	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		<b>MB NO. 0938-0391</b> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
	of conduction	155650	B. WING	00		9/2021
		133030				0/2021
NAME OF I	PROVIDER OR SUPPLIE	2R		ADDRESS, CITY, STATE, ZIP CODE	l	
LINCOLI	NSHIRE HEALTH &	& REHABILITATION CENTER		′IRGINIA ST ILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	Γ		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE
= 0000	ill go Entroit i o					DATE
0000						
Bldg. 00						
Blug. 00	This visit was for the Investigation of Complaints		F 0000	Please accept the followin	a as the	
	IN00367858 and I		1 0000	facility's credible allegation	-	
	11100507050 and 1	100500255.		compliance. This plan of	101	
	Complaint IN0036	57858 - Unsubstantiated due to		correction does not constit	tute an	
	lack of evidence.	7656 - Onsubstantiated due to		admission of guilt or liabili		
	lack of evidence.			facility and is submitted or		
	Complaint IN0036	58255 - Substantiated.		response to the regulatory	-	
	-	viencies related to the		requirement. The facility		
		ed at F694 and F726.		respectfully request paper		
	anegations are end	at 1 074 and 1 720.		compliance.		
	Unrelated deficiency is cited. Survey dates: December 8 & 9, 2021					
	Facility number: 0	00577				
	Provider number:	155650				
	AIM number: 100	0266950				
	Census Bed Type:					
	SNF/NF: 81					
	Total: 81					
	Census Payor Typ	e:				
	Medicare: 21					
	Medicaid: 53					
	Other: 7					
	Total: 81					
	These deficiencies	reflect State Findings cited in				
	accordance with 4					
	Quality review con	mpleted on 12/13/21.				
0609	483.12(c)(1)(4)					
SS=D	Reporting of Alle	and Violations				
Bldg. 00		ponse to allegations of				
Diug. 00		exploitation, or mistreatment,				
		Apoliation, or misticalment,				1

PRINTED:

12/29/2021

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.

STATEMENT	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		A. BUIL B. WINC	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 12/09/2021	
	NAME OF PROVIDER OR SUPPLIER			8380 VI	DDRESS, CITY, STATE, ZIP CODE RGINIA ST LLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O the facility must:	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETIC DATE	
	violations involvir exploitation or mi of unknown source resident property but not later than is made, if the evaluation involve bodily injury, or me events that cause abuse and do no injury, to the admi to other officials ( Survey Agency a where state law property long-term care fa State law through §483.12(c)(4) Re- investigations to her designated re- officials in according to the S 5 working days of alleged violation corrective action Based on record re- facility failed to re- the Administrator manner, related to touch, for 1 of 1 re- abuse allegation. ( Finding includes: An Indiana Depart	eview and interview, the port an allegation of abuse to of the facility in a timely an allegation of inappropriate sident reviewed for a reported	F 060	9	F 609 /p> 1. What corrective action( will be accomplished for those residents found to have been affected by the deficient practice?	se 1	12/16/20	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/09/2021	
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN 46410		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	Resident F alleged manner during inc	she was touched in a sexual ontinent care.		abuse policy including tiemly notification to the facility Administrator.		
	12:35 p.m. The dia	d was reviewed on 12/9/21 at agnoses included, but were not hrenia, bipolar disease, and				
	cognitive commun			2. How will facility identify other residents who have the potential to be affected by the		
	dated 11/29/21, in required extensive	dicated an intact cognition, assistance of one staff for		same alleged deficient practice	e?	
	-	iving, was occasionally e and frequently incontinent nt.		allegations have the potential to affected.	be	
	-	s Note, dated 12/3/21 at 8		3. What corrective		
	a.m., indicated dui resident had stated	ing the morning rounds, the		measures will the facility take or will alter to ensure that the		
		a CNA the prior evening.		problem will not recur?		
	a.m., indicated the with the resident a male CNA had ent	s Note, dated 12/3/21 at 8:30 Nurse and Administrator met nd the resident indicated a tered her room and molested		• Staff were educated on the facility abuse policy including timely notification to the facility Administrator	ne	
	stated no, and he r	her if she needed changed, she ipped off the covers and				
	had called for the			4. What quality assurance plans will be implemented to monitor facility performance to	D I	
	unsigned statemen indicated a male C he was making his	included an undated and t from Employee 3, which 'NA had come to her and stated final rounds and the resident		ensure corrections are achieved and permanent?		
	Employee 3 spoke informed the resid	f touching her private area. with the resident and ent the CNA had just checked		The administrator/designed will audit all abuse allegations weekly to ensure timely	e	
		een incontinent. She reoriented ) minutes later the resident was		notification to the facility Administrator. A summary of these reviews will be presented the Q/A committee monthly for 6		

PRINTED: 12/29/2021 FORM APPROVED OMB NO 0938-0391

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			
	OF CORRECTION	IDENTIFICATION NUMBER:			
UND LAN	OF CORRECTION		A. BUILDING B. WING	00	COMPLETED
		155650			12/09/2021
NAME OF	PROVIDER OR SUPPLIEF			ET ADDRESS, CITY, STATE, ZIP	CODE
				VIRGINIA ST	
LINCOL	NSHIRE HEALTH &	REHABILITATION CENTER	MER	RILLVILLE, IN 46410	
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION ) CROSS-REFERENCED TO THE	SHOULD BE COMPLET
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	-	on 12/9/21 at 1:36 p.m.,		months or until compl	iance is
	Employee 3 indicat			met.	
		.m. the male CNA had come			
		vas doing final rounds when			
		e allegation he had touched		5. By what date th	
		mployee 3 then entered the		systemic changes w	ill be
		the resident alleged a strange		completed?	
		er private area. The resident		40/40/0001	
		ne file a Police Report. She		12/16/2021	
		otified. This information was			
		t nurse who notified the			
		(DON). The DON had not			
	-	ll, so she notified her again at			
		n. on $12/3/21$ . When she had			
	left her shift, the res	sident was sleeping.			
	During an interview	on 12/9/21 at 1:20 p.m., the			
		had received a text at 12:30			
	a.m. on 12/3/21. Th	ne text had indicated the			
	resident made an al	legation she was touched			
	inappropriately by a	a CNA and was requesting the			
	Police be notified.	She indicated she had not			
	read the text until the	ne morning, due to she was			
	sleeping and did no	t hear the text come in. She			
	indicated the Nurse	should have notified the			
		vas unsure if the Nurse had			
	also notified the Ad	ministrator.			
	D · · · · ·	12/0/21 / 1.25 /1			
		y on 12/9/21 at 1:35 p.m., the ated she had not been notified			
		Employee 3. When the DON 12/3/21 the Police were			
		estigation was initiated.			
		consulon was initiated.			
	A facility policy, da	tted 6/2018, received from			
		s current, and titled, "Abuse			
		ted the employees were			
		ny allegation of abuse to the			
	Administrator imm				
	1	-			

ENTERS FU	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155650	B. WING		12/09/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
LINCOLI	NSHIRE HEALTH	& REHABILITATION CENTER		/IRGINIA ST ILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
	3.1-28(c)					
0694	483.25(h)					
SS=D	Parenteral/IV Flu	ids				
Bldg. 00	§ 483.25(h) Pare					
5		must be administered				
	consistent with p	rofessional standards of				
		ccordance with physician				
	orders, the comprehensive person-centered care plan, and the resident's goals and					
	preferences.					
		ion, record review and	F 0694	F694	12/16/202	
		lity failed to care for PICC				
		ted central catheter) lines in		="" span="">		
	-	rofessional standards of			、	
	-	no measurement of the		1. What corrective action(s		
		dislodgement had not		will be accomplished for thos		
		the infusion has of TPN (total		residents found to have been		
		and not changing the infusion bag of TPN (total parenteral nutrition) timely, not ensuring the		affected by the deficient practice?		
	TPN was infusing, and not initiating a new bag of TPN timely for 1 of 1 residents receiving TPN.					
				· Placement of PICC line		
	(Residents C and I	0		was verified for resident C and	D	
		- ,		had no adverse effects to relate		
	Findings include:			to no measurement of the		
				catheter.		
	1. During an obse	rvation on 12/8/21 at 9:15		· The facility immediately		
	a.m., Resident C was lying in bed. There was a PICC line in her left arm. The dressing on the			corrected by initiating a new		
				infusion bag of TPN and ensur	•	
		ed 12/7/21. A bag of TPN,		it was properly infusing. Reside		
		30 (no a.m. or p.m.		C had no adverse effects relate		
	documented), was infusing at 76 cc's (cubic			to not changing the infusion ba	•	
	centimeters) per h	our.		timely, not making sure the TP		
	During an observe	tion on 12/9/21 at 8:24 a.m.,		was infusing, and not initiating new bag of TPN.	a	
	-	ing in bed with her eyes closed.		Hew bay OF IFIN.		
	-	pump was shut off.		2. How will facility identify		
		pump was shut on.		other residents who have the		
	During an intervie	w on 12/9/21 at 8:30 a.m.,		potential to be affected by the		
	-	tted she was Resident C's		same alleged deficient practic		
	I mproyee i mulea	and she was restucht $C\delta$		anne anegeu dencient practit	~ .	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155650 B. WING 12/09/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8380 VIRGINIA ST LINCOLNSHIRE HEALTH & REHABILITATION CENTER MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) Nurse and was unsure why the TPN had been turned off. Employee 1 then entered the room All residents with a PICC lines will have the potential to be affected. 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 3. What corrective "guy nurse" had come in the room and did measures will the facility take something with the pump and left the room. She or will alter to ensure that the was unsure what time this occurred. problem will not recur? During an interview on 12/9/21 at 8:33 a.m., Nursing staff educated on Employee 2 indicated the infusion pump alarm PICC lines including: was activated around 7:40 a.m. and he had o Obtaining measurements of the entered the room and reset the infusion pump. external catheter and catheter to He indicated the infusion pump was on when he ensure placement and to ensure left the room. no dislodgement. o Following physician orders During an interview on 12/9/21 at 9:18 a.m., the related to initiating TPN at the correct time and timely bag Unit Manager indicated she was unaware how long the TPN infusion had been turned off and changes. o Verification of correct labeling who had turned the pump off. of the TPN including verification of During an observation on 12/9/21 at 9:18 a.m., physician's order, date and time Employee 1 indicated she had flushed the PICC TPN bag initiated, signature of line tubing and had restarted the TPN. The TPN initiating nurse o TPN bag storage. bag indicated it had been initiated on 12/8/21 at o Monitoring of TPN infusions 8:30. Employee 1 indicated the bag had been initiated on 12/8/21 at 8:30 a.m. What quality assurance 4. plans will be implemented to During an observation on 12/9/21 at 10:23 a.m., the TPN infusion pump's alarm had been monitor facility performance to activated. ensure corrections are achieved and permanent? 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 The DON/designee will audit all residents weekly with 250 cc's of TPN left in the bag. Employee 1 indicated the TPN bag should not have lasted for PICC lines to ensure measurement of the PICC line has 24 hours and the TPN bag had been initiated over

FORM CMS-2567(02-99) Previous Versions Obsolete

24 hours ago. She indicated another bag of TPN

had not been removed from the refrigerator, and

Event ID:

7CRW11

Facility ID: 000577

been completed, and PICC lines

are infusing according physicians

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155650	B. WING	<u></u>	12/09/2021	
		100000			12/03/2021	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
				/IRGINIA ST		
LINCOLN	ISHIRE HEALTH 8	REHABILITATION CENTER	MERR	RILLVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
	she could not admi	nister a new bag until the new		order and were initiated on time	e.	
	bag of TPN was re	moved from the refrigerator		A summary of these reviews wi	I	
	and was room tem	berature.		be presented to the Q/A		
	-			committee monthly for 6 month	S	
	Resident C's record	l was reviewed on 12/8/21 at		or until compliance is met.		
	12:40 p.m. The di	agnoses included, but were				
	•	toneal adhesions and fistula of				
	intestine.			5. By what date the		
				systemic changes will be		
	An Admission Mir	imum Data Set (MDS)		completed? 12/16/2021		
		1/19/21, indicated an intact				
		d received 51% of nutrition				
	-	fluids by parenteral/IV				
	feeding.					
	The Care Plan, date	ed 11/19/21, indicated TPN				
	was initiated for nu	trition and hydration. The				
	interventions inclu	ded, provide parenteral/IV as				
	ordered by the Phy	sician.				
	A PICC line was p	resent and required monitored				
	-	on and occlusion. The				
	-	ded, the external catheter				
		easured on admission, weekly				
		change, and as needed.				
	A Dhusisian's Ord-	r dated 11/15/21 indicated				
	-	r, dated 11/15/21, indicated				
	weekly and as need	PICC line was to be changed				
	weekiy and as need	icu.				
	A Physician's Orde	rs dated 11/20/21, indicated				
	-	c's per 24 hours of TPN was				
	to be infused at 76/	-				
	An Admission Full	Clinical Assessment, dated				
		m., indicated an I.V. was				
	_	prachial area. There was no				
		e length of the external PICC				
	line.	0				
			1			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

STATEME	OR MEDICARE & MEDICAID SERVICES           ENT OF DEFICIENCIES         X1) PROVIDER/SUPPLIER/CLIA         X2) MULTIPLE CONSTRUCTION			(V2) DA	OMB NO. 0938-0 (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		155650	B. WING		12/0	)9/2021	
NAME OF	PROVIDER OR SUPPLIE	{		EET ADDRESS, CITY, STATE,	, ZIP CODE		
				0 VIRGINIA ST			
LINCOL	NSHIRE HEALTH &	REHABILITATION CENTER	MER	RRILLVILLE, IN 46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO	O THE APPROPRIATE	COMPLET	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIEN	NCY)	DATE	
		ministration Records (MAR)					
		ninistration Records (TAR),					
		12/2021, indicated the PICC					
	-	changed weekly. There were					
	no measurements o	f the external PICC line.					
	During an interview	v on 12/8/21 at 3:05 p.m.,					
		ed the RNs completed the					
		the PICC line insertion area					
		nts were also to be completed					
	by the RNs.	1					
	2. During an obser	vation on 12/8/21 at 10:10					
	-	as lying in bed with her head					
		There was a PICC line placed					
	in her right arm.						
	An Admission MD	S assessment, dated 11/30/21,					
	indicated she receiv						
	A Care Plan, dated	11/30/21, indicated IV					
	medications were a	dministered through a PICC					
	line. The intervent	ions included, the external					
	length of the PICC	line catheter was to be					
	measured on admis	sion, weekly with dressing					
	changes, and as nee	eded.					
	A Physician's Orde	rs, dated 11/24/21, indicated					
		ing was to be changed weekly.					
	An Admission Full	Clinical Assessment, dated					
		a PICC line was in the right					
		measurement of the external					
	PICC line.						
	The MARs and TA	Rs, dated 11/2021 and					
		the PICC dressing had been					
		here were no measurements of					
	the external PICC 1						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/09/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		TADDRESS, CITY, STATE, ZIP CO VIRGINIA ST	DDE		
LINCOL	INCOLNSHIRE HEALTH & REHABILITATION CENTER			RILLVILLE, IN 46410			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	TROFINATE	DATE	
	Uses of Intravenor and received as cu on 12/9/21 at 9:40 catheter of the PIC	itled, "Overview: Principle us Therapy", dated 9/1/2016, rrent from the Administrator a.m., indicated the external CC line should be monitored on ekly for outward migration of					
	dated 9/1/16, and a Director of Nursin infused at the sam the bag and equip approximately the solutions should b 24 hours of the ad The TPN bags we refrigerated until a use and must be al temperature natura	itled, "Parenteral Nutrition", received as current from the g, indicated the TPN was to be e rate for 24 hours a day and nent were to be changed at same time each day. The TPN e infused or discarded within ministration set being attached. re to be stored in the upproximately one hour before lowed to come up to room ally. elates to Complaint					
F 0726 SS=D Bldg. 00	with the appropri sets to provide n to assure resider maintain the high mental, and psyc resident, as dete assessments and considering the r diagnoses of the	ing Staff					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/09/2021	
	NAME OF PROVIDER OR SUPPLIER		838	EET ADDRESS, CITY, STATE, ZIP 30 VIRGINIA ST RRILLVILLE, IN 46410	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC DATE	
	licensed nurses I competencies an care for residents through resident described in the §483.35(a)(4) Pr not limited to ass and implementing responding to res §483.35(c) Profic The facility must able to demonstr techniques neces needs, as identifi assessments, an care. Based on observat interview, the faci competent and trai infusion of TPN (t of a PICC line, rel demonstration of c Staff prior to carin receiving TPN. (R Finding includes: Resident C was ob with a PICC line in There was a bag o (no a.m. or p.m. de	e facility must ensure that have the specific id skill sets necessary to s' needs, as identified assessments, and plan of care. oviding care includes but is essing, evaluating, planning g resident care plans and sident's needs. clency of nurse aides. ensure that nurse aides are ate competency in skills and sary to care for residents' ed through resident d described in the plan of ion, record review and lity failed to provide ined Nursing Staff to complete otal parental nutrition) by way ated to no prior training and competency of the Nursing g for a resident who was	F 0726	F726 /p> What corrective actions be accomplished for residents found to have affected by the defice practice? Licensed nurses were education and return demonstration on TPN How will facility iden residents who have to potential to be affect	those ave been ient e provided N. tify other the	12/16/20	

CENTER FOR MEDICAR & MEDICAR SWUCES     OMB NO. 093.693       STATEMENT OF DEFICIENCY     IN PROVIDER SUPPLIER LIDENTIFICATION NUMBER: 15650     NO PLANOF CORRECTION N.WIG     NO N.WIG     NO N.WIG <td< th=""><th>DEPARTMEN</th><th>T OF HEALTH AND HU</th><th>MAN SERVICES</th><th></th><th></th><th>FORM APPROVED</th></td<>	DEPARTMEN	T OF HEALTH AND HU	MAN SERVICES			FORM APPROVED
AND PLAN OF CORRECTION       DENTIFICATION NUMBER: 155650       A. BUILDING       OO       COMPLETED 12/09/2021         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS. CTTY, STATE, 2JP CODE: 3300 VIRGINIA ST MERRILLVILLE, IN 46410       STREET ADDRESS. CTTY, STATE, 2JP CODE: 3300 VIRGINIA ST MERRILLVILLE, IN 46410       SUMMARY STATEMENT OF DEFICIENCIES RESULTATORY OR LSC IDENTIFYING INFORMATION)       D       STREET ADDRESS. CTTY, STATE, 2JP CODE: 3300 VIRGINIA ST MERRILLVILLE, IN 46410       (55)         VIRGATORY OR LSC IDENTIFYING INFORMATION)       TAG       PROVIDER OR SURPLATE       (55)         On 12/9/21 at 8:24 a.m., the TYP pump was shut off and the TYP bag and tubing were still attached to the pump.       The deficient practice has the potential to affect any facility resident receiving TPN Infusion by way of PICC line.       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 takes or will after to ansaure that the problem will not recur?       Image: ODD uring 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.       · Nursing staff educated on PICC lines and TPN infusions including: o Obtaining measurements of the external catheter and to ensure no dislodgreent.       O Following Physician orders related to initiating TPN at the correct time and timely bag changes.       O Verification of physician's order, date and time TPN bag initiated, signature of initiated, signature of initiated, signature of initiated, signature of initiated pures	CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-0391
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the TPN infusion pump's alarm had been       o       Verification of correct labeling         activated.       of the TPN including verification of         During an observation on 12/9/21 at 10:26 a.m.,       physician's order, date and time         Employee 1 entered the room, and turned the       initiating nurse		Duning on charmon	ion on 12/0/21 at 10:22 a m			
activated.of the TPN including verification of physician's order, date and timeDuring an observation on 12/9/21 at 10:26 a.m., Employee 1 entered the room, and turned theTPN bag initiated, signature of initiating nurse		-			5	ling
During an observation on 12/9/21 at 10:26 a.m.,physician's order, date and timeDuring an observation on 12/9/21 at 10:26 a.m.,TPN bag initiated, signature ofEmployee 1 entered the room, and turned theinitiating nurse		-	ump's alarm had been			-
During an observation on 12/9/21 at 10:26 a.m.,TPN bag initiated, signature ofEmployee 1 entered the room, and turned theinitiating nurse		activated.			-	
Employee 1 entered the room, and turned the initiating nurse		During an observet	tion on 12/9/21 at 10.26 a m			
						`
infusion pump off. There was approximately 250 o TPN bag storage.					o TPN bag storage.	
cc's of TPN left in the bag. Employee 1 indicated o Monitoring of TPN infusions						s
the TPN bag should not have lasted for 24 hours						- -
and the TPN bag had been initiated over 24 hours Licensed nurses have completed					Licensed nurses have comple	ted
ago. She indicated another bag of TPN had not return demonstrations of		-				
been removed from the refrigerator, and she competency.						
could not start a new bag until the new bag of						
TPN was removed from the refrigerator and was						
at room temperature.						

Event ID:

7CRW11 Facility ID: 000577

If continuation sheet Page 11 of 13

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	(X2) MULTIPLE CONSTRUCTION		(X3) DA'	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COM	COMPLETED		
		155650	B. WING		12/0	09/2021		
NAME OF	PROVIDER OR SUPPLIE	ER	ST	FREET A	DDRESS, CITY, STATE, ZIP C	CODE		
					RGINIA ST			
LINCOL	NSHIRE HEALTH	& REHABILITATION CENTER	M	IERRIL	LVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	II	)	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETI	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE	
					What quality assurance	-		
		d was reviewed on 12/8/21 at			will be implemented to			
	_	liagnoses included, but were			facility performance to			
		itoneal adhesions and fistula of			corrections are achiev	ved and		
	intestine.		permanent?					
	A Physician's Ord			The DON/ designee wi	ill complete			
	an order for 2000			observations of TPN in	nitiation and			
	to be infused at 76	b/cc an hour.			care of PICC lines for a	all		
					residents with TPN we	ekly to		
		ew on 12/9/21 at 9:53 a.m., the			ensure nurse compete	-		
		ng indicated she was unable to			Additionally, all new lic			
	-	lemonstration of competency			nursing staff will be tra			
	regarding TPN inf	fusion for the nursing staff.			competency will be ver			
					summary will be prese			
	-	ew on 12/9/21 at 10:31 a.m.,			Quality Assurance con	nmittee		
		ated when the resident was			monthly x 6 months.			
		re Physician's Orders in the						
	_	and the Nurses look at the			By what date the syst			
		ot able to verbalize when she			changes will be comp	leted:		
		ompetency evaluated for TPN			12/16/2021			
		sometimes the Director of						
	Nursing was in the	e room during PICC line/TPN						
	care.							
	A facility policy, t	titled, "Parenteral Nutrition",						
	dated 9/1/16, and	received as current from the						
	Director of Nursin	ng, indicated all nursing staff						
		ing for a resident who received						
	TPN, would receiv	ve training and demonstrate						
		ding TPN nutrition to ensure						
	proper assessment	and monitoring of the						
	resident was comp	bleted. The TPN was to be						
	infused at the sam	e rate for 24 hours a day and						
	the bag and equip	ment were to be changed at						
	approximately the	same time each day. The TPN						
	solutions should b	e infused or discarded within						
	24 hours of the ad	ministration set being attached.						
	The TPN bags we	re to be stored in the						
	refrigerated until a	approximately one hour before						

						PRIN	TED: 12/29/2021
DEPARTMEN	F OF HEALTH AND HU	MAN SERVICES				FO	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. B	UILDING	00	COMPL	ETED
	155650		B. WING		12/09/2021		
NAME OF I	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RGINIA ST		
LINCOL	LINCOLNSHIRE HEALTH & REHABILITATION CENTER			MERRI	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)					DATE
	use and must be all	owed to come up to room					
	temperature natural	ly.					
	This Federal tag rel IN00368255.	ates to Complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete