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	01/04/2022

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

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F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00369248 and IN00369727. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00369248 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00369727 - Unsubstantiated due to lack of evidence. Unrelated deficiency is cited. Survey dates: January 3 & 4, 2022 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 16 Medicaid: 51 Other: 7 Total: 74 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/6/22.	F 0000	/b>	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure care was provided in accordance with profession standards of practice, related to medications not administered as ordered for 1 of 7 residents reviewed for quality of care. (Resident 3) Finding includes: During an interview on 1/3/22 at 9:43 a.m., Resident 3 indicated the facility had changed the time of his eye drops and medications and now some of them were to be given in the early morning by the night shift nurse. He indicated LPN 1 had not given him his medications as ordered. He had reported the concerns to the Administrator and he has still not received his medications and eye drops in the early morning. During an interview on 1/4/21 at 9 a.m., Resident 3 indicated he again had not received his medications and eye drops that morning. Resident 3's record was reviewed on 1/4/22 at 11:21 a.m. The diagnoses included, but were not limited to, glaucoma, end stage renal disease, and chronic obstructive lung disease (COPD). A Quarterly Minimum Data Set assessment, dated 12/8/21, indicated his cognitive status was intact and had no behaviors.	F 0684	F684 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. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R3 had no adverse outcomes related to medication administration. A medication error/discrepancy report was completed for R3. R3's physician and family were notified. R3's medication times have been revised. How will the facility identify other residents having the potential to be affected by the same deficient practice?	01/11/2022

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	A Care Plan, dated 12/5/21 and 12/13/21, indicated at times he refuses to take medications. The interventions included education would be provided on the risks and consequences of refusing care. A Care Plan, dated 7/9/21 and 12/9/21, indicated there was impaired vision related to glaucoma and left corneal ulcer. An intervention, dated 7/9/21, indicated medications would be administered at appropriate times and in the appropriate order. A Care Plan, dated 7/5/21 and 12/9/21, indicated there was a risk for complications related to COPD. the interventions included activity tolerance would be assessed. The Physician's Orders, included: On 8/5/21, pantoprazole (stomach medication) 40 milligrams (mg) daily at 6 a.m. On 7/2/21, combivent Respimat (breathing medication) one puff, four times a day at 6 a.m., 1 p.m., 5 p.m., and 9 p.m. On 11/16/21, famotidine (stomach medication), 20 mg twice a day at 6 a.m. and 5 p.m. Also, Artificial tears (dry eyes) one drop into both eyes four times a day at 6 a.m., 1 p.m., 5 p.m., and 9 p.m. On 11/18/21, brimonidine eye drops (to decrease the pressure with glaucoma), one drop both eyes three times a day at 6 a.m., 1 p.m., and 9 p.m. The Medication Administration Record (MAR), dated 12/2021, indicated by a lack of initials on the MAR, the pantoprazole, combivent Respimat, famotidine, artificial tears, and brimonidine eye drops were not administered as ordered at 6 a.m.		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 were educated on the policy titled Medication Administration with the focus being: • Timely medication administration • Documentation of any medication refusal and reason for refusal • Documentation in MATRIX EMAR for any medication given and or refused 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 monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done	

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	on December 9, 10, 15, 18, 20, 21, 22, 23, 24, 27. 28, 29, and 31, 2021. The MAR, dated 1/2022, indicated by a lack of initials on the MAR, the pantoprazole, combivent Respimat, famotidine, artificial tears, and brimonidine eye drops were not administered as ordered at 6 a.m. on January 1, 3, and 4, 2021. Review of Resident 3's roommate's MARs for December 2021 and January 2022, indicated LPN 1 had administered the early morning medications to the roommate on the above dates. The Nurses' Progress Notes were reviewed for December 9 through December 31, 2021 and January 1 through January 4, 2022. There was no documentation that indicated Resident 3 had refused the 6 a.m. medications. A facility Grievance Form from Resident 3, dated 12/17/21, indicated on 12/15/21 on midnights, LPN 1 refused to give the 6 a.m. eye drops and he does not care for the nurse. During the investigation of the grievance, LPN 1 indicated the resident would refuse the eye drops and the resident would, "give her a hard time." The Administrator spoke with the resident on 12/21/21, and he agreed to let LPN 1 take care of him if another nurse was not working on the shift. During an interview on 1/4/22 at 1:05 p.m., LPN 1 indicated since he had voiced the grievance, she was not to take care of the resident if another nurse was available to care for him. The other nurses knew they had to give the resident his medications.		quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date of Completion: 01/11/2022	

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	A facility policy, dated 10/25/14, titled, "Medication Administration", was received from the Corporate RN. The policy indicated medications were to be administered as prescribed in accordance with good nursing principles and practices. Medications were to be administered in accordance with the written orders of the prescriber. The resident's MAR was to be initialed by the person who administered the medication in the space provided. If the medication was withheld or refused, an explanatory note was to be entered on the MAR. 3.1-37			