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	05/09/2023

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 Complaints IN00407716 and IN00408215. Complaint IN00407716 - Federal/state deficiencies related to the allegations are cited at F609 and F842. Complaint IN00408215 - Federal/state deficiencies related to the allegations are cited at F609 and F842. Survey date: 5/9/23 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 14 Medicaid: 43 Other: 12 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/15/23.	F 0000	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *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.*	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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

Rita Gatson | Administrator | 05/23/2023

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.

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	05/09/2023

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
	§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of abuse was immediately reported to the Administrator for 2 of 3 residents reviewed for reporting abuse. (Residents C and D) Finding includes: A Confidential Interview on 5/9/23 at 12:12 p.m., indicated Resident C had been found in Resident D's room with her hand on Resident D's genitals on 5/3/23.	F 0609	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *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*	05/23/2023

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	05/09/2023

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
	An interview with the Administrator on 5/9/23 at 12:25 p.m., indicated she had not been informed of the incident and an investigation would be initiated immediately. During an interview on 5/9/23 at 12:36 p.m., QMA 1 indicated on 5/3/23 on the evening shift, Resident C had not been seen for "a while" and the staff began looking for her. Resident D's room door was closed and when it was opened by RN 2, Resident D was lying in bed with his covers pulled down and Resident C had her hands on his genitals. RN 3 was informed of the incident by RN 2 and had indicated she would notify the Director of Nursing (DON). During an interview on 5/9/23 at 12:43 p.m., RN 2 indicated Resident C was observed in Resident D's room. Resident C was observed touching Resident D's genitals. Resident D's bed covers were pulled down. She indicated she immediately reported the incident to Unit Manager 4, who was the Supervisor in the facility. During an interview on 5/9/23 at 12:50 p.m., Unit Manager 4 indicated RN 3 had notified her that Resident C had not been recently seen in the facility and was not in her room. A search of the facility was initiated. RN 2 had opened Resident D's room door, and she was standing behind RN 2 when the door was opened. She observed Resident C in the room close to the bed and at that time RN 2 had informed her the resident's hands were on Resident D's genitals. Unit Manager 4 indicated Resident C was immediately removed from the room and she notified the DON of the incident. During an interview on 5/9/23 at 12:54 p.m., RN 3		*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.* **1) Immediate actions taken for those residents identified:** Investigation for allegation involving Resident's (C) and (D) was completed with findings. Resident (C) Psychosocial assessment was completed and remains within baseline. Resident (D) Psychosocial assessment was completed and remains within baseline. Head to toe assessment completed on both residents. MD's and family were notified. Plan of Care's were updated. **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educated on Abuse and Neglect Policy. Staff is to report all allegations immediately to Abuse Coordinator or Manager on Duty. **4) How the corrective actions**	

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	05/09/2023

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
	indicated she was informed Resident C had been observed in Resident D's room and as RN 2 entered the room, Resident D had attempted to cover himself up. She had not been informed Resident C had been touching Resident D's genitals. She indicated Unit Manager 4 had been informed and she had said she would notify the DON the next day (5/4/23) and she informed the Unit Manager the DON needed to be notified that evening. During an interview on 5/9/23 at 1:05 p.m., the DON indicated she had received a call from Unit Manager 4 on 5/3/23 and was informed Resident C had been found sitting beside Resident D's bed. She had directed the Unit Manager to speak with Resident D and ask him why he had not activated his call light when Resident C was in the room. She indicated she had not been informed Resident C had been touching Resident D's genitals. On 5/5/23, Unit Manager 5 had reported to her that CNA 6 and CNA 7 had informed her they had heard from other staff that Resident C was found fondling Resident D's genitals on 5/3/23. She then notified RN 3, who had told her she was not the one who observed the resident. She was unable to reach RN 2 to question her about the incident. She indicated there had not been anything documented in the either of the resident's records. The DON had not spoken with QMA 1 and had not interviewed other staff members. During an interview on 5/9/23 at 1:16 p.m., Unit Manager 5 indicated on 5/4/23, CNA 6 and CNA 7 had reported to her that they had heard Resident C had been found in Resident D's room and was observed fondling Resident D. She reported the information to the DON. She had not reported the incident to the Administrator because the DON had informed her it was not a reportable incident.		**will be monitored:** The Administrator or Designee will complete Abuse drills 1 time weekly for 4 weeks and monthly thereafter to ensure compliance with facility reporting guidelines. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	05/09/2023

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
	Resident C's record was reviewed on 5/9/23 at 2:44 p.m. The diagnoses included, but were not limited to fracture right femur, stroke, and dementia A Quarterly Minimum Data Set (MDS) assessment, dated 4/25/23, indicated her cognitive status was severely impaired. Resident D's record was reviewed on 5/9/23 at 3:48 p.m. The diagnosis included, but were not limited to dementia. A Quarterly MDS assessment, dated 2/1/23, indicated a moderately impaired cognitive status. A facility policy, dated 9/1/20, titled, "Abuse Prevention and Reporting", and received as current by the Administrator, indicated, "...Employees and volunteers are required to report any incident, allegation or suspicion of potential abuse...they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report to the administrator..." This Federal tag relates to Complaints IN00407716 & IN00408215. 3.1-28(c)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the			

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	05/09/2023

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
	information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be			

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	05/09/2023

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
	retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure a medical record was complete related to lack of documentation of observations of alleged abuse, for 2 of 3 residents reviewed for medical records. (Residents C and D) Finding includes: A Confidential Interview on 5/9/23 at 12:12 p.m., indicated Resident C had been found in Resident D's room with her hand on Resident D's genitals on 5/3/23. Cross reference F609. Resident C's record was reviewed on 5/9/23 at 2:44 p.m. The diagnoses included, but were not limited to fracture right femur, stroke, and dementia.	F 0842	The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *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.*	05/23/2023

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	05/09/2023

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
	There was no documentation of the the incident observed by staff on 5/3/23. Resident D's record was reviewed on 5/9/23 at 3:48 p.m. The diagnosis included, but were not limited to dementia. There was no documentation of the incident observed by staff on 5/3/23. During an interview on 5/9/23 at 1:05 p.m., the Director of Nursing indicated she was aware the incident had not been documented in either record on 5/5/23. This Federal tag relates to Complaints IN00407716 & IN00408215. 3.1-50(a)(1)		**1) Immediate actions taken for those residents identified:** Abuse and Neglect Observations were completed for residents (C) and (D). **2) How the facility identified other residents:** All the residents have the potential to be affected by this alleged practice. **3) Measures put into place/ System changes:** Facility staff was re-educatedall documentation required in the medical record for allegations of abuse. **4) How the corrective actions will be monitored:** The Administrator or Designee will complete an audit of the medical record for all Abuse allegations 1 time weekly for 6 months to ensure all documentation required for allegations of Abuse is in the medical record. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee**	

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	05/09/2023

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
			will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	