutrition assessment for 1 of 3 residents reviewed for nutrition. (Resident 9) Finding includes: On 6/2/21 at 3:52 p.m., Resident 9 was observed seated in her wheelchair in her room eating food from a tray. She indicated she had just returned from dialysis and was hungry. The record for Resident 9 was reviewed on 6/4/21 at 2:28 p.m. Diagnoses included, but were not limited to, chronic kidney disease, type 2 diabetes mellitus, and heart failure. The Significant Change Minimum Data Set (MDS)	F 0692	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nutrition assessment completed by the Registered Dietician for Resident 9. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are potentially at risk of the same alleged deficient practice. What measures will the facility	06/14/2021

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	06/07/2021

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
	assessment, dated 3/11/21, indicated the resident received dialysis services and had not had any significant weight loss or gain. The resident had monthly weights recorded in 2021 but lacked a completed nutrition assessment or any Dietary or Registered Dietician (RD) notes for 2021. Interview with the DON on 6/7/21 at 1:44 p.m., indicated the Dietary Manager had just completed the quarterly note today for the Quarterly MDS assessment currently in progress and the RD would be in this afternoon. She provided RD notes from the resident's dialysis center and indicated the Nurse Consultant was unable to find any facility nutrition assessment for 2021. 3.1-46(a)(1)		take or what systems will the facility alter to ensure that the problem will be corrected and will not recur? Dietary Manager and Registered Dietician were in-serviced on ensuring all residents have a nutrition assessment completed according to the facility policy. An audit was completed on all resident's care to ensure a nutrition assessment has been completed according to the facility policy. 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? The DON/Designee will audit 5 residents weekly for 6 months to ensure residents have a nutrition assessment completed according to the facility policy. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. ="" span5 residents="" weekly for="" 6="" months="" to="" ensure="" residents=""	

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	06/07/2021

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
			have="" a="" nutrition="" assessment="" completed="" according="" facility="" policy.="" present="" summary="" of="" audits="" quality="" assurance="" committee="" monthly="" for="" months.="" thereafter,="" it="" be="" determined="" by="" if="" further="" monitoring="" should="" continue="" and="" what="" time="" period. ="" p=""> ="" span5 residents="" weekly for="" 6="" months="" to="" ensure="" residents="" have="" a="" nutrition="" assessment="" completed="" according="" facility="" policy.="" present="" summary="" of="" audits="" quality="" assurance="" committee="" monthly="" for="" months.="" thereafter,="" it="" be="" determined="" by="" if="" further="" monitoring="" should="" continue="" and="" what="" time="" period.<="" p=""> ="" span5 residents="" weekly for="" 6="" months="" to="" ensure="" residents="" have="" a="" nutrition="" assessment="" completed="" according="" facility="" poliy.="" present="" summary="" of="" audits="" quality="" assurance="" committee="" monthly="" for="" months.="" thereafter,="" it="" be="" determined="" by="" if="" further="" monitoring="" should="" continue="" and="" what="" time="" period.<="" p="">	

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	06/07/2021

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 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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.			
	Based on observation, interview, and record review, the facility failed to ensure medications were safely and properly stored, dated, labeled, and not expired for 2 of 3 medication carts observed. (B Wing C Hall Medication Cart and B Wing A Hall Medication Cart) Findings include: 1. On 6/7/21 at 1:57 p.m., with LPN 1, the B Wing C Hall medication cart was observed. There were	F 0761	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? B Wing A Hall and C Hall medication carts were cleaned and any loose pills were discarded; outdated insulin vials and insulin pens were removed and discarded. All insulin vials and	06/14/2021

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	06/07/2021

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
	approximately 45 pills of different sizes and colors that were loose and out of packages throughout the bottoms of the drawers in the cart. The LPN indicated she did not normally work on that hall and was unaware of the loose pills in the cart. 2. On 6/7/21 at 2:08 p.m., with LPN 2, the B Wing A Hall medication cart was observed. There were approximately 20 pills of different sizes and colors loose and out of packages throughout the bottoms of the drawers in the cart. There was a Humulin R (insulin) vial with an open date of 4/1/21 on the box, a Humulin N (insulin) vial with no name and open date of 4/1/21 on the box, a Lispro (insulin) vial with an open date of 4/11/21 on the box, another Lispro vial with no name and an open date of 4/11//21 on the box, an Aspart (insulin) vial that had expiration date of 4/18/21 on the vial, and a Basaglar KwikPen (insulin) with no name, open date, or instructions on the pen. The LPN indicated she was unaware of the loose pills in the cart and they should have been disposed of. She was also unaware of the expired insulin vials & pen and they should have been labeled and disposed of 28 days after they were opened. Interview with the Director of Nursing on 6/7/21 at 2:37 p.m., indicated the nursing staff should have discarded the loose pills in the medication carts. All the insulin vials and pen should have been labeled with the resident names, open dates and expiration dates and should have been disposed of after 30 days of opening the insulin. A facility policy, titled, "Storage of Medications" and received as current from the Regional Nurse Consultant on 6/7/21, indicated, "...Procedures...H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are		pens were dated appropriately and labeled with the appropriate resident name. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are potentially at risk of the same alleged deficient practice. What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur? Nursing staff were in-serviced on ensuring all medication carts are to be cleaned daily; all insulin vials and insulin pens are to be dated upon opening, discarded upon expiration, and labeled with the residents name. An audit was completed on all medication carts in the facility to ensure carts are clean, free of loose pills, all medications are labeled including insulin with date opened and residents name, as well as any expired medications. 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?	

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	06/07/2021

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
	immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy...Expiration Dating...E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a "date opened" sticker on the medication and enter the date and the new date of expiration. The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating. F. The nurse will check the expiration date of each medication before administering. G. No expired medications will be administered to a resident...." 3.1-25(j)(k) 3.1-25(o)		The DON/Designee will audit all medication carts weekly for 6 months to ensure carts are clean, free of loose pills, expired medications, as well as all medications are labeled including insulin with date opened and residents name. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. ="" p="">	