

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00125407 and IN00129251.</p> <p>Complaint IN00125407- Substantiated. Federal/state deficiency related to the allegations is cited at F323.</p> <p>Complaint IN00129251- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: May 20 & 21, 2013</p> <p>Facility number: 000577 Provider number: 155650 AIM number: 100266950</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 72 Total: 72</p> <p>Census payor type: Medicare: 11 Medicaid: 53 Other: 8</p>	F000000		
---------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Total: 72</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 29, 2013, by Brenda Meredith, R.N.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F000223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview the facility failed to ensure resident's remained free of verbal abuse from CNA related to a substantiated allegation of verbal abuse voiced by a resident related for 1 of 1 allegations of verbal abuse reviewed. (Resident #G) (CNA #1)</p> <p>Finding includes:</p> <p>A completed Facility Incident Report Form related to an allegation of verbal abuse voiced by Resident #G was reviewed on 5/21/13 at 2:30 p.m. The form indicated the allegation occurred on 3/3/13 at 11:30 a.m. The form indicated Resident #G made an allegation of CNA #1 being verbally abusive to him while providing care to him. The report indicated the CNA was sent home and an investigation was started.</p> <p>Therapy Staff #1 provided statements she heard while providing care to</p>	F000223	<p>F223</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified: As stated in 2567, the CNA was suspended pending investigation and terminated.</p> <p>2) How the facility identified other residents:</p>	06/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Resident #G's roommate during the time CNA #1 was providing care to Resident #G. The statements made by CNA #1 and Resident #G included:</p> <p>Resident #G- "wring that cloth out, there is too much water" CNA #1- "I thought you said you weren't going to give me a hard time today." Resident #G- "this is my surgery side... wring out the water" CNA #1- "this is why nobody...." The report indicated the Therapy Staff indicated she did not hear the end well enough to repeat but was something to the effect of why nobody wants to work with you or put up with you. Resident #G- "how would you like it if someone stuck wet washcloth in your ear" CNA #1- "that is it, I am done" and the CNA left the room.</p> <p>Social Service staff also interviewed the resident on 3/3/13. Documentation of the interview indicated Resident #G indicated CNA #1's told him "just shut the h___ up" and "I don't want to give you a bath because you are a winny a__."</p> <p>The facility's investigation also included interview with other residents</p>		<p>Interviews were completed with interviewable residents, and no issues were noted.</p> <p>3) Measures put into place/ System changes:</p> <p>Facility management will interview 2 residents per week regarding staff treatment.</p> <p>The administrator will be responsible for oversight of these audits.</p> <p>Staff will be re-educated on abuse as indicated.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in monthly Quality Assurance meeting monthly x3 months, then quarterly x1 or until compliance is 80% or greater for 3 consecutive months.</p> <p>5) Date of compliance: 6/17/13</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>on the unit that CNA #1 would have cared for. The interviews did not indicate there were any complaints or concern noted.</p> <p>When interviewed on 5/21/13 at 3:00 p.m., the facility Administrator indicated residents on unit were interviewed. The Administrator indicated the CNA was suspended at the time of the allegation and did not return to work. The Administrator indicated the allegation of verbal abuse was substantiated at the time the interviews were written on 3/3/13, and the CNA was terminated on 3/7/13, for substantiated verbal abuse.</p> <p>3.1-27(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, record review</p>	F000225	F225	06/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>and interview, the facility failed to ensure an allegation of physical abuse was thoroughly investigated related to the lack of interviewing a resident and staff on all shifts and completing a physical assessment of the identified resident for 1 of 2 abuse allegations reviewed. (Residents #F and #G) (CNA #1)</p> <p>Finding includes:</p> <p>On 5/21/13 at 10:00 a.m., Resident # F was observed in bed. The resident was awake and his television was on.</p> <p>On 5/21/13 at 10:00 a.m., Resident #G was observed in bed in his room. Resident #G shared a room with Resident #F.</p> <p>A Facility Incident Reporting Form for an incident which had occurred on 3/13/13, was reviewed on 5/21/13 at 8:00 a.m. The form indicated Resident #F and Resident #G were identified as the residents involved. The form indicated Resident #F and Resident #G resided in the same room. A "Description of Incident" section indicated Resident #G reported to a CNA that an employee that used to work at the facility was fondling his roommate at night.</p>		<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #F was interviewed and statements obtained from staff working midnight shift during the time frame of allegation. Psychosocial assessment was completed for Resident #F.</p> <p>2) How the facility identified other residents:</p> <p>Review of abuse allegations in last 30 days to ensure investigations were complete and assessments were performed as indicated.</p> <p>3) Measures put into place/</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>Resident #G reported that he was woken up by his roommate (Resident #F) saying "...that's enough, stop it." Resident #G reported he looked over and saw CNA #1 fondling Resident #F. Resident #G reported to staff the above happened "...a while ago, maybe a month ago." Resident #G indicated he was just now reporting the incident because he had forgotten about it. The report also indicated the CNA named as the employee no longer worked at the facility. The report also indicated Resident #F was aphasic (unable to verbalize) and was unable to be interviewed for the investigation.</p> <p>Immediate Action listed on the Reporting Form indicated staff and resident interviews were started. Staff and resident interviews showed no one had witnessed any inappropriate touching or had been inappropriately touched. The report indicated the allegation could not be substantiated. The staff and resident interviews were provided with the investigation of the report. There was no documented interview from the CNA who first reported the allegation made by Resident #G as written in the above report.</p> <p>The facility investigation included</p>		<p>System changes:</p> <p>Interdisciplinary Team will be re-educated regarding requirements of abuse allegation investigations.</p> <p>Abuse allegations will be reviewed by the Interdisciplinary Team prior to 5 day follow up report being sent to ensure investigations and assessments are complete.</p> <p>The Executive Director is responsible for the oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in the monthly Quality Assurance meeting for 3 months, then quarterly x1 or until compliance is 100% for 3 consecutive months.</p> <p>5) Date of compliance: 6/17/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>interviews with other residents and staff members. A total of five residents were interviews were reviewed. The interviews indicated no residents reported any concerns with care provided by CNA's. The facility investigation also included interviews from three staff members. The staff members included two CNA's and a LPN. There was no interview obtained from Resident #F.</p> <p>The record for Resident #G was reviewed on 5/21/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, anxiety disorder, vascular dementia, high blood pressure, and chronic airway obstruction. The 3/23/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 12. This indicated the resident's cognitive patterns were moderately impaired.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 3/13/13, indicated the resident exhibited behaviors of filing unsubstantiated false accusations about staff. Care plan interventions included for two staff members to be present when care was provided to the resident.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>The record for Resident #F was reviewed on 5/21/13 at 9:30 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, aphasia, and anemia.</p> <p>The 2/2013 and 3/2013 Social Service Progress Notes were reviewed. The following entries were noted:</p> <p>2/8/13 at 10:16 a.m. The resident was observed in his his room during breakfast and the resident started to cry when asked if he was feeling OK. The resident said yes when asked if when asked if it was because his sons and also said yes when asked if he was missing his two sons.</p> <p>2/15/13 at 2:51 p.m. The staff spoke with the resident earlier in the day about wanting to visit his sons and the resident said yes.</p> <p>2/19/13 at 1:35 p.m. The staff met with the resident and the resident shook his head no when asked if he was doing OK.</p> <p>3/1/13 at 2:27 p.m. The resident was observed in the Dining Room at lunch with tearfulness. The resident was not willing to speak with the writer at this time and continued with his meal.</p> <p>3/13/13 at 10:25 a.m.-The resident was seen by the Nurse Practitioner and new orders were obtained related</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>laboratory levels. There was no documentation of the resident being interviewed related the allegation made by the resident roommate on this date.</p> <p>The 3/13/2013, Nursing Progress Notes were reviewed. There was no documentation of a physical assessment of the resident.</p> <p>The 3/14/2013, Nursing Progress Noted were reviewed. An entry made at 9:23 a.m. indicated the resident was observed in bed eating breakfast. The resident was asked by staff if he needed anything and he shook his head "no." There was no physical assessment of the resident in the Progress Note. There was no documentation of the staff interviewing the resident related to the allegation made by his roommate this day.</p> <p>When interviewed on 5/21/13 at 2:00 p.m., the facility Administrator indicated Resident #F had a diagnosis of aphasia but could respond to yes and no questions appropriately. The Administrator indicated the staff should have attempted to interview the resident on 3/13/13, and a physical assessment of the resident should have been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>completed related to the allegation reported by the resident's roommate on 3/13/13. The facility Administrator also indicated the three staff members who were interviewed all worked the day or evening shifts. The Administrator indicated Resident #G's allegation indicated the alleged event occurred on the night shift and a night shift staff member probably should have been interviewed during the investigation. The Administrator indicated he could not locate an interview from the CNA who is listed in Reporting Form.</p> <p>3.1-28(d)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the facility Abuse Policy was implemented regarding the lack of a thorough investigation of an allegation of abuse including the lack of completion of a physical assessment of and the lack of an interview with the resident identified as allegedly being abused by a CNA. The facility also failed to obtain interviews from staff members who worked on shifts the abuse was reported to have occurred on for 1 of 2 allegations reviewed. (Residents #F and #G) (CNA #1)</p> <p>Finding includes:</p> <p>A Facility Incident Reporting Form for an incident which had occurred on 3/13/13, was reviewed on 5/21/13 at 8:00 a.m. The form indicated Resident #F and Resident #G were identified as the residents involved. The form indicated the Resident #F and Resident #G resided in the same room. A "Description of Incident"</p>	F000226	<p>F226</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #F was interviewed and statements obtained from staff working midnight shift during the time frame of allegation. Psychosocial assessment was completed for Resident #F.</p> <p>2) How the facility identified other residents:</p>	06/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>section indicated Resident #G reported to CNA that an employee that used to work at the facility was fondling his roommate at night. Resident #G reported that he was woken up by his roommate (Resident #F) saying "...that's enough, stop it." Resident #G reported he looked over and saw CNA #1 fondling Resident #F. Resident #G reported to staff the above happened "...a while ago, maybe a month ago." Resident #G indicated he was just now reporting the incident because he had forgotten about it. The report also indicated the CNA named as the employee no longer worked at the facility. The report also indicated Resident #F was aphasic (unable to verbalize) and was unable to be interviewed for the investigation.</p> <p>Immediate Action listed on the Reporting Form indicated staff and resident interviews were started. Staff and resident interviews showed no one had witnessed any inappropriate touching or had been inappropriately touched. The report indicated the allegation could not be substantiated.</p> <p>The facility investigation included interviews with other residents and staff members. A total of five resident</p>		<p>Review of abuse allegations in last 30 days to ensure investigations were complete and assessments were performed as indicated.</p> <p>3) Measures put into place/ System changes:</p> <p>Interdisciplinary Team will be re-educated regarding requirements of abuse allegation investigations.</p> <p>Abuse allegations will be reviewed by the Interdisciplinary Team prior to 5 day follow up report being sent to ensure investigations and assessments are complete.</p> <p>The Executive Director is responsible for the oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in the monthly Quality Assurance meeting for 3 months, then quarterly x1 or until compliance is 100% for 3 consecutive months.</p> <p>5) Date of compliance: 6/17/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>interviews were reviewed. The interviews indicated no residents reported any concerns with care provided by CNA's. The facility investigation also included interviews from three staff members. The staff members included two CNA's and a LPN. There was no interview obtained from Resident #F. There was no documented interview from the CNA who first reported the made by Resident #G as written in the above report.</p> <p>The record for Resident #G was reviewed on 5/21/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, anxiety disorder, vascular dementia, high blood pressure, and chronic airway obstruction. The 3/23/13, Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 12. This indicated the resident's cognitive patterns were moderately impaired.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 3/13/13, indicated the resident exhibited behaviors of filing unsubstantiated false accusations about staff. Care plan interventions included for two staff members to be</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>present when care was provided to the resident.</p> <p>The record for Resident #F was reviewed on 5/21/13 at 9:30 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, aphasia, and anemia.</p> <p>The 2/2013 and 3/2013, Social Service Progress Notes were reviewed. The following entries were noted: 2/8/13 at 10:16 a.m. The resident was observed in his his room during breakfast and the resident started to cry when asked if he was feeling OK. The resident said yes when asked if when asked if it was because his sons and also said yes when asked if he was missing his two sons. 2/15/13 at 2:51 p.m. The staff spoke with the resident earlier in the day about wanting to visit his sons and the resident said yes. 2/19/13 at 1:35 p.m. The staff met with the resident and the resident shook his head no when asked if he was doing OK. 3/1/13 at 2:27 p.m. The resident was observed in the Dining Room at lunch with tearfulness. The resident was not willing to speak with the writer at this time and continued with his meal. 3/13/13 at 10:25 a.m.-The resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>was seen by the Nurse Practitioner and new orders were obtained related laboratory levels. There was no documentation of the resident being interviewed related the allegation made by the resident roommate on this date.</p> <p>The 3/13/2013, Nursing Progress Notes were reviewed. There was no documentation of a physical assessment of the resident.</p> <p>The 3/14/2013, Nursing Progress Noted were reviewed. An entry made at 9:23 a.m. indicated the resident was observed in bed eating breakfast. The resident was asked by staff if he needed anything and he shook his head "no." There was no physical assessment of the resident in the Progress Note. There was no documentation of the staff interviewing the resident related to the allegation made by his roommate this day.</p> <p>When interviewed on 5/21/13 at 2:00 p.m., the facility Administrator indicated Resident #F had a diagnosis of aphasia but could respond to yes and no questions appropriately. The Administrator indicated the staff should have attempted to interview the resident on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>3/13/13, and a physical assessment of the resident should have been completed related to the allegation reported by the resident's roommate on 3/13/13. The facility Administrator also indicated the three staff members who were interviewed all worked the day or evening shifts. The Administrator indicated Resident #G's allegation indicated the alleged event occurred on the night shift and a night shift staff member probably should have been interviewed during the investigation. The Administrator indicated he could not locate an interview from the CNA who is listed in Reporting Form.</p> <p>The facility policy titled "Abuse, Neglect, and Misappropriation of Resident Property" was received from the facility Administrator on 5/21/13 at 1:45 p.m. The Administrator identified the policy as current. The policy had a current version date of 01/2012.</p> <p>The policy indicated the purpose of the policy was to ensure resident rights are protected by providing a method to investigate and report allegations of mistreatment, neglect, abuse, injuries of unknown origin, and occurrences of misappropriation of property.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The policy indicated alleged violations were to be thoroughly investigated and evidence of the investigation was kept. The policy indicated all resident's were to be assessed by a licensed nurse immediately upon notification of the the alleged abuse.</p> <p>3.1-26(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to alarms not turned on, beds left in a high position, and floor mats on the on one side of the bed for 2 of 3 residents reviewed for falls in the sample of 11. (Residents #C & #D)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 5/20/13 at 9:20 a.m., Resident #D was observed in bed. A floor mat was in place next to the bed on the resident's left side. This was the side closest to the room entrance door.</p> <p>On 5/20/13 at 9:55 a.m., the resident was in laying in bed on his right side facing the window. There were no staff members or visitors in the room. A floor mat was in place on the left side of the bed. There was no floor mat in place on the right side of the bed.</p>	F000323	<p>F323</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>As stated in the 2567, Resident #C & #D bed alarms were turned on, Resident #D bed was placed in low position and floor mat was placed on right side of bed.</p> <p>2) How the facility identified other residents:</p>	06/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>On 5/21/13 at 7:45 a.m., the resident was observed in bed. The resident's bed was in a high level position. The resident was not receiving care at this time.</p> <p>On 5/21/13 at 8:40 a.m., the resident was observed in bed. The resident's bed was in the low level position. There were no staff members or visitors in the room. There was a white alarm box attached to the bed frame. A cord was attached to the box and the other end of the cord was attached to a pad under the resident's bed sheet. The switch on the box was in the "off" position. QMA #1 entered the resident's room at 8:42 a.m. The QMA checked the resident's alarm box and the alarm box was in the "off" position. The QMA then pushed the on/off button to the "on" position and the alarm started beeping. The QMA then indicated the alarm button had been in the "off" position.</p> <p>The record for Resident #D was reviewed on 5/20/13 at 3:40 p.m. The resident's diagnoses included, but were not limited to, aphasia, congestive heart failure, high blood pressure, and atrial fibrillation (an irregular heart rhythm).</p>		<p>Residents with safety devices will be reviewed to determine appropriateness and presence of devices.</p> <p>3) Measures put into place/ System changes:</p> <p>Nursing staff will be re-educated regarding safety interventions, including ensuring that beds are placed in lowest position after providing care and ensuring safety devices are in place and functioning every shift.</p> <p>Random observations will be completed on varied shifts for at least 5 residents identified as fall risk per week to ensure safety devices are in place and beds are in low position.</p> <p>The DNS/designee will be responsible for oversight of these audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in the Quality Assurance meeting monthly for 3 months, then quarterly x1 or until compliance is above 80% for 3 consecutive months.</p> <p>5) Date of compliance: 6/17/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The 3/28/13, Minimum Data Set (MDS) admission assessment indicated the resident's cognitive skills for decision making were impaired and the resident rarely or never understood.</p> <p>Review of the 4/2013 Nursing Progress Notes indicated a entry was made on 4/19/13 at 7:30 p.m. The entry indicated the resident was observed 1/2 way out of his bed with his feet on the floor, his upper body on the bed, and the resident was hanging onto the side rail. The resident was assessed and no injuries were noted. The entry also indicated the Physician was notified and an order for the resident to have a bed alarm was received.</p> <p>A Care Plan Progress Note was completed on 4/25/13 at 12:22 p.m. The note indicated the IDT (Inter-Disciplinary Team) met and interventions were for the resident to have a mat to the floor and a bed alarm in place.</p> <p>The CNA Assignment Sheet for Resident #D was received from the Assistant Director of Nursing on 5/21/13 at 8:50 a.m. The Assignment Sheet indicated Resident #D was to have a bed alarm and floor mat in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>place.</p> <p>When interviewed on 5/21/13 at 8:50 a.m., the Assistant Director of Nursing indicated the floor mat is to be placed on the side the resident "favors". The Assistant Director of Nursing indicated Resident #D favors the right side and the floor mat was to be on the right side. The Assistant Director of Nursing also indicated the resident was to have a bed alarm in place.</p> <p>2. On 5/21/13 at 8:55 a.m., Resident #C was observed sitting on the side of the bed with her legs dangling down. There was a white alarm box attached the bed frame. There were no staff members or visitors in the resident's room at this time.</p> <p>On 5/21/13 at 8:56 a.m., LPN #2 entered the resident's room. The resident was still sitting on the side of the bed with her legs dangling down. LPN #2 checked the resident's alarm box. The alarm box was in the "off " position.</p> <p>The record for Resident #C was reviewed on 5/20/13 at 11:45 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, end stage renal disease,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>depressive disorder, and diabetes mellitus.</p> <p>The 4/23/13, Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Cognitive Status) score was (11). This indicated the resident's cognitive patterns were moderately impaired. The MDS assessment also indicated the resident required the assistance of staff for transferring and toileting. The assessment also indicated the resident had a fall since the last prior assessment or admission.</p> <p>A care plan initiated on 11/5/12 indicated the resident was at risk for falls characterized by a history of falls/injury, multiple fall risks, unsteady gait, and impaired vision. The care plan was last updated on 5/15/13. A chair alarm was added as an intervention on 5/13/13. A bed alarm was initiated as an intervention on 5/15/13.</p> <p>The 3/2013 Nursing Progress Notes were reviewed. An entry made on 3/4/13 at 11:17 p.m. indicated the resident had fallen. The note indicated the resident stated she stumbled while trying to use the washroom. There was no</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/21/2013	
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>documentation of any injury. The Physician was notified.</p> <p>A Care Plan Progress note was made on 3/6/13 at 3:58 p.m. The note indicated the IDT met to discuss the resident's fall which had occurred on 3/4/13. The note indicated the resident did not sustain any injury. The note also indicated the resident was attempting to use the washroom and did not use her call light to call for assistance.</p> <p>The 5/2013 Nursing Progress Notes were reviewed. An entry made on 5/12/13 at 9:50 p.m. indicated the resident was found on the floor in her room by a CNA. The resident was interviewed by the Nurse at this time and indicated she was coming from the bathroom. The resident was assisted to be and assessed by the Nurse. The Physician was notified of the fall.</p> <p>Review of a 5/13/13, Care Plan Progress Note indicated the IDT team met to review the recent fall. The note indicated the resident reported she leaned forward in her wheel chair to pick up a brief.</p> <p>When interviewed on 5/21/13 at 8:56 a.m., LPN #2 indicated the resident's</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>alarm box should have been turned on.</p> <p>This federal tag relates to Complaint IN00125407.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			