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	04/06/2021

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00350572, IN00350747, and IN00350787. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00350572 - Substantiated. Federal/State deficiencies related to the allegations are cited at F759. Complaint IN00350747 - Substantiated. Federal/State deficiencies related to the allegations are cited at F678. Complaint IN00350787 - Substantiated. Federal/State deficiencies related to the allegations are cited at F759. Survey dates: April 5 & 6, 2021 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 25 Medicaid: 43 Other: 3 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The facility respectfully ask for paper compliance.	

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.

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	Quality review completed on 4/8/21.			
F 0678 SS=J Bldg. 00	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.			
	Based on record review and interview, the facility failed to provide continuous CPR (cardiopulmonary resuscitation) to a resident until EMS (Emergency Medical Services) arrived. The resident had an Advance Directive indicating the desire for CPR (full code status). The staff ceased CPR and canceled the EMS call after CPR was initiated for 7 minutes, without an order from the Resident's Physician, resulting in the death of a resident for 1 of 6 residents reviewed for Advanced Directives. The immediate jeopardy began on 3/30/21 when two RNs ceased CPR prior to EMS arriving at the facility and without a Physician's Order and the resident expired. The Administrator was notified of the immediate jeopardy at 8:55 a.m. on 4/6/21. The Immediate Jeopardy was removed on 4/6/21, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: Resident C's closed record was reviewed on 4/5/21 at 10:24 a.m. Diagnoses included, but were not limited to, cancer of the liver.	F 0678	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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident C expired. **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**	04/14/2021

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	A "State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order/Post Declination" form, indicated the resident had chosen to be a full code. The form was signed by the Social Service Director on 3/11/21 and indicated the person making the decision was the resident. An Admission Minimum Data Set assessment, dated 3/17/21, indicated the resident had an intact cognitive status. A Nurse's Note, dated 3/30/21 at 5:05 a.m. and documented on 3/30/21 at 3:16 p.m., indicated the resident had shallow respirations, CPR was initiated and EMS was notified. After seven minutes of CPR, there was no pulse or respirations and the CPR was stopped. A Nurse's Note, dated 3/30/21 at 5:30 a.m. and documented on 3/30/21 at 3:22 p.m., indicated the resident's spouse was notified of the death. A Nurse's Note, dated 3/30/21 at 6:45 a.m., indicated the Physician's Office was notified of the resident's death. The Notification of Death form, dated 3/30/21, indicated the time of death was 5:25 a.m. on 3/30/21. During a telephone interview on 4/5/21 at 12:20 p.m., RN 1 indicated she had just started the morning medication administration pass when RN 2 informed her she found the resident's pillow on the floor. They entered the room and RN 2 indicated the resident was not breathing. They started CPR, then she left the room to go to the Nurses' Station to call 911, RN 2 remained in the room and continued CPR. She then returned to		**will not recur?** All staff including RN 1 and RN 2 were in-serviced on the facility policy Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS). All staff were in-serviced on where to locate the CODE Status for each resident and continuing CPR until EMS arrives. 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 complete an investigation immediately, upon notification, for any death or code blue event to determine if the facility policy was followed regarding Advanced Directives for 6 months. The DON/designee will present a summary of the investigation 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.	

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the room and there was blood all over. The resident was bleeding from the mouth, nose, and rectum. RN 2 had informed her there were no respirations or pulse and directed her to cancel the EMS call. She then went back to the Nurses' Station and canceled the call. She and RN 2 had made the decision to stop the CPR.

During a telephone interview on 4/5/21 at 2:43 p.m., RN 2 indicated she was "checking" her residents, she saw Resident C's foot hanging down off the side of the bed. The resident was gasping for air. She informed RN 1 the resident "was not looking good." RN 1 then left the room to notify EMS and she started CPR. Blood "gushed out" of the mouth, nose, and anus with the first compression. She continued CPR. RN 1 returned to the room after calling EMS and assisted with the CPR. They called the TNA (Temporary Nursing Assistant) 3 in to assist. EMS had not arrived. CPR was administered for seven minutes and was stopped since he was no longer breathing. She indicated there was blood everywhere and TNA 3 assisted in caring for the resident. RN 2 was not sure who canceled EMS. She and RN 1 had both made the decision to stop the CPR due to the bleeding.

During a telephone interview on 4/5/21 at 2:49 p.m., TNA 3 indicated RN 1 had asked her go with her to check on the resident and to assist with incontinent care. He had a reddish/brown bowel movements. They started the care and he started breathing heavily. He then stopped breathing. RN 1 left the room to call EMS and RN 2 went to get oxygen. No CPR was initiated. Post-mortem care was provided and when he was turned on his side, blood came out of his mouth.

During a telephone interview on 4/6/21 at 8:17

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a.m., the resident's spouse indicated there had been an autopsy performed on the resident. She was notified by telephone of the resident's death and informed he had heavy breathing, had a bowel movement, and was bleeding. The nurse indicated when she had gone back into the room, he had passed. She and a family friend then spoke to the Director of Nursing and two nurses over the phone later in the day and was told there was blood coming from the resident's mouth and nose, a low pulse, and then CPR was initiated. One of the nurses called 911, and the other continued CPR. CPR was completed for seven minutes and there was no pulse. The CPR was stopped and the Nurse then canceled the EMS.

An Autopsy Report, received on 4/6/21 at 8:34 a.m. from the resident's spouse, indicated the autopsy was completed on 4/3/21. The findings included, a malignant mass of the liver and there had been no evidence of CPR being performed. The cause of death was a malignant tumor of the liver.

An Email, received from the County EMS and dated 4/6/21 at 9:57 a.m., indicated a call from the facility was received on 3/30/21 at 5:19 a.m. and a second call was received on 3/30/21 at 5:26 a.m.

An interview with the Director of Nursing (DON) on 4/6/21 at 0:08 a.m., indicated RN 1 was called to come back to the facility to document the events of the code. She indicated it was not the facility's protocol to stop the CPR before EMS arrived/ without a Physician's Order. She indicated there was no documentation the resident had been bleeding from the nose, mouth, and anus. All CPR events were investigated. RN 1 and RN 2 were interviewed but she had not interviewed TNA 3.

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There were 58 residents with Advance Directives indicating full code status residing in the facility.

A facility policy, dated 8/2008 and received from the DON as current, titled, "Cardiopulmonary Resuscitation [CPR] and Basic Life Support [BLS]", indicated if an individual was found unresponsive and without a pulse, a licensed staff person, who was certified in CPR/BLS, would initiate CPR unless there was a do not resuscitate (DNR) order. If there was not a DNR directive/order, CPR was to be initiated, a "code was to be called, and EMS were to be notified. The resident's Attending Physician and family were then to be notified.

The immediate jeopardy that began on 3/30/21 was removed on 4/6/21 when the facility reviewed the Advance Directives for all residents in the facility and placed all Advanced Directives in a binder on the CPR cart and ensured all Advance Directives were available in all the medical records. The facility educated 67 employees on the locations of the Advance Directives and initiating CPR for any resident with an Advance Directive indicating CPR or in the event the Advance Directive could not be found, Advance Directives and CPR were to be continued until EMS arrived at the facility, and notification of the DON/designee if CPR was initiated or a death occurred. The Administrator/or designee will continue to educate the remaining staff prior to the start of their next scheduled shift. The facility also initiated protocols for the DON/designee to investigate any death or CPR event immediately to ensure the facility policy was followed for Advance Directives. The Social Service Director/designee will audit the locations of the Advance Directives weekly. The noncompliance

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	remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because not all staff had been inserviced and monitoring of the implemented systems was ongoing. This Federal tag relates to Complaint IN00350747.			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 7 residents observed during medication pass administration. Four errors in medications were observed during 25 opportunities for errors in medication administration. This resulted in a medication error rate of 16%. (Residents M and T) Findings include: 1. On 4/5/21 at 10:47 a.m., LPN 1 was observed preparing Resident M's medication. She prepared sodium bicarbonate (an antacid) 650 mg (milligrams) 1 capsule. She then administered the medication to the resident. Resident M's record was reviewed on 4/5/21 at 11:45 a.m. The Medication Administration Record (MAR) indicated the resident was to receive sodium bicarbonate four times daily at 9:00 a.m., 1:00 p.m., 5:00 p.m. and 9:00 p.m. The medication observed had been signed out as administered on time at 9:00 a.m. There was no documentation the	F 0759	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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident M had no adverse outcomes related to medication administration. A medication error/discrepancy report was completed for resident M. The family and physician were notified. Resident T had no adverse outcomes related to medication administration. A medication	04/14/2021

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	medication was given late or the Physician was notified. 2. On 4/5/21 at 10:53 a.m., LPN 1 was observed preparing Resident T's medications, which included Risperdone (an antipsychotic) 0.5 mg tablet, Vimpat (an anticonvulsant) 100 mg tablet, and Keppra (an anticonvulsant) 500 mg tablet and 750 mg tablet. She then administered the medications to the resident. Resident T's record was reviewed on 4/5/21 at 11:50 a.m. The MAR indicated the resident was to receive Risperdone, Vimpat and Keppra twice daily at 9:00 a.m. and 5:00 p.m. The MAR indicated the medications observed had been signed out at 11:01 a.m., and noted as given on time, charted late. There was no documentation the Physician had been notified of the late administration. The policy, "Medication Administration Policy", dated March 2014, was received from the Regional Director on 4/6/21 at 9:40 a.m. The policy indicated, "...15. Medications shall be administered one (1) hour before/after of the medication schedule unless specifically ordered otherwise...." Interview with LPN 1 on 4/5/21, indicated the medications for the residents were late because she had to reapproach them due to previous refusals. Late medications should be noted in the resident's record and the Physician should be notified. This Federal tag relates to Complaints IN00350572 and IN00350787. 3.1-48(c)(1)		error/discrepancy report was completed for resident T. The family and physician were notified. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents with medication orders 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?** Licensed nurses including LPN 1 were educated on the policy titled Medication Administration with the focus being time frame of administering medications according to the 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 observe 2 nurses administer medications weekly for 6 months to ensure residents receive medications on time and as ordered. The DON/designee will present a summary of the audits to the Quality Assurance committee	

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			monthly for 3 months. Thereafter, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.	