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

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	12/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00367858 and IN00368255. Complaint IN00367858 - Unsubstantiated due to lack of evidence. Complaint IN00368255 - Substantiated. Federal/State deficiencies related to the allegations are cited at F694 and F726. Unrelated deficiency is cited. Survey dates: December 8 & 9, 2021 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 21 Medicaid: 53 Other: 7 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/13/21.	F 0000	Please accept the following as the facility's credible allegation of compliance. 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 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment,			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to report an allegation of abuse to the Administrator of the facility in a timely manner, related to an allegation of inappropriate touch, for 1 of 1 resident reviewed for a reported abuse allegation. (Resident F) Finding includes: An Indiana Department of Health (IDOH) reportable incident, dated 12/2/21, indicated	F 0609	F 609 /p> **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · RN was re-educated on the	12/16/2021

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	Resident F alleged she was touched in a sexual manner during incontinent care. Resident F's record was reviewed on 12/9/21 at 12:35 p.m. The diagnoses included, but were not limited to, schizophrenia, bipolar disease, and cognitive communication deficit. An Admission Minimum Data Set assessment, dated 11/29/21, indicated an intact cognition, required extensive assistance of one staff for activities of daily living, was occasionally incontinent of urine and frequently incontinent of bowel movement. A Nurse's Progress Note, dated 12/3/21 at 8 a.m., indicated during the morning rounds, the resident had stated she was touched inappropriately by a CNA the prior evening. A Nurse's Progress Note, dated 12/3/21 at 8:30 a.m., indicated the Nurse and Administrator met with the resident and the resident indicated a male CNA had entered her room and molested her. He had asked her if she needed changed, she stated no, and he ripped off the covers and touched her vagina. When he left the room, she had called for the nurse. The Investigation included an undated and unsigned statement from Employee 3, which indicated a male CNA had come to her and stated he was making his final rounds and the resident had accused him of touching her private area. Employee 3 spoke with the resident and informed the resident the CNA had just checked to see if she had been incontinent. She reoriented the resident and 30 minutes later the resident was sleeping.		abuse policy including tiemly notification to the facility Administrator. **2. How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** All residents with abuse allegations have the potential to be affected. **3. What corrective measures will the facility take or will alter to ensure that the problem will not recur?** · Staff were educated on the facility abuse policy including timely notification to the facility Administrator **4. What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** · The administrator/designee will audit all abuse allegations weekly to ensure timely notification to the facility Administrator. A summary of these reviews will be presented to the Q/A committee monthly for 6	

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	During an interview on 12/9/21 at 1:36 p.m., Employee 3 indicated on 12/2/21 at approximately 10 p.m. the male CNA had come to her and said he was doing final rounds when Resident F made the allegation he had touched her private parts. Employee 3 then entered the resident's room and the resident alleged a strange man had touched her private area. The resident was insistent that she file a Police Report. She wanted the Police notified. This information was reported to the night nurse who notified the Director of Nursing (DON). The DON had not responded to the call, so she notified her again at approximately 6 a.m. on 12/3/21. When she had left her shift, the resident was sleeping. During an interview on 12/9/21 at 1:20 p.m., the DON indicated she had received a text at 12:30 a.m. on 12/3/21. The text had indicated the resident made an allegation she was touched inappropriately by a CNA and was requesting the Police be notified. She indicated she had not read the text until the morning, due to she was sleeping and did not hear the text come in. She indicated the Nurse should have notified the Administrator and was unsure if the Nurse had also notified the Administrator. During an interview on 12/9/21 at 1:35 p.m., the Administrator indicated she had not been notified of the allegation by Employee 3. When the DON had notified her on 12/3/21 the Police were notified and the investigation was initiated. A facility policy, dated 6/2018, received from the Administrator as current, and titled, "Abuse Prevention", indicated the employees were required to report any allegation of abuse to the Administrator immediately.		months or until compliance is met. **5. By what date the systemic changes will be completed?** 12/16/2021	

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	3.1-28(c)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review and interview, the facility failed to care for PICC (peripherally inserted central catheter) lines in accordance with professional standards of practice, related to no measurement of the catheter to ensure dislodgement had not occurred for 2 of 2 residents with PICC lines, and not changing the infusion bag of TPN (total parenteral nutrition) timely, not ensuring the TPN was infusing, and not initiating a new bag of TPN timely for 1 of 1 residents receiving TPN. (Residents C and D) Findings include: 1. During an observation on 12/8/21 at 9:15 a.m., Resident C was lying in bed. There was a PICC line in her left arm. The dressing on the PICC line was dated 12/7/21. A bag of TPN, dated 12/8/21 at 8:30 (no a.m. or p.m. documented), was infusing at 76 cc's (cubic centimeters) per hour. During an observation on 12/9/21 at 8:24 a.m., Resident C was lying in bed with her eyes closed. The TPN infusion pump was shut off. During an interview on 12/9/21 at 8:30 a.m., Employee 1 indicated she was Resident C's	F 0694	F694 ="" span="">; **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Placement of PICC line was verified for resident C and D had no adverse effects to related to no measurement of the catheter. · The facility immediately corrected by initiating a new infusion bag of TPN and ensuring it was properly infusing. Resident C had no adverse effects related to not changing the infusion bag timely, not making sure the TPN was infusing, and not initiating a new bag of TPN. **2. How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?**	12/16/2021

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	Nurse and was unsure why the TPN had been turned off. Employee 1 then entered the room and asked the resident if she knew when the TPN had been turned off. The resident indicated the infusion pump alarm had been activated and a "guy nurse" had come in the room and did something with the pump and left the room. She was unsure what time this occurred. During an interview on 12/9/21 at 8:33 a.m., Employee 2 indicated the infusion pump alarm was activated around 7:40 a.m. and he had entered the room and reset the infusion pump. He indicated the infusion pump was on when he left the room. During an interview on 12/9/21 at 9:18 a.m., the Unit Manager indicated she was unaware how long the TPN infusion had been turned off and who had turned the pump off. During an observation on 12/9/21 at 9:18 a.m., Employee 1 indicated she had flushed the PICC line tubing and had restarted the TPN. The TPN bag indicated it had been initiated on 12/8/21 at 8:30. Employee 1 indicated the bag had been initiated on 12/8/21 at 8:30 a.m. During an observation on 12/9/21 at 10:23 a.m., the TPN infusion pump's alarm had been activated. During an observation on 12/9/21 at 10:26 a.m., Employee 1 entered the room and turned the infusion pump off. There were approximately 250 cc's of TPN left in the bag. Employee 1 indicated the TPN bag should not have lasted for 24 hours and the TPN bag had been initiated over 24 hours ago. She indicated another bag of TPN had not been removed from the refrigerator, and		All residents with a PICC lines will have the potential to be affected. **3. What corrective measures will the facility take or will alter to ensure that the problem will not recur?** · Nursing staff educated on PICC lines including: o Obtaining measurements of the external catheter and catheter to ensure placement and to ensure no dislodgement. o Following physician orders related to initiating TPN at the correct time and timely bag changes. o Verification of correct labeling of the TPN including verification of physician's order, date and time TPN bag initiated, signature of initiating nurse o TPN bag storage. o Monitoring of TPN infusions **4. What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** · The DON/designee will audit all residents weekly with PICC lines to ensure measurement of the PICC line has been completed, and PICC lines are infusing according physicians	

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	she could not administer a new bag until the new bag of TPN was removed from the refrigerator and was room temperature. Resident C's record was reviewed on 12/8/21 at 12:40 p.m. The diagnoses included, but were not limited to, peritoneal adhesions and fistula of intestine. An Admission Minimum Data Set (MDS) assessment, dated 11/19/21, indicated an intact cognition status and received 51% of nutrition and over 501 cc of fluids by parenteral/IV feeding. The Care Plan, dated 11/19/21, indicated TPN was initiated for nutrition and hydration. The interventions included, provide parenteral/IV as ordered by the Physician. A PICC line was present and required monitored for catheter migration and occlusion. The interventions included, the external catheter length was to be measured on admission, weekly with each dressing change, and as needed. A Physician's Order, dated 11/15/21, indicated the dressing on the PICC line was to be changed weekly and as needed. A Physician's Orders dated 11/20/21, indicated an order for 2000 cc's per 24 hours of TPN was to be infused at 76/cc an hour. An Admission Full Clinical Assessment, dated 11/13/21 at 4:51 p.m., indicated an I.V. was located in the left brachial area. There was no measurement of the length of the external PICC line.		order and were initiated on time. A summary of these reviews will be presented to the Q/A committee monthly for 6 months or until compliance is met. **5. By what date the systemic changes will be completed? 12/16/2021**	

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	The Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 11/2021 and 12/2021, indicated the PICC dressing had been changed weekly. There were no measurements of the external PICC line. During an interview on 12/8/21 at 3:05 p.m., Employee 1 indicated the RNs completed the dressing changes to the PICC line insertion area and the measurements were also to be completed by the RNs. 2. During an observation on 12/8/21 at 10:10 a.m., Resident D was lying in bed with her head of the bed elevated. There was a PICC line placed in her right arm. An Admission MDS assessment, dated 11/30/21, indicated she received IV medications. A Care Plan, dated 11/30/21, indicated IV medications were administered through a PICC line. The interventions included, the external length of the PICC line catheter was to be measured on admission, weekly with dressing changes, and as needed. A Physician's Orders, dated 11/24/21, indicated the PICC line dressing was to be changed weekly. An Admission Full Clinical Assessment, dated 11/24/21, indicated a PICC line was in the right arm. There was no measurement of the external PICC line. The MARs and TARs, dated 11/2021 and 12/2021, indicated the PICC dressing had been changed weekly. There were no measurements of the external PICC line.			

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	A facility policy, titled, "Overview: Principle Uses of Intravenous Therapy", dated 9/1/2016, and received as current from the Administrator on 12/9/21 at 9:40 a.m., indicated the external catheter of the PICC line should be monitored on admission and weekly for outward migration of the catheter. A facility policy, titled, "Parenteral Nutrition", dated 9/1/16, and received as current from the Director of Nursing, indicated the TPN was to be infused at the same rate for 24 hours a day and the bag and equipment were to be changed at approximately the same time each day. The TPN solutions should be infused or discarded within 24 hours of the administration set being attached. The TPN bags were to be stored in the refrigerated until approximately one hour before use and must be allowed to come up to room temperature naturally. This Federal tag relates to Complaint IN00368255. 3.1-47(a)(2)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment			

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	required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on observation, record review and interview, the facility failed to provide competent and trained Nursing Staff to complete infusion of TPN (total parental nutrition) by way of a PICC line, related to no prior training and demonstration of competency of the Nursing Staff prior to caring for a resident who was receiving TPN. (Resident C) Finding includes: Resident C was observed on 12/8/21 at 9:15 a.m. with a PICC line inserted into her left arm. There was a bag of TPN, dated 12/8/21 at 8:30 (no a.m. or p.m. documented). The TPN was being infused at 76 cc's (cubic centimeters) per hours.	F 0726	F726 /p> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Licensed nurses were provided education and return demonstration on TPN. **How will facility identify other residents who have the potential to be affected by the**	12/16/2021

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	On 12/9/21 at 8:24 a.m., the TPN pump was shut off and the TPN bag and tubing were still attached to the pump. During an interview on 12/9/21 at 8:30 a.m., Employee 1 indicated she was unsure why the infusion pump was shut off. During an interview on 12/9/21 at 8:33 a.m., Employee 2 indicated the infusion pump alarm had been activated, and he entered the room and resent the pump and when he left the room the infusion pump was on. During an interview on 12/9/21 at 9:18 a.m., the Unit Manager indicated she was unaware how long the TPN had been turned off and who had turned the pump off. During an observation on 12/9/21 at 9:18 a.m., Employee 1 indicated she had flushed the PICC line tubing and restarted the TPN. She indicated the TPN bag on infusing had been initiated on 12/8/21 at 8:30 a.m. During an observation on 12/9/21 at 10:23 a.m., the TPN infusion pump's alarm had been activated. During an observation on 12/9/21 at 10:26 a.m., Employee 1 entered the room, and turned the infusion pump off. There was approximately 250 cc's of TPN left in the bag. Employee 1 indicated the TPN bag should not have lasted for 24 hours and the TPN bag had been initiated over 24 hours ago. She indicated another bag of TPN had not been removed from the refrigerator, and she could not start a new bag until the new bag of TPN was removed from the refrigerator and was at room temperature.		**same alleged deficient practice?** The deficient practice has the potential to affect any facility resident receiving TPN infusion by way of PICC line. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** · Nursing staff educated on PICC lines and TPN infusions including: o Obtaining measurements of the external catheter and catheter to ensure placement and to ensure no dislodgement. o Following physician orders related to initiating TPN at the correct time and timely bag changes. o Verification of correct labeling of the TPN including verification of physician's order, date and time TPN bag initiated, signature of initiating nurse o TPN bag storage. o Monitoring of TPN infusions Licensed nurses have completed return demonstrations of competency.	

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	Resident C's record was reviewed on 12/8/21 at 12:40 p.m. The diagnoses included, but were not limited to, peritoneal adhesions and fistula of intestine. A Physician's Orders dated 11/20/21, indicated an order for 2000 cc's per 24 hours of TPN was to be infused at 76/cc an hour. During an interview on 12/9/21 at 9:53 a.m., the Director of Nursing indicated she was unable to find training and demonstration of competency regarding TPN infusion for the nursing staff. During an interview on 12/9/21 at 10:31 a.m., Employee 1 indicated when the resident was admitted there were Physician's Orders in the admission packet and the Nurses look at the orders. She was not able to verbalize when she had training and competency evaluated for TPN care and indicated sometimes the Director of Nursing was in the room during PICC line/TPN care. A facility policy, titled, "Parenteral Nutrition", dated 9/1/16, and received as current from the Director of Nursing, indicated all nursing staff who would be caring for a resident who received TPN, would receive training and demonstrate competency regarding TPN nutrition to ensure proper assessment and monitoring of the resident was completed. The TPN was to be infused at the same rate for 24 hours a day and the bag and equipment were to be changed at approximately the same time each day. The TPN solutions should be infused or discarded within 24 hours of the administration set being attached. The TPN bags were to be stored in the refrigerated until approximately one hour before		**What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/ designee will complete observations of TPN initiation and care of PICC lines for all residents with TPN weekly to ensure nurse competency. Additionally, all new licensed nursing staff will be trained and competency will be verified. A summary will be presented to the Quality Assurance committee monthly x 6 months. **By what date the systemic changes will be completed: 12/16/2021**	

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	use and must be allowed to come up to room temperature naturally. This Federal tag relates to Complaint IN00368255.			