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

FORM APPROVED
OMB NO. 0938-039

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	11/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00393439. Complaint IN00393439 - Substantiated. Federal/state deficiencies related to the allegations are cited at F622, F624, F689, and F921. Survey date: 11/7/22 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 21 Medicaid: 49 Other: 6 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/10/22.	F 0000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully request paper compliance.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rita Gatson	Administrator	11/18/2022

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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	the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F)			

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	of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on record review and interview, the facility	F 0622	**F 622 Transfer and Discharge**	11/18/2022

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	failed to ensure a Notice of Transfer form was completed accurately for a resident who had been transferred to the Hospital for 1 of 3 residents reviewed for Notice of Transfer. (Resident C) Finding includes: Resident C's record was reviewed on 11/7/22 at 9:55 a.m. The diagnoses included, but were not limited to, stroke and hemiplegia of the right side. A Nurse's Progress Note, dated 10/15/22 at 3:33 p.m., indicated a family member had called 911 for the resident to be transferred an Emergency Room. A Notice of Transfer or Discharge form, dated 10/15/22, indicated the resident had been transferred to a private residence. The reason for the transfer or discharge indicated the resident had improved sufficiently and no longer needed the services provided by the nursing facility. During an interview on 11/7/22 at 2:24 p.m., The Medical Records Clerk indicated she had sent the notice to the resident's responsible party. She had been informed by the Unit Manager the family would not indicate what Hospital they were transferring him to, so she didn't know what address of the facility to document and used the home address instead of indicating he went to another health facility. This Federal tag relates to Complaint IN00393439. 3.1-12(a)(9) .		**Requirements** 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(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility notice of transfer discharge was corrected with the accurate transfer destination and mailed to the responsible parties for Resident C. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed staff and H.I.M. were re-educated on ensuring the facility notice of transfer discharge is accurate prior to resident transfer and mailing to the responsible party. **How the corrective action(s)**	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit all resident transfer/discharge weekly to ensure the facility notice of transfer discharge is accurate prior to resident transfer and mailing to the responsible party. The Administrator/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 quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to ensure a safe and orderly transfer for a resident who was transferred to the hospital Emergency Room, related to a transfer form with information about the resident's care not sent with the resident for 1 of 3 residents reviewed for transfers to the hospital. (Resident C)	F 0624	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.	11/18/2022

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	Finding includes: Resident C's record was reviewed on 11/7/22 at 9:55 a.m. The diagnoses included, but were not limited to, stroke and hemiplegia of the right side. A Nurse's Progress Note, dated 10/15/22 at 3:33 p.m., indicated a family member had called 911 for the resident to be transferred an Emergency Room. A Resident Grievance/Complaint Form, dated 10/15/22, indicated a family member was upset they had found the resident sitting on the floor on a mat and had smeared feces on him. Actions taken indicated the staff had cleaned the resident due to pulling the brief off and he had gotten out of bed and was sitting on the floor mat. A typed statement, signed by Employee 1, dated 10/15/22, indicated a family member had arrived around 2 p.m. and found the resident sitting on the floor on a mat. There were three staff members in the room. The family member called 911 so the resident could be transferred to the hospital. Employee 1 was interviewed on 11/7/22 at 11:26 a.m., and indicated a Transfer Form was not sent with the resident to the hospital. She indicated the family member wanted nothing to do with the employees. The EMS had not asked for any transfer forms nor asked the staff any questions. This Federal tag relates to Complaint IN00393439. 3.1-12(a)(21)		**F 624 Preparation for Safe/Orderly Transfer/Discharge** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C has discharged from the facility. The facility has mailed the resident’s Continuity of Care Document from MATRIX EMR. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed staff were in-serviced on sending the following with any transfer to the hospital and documenting documents given in the MATRIX EMR. · MATRIX Continuity of Care Document · Notice of Transfer · Interact Transfer form **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put**	

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			into place; The Director of Nursing/designee will audit progress notes weekly on all residents that were sent to the hospital to ensure there is documentation that the resident was sent with Interact Nursing Home to Hospital Transfer Form, Notice of Transfer, and the Continuity of Care document at the time of transfer to the hospital. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to complete follow up assessments after a resident fall, investigate the circumstances of why a resident who was a fall risk was found on the floor, and assess the resident for injuries due to	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those**	11/18/2022

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	another possible fall, for 1 of 3 residents reviewed for accidents. (Resident C) Finding includes: Resident C's record was reviewed on 11/7/22 at 9:55 a.m. The diagnoses included, but were not limited to, stroke and hemiplegia of the right side. An Admission Fall Risk Assessment, dated 10/13/22, indicated a high risk for falls. An Admission Mental Status Assessment, dated 10/14/22, indicated a severely impaired cognitive status. A Care Plan, dated 10/14/22, indicated a risk for falls. The interventions included, a floor mat was to be placed on the open side of the bed, well maintained footwear was to be provided, and the call light was to be within in reach. The Nurses' Progress Notes indicated the following: At 10/14/22 at 11:57 p.m., the resident was found lying on the right side with both legs bent on the floor in the room. The resident had stated he slid out of the bed. The assessment indicated no additional bruising, skin tears, or lacerations. He had indicated he had not hit his head. There was full passive range of motion to the upper and lower extremities. There was no external rotation or shortening of the lower extremities. He denied pain. The Physician and Responsible party had been made aware and three staff members had assisted him back to bed. A mat was placed on the side of the bed, the bed was placed in low position, and the call light was placed within reach.		**residents found to have been affected by the deficient practice;** Resident C has discharged from the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed staff were in-serviced on ensuring all appropriate assessments and investigations are completed after every fall. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will review all falls weekly for 6 months to ensure all appropriate assessments and investigations are completed after every fall. The Director of Nursing/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	

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	At 10/15/22 at 2:28 p.m. (next documentation in the Nurses' Progress Notes), indicated the resident was not easily re-directed while care was being completed by staff. At 10/15/22 at 3:33 p.m., a family member had called 911 for the resident to be transferred an Emergency Room. Vital signs had been obtained on 10/15/22 at 12:35 p.m. without further assessment for injuries due to an unwitnessed fall. A Resident Grievance/Complaint Form, dated 10/15/22, indicated a family member was upset they had found the resident sitting on the floor on a mat and had smeared feces on him. Actions taken indicated the staff had cleaned the resident due to pulling the brief off and he had gotten out of bed and was sitting on the floor mat. A typed statement, signed by Employee 1, dated 10/15/22, indicated the Midnight Nurse had informed her the resident had climbed out of bed numerous times during the shift and because of this a floor mat was placed on the floor. A family member had arrived at the facility about 2 p.m. The resident had been receiving care by three staff members and the family member had demanded the care be stopped and wanted to know why the resident was on the mat located on the floor. The family member would not allow the care to be completed and the family member called 911 so the resident could be transferred to the hospital. A typed statement, signed by Employee 2, dated 10/15/22, indicated a family member had confronted them about the resident being on the floor and it was explained the resident falls out of		and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	bed and the mat was placed to protect the resident from injury. The family member then notified 911 for a transfer to the hospital. There was no documentation in the record to indicate the resident had been found on the floor mat. There had been no assessment of the resident after being found on the floor mat. During an interview on 11/7/22 at 11:26 a.m., Employee 1 indicated they received in report the resident had been attempting to get out of bed throughout the night. The bed had been in the lowest position and he would move from the bed to the floor mat. When a family member entered the resident's room, they had found the resident on the mat and requested that staff stop providing care to the resident. Right before the family member entered the room, the staff were in the room. They had shut the door and were obtaining supplies so care could be provided. The resident was covered in feces and had been incontinent of urine. The family member was upset and finally had agreed to let staff clean the resident up. The family member requested Employee 1 to "get out" of the room. The incident had not been documented. She had been in the room approximately around noon and administered medication and obtained vital signs and the resident was in bed and the bed was in the lowest position. She indicated Employee 2 assisted another employee with the care, but could not remember who the other employee was. Employee 2 was interviewed on 11/7/22 at 11:50 a.m., and indicated another CNA had been taking care of the resident. The resident was on a mat on the floor when they entered the room to assist the other employee. The family member then entered the room and voiced they had not wanted the			

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	staff to touch the resident. They were upset. The family member allowed he care to be provided. Care was provided prior to the EMS (Emergency Medical System) arriving. The family member would not allow the staff to assist the resident off the floor. Employee 2 had not been in the resident's room prior to this incident. Employee 3 was interviewed on 11/7/22 at 11:55 a.m. and indicated the resident was not on her assignment and she had not taken care of the resident. Agency Employee 4 was interviewed on 11/7/22 at 11:58 p.m. and indicated the CNA had reported to her on 10/14/22 at 11:57 p.m. that the resident had been found on the floor. He was assessed and had no injuries and was assisted back to bed. The bed had been placed in the low position and a mat was placed on the floor as an intervention due to the slide out of the bed. After he had been assisted back to bed, he went to sleep. He had not been attempting to get out of bed. After the fall she had attempted to call the Responsible Party, there had been no answer, and she had not left a voicemail. Agency Employee 5 was interviewed on 11/7/22 at 12:18 p.m., and indicated the resident was not on her assignment and was unsure of the CNA's name who was assigned to him. She indicated when she entered his room, he was on the floor and had feces and urine on him. She indicated she had not been one of the employees who assisted in the care and was unsure of the names of the employees who did provide the care to him. Agency Employee 6 was interviewed on 11/7/22 at 12:38 p.m., indicated she had assisted the resident off the floor with Agency Employee 4 on 10/14/22			

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	at 11:57 p.m.. She had been informed the resident moved around in the bed. She was unable to recall any further falls on that day. Employee 7 was interviewed on 11/7/22 at 1:30 p.m. and indicated the first time she had observed the resident on 10/15/22 was at 2:45 p.m., after the family had come down the hallway yelling the resident was on the floor. They went to the resident's room and he was on the floor and had crawled off the mat. She was not sure if he was on a mat or a mattress, though it had covers and a pillow on it. There was no linen or pillows on the actual bed and it had looked like he had been sleeping on the mat/mattress on the floor. There had been feces smeared and the brief was partially off. Employee 8 was interviewed on 11/7/22 at 1:55 p.m. and indicated the family member had came down the hallway yelling the resident was on the floor. She entered the room and an inflated mattress was observed on the floor in the resident's room and he was on the mattress. There was feces on his gown and the sheet. There were no linens on the bed. A CNA, who she had not recognized, had come into the room and was going to provide care. Agency Employee 9 was interviewed on 11/7/22 at 3 p.m. and indicated she had worked the midnight shift of 10/15/22. The resident had fallen already and a mat was placed on the floor by Agency Employee 4. A CNA had informed her she had put the resident on a mattress on the floor so he would not fall. She was unable to remember who the CNA was. The CNA was informed she could not put a mattress on the floor and the employees assisted the resident back to bed. She had looked in on him through out the night and he had been			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	sleeping soundly and had not attempted to get out of bed on his own. She indicated she had not completed any follow up assessments to the previous fall since he had no injury at the time of the fall and he had been sleeping. A facility fall policy, dated 8/2008, and received from the Director of Nursing as current, indicated the staff were to evaluate and document falls that have occurred. The staff were to follow up on any falls until the resident was stable and delayed complications were ruled out or resolved. Delayed complication could occur hours or several days after a fall. The Federal tag relates to Complaint IN000393439. 3.1-45(a)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations, interview, and record review, the facility failed to maintain a sanitary and homelike environment, related to resident rooms with dirty floors, walls, privacy curtains, and over the bed tables, broken and missing floor tile, over the bed tables with missing or peeling veneer, peeling floor grips, and broken plastic slats on the air conditioner/heater, for 4 of 25 rooms observed. (Rooms A-Unit - 1, 11, and 15. B-Unit - 21) Findings Include: 1. During an Environmental Tour on 11/7/22 at 8:38 a.m. through 8:54 a.m., of the A-Unit, the	F 0921	F 921 Safe/Functional/Sanitary/Comfortable Environment **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The cover of the heating/air conditioner unit has been replaced in room B21.	11/18/2022

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	11/07/2022

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	following was observed: a. In room 1 there was a dark brown substance on the privacy curtains and wall next to bed 1. b. In room 11, the area for Bed 1 had dried liquid stains on the over bed tables, dirty floor around the base board and in the upper left hand corner of the room. There were brown stained tiles on the floor behind the head of the bed. There was a brown liquid substance that had run down the wall and dried on the wall behind the bed. c. In room 15, there were 2 over the bed tables in the room with the veneer off. The base board by the closet was dirty next to the closet in the Bed 2 area. The Bed 1 area had a dirty floor, stains on the wall, and peeling floor grips. 2. During an Environmental Tour on 11/7/22 at 8:54 p.m. of the B-Unit, The following was observed: In Room 21, the Bed 2 area had an over the bed table with peeling veneer. There was a cracked and missing tile on the floor and the air conditioning/heater had several broken plastic slats. During an Environmental Tour on 11/7/22 at 2:39 p.m., the Maintenance Director acknowledged all of the above findings as needing cleaning or repair. An undated policy, titled, "Competencies for Housekeeping", received as current from the Director of Housekeeping and Maintenance on 11/7/22 at 2:58 p.m., indicated daily cleaning of the room included, but was not limited to, mopping the entire floor and cleaning the furniture.		The cracked floor tile in room B21 has been replaced. The overbed table in room B21 was replaced. The privacy curtains and wall in room A1 were replaced and cleaned immediately. The floor, base boards, wall, and over bed tables in room A11 were cleaned immediately. The bedside tables in room A15 was replaced immediately. The base boards and floor in room A15 was cleaned immediately. The peeling floor grips in room A15 has been replaced. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** The Housekeeping Director, Housekeeping Staff, and facility	

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	This Federal tag relates to Complaint IN00393439. 3.1-19(f)(5)		staff were educated on making daily rounds to ensure floors are clean, floor grips intact, covers to heating/air conditioning units are intact, bedside tables are in good condition, as well as privacy curtains and wall are clean throughout the facility. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Housekeeping Director/designee will audit 5 rooms weekly for 3 months to ensure floors are clean, floor grips are intact, covers to heating/air conditioning units are intact, bedside tables are in good condition, as well as privacy curtains and wall are clean throughout the facility. A summary of the audits will be presented to the Quality Assurance committee monthly for 3 months or until compliance is met.	