

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  08/30/2013
--	---	--	---

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 IN00133030, IN00133794, IN00134446, and IN00134487. This visit resulted in a partially extended survey-Substandard Quality of Care.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00125407 completed on May 21, 2013.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00130573 completed on June 13, 2013.</p> <p>Complaint IN00133030-Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Complaint IN00133794-Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, F281, F309, F329, and F333.</p> <p>Complaint IN00134446-Substantiated.</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  08/30/2013	
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>Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Complaint IN00134487-Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Survey dates: August 26 &amp; 27, 2013 Extended survey dates: August 28, 29, &amp; 30, 2013</p> <p>Facility number: 000577 Provider number: 155650 AIM number: 100266950</p> <p>Survey team: Janet Adams, RN, TC Heather Tuttle, RN August 26 &amp; 27, 2013</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 10 Medicaid: 59 Other: 10 Total: 79</p> <p>Sample: 15</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  08/30/2013
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>Supplemental sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 10, 2013, by Janelyn Kulik, RN.</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 08/30/2013	
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=F	<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 record review and</p>	F000225	F225 Preparation and/or	09/25/2013			

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  08/30/2013	
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>interview, the facility failed to ensure allegations of abuse were reported to the Administrator in a timely manner for 2 of 7 allegation of abuse reviewed resulting in the delay of initiating an investigation of the allegation of abuse. (Residents #F and #R)</p> <p>The facility also failed to ensure allegations of abuse were investigated at the time they were first reported for 1 of 7 allegations of abuse reviewed. (Resident #R) This deficient practice had the potential to affect 79 of 79 residents residing in the facility and resulted in Substandard Quality of Care.</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 8/27/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, chronic kidney disease, vascular dementia, insomnia, cognitive communication deficits, and cerebral vascular disease with hemiplegia (weakness in one side).</p> <p>The 6/17/13 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Cognitive Status) score was (5). This score indicated the</p>		<p>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. Immediate actions taken for those residents identified: The occurrence for Resident #F was reported to Indiana State Department of Health on 08/20/2013 when Administrator received notification of allegation. The occurrence for Resident #R was reported to Indiana State Department of Health on 07/10/2013 when Administrator received notification of allegation. How the facility identified other residents: All residents have the potential to be affected by this alleged deficiency. Measures put into place/ System changes: All facility personnel were provided direct and computer based re-education about facility procedures for identification and reporting of alleged violations. Completed in-servicing included post test(s) demonstrating retention and understanding of facility policy; specifically Administrator is the immediate contact for reporting alleged violations. Administrator, or designee, will continue ongoing educational abuse questionnaires with personnel; presenting</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  08/30/2013
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's cognitive pattern were severely impaired. The MDS assessment also indicated the resident required extensive assistance of staff for bed mobility, transfers, dressing, eating, and hygiene. The assessment also indicated the resident had impairment of range of motion of the upper and lower extremities on one side.</p> <p>An Abuse Investigation Interdisciplinary Team Review report was reviewed. The report indicated an alleged abuse occurred on 8/17/13 related to Resident #F. The report indicated the above allegation was first reported to the Quality Assurance Consultant on 8/19/13.</p> <p>An Incident Report Form was completed on 8/20/13. This was an initial and follow up report. The report indicated the Quality Assurance Consultant received the report of an allegation of abuse on 8/19/13. the report indicated Resident #F alleged a staff member was rough during care provided on 8/17/13. There was no Incident Report Form completed on 8/17/13.</p> <p>Review of the facility investigation indicated a written statement was obtained from Activity Assistant #1 on</p>		<p>hypothetical situations to personnel, determining appropriate responses, and providing further re-education measures if needed. Abuse questionnaires will be completed with 5 randomly selected personnel 4x/week continuing for 4 weeks. Thereafter, conducted with 5 randomly selected personnel per week for QA monitoring as detailed in section #4 below. Administrator has amended departmental meeting head agenda to include specific questioning about any occurrences that potentially meet criteria for reporting under ISDH reporting requirements r/t abuse. This questioning will be conducted 5x/weekly. Administrator, or designee, will review all written witness statements (including staff and resident interviews) to determine if any further follow-up is needed related to statement. Administrator has posted direct contact number in designated areas throughout the facility; on-going educational abuse questionnaires include education about the location of these designated areas. Administrator or designee will be responsible for oversight of these audit(s). How the corrective actions will be monitored: The results of these questionnaire audits will be reviewed in monthly Quality Assurance meetings monthly x3 months, then quarterly</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  08/30/2013
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>8/19/13. The statement indicated the resident stated his left arm hurt because someone was rough with him on Saturday when a girl in a colored, flowered top grabbed him by the arm.</p> <p>An interview with the SSD (Social Service Director) on 8/28/13 at 8:10 a.m., indicated she was working on Saturday 8/17/13 when Activity Aide #1 reported to her that Resident #F said someone had been rough with his care and the resident did not know who the staff member was but indicated it was someone wearing a flowered top. The SSD indicated the resident was in a Church activity at the time and was seated near the front row of the activity. The SSD indicated she asked the Activity Aide how much longer the Church Activity was going to last and was told it would be about 15 minutes longer. The SSD indicated she did not assess the resident then as he was seated near the front of the activity. The SSD indicated she did not report the allegation to Nursing staff or the Administrator at the time. The SSD indicated she became involved in other events occurring in the facility and forgot to follow up with or report the allegation to the Administrator as required by the facility Abuse Policy.</p>		x1 for a total of 6 months. Date of compliance: September 25th, 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  08/30/2013
--	---	--	---

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 SSD indicated she was aware it was her responsibility to immediately report any allegations to the Administrator and ensure an investigation was initiated at that time to ensure the resident's safety. The SSD indicated it was on Monday afternoon on 8/19/13 when the Nurse Consultant approached her about Resident #F's allegation which occurred on 8/17/13 that she remembered she had forgotten to follow through on the allegation reported by the Activity Aide on Saturday.</p> <p>An interview 8/27/13 at 4:30 p.m., with the Nurse Consultant indicated APS (Adult Protective Services) called the facility Administrator on 8/19/13 in the afternoon regarding reports of abuse allegations in the facility. The Nurse Consultant indicated they immediately began conducting staff interviews related to the phone call the Administrator received. The Nurse Consultant indicated during the interview process Activity Aide #1 was one of the several staff members interviewed related to Abuse. During the interview Activity Aide #1 reported she had received an allegation from Resident #F on Saturday 8/17/13 and reported it to the SSD who was the Weekend Manager present at the</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  08/30/2013
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>time. The Activity Aide reported Resident #F had informed her someone had twisted his arm and she then informed the Social Worker. The Nurse Consultant indicated the above allegation made on 8/17/13 had not been conveyed to anyone else in management prior to 8/19/13. The Nurse Consultant indicated the SSD was interviewed on 8/19/13 and now realized she had become distracted with events on 8/17/13 and forgot to follow through with the allegation the Activity Aide reported to her on Saturday 8/17/13.</p> <p>Continued interview with the Nurse Consultant, indicated the Nurses were instructed to assess Resident #F on 8/19/13. The Nurse Consultant indicated the resident was not interviewed until 8/20/13.</p> <p>2. When interviewed on 8/27/13 at 3:50 p.m. the facility Activity Director indicated Activity Aide #1 came to her one day and reported that she heard Activity Aide #2 yelling at residents in an activity event. The Activity Director indicated she intervened and Activity Aide #2 reported that she told the residents "you all are getting on my nerves." The Activity Director indicated she then went and asked</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  08/30/2013
--	---	--	---

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 Medical Records staff member and the front desk staff member if they heard anything and they did not. The Activity Director indicated she did not recall the date this occurred on.</p> <p>When interviewed on 8/27/13 at 4:30 p.m., the Nurse Consultant indicated the Activity Director did not report the above incident to the facility Administrator on the day it occurred. The Nurse consultant indicated the Activity Director reported it at a later date when she was being interviewed by the Corporate Administrator during the investigation of an unrelated allegation of abuse filed on 8/9/13. The Nurse Consultant indicated the Activity Director had been suspended on 8/9/13 when the unrelated allegations occurred.</p> <p>When interviewed on 8/28/13 at 9:06 a.m., the Corporate Administrator indicated during the investigation of an unrelated allegation of abuse on 8/12/13 she interviewed Activity Aide #1 and the aide informed her about an occurrence that had occurred once where Activity Aide #2 raised her voice at the resident's telling them to be quiet and they were getting on her nerves. Activity Aide #1 indicated she told her Activity Director about the above on the day it occurred. The</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  08/30/2013
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>Administrator indicated she suspended Activity Aide #2 on 8/12/13 after the above interview with Activity Aide #1. The Administrator indicated Activity Aide #1 did not remember the day the above occurred. The Corporate Administrator indicated during her 8/12/13 interview with the Activity Director, the Activity Director informed her about Activity Aide #2 raising her voice at the residents during an activity but did not recall the date. The Administrator indicated the Activity Director should have reported the statement made by Activity Aide #2 to the Administrator on the day they occurred.</p> <p>3. An Abuse Investigation Interdisciplinary Team Review form was reviewed on 8/28/13. The form indicated an allegation of staff to resident verbal abuse was reported on 7/9/13 by Resident #R. The form also indicated the resident indicated the alleged abuse occurred on Sunday (7/7/13). The Facility Incident Reporting Form related to the above incident indicated an incident occurred on 7/9/13 on the evening shift. The form indicated the resident reported on 7/9/13 that a CNA on the Sunday evening shift was rude and refused to put her to bed. The</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  08/30/2013
--	---	--	---

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>Director of Nursing and the Administrator were notified at the time and the CNA was immediately suspended. The investigation included interviews from staff members. An interview written(no date noted) by LPN #1 indicated she was on her way to lunch and Resident #R asked her to put her to bed as she did not like (CNA #3's name). LPN #1's statement also indicated she rendered care to the resident and put her to bed. The statement also indicated the next day Resident #R asked her if she had told RN #5 about her having to put the resident to bed and LPN #1 stated yes she had. The resident tried to tell her something else but she could not understand her so she told the resident she would have RN #5 come and talk to her. LPN #1's statement also indicated RN #5 came and talked to the resident and RN #5 came back stating the resident stated CNA #3 was being mean to her. There was no interview with RN #5 included in the investigation.</p> <p>The record for Resident #R was reviewed on 8/28/13 at 10:55 a.m. The resident's diagnoses included, but were not limited to, dementia, joint contractors, anxiety state, and depressive disorder. The 7/19/13</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  08/30/2013
--	---	--	---

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>Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact. A Social Service Progress Notes completed on 7/10/13 at 10:04 a.m. indicated the Social worker met with the resident and the resident told her about the incident. The progress note also indicated the resident indicated she did not want the staff member to provide care to her because she "gets in her face and is rude."</p> <p>When interviewed on 8/28/13 at 1:25 p.m., RN #5 indicated she works as both a shift supervisor and also as a staff nurse. RN #5 indicated on Monday 7/8/13 Resident #R told me that LPN #1 had put her to bed yesterday and the resident also stated she did not like CNA #3's voice. RN #5 indicated she spoke with LPN #1 that same night.</p> <p>When interviewed on 8/28/13 at 1:35 p.m., LPN #1 indicated Resident #R was sitting in doorway of her room and asked her to lay her down. The LPN indicated she put the resident into bed. The LPN then indicated the next day while she was in the Dining Room, Resident #R asked her if she</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  08/30/2013
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>had told RN #5 that she put her into bed last night and then could not really understand what else the resident was saying and told the resident she would get RN #5 to try and understand what the resident was saying. LPN #1 indicated RN #5 came and talked with the resident and then the RN came back and indicted Resident #R had said the CNA mean. The LPN indicated this was what she thought she heard.</p> <p>When interviewed on 8/28/13 at 11:30 a.m., the Director of Nursing indicated she did not recall who first reported Resident #R's allegation to her on 7/9/13. The Director of Nursing indicated staff interviews were conducted on 7/9/13. The Director of Nursing indicated she did not interview RN #5.</p> <p>When interviewed on 8/29/13 at 8:00 a.m., the facility Nurse Consultant indicated written interviews were obtained from the Nurses involved as part of the investigation. The Nurse Consultant indicated the resident reported the allegation on 7/9/13. The Nurse Consultant indicated LPN #1's written statement did note that on 7/8/13 RN #5 said the resident told her CNA #3 had been mean to her. The Nurse Consultant indicated the</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  08/30/2013
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>LPN did not report on 7/8/13 when the resident indicated a staff member was mean.</p> <p>The facility policy titled "Abuse, Neglect, and Misappropriation of Resident Property" was reviewed on 8/28/13 at 11:30 a.m. The policy had a current version date of 01/2012. The policy indicated all allegations of mistreatment, neglect, or abuse were to be reported immediately to the Administrator of the facility. The policy also indicated all alleged violations were to be thoroughly investigated.</p> <p>This federal tag was cited on May 21, 2103. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to Complaints IN00133030, IN00133794, IN00134446, and IN00134487.</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  08/30/2013
--	---	--	---

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

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  08/30/2013
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=F	<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 followed related to reporting of abuse allegations at the time of occurrence for 3 of 7 completed abuse investigations reviewed. (Residents #F and #R) (Activity Aide #2) (Activity Director)</p> <p>The facility also failed to follow their policy related to completing a thorough investigation related to not addressing a written statement which indicated staff were informed of the allegation prior to it being reported to the Administrator or an investigation being initiated. (Resident #R) (RN #5) (LPN #1)</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 8/27/13 at 9:00 a.m. The resident's diagnoses included, but</p>	F000226	<p>F226 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. Immediate actions taken for those residents identified: The occurrence for Resident #F was reported to Indiana State Department of Health on 08/20/2013 when Administrator received notification of allegation. The occurrence for Resident #R was reported to Indiana State Department of Health on 07/10/2013 when Administrator received notification of allegation. How the facility identified other residents: All residents have the potential to be affected by this alleged deficiency. Measures put into place/ System changes: All facility personnel were provided direct and computer based re-education about facility procedures for identification and reporting of alleged violations. Completed in-servicing included</p>	09/25/2013	

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  08/30/2013
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>were not limited to, high blood pressure, chronic kidney disease, vascular dementia, insomnia, cognitive communication deficits, and cerebral vascular disease with hemiplegia (weakness in one side).</p> <p>An Abuse Investigation Interdisciplinary Team Review report was reviewed. The report indicated an alleged abuse occurred on 8/17/13 related to Resident #F. The report indicated the above allegation was first reported to the Quality Assurance Consultant on 8/19/13.</p> <p>An Incident Report Form was completed on 8/20/13. This was an initial and follow up report. The report indicated the Quality Assurance Consultant received the report of an allegation of abuse on 8/19/13. the report indicated Resident #F alleged a staff member was rough during care provided on 8/17/13. There was no Incident Report Form completed on 8/17/13.</p> <p>Review of the facility investigation indicated a written statement was obtained from Activity Assistant #1 on 8/19/13. The statement indicated the resident stated his left arm hurt because someone was rough with him on Saturday when girl in a</p>		<p>post test(s) demonstrating retention and understanding of facility policy; specifically Administrator is the immediate contact for reporting alleged violations. Administrator, or designee, will continue ongoing educational abuse questionnaires with personnel; presenting hypothetical situations to personnel, determining appropriate responses, and providing further re-education measures if needed. Abuse questionnaires will be completed with 5 randomly selected personnel 4x/week continuing for 4 weeks. Thereafter, conducted with 5 randomly selected personnel per week for QA monitoring as detailed in section #4 below. Administrator has amended departmental meeting head agenda to include specific questioning about any occurrences that potentially meet criteria for reporting under ISDH reporting requirements r/t abuse. This questioning will be conducted 5x/weekly.</p> <p>Administrator, or designee, will review all written witness statements (including staff and resident interviews) to determine if any further follow-up is needed related to statement. Administrator has posted direct contact number in designated areas throughout the facility; on-going educational abuse questionnaires include education about the location of these</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  08/30/2013
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>colored, flowered top grabbed him by the arm.</p> <p>An interview with the SSD (Social Service Director) on 8/28/13 at 8:10 a.m., indicated she was working on Saturday 8/17/13 when Activity Aide #1 reported to her that Resident #F said someone had been rough with his care and the resident did not know who the staff member was but indicated it was someone wearing a flowered top. The SSD indicated the resident was in a Church activity at the time and was seated near the front row of the activity. The SSD indicated she asked the Activity Aide how much longer the Church Activity was going to last and was told it would be about 15 minutes longer. The SSD indicated she did not assess the resident then as he was seated near the front of the activity. The SSD indicated she did not report the allegation to Nursing staff or the Administrator at the time. The SSD indicated she became involved in other events occurring in the facility and forgot to follow up with or report the allegation to the Administrator as required by the facility Abuse Policy. The SSD indicated she was aware it was her responsibility to immediately report any allegations to the Administrator and ensure an</p>		<p>designated areas. Administrator or designee will be responsible for oversight of these audit(s). How the corrective actions will be monitored: The results of these questionnaire audits will be reviewed in monthly Quality Assurance meetings monthly x3 months, then quarterly x1 for a total of 6 months. Date of compliance: September 25th, 2013</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  08/30/2013
--	---	--	---

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>investigation was initiated at that time to ensure the resident's safety. The SSD indicated it was on Monday afternoon on 8/19/13 when the Nurse Consultant approached her about Resident #F's allegation which occurred on 8/17/13 that she remembered she had forgotten to follow through on the allegation reported by the Activity Aide on Saturday.</p> <p>An interview 8/27/13 at 4:30 p.m., with the Nurse Consultant indicated APS (Adult Protective Services) called the facility Administrator on 8/19/13 in the afternoon regarding reports of abuse allegations in the facility. The Nurse Consultant indicated they immediately began conducting staff interviews related to the phone call the Administrator received. The Nurse Consultant indicated during the interview process Activity Aide #1 was one of the several staff members interviewed related to Abuse. During the interview Activity Aide #1 reported she had received an allegation from Resident #F on Saturday 8/17/13 and reported it to the SSD who was the Weekend Manager present at the time. The Activity Aide reported Resident #F had informed her someone had twisted his arm and she then informed the Social Worker.</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  08/30/2013
--	---	--	---

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 Nurse Consultant indicated the above allegation made on 8/17/13 had not been conveyed to anyone else in management prior to 8/19/13. The Nurse Consultant indicated the SSD was interviewed on 8/19/13 and now realized she had become distracted with events on 8/17/13 and forgot to follow through with the allegation the Activity Aide reported to her on Saturday 8/17/13.</p> <p>Continued interview with the Nurse Consultant indicated the Nurses were instructed to assess Resident #F on 8/19/13. The Nurse Consultant indicated the resident was not interviewed until 8/20/13.</p> <p>2. When interviewed on 8/27/13 at 3:50 p.m. the facility Activity Director indicated Activity Aide #1 came to her one day and reported that she heard Activity Aide #2 yelling at residents in an activity event. The Activity Director indicated she intervened and Activity Aide #2 reported that she told the residents "you all are getting on my nerves." The Activity Director indicated she then went and asked the Medical Records staff member and the front desk staff member if they heard anything and they did not. The Activity Director indicated she did not recall the date this occurred 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  08/30/2013
--	---	--	---

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>When interviewed on 8/27/13 at 4:30 p.m., the Nurse Consultant indicated the Activity Director did not report the above incident to the facility Administrator on the day it occurred. The Nurse consultant indicated the Activity Director reported it at a later date when she was being interviewed by the Corporate Administrator during the investigation of an unrelated allegation of abuse filed on 8/9/13. The Nurse Consultant indicated the Activity Director had been suspended on 8/9/13 when the unrelated allegations occurred.</p> <p>When interviewed on 8/28/13 at 9:06 a.m., the Corporate Administrator indicated during the investigation of an unrelated allegation of abuse on 8/12/13 she interviewed Activity Aide #1 and the aide informed her about an occurrence that had occurred once where Activity Aide #2 raised her voice at the resident's telling them to be quiet and they were getting on her nerves. Activity Aide #1 indicated she told her Activity Director about the above on the day it occurred. The Administrator indicated she suspended Activity Aide #2 on 8/12/13 after the above interview with Activity Aide #1. The Administrator indicated Activity Aide #1 did not</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  08/30/2013
--	---	--	---

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>remember the day the above occurred. The Corporate Administrator indicated during her 8/12/13 interview with the Activity Director, the Activity Director informed her about Activity Aide #2 raising her voice at the residents during an activity but did not recall the date. The Administrator indicated the Activity Director should have reported the statement made by Activity Aide #2 to the Administrator on the day they occurred.</p> <p>3. An Abuse Investigation Interdisciplinary Team Review form was reviewed on 8/28/13. The form indicated an allegation of staff to resident verbal abuse was reported on 7/9/13 by Resident #R. The form also indicated the resident indicated the alleged abuse occurred on Sunday (7/7/13). The Facility Incident Reporting Form related to the above incident indicated an incident occurred on 7/9/13 on the evening shift. The form indicated the resident reported on 7/9/13 that a CNA on the Sunday evening shift was rude and refused to put her to bed. The Director of Nursing and the Administrator were notified at the time and the CNA was immediately suspended. The investigation included interviews from staff</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  08/30/2013	
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>members. An interview written(no date noted) by LPN #1 indicated she was on her way to lunch and Resident #R asked her to put her to bed as she did not like (CNA #3's name). LPN #1's statement also indicated she rendered care to the resident and put her to bed. The statement also indicated the next day Resident #R asked her if she had told RN #5 about her having to put the resident to bed and LPN #1 stated yes she had. The resident tried to tell her something else but she could not understand her so she told the resident she would have RN #5 come and talk to her. LPN #1's statement also indicated RN #5 came and talked to the resident and RN #5 came back stating the resident stated CNA #3 was being mean to her. There was no interview with RN #5 included in the investigation.</p> <p>The record for Resident #R was reviewed on 8/28/13 at 10:55 a.m. The resident's diagnoses included, but were not limited to, dementia, joint contractors, anxiety state, and depressive disorder. The 7/19/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive</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  08/30/2013
--	---	--	---

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>patterns were intact. A Social Service Progress Notes completed on 7/10/13 at 10:04 a.m. indicated the Social worker met with the resident and the resident told her about the incident. The progress note also indicated the resident indicated she did not want the staff member to provide care to her because she "gets in her face and is rude."</p> <p>When interviewed on 8/28/13 at 1:25 p.m., RN #5 indicated she works as both a shift supervisor and also as a staff nurse. RN #5 indicated on Monday 7/8/13 Resident #R told me that LPN #1 had put her to bed yesterday and the resident also stated she did not like CNA #3's voice. RN #5 indicated she spoke with LPN #1 that same night.</p> <p>When interviewed on 8/28/13 at 1:35 p.m., LPN #1 indicated Resident #R was sitting in doorway of her room and asked her to lay her down. The LPN indicated she put the resident into bed. The LPN then indicated the next day while she was in the Dining Room, Resident #R asked her if she had told RN #5 that she put her into bed last night and then could not really understand what else the resident was saying and told the resident she would get RN #5 to try</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  08/30/2013
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 understand what the resident was saying. LPN #1 indicated RN #5 came and talked with the resident and then the RN came back and indicted Resident #R had said the CNA mean. The LPN indicated this is what she thought she heard.</p> <p>When interviewed on 8/28/13 at 11:30 a.m., the Director of Nursing indicated she did not recall who first reported Resident #R's allegation to her on 7/9/13. The Director of Nursing indicated staff interviews were conducted on 7/9/13. The Director of Nursing indicated she did not interview RN #5.</p> <p>When interviewed on 8/29/13 at 8:00 a.m., the facility Nurse Consultant indicated written interviews were obtained from the Nurses involved as part of the investigation. The Nurse Consultant indicated the resident reported the allegation on 7/9/13. The Nurse Consultant indicated LPN #1's written statement did note that on 7/8/13 RN #5 said the resident told her CNA #3 had been mean to her. The Nurse Consultant indicated the LPN did not report on 7/8/13 when the resident indicated a staff member was mean.</p> <p>The facility policy titled "Abuse,</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  08/30/2013
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>Neglect, and Misappropriation of Resident Property" was reviewed on 8/28/13 at 11:30 a.m. The policy had a current version date of 01/2012. The policy indicated all allegations of mistreatment, neglect, or abuse were to be reported immediately to the Administrator of the facility. The policy also indicated all alleged violations were to be thoroughly investigated.</p> <p>This federal tag was cited on May 21, 2103. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to Complaints IN00133030, IN00133794, IN00134446, and IN00134487.</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  08/30/2013
--	---	--	---

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
F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were followed related to medications not prepared and administered by the same Nursing staff member for 1 of 2 Nurse observed during medication administration pass on 1 of 2 Nursing Units (Resident #K) (RN #1 and RN #2) (A Wing)</p> <p>Finding include:</p> <p>The evening medication administration pass on the A-wing was observed on 8/26/13 at 5:10 p.m. RN #1 prepared two pills from the Medication Cart to administer to Resident #K. Lorazepam (an medication of anxiety)) one milligram was the first pill prepared and Hydrocodone (a narcotic pain medication) 10/325 milligrams was the second. The RN signed the medications out on the corresponding count records for each of the medications. At this time RN #1 indicated the rest of the resident's</p>	F000281	<p>F281 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified:</p> <p>Resident #K received the correct medications and was not affected. RN #1 and RN #2 were educated on standards of practice related to medication preparation and administration. How the facility identified other residents: All residents have the potential to be affected. Measures put into place/ System changes:</p> <p>Licensed staff has been re-educated on standards of practice related to medication preparation and administration; as well as post test and competencies completed. The DON or designee will complete at least 5 medication pass observations per week on varied shifts to ensure medications are administered properly. How the corrective actions will be monitored: The results of these audits will be reviewed in the</p>	09/25/2013

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  08/30/2013
--	---	--	---

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>medications were in the other Medication Cart. The RN placed the two pills in a small medication cup and walked down the hall near the Nursing Station. RN #1 stopped at the second Medication Cart where RN #2 was standing. RN #2 instructed RN #1 to administer the two above pills to Resident #K and she would administered the rest of the resident's pills to her.</p> <p>RN #1 then walked to Resident #K and started to hand the medication cup to the resident to take the two pills. Resident #K refused to take the two pills until she had all of her medications. RN #2 instructed RN #1 to give the medication cup with the Lorazepam and the Hydrocodone to her and then to go and mark an entry on the computer to note the Lorazepam and Hydrocodone were given. RN #2 then indicated she would give the resident the two pills in addition to the other pills she had scheduled for this time. RN #1 then gave the medication cup with the Lorazepam and Hydrocodone pills in it to RN #2.</p> <p>RN #2 then prepared four other medications for Resident #K and placed them in the medication cup at this time. RN #2 verified there were a</p>		<p>Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. 5) Date of compliance: 09/25/2013</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  08/30/2013	
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 of (6) pills in the medication cup and proceeded to administer the (6) pills to Resident #K.</p> <p>When interviewed at this time, RN #2 indicated the facility policy allowed for her to administer the medications prepared by another Nurse as long as she was able to identify the medications. The RN then indicated she did not see RN #1 remove the Lorazepam or the Hydrocodone from the Pharmacy labeled package for Resident #K.</p> <p>The record for Resident #K was reviewed on 8/27/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, anxiety peripheral vascular disease, depressive disorder, and bi-polar disease. Review of the 8/2013 Medication Administration Record indicated there were Physician orders for the resident to receive Norco (Hydrocodone) 10-325 milligrams three times a day at 9:00 a.m., 1:00 p.m., and 5:00 p.m. and Lorazepam 1 milligram three times a day at 9:00 a.m., 1:00 p.m., and 5:00 p.m.</p> <p>When interviewed on 8/26/13 at 6:20 p.m., the Nurse Consultant indicated RN#1 should not have administered medications she had not prepared to</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  08/30/2013	
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><b>Resident #K.</b></p> <p>The facility policy titled "General Dose Preparation and Medication Administration" was reviewed on 8/26/13 at 5:50 p.m. The policy was dated May 2010. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated facility staff were to verify that the medication name and dose were correct prior to administering any medications.</p> <p>The Indiana State Board of Nursing Statue for RN's indicated the following: Rule 2. Registered Nursing: 848 IAC 2-2-3 Section 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing licensed practical nursing practices, which could jeopardize the health, safety, and welfare of the public shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (1) Using unsafe judgement, technical skills, or inappropriate interpersonal behaviors providing nursing care. (8) Delegating nursing care, functions, tasks, or responsibility to others when the nurse knows, that such</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  08/30/2013
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>delegation is to the detriment of patient safety.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated "Nurses are legally responsible for applying and ensuring the "five rights" of drug administration." One of the five rights included administering the right drug. Ensuring the right drug was administered required matching the drug label against the order on the Medication Administration Record (MAR). Ensuring the right drug was administered also included never administering a drug that was unlabeled.</p> <p>This federal tag relates to Complaint IN00133794.</p> <p>3.1-35(g)(1)</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  08/30/2013	
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			
F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide to the necessary treatment and services for residents to attain or maintain the highest practicable physical well-being related to the failure to ensure Licensed Nursing staff had knowledge of the indication of the use of a medication prior to preparing and administering the medication to a resident. This resulted in the administration of a medication used to lower elevated potassium levels to a resident with a critically low potassium level. The resident was found unresponsive and CPR (Cardio Pulmonary Resuscitation) was initiated. (Resident #B) (LPN #3)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 8/27/13 at 1:30 p.m. The resident was admitted to the facility on 8/23/13. The resident's diagnoses</p>	F000309	<p>F309 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified:</p> <p>Regarding Resident #B, LPN # 3 was suspended immediately, and an internal investigation was started. How the facility identified other residents: Audit was completed on all residents that received Kionex (Kayexalate) in the last 30 days, and no further issues were identified. Measures put into place/ System changes: Licensed staff has been re-educated regarding indications for use of medications, such as Kionex (Kayexalate); as well as signs and symptoms of hyperkalemia and hypokalemia. Licensed staff has been re-educated regarding procedure for administering unfamiliar drugs. Licensed staff has been</p>	09/25/2013			

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  08/30/2013	
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>included, but were not limited to, congestive heart failure, syncope and collapse, cataract, high blood pressure, permanent cardiac pacemaker, cerebral vascular accident (stroke).</p> <p>Review of the 8/24/13 admission Physician orders indicated there were orders for the resident to receive the following medications: Furosemide (a diuretic) 80 milligrams once a day at 9:00 a.m. and Potassium Bicarbonate &amp; Chloride 25 milliequivalent tablet one time a day at 9:00 a.m. Review of the 8/2013 Medication Administration Record indicated the above two medications were signed out as administered to the resident on 8/24/13 thru 8/27/13.</p> <p>A Physician's order was entered on 8/27/13 at 4:15 p.m. for Kionex (a medication to lower Potassium levels) suspension 15 Grams/60 ml (milliliters) -give 30 mls by mouth Stat and 30 mls at bedtime one time. Another Physician's order was entered on 8/27/13 at 8:46 p.m. for a Potassium level to be drawn on 8/28/13 and to notify the Physician of the results.</p> <p>Review of the laboratory test results indicated a BMP was collected by the</p>		<p>re-educated regarding critical abnormal lab values, assessment and immediate physician notification. A post test was completed. The DON will be notified of all alert and critical labs as well as the physician. The DON or designee will complete at least 5 medication pass observations per week on varied shifts to ensure licensed staff is familiar of the medications they are giving. The DON/ designee is responsible for oversight of these audits. Staff will be addressed and re-educated if concerns are noted. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. Date of compliance:09/25/2013</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  08/30/2013
--	---	--	---

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 on 8/27/13 at 5:45 a.m. The test results indicated the resident's Potassium level was 2.7 (normal level 3.7-5.1). The level of 2.7 was identified as a Critical level. The report indicated the critical level was called to, faxed, and read back to LPN #3 on 8/27/13 at 3:52 p.m. There was handwritten documentation on the bottom of the above report. The documentation indicated the Physician was notified, new orders were received for Kionex (a medication to lower high potassium levels) 30 mls (milliliters) STAT and 30 mls at hour of sleep. The hand written documentation also indicated a repeat potassium laboratory test was to be completed on 8/28/13 and the Physician was to be called with the results and all orders were verified and carried out. LPN #3 signed her signature under the above documentation with the date of 8/27/13.</p> <p>A Physician's order was entered on 8/27/13 at 4:15 p.m. for Kionex (a medication to lower Potassium levels) suspension 15 Grams/60 ml (milliliters) -give 30 mls by mouth Stat and 30 mls at bedtime one time. Another Physician's order was entered on 8/27/13 at 8:46 p.m. for a Potassium level to be drawn 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  08/30/2013	
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>8/28/13 and to notify the Physician of the results.</p> <p>Review of the 8/27/13 Nursing Progress Notes indicated an entry was made at 8:28 p.m. This entry indicted a call was received from (Laboratory staff members name) reporting a critical low potassium level of 2.7, the Doctor was called, and orders were received for Kionex 15 grams/60 mls to give 30 mls Stat and 30 mls at bedtime. The entry also indicated all orders were verified and carried out and Kionex 15 grams/60 ml was pulled from the EDK (Emergency Drug Kit). The entry was made by LPN #3.</p> <p>An EDK sign out sheet was completed by LPN #3 on 8/27/13 at 5:00 p.m. The sheet indicated LPN signed as removing Kionex 15 gms/60 ml from the EDK for Resident #B.</p> <p>Review of the 8/2013 Medication Administration Record indicated Kionex 30 mls of Kionex suspension 15 GM/60 ml was signed out as given on 8/27/13 at 9:56 p.m. LPN #3's initials were entered on the above entry. The entry did not indicate the resident refused the medication, spit out the medication, or the medication</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  08/30/2013
--	---	--	---

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 not given.</p> <p>When interviewed on 8/29/13 at 9:55 p.m., the Nurse Consultant indicated the resident's 8/27/13 critical Potassium level of 2.7 was called to LPN #3 on 8/27/13 at 3:52 p.m. The Nurse Consultant indicated the LPN was interviewed and had been suspended. The Nurse Consultant indicated the LPN was interviewed and stated she received the call from the lab and attempted to call the Physician and then spoke to him around 7:00 p.m. and received orders from the Physician. The Nurse Consultant indicated the LPN indicated the Physician was talking fast and she could not understand what he was saying and the fourth time she asked him he started to spell the name of the medication out to her and the LPN stated the said the letters K, A, Y, E . In the interview the LPN also indicated she had never heard of the medication and it was around 9:30 p.m. when she went to administer the medication to the resident. The LPN indicated she went to the EDK with the spelling the Physician gave and she had to ask the Evening Supervisor about the name and the Supervisor told her the medication name would be under "Kionex." The LPN indicated she</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  08/30/2013
--	---	--	---

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>then prepared 30 mls of the medication but the resident stuck her tongue in the medication cup and refused to drink it and she then went back to call the Physician to inform him the resident refused and the Physician told her he said K-lyte and not Kayexalate and this phone call was around 10:30 p.m. LPN #3 indicated at the time there was about 25 cc's left in the med cup and she threw it away without having a witness. The LPN stated when the midnight shift Nurse (RN #4) went into the resident's room about 10:30 p.m. she yelled out there was a Code, the crash cart was pulled and CPR was initiated until the paramedics arrived.</p> <p>Continued interviewed with the Nurse Consultant at the above time, indicated LPN #3 indicated she did not know Kayexalate decreased Potassium levels as she had never given the medication before. The Nurse Consultant indicated they had called the LPN to come back to facility for further interview and the LPN did not return to the facility. The Nurse Consultant indicated the facility request the Physician to come to the facility to further review the incident. The Physician indicated he reviewed his phone calls from 8/27/13 and indicated he had received a call at</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  08/30/2013
--	---	--	---

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>4:27 p.m. that lasted 16 minutes. The Physician indicated this call was from LPN #3 as he recalled how he had to keep repeating himself to the Nurse during this call as she kept asking him what he said. The Physician indicated he finally said " K L Y T E , spelling out the letters and saying 25 milliequivalent. The Physician indicated he received the next call at 10:43 p.m. when the Nurse reported she had given Kayexalate and wanted to know what she should do. The Physician indicated he responded to the Nurse that he had not given the order for Kayexalate as that would decrease the potassium level.</p> <p>Continued interview with the Nurse Consultant at this time, indicated RN #4 had also been interviewed. The Nurse Consultant indicated RN #4 told them when receiving report from LPN #3 on 8/27/13 around 10:30 - 10:55 p.m., the LPN told her Resident #B's potassium level was 2.7 and she had given Kayexalate. RN #4 indicated she asked the LPN if she was sure it was Kayexalate and the LPN said yes. The RN indicated she then told the LPN she needed to call the Physician because Kayexalate was to lower the potassium and that is when LPN called the Physician and RN #4 went to assess 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  08/30/2013
--	---	--	---

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>found the resident unresponsive breathing shallow, without a palpated pulse, yelled out for other staff to call 911, and CPR was started by herself and LPN #3 until the paramedics arrived. The RN also reported that LPN #3 told her the resident did not drink all of the Kayexalate medication.</p> <p>This federal tag relates to Complaint IN00133794.</p> <p>3.1-37(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  08/30/2013
--	---	--	---

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
F000329 SS=G	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure the resident's drug regime remained free of unnecessary medications related to the continued administration of cardiac medications without adequate monitoring of vital signs for 1 of 4 residents reviewed for unnecessary medications in the sample of 15. (Resident #B)</p> <p>Findings include:</p>	F000329	F329 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified: Licensed staff that cared for Resident #B received education and corrective action in relation to informing the physician of the pulse rate below 60. How the	09/25/2013

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  08/30/2013
--	---	--	---

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>1. The record for Resident #B was reviewed on 8/27/13 at 1:30 p.m. The resident was admitted to the facility on 8/23/13. The resident's diagnoses included, but were not limited to, congestive heart failure, syncope and collapse, cataract, high blood pressure, permanent cardiac pacemaker, cerebral vascular accident (stroke).</p> <p>Review of the 8/24/13 admission Physician orders indicated there were orders for the resident to receive the following medications:</p> <ul style="list-style-type: none"> <li>-Amiodarone HCL (a cardiac medication to control irregular heart beats) 200 milligrams twice day at 9:00 a.m. and 5:00 p.m.</li> <li>-Carvedilol (a cardiac medication to lower blood pressure) 12.5 milligrams twice a day at 9:00 a.m. and 5:00 p.m.</li> <li>-Spironalactone (a diuretic) 25 milligrams - give 1/2 tablet once a day at 9:00 a.m.</li> <li>-Furosemide (a diuretic medication to lower blood pressure) 80 milligrams once a day at 9:00 a.m.</li> <li>-Digoxin (a cardiac medication to decrease heart rate and control irregular heart rates) 0.125 milligrams once a day at 9:00 a.m.</li> <li>-Metolazone(a diuretic medication to lower blood pressure) 5 milligrams</li> </ul>		<p>facility identified other residents: An audit was completed on residents receiving digoxin, and no further issues were identified. Measures put into place/ System changes: Licensed staff has been re-educated by Pharmacist on monitoring of cardiac medications and their effect, as well as reporting abnormal vital sign findings to the physician. The DON or designee will audit MAR on at least 3 residents per week receiving digoxin for pulse rates below 60 and physician notification. The DON/ designee is responsible for oversight of these audits. Staff will be addressed and re-educated if concerns are noted. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. 5) Date of compliance: 09-25-2013</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  08/30/2013
--	---	--	---

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>once a day at 9:00 a.m.</p> <p>There were no Physician ordered parameters to hold the above medications for low heart rates or low blood pressure readings. There were no Physician orders for checking the resident's blood pressure or heart rate prior to administering the above medications. All of the above ordered medications were signed out as administered to the resident on 8/25/13.</p> <p>All of the above ordered medications were signed out as administered to the resident on 8/27/13 except the 9:00 a.m. dose of Digoxin .125 milligrams.</p> <p>Review of the 8/2013 Vital Signs record indicated the resident's pulse (heart rate) rates were recorded as below 60 beats per minute on the following dates/times: 8/25/13 at 5:09 a.m.- Pulse 46 and irregular 8/25/13 at 10:00 a.m.- Pulse rate 58 8/27/13 at 3:15 p.m.- Pulse rate 40</p> <p>The 2010 Nursing Spectrum Drug Handbook was reviewed. The Drug Handbook indicated Digoxin was an antiarrhythmic medication and indications for the use of the medication included, heart failure, atrial fibrillation and atrial flutter.</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  08/30/2013
--	---	--	---

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>Adverse reactions to Digoxin included bradycardia (slow heart rate). Patient monitoring included assessing the patient's apical pulse regularly for one full minute. Patient monitoring also included to withhold the medication for a heart rate less than 60 beats/minute and notify the prescriber.</p> <p>The 2010 Nursing Spectrum Drug Handbook also indicated Amiodarone was an antiarrhythmic medication and indications for the use of the medication included,ventricular arrhythmias. Patient monitoring included checking the resident's pulse and heart rhythm regularly.</p> <p>The 2012 Nursing Spectrum Drug Handbook also indicated Carvedilol as an antihypertensive medication and patient monitoring included monitoring vital signs. Contraindications to the use of the medication included bradycardia(a slow heart rate).</p> <p>When interviewed via telephone on 8/29/13, the resident's Physician indicated he had not been informed of the resident's heart rates being below 60 since she was admitted.</p> <p>When interviewed on 8/29/13 at 2:10</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  08/30/2013
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>p.m., the Nurse Consultant indicated inservicing was initiated on 8/28/13 related to the administration of medications, Kayexalate, and procedure for administering unfamiliar medications. The Nurse Consultant indicated the facility did not address the residents other medications or heart rates as this time as the main concern was related to the administration of the Kayexalate medication.</p> <p>This federal tag relates to Complaint IN00133794.</p> <p>3.1-48(a)(3) 3.1-48(a)(5)</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  08/30/2013
--	---	--	---

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
F000333 SS=G	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents remained free of significant medication errors related to not administering the correct medication as ordered by the Physician for 1 of 5 resident's reviewed for the administration of medications in the sample of 15. This resulted in the resident being found unresponsive with shallow breathing and the absence of a palpated pulse requiring the initiation of CPR (Cardio Pulmonary Resuscitation) and transport to the hospital via EMS (Emergency Medical Services) ambulance. (Resident #B) (LPN #3)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 8/27/13 at 1:30 p.m. The resident was admitted to the facility on 8/23/13. The resident's diagnoses included, but were not limited to, congestive heart failure, syncope and collapse, cataract, high blood pressure, permanent cardiac pacemaker, cerebral vascular</p>	F000333	<p>F333 The facility requests paper compliance for this citation. The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified: Regarding Resident #B, LPN # 3 was suspended immediately, and an internal investigation was started. How the facility identified other residents: Audit was completed on all residents that received Kionex (Kayexalate) in the last 30 days, and no further issues were identified. Measures put into place/ System changes: Licensed staff has been re-educated regarding indications for use of medications, such as Kionex (Kayexalate); as well as signs and symptoms of hyperkalemia and hypokalemia. Licensed staff has been re-educated regarding procedure for administering unfamiliar drugs. Licensed staff has been re-educated regarding critical abnormal lab values, assessment and immediate physician notification. A post test was completed. The DON will be</p>	09/25/2013

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  08/30/2013	
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>accident (stroke).</p> <p>Review of the 8/24/13 admission Physician orders indicated there were orders for the resident to receive the following medications: Furosemide (a diuretic) 80 milligrams once a day at 9:00 a.m. Potassium Bicarbonate &amp; Chloride 25 milliequivalent tablet one time a day at 9:00 a.m. Review of the 8/2013 Medication Administration Record indicated the above two medications were signed out as administered to the resident on 8/24/13 thru 8/27/13.</p> <p>The 8/23/13 Nursing Progress Notes indicated the first entry was made at 2:00 p.m. This entry indicated the resident was admitted to the facility via ambulance and was in stable condition. The entry also indicated the Physician was notified of the admission and orders were received for a BMP (laboratory test) to be drawn every three months.</p> <p>Review of the laboratory test results indicated a BMP was collected by the Laboratory on 8/27/13 at 5:45 a.m. The test results indicated the resident's Potassium level was 2.7 (normal level 3.7-5.1). The level on 2.7 was identified as a Critical level. The report indicated the critical level</p>		<p>notified of all alert and critical labs as well as the physician. The DON or designee will complete at least 5 medication pass observations per week on varied shifts to ensure licensed staff is familiar of the medications they are giving. The DON/ designee is responsible for oversight of these audits. Staff will be addressed and re-educated if concerns are noted. How the corrective actions will be monitored: The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. Date of compliance:09/25/2013</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  08/30/2013
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 called to, faxed, and read back to LPN #3 on 8/27/13 at 3:52 p.m. There was handwritten documentation on the bottom of the above report. The documentation indicated the Physician was notified, new orders were received for Kionex (a medication to lower high potassium levels) 30 mls (milliliters) STAT and 30 mls at hour of sleep. There hand written documentation also indicated a repeat potassium laboratory test was to be completed on 8/28/13 and the Physician was to be called with the results and all orders were verified and carried out. LPN #3 signed her signature under the above documentation with the date of 8/27/13.</p> <p>A Physician's order was entered on 8/27/13 at 4:15 p.m. for Kionex suspension 15 Grams/60 ml (milliliters) -give 30 mls by mouth Stat and #0 mls at bedtime one time. Another Physician's order was entered on 8/27/13 at 8:46 p.m. for a Potassium level to be drawn on 8/28/13 and to notify the Physician of the results.</p> <p>Review of the 8/27/13 Nursing Progress Notes indicated an entry was made at 8:28 p.m. This entry indicted the a call was received from</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  08/30/2013
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 staff members name) reporting a critical low potassium level of 2.7, the Doctor was called, and orders were received for Kionex 15 grams/60 mls to give 30 mls Stat and 30 mls at bedtime. The entry also indicated all orders were verified and carried and Kionex 15 grams/60 ml was pulled from the EDK (Emergency Drug Kit). This entry was completed by LPN #3.</p> <p>An EDK sign out sheet was completed by LPN #3 on 8/27/13 at 5:00 p.m. The sheet indicated LPN signed as removing Kionex 15 gms/60 ml from the EDK for Resident #B.</p> <p>Review of the 8/2013 Medication Administration Record indicated Kionex 30 mls of Kionex suspension 15 GM/60 ml was signed out as given on 8/27/13 at 9:56 p.m. LPN #3's initials were entered on the above entry. The entry did not indicate the resident refused the medication, spit out the medication, or the medication was not given.</p> <p>The 8/27/13 EMS ambulance service Final Patient Care Report was reviewed on 8/29/13. The report indicated the ambulance service arrived at the facility on 8/27/13 at</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  08/30/2013
--	---	--	---

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>11:00 p.m. The report indicated the ambulance was dispatched to the facility related to a full arrest with CPR in progress per the facility staff, CPR was paused, the patient was pulseless and anemic(not breathing), and CPR was resumed. The report also indicated the facility staff reported the resident had a low potassium level and was supposed to be given potassium but was mistakenly given Kayexalate. The resident was transported to hospital.</p> <p>When interviewed on 8/29/13 at 9:55 p.m., the Nurse Consultant indicated the resident's 8/27/13 critical Potassium level of 2.7 was called to LPN #3 on 8/27/13 at 3:52 p.m. The Nurse Consultant indicated the LPN was interviewed and had been suspended. The Nurse Consultant indicated the LPN was interviewed and stated she received the call from the lab and attempted to call the Physician and then spoke to him around 7:00 p.m. and received orders from the Physician. The Nurse Consultant indicated the LPN indicated the Physician was talking fast and she could not understand what he was saying and the fourth time she asked him he started to spell the name of the medication out to her and the LPN stated the said the</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  08/30/2013
--	---	--	---

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>letters K, A, Y, E . In the interview the LPN also indicated she had never heard of the medication and it was around 9:30 p.m. when she went to administer the medication to the resident. The LPN indicated she went to the EDK with the spelling the Physician gave and she had to ask the Evening Supervisor about the name and the Supervisor told her the medication name would be under "Kionex." The LPN indicated she then prepared 30 mls of the medication but the resident stuck her tongue in the medication cup and refused to drink it and she then went back to call the Physician to inform him the resident refused and the Physician told her he said K-lyte and not Kayexalate and this phone call was around 10:30 p.m. LPN #3 indicated at the time there was about 25 cc's left in the med cup and she threw it away without having a witness. The LPN stated when the midnight shift Nurse (RN #4) went into the resident's room about 10:30 p.m. she yelled out there was a Code, the crash cart was pulled and CPR was initiated until the paramedics arrived.</p> <p>Continued interviewed with the Nurse Consultant at the above time, indicated LPN #3 indicated she did not know Kayexalate decreased</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  08/30/2013	
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>Potassium levels as she had never given the medication before. The Nurse Consultant indicated they had called the LPN to come back to facility for further interview and the LPN did not return to the facility. The Nurse Consultant indicated the facility request the Physician to come to the facility to further review the incident. The Physician indicated he reviewed his phone calls from 8/27/13 and indicated he had received a call at 4:27 p.m. that lasted 16 minutes. The Physician indicated this call was from LPN #3 as he recalled how he had to keep repeating himself to the Nurse during this call as she kept asking him what he said. The Physician indicated he finally said " K L Y T E , spelling out the letters and saying 25 milliequivalent. The Physician indicated he received the next call at 10:43 p.m. when the Nurse reported she had given Kayexalate and wanted to know what she should do. The Physician indicated he responded to the Nurse that he had not given the order for Kayexalate as that would decrease the potassium level.</p> <p>Continued interview with the Nurse Consultant at this time, indicated RN #4 had also been interviewed. The Nurse Consultant indicated RN #4 told them when receiving report from</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  08/30/2013
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>LPN #3 on 8/27/13 around 10:30 - 10:55 p.m., the LPN told her Resident #B's potassium level was 2.7 and she had given Kayexalate. RN #4 indicated she asked the LPN if she was sure it was Kayexalate and the LPN said yes. The RN indicated she then told the LPN she needed to call the Physician because Kayexalate was to lower the potassium and that is when LPN called the Physician and RN #4 went to assess the resident, found the resident unresponsive breathing shallow, without a palpated pulse, yelled out for other staff to call 911, and CPR was started by herself and LPN #3 until the paramedics arrived. The RN also reported that LPN #3 told her the resident did not drink all of the Kayexalate medication.</p> <p>This federal tag relates to Complaint IN00133794.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>				