STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE HEALTH & REHABILITATION CENTER	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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00184006. Complaint IN00184006-Substantiated. Federal/State deficiencies related to the allegations were cited at F225 and F226. Survey dates: October 7 and 8, 1015 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census bed type: SNF/NF: 80 Total: 80 Census Payor type: Medicare: 15 Medicaid: 62 Other: 03 Total: 80 Sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on October 13, 2015.	F 0000	Lincolnshire Healthcare and Rehab Center 8380 Virginia ST Merrillville, IN 46410-6231 Provider#: 155650 AIM Number: 100266950 Facility ID: 000577 COMPLAINT SURVEY 10/8/15 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility formally request paper compliance for all citations identified regarding complaint survey 10/8/15. Please feel free to contact me, Kenan Weekley, Administrator, with any questions or concerns. Thank you in advance. KENAN WEEKLEY	

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

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F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his			

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	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. Based on record review and interview, a Covered Individual (Volunteer through a contracted agency), failed to immediately report an allegation of abuse to the Administer related to an allegation of sexual abuse for 1 of 3 abuse allegations/unusual occurrences reviewed for 1 of 3 residents reviewed for abuse. (Resident #G) Finding includes: During an interview on 10/07/15 at 10:49 a.m., Resident #G indicated, "one of the boys tried to get into bed with me". She indicated this occurred eight weeks ago and the boy had touched her personal area. She indicated it had happened again, the next night. Resident #G's record was reviewed on 10/07/15 at 11:15 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and dementia. The resident was on Hospice services. An Annual Minimum Data Set assessment, dated 08/21/15, indicated the	F 0225	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** F 225 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon notification of the allegation for RG, the facility immediately reported the allegation to ISDH. A thorough investigation was completed and a final report was sent to ISDH. The facility was unable to substantiate the allegation of abuse. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice.	10/21/2015

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	resident's cognition was intact, and was extensive assistance to dependent on staff for all activities of daily living. An Event Note, dated 09/30/15 at 1:42 p.m., indicated the resident had reported to a Hospice Volunteer a white male failed to conduct themselves in accordance to the facility policy. An Indiana State Department of Health (ISDH) Incident , dated 09/30/15, indicated, "...Incident Date: 09/30/15 Incident Time: 01:15 p.m....09/30/15 Director of Nursing received a phone call from residents hospice company in which they stated that a volunteer informed them that this resident reported actions by someone at the facility that are not consistent with facility's policy...Follow up added--10/05/15 It was reported to the Adminsitrator that a volunteer from (Hospice Company) reported that this resident had reported to her that every week a white male comes to her room and ask (sic) her to comb his private area. An investigation was initiated by Administrator...unable to substantiate the allegation of abuse..." A hand-written note, included in the investigation, written by the Director of Nursing (DoN), dated 09/30/15, no time documented, indicated she had received a		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Unity Hospice has completed in-servicing with employees including volunteers related to the immediate notification of the facility administrator with any allegation of abuse. Unity Hospice has submitted an addendum to their contract which includes the “immediate notification to the administrator with any allegation of abuse.” The facility has notified Unity Hospice by letter informing the vendor of the following requirements. To provide guidelines for the Facility compliance with Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requiring specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility. The facility has reviewed additional vendors and a letter has been sent to vendors of the following requirements.To provide	

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	call from the Hospice Company and was informed the Volunteer for Resident #G documented the resident made the following statement, "a white male comes in her room weekly and makes her comb his p....". The DoN further indicated during an interview with the resident, Resident #G denied the statement. A Fax from the Hospice Company, dated 09/30/15, indicated, "Volunteer Visit Note...Not completely sure if she is hallicunating (sp?) (spelling) Told me a white man comes into her room once a week and makes her 'comb his p....'..." The note was signed by the Volunteer and dated 09/28/15. A contract with the Hospice Company, dated 08/07/14, received from the Administrator as current, on 10/08/15 at 12 p.m., indicated, "This letter will confirm our agreement by and between (Facility Name)...and (Hospice Name)...to provide hospice services in accordance with applicable state and Medicare regulations...Appendix... (Hospice Name) is required to report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse...to the Nursing Facility administrator (sic) within 24 hours of (Hospice Name)		guidelines for the Facility compliance with Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requiring specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility. This letter will be sent annually. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The Administrator/designee will interview 3 care and services vendors monthly. Interview will include knowledge of facility abuse policy. A summary of interview findings will be presented to the Quality Improvement committee monthly for 6 months. The Quality Improvement committee will determine if additional monitoring is required thereafter. **Date by which systemic corrections will be completed.** 10/21/2015	

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	becoming aware of the alleged violation..." During an interview on 10/08/15 at 9:43 a.m., the DoN indicated the Hospice Company had not been informed about the allegation immediately from the Volunteer. During an interview on 10/08/15 at 10:47 a.m., the Administrator indicated the Hospice Company was a contracted provider. During an interview on 10/08/15 at 11:59 a.m., the Administrator indicated the Hospice Company were aware they had to report the allegation of abuse to the facility immediately. He indicated the Hospice Company knew the facility's expectations. This Federal Tag relates to Complaint IN00184006. 3.1-28(c)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES			

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	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to a Volunteer with a contracted agency failed to report an allegation of sexual abuse immediately to the facility's Administrator, for 1 of 3 abuse allegations/unusual occurrences reviewed for 1 of 3 residents reviewed for abuse. (Resident #G) Finding includes: Resident #G's record was reviewed on 10/07/15 at 11:15 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and dementia. The resident was on Hospice services. An Indiana State Department of Health (ISDH) Incident , dated 09/30/15, indicated, "...Incident Date: 09/30/15 Incident Time: 01:15 p.m....09/30/15 Director of Nursing received a phone call from residents hospice company in which they stated that a volunteer informed them that this resident reported actions by someone at the facility that are not consistent with facility's policy...Follow up added--10/05/15 It was reported to the	F 0226	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** F 226 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Upon notification of the allegation for RG, the facility immediately reported the allegation to ISDH. A thorough investigation was completed and a final report was sent to ISDH. The facility was unable to substantiate the allegation of abuse. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Unity Hospice has completed in-servicing with employees including volunteers related to the	10/21/2015

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	Adminsitrator that a volunteer from (Hospice Company) reported that this resident had reported to her that every week a white male comes to her room and ask (sic) her to comb his private area. An investigation was initiated by Administrator...unable to substantiate the allegation of abuse..." A hand-written note, included in the investigation, written by the Director of Nursing (DoN), dated 09/30/15, no time documented, indicated she had received a call from the Hospice Company and was informed the Volunteer for Resident #G documented the resident made the following statement, "a white male comes in her room weekly and makes her comb his ....". The DoN further indicated during an interview with the resident, Resident #G denied the statement. A Fax from the Hospice Company, dated 09/30/15, indicated, "Volunteer Visit Note...Not completely sure if she is hallicunating (sp?) (spelling) Told me a white man comes into her room once a week and makes her 'comb his p....'..." The note was signed by the Volunteer and dated 09/28/15. A contract with the Hospice Company, dated 08/07/14, received from the Administrator as current, on 10/08/15 at		immediate notification of the facility administrator with any allegation of abuse. Unity Hospice has submitted an addendum to their contract which includes the "immediate notification to the administrator with any allegation of abuse." The facility has notified Unity Hospice by letter informing the vendor of the following requirements. To provide guidelines for the Facility compliance with Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requiring specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility. The facility has reviewed additional vendors and a letter has been sent to vendors of the following requirements. To provide guidelines for the Facility compliance with Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requiring specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility. This letter will be sent annually per facility policy. **How the corrective**	

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	12 p.m., indicated, "This letter will confirm our agreement by and between (Facility Name)...and (Hospice Name)...to provide hospice services in accordance with applicable state and Medicare regulations...Appendix... (Hospice Name) is required to report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse...to the Nursing Facility administrator (sic) within 24 hours of (Hospice Name) becoming aware of the alleged violation..." During an interview on 10/08/15 at 9:43 a.m., the DoN indicated the Hospice Company had not been informed about the allegation immediately from the Volunteer. During an interview on 10/08/15 at 9:53 a.m., the Administrator indicated he had not contacted the Hospice Company to inquire if the Volunteers were notified of the policy for reporting allegations of abuse. During an interview on 10/08/15 at 10:47 a.m., the Administrator indicated the Hospice Company was a contracted provider. He indicated he would check to see if the Hospice Company had been in-serviced on the Abuse and		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The Administrator/designee will interview 3 care and services vendors monthly. Interview will include knowledge of facility abuse policy, requiring immediate notification of any allegation to the facility administrator. A summary of interview findings will be presented to the Quality Improvement committee monthly for 6 months. The Quality Improvement committee will determine if additional monitoring is required thereafter. **Date by which systemic corrections will be completed.** 10/21/2015	

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	ElderJustice Act policy of the facility. During an interview with the RN Corporate Nurse Consultant, on 10/08/15 at 11:24 a.m., she indicated there was a sign posted (facility entrance hallway) which informed the Volunteer, visitors, and Covered Individuals of who and when to report a crime/allegations of abuse. During an interview on 10/08/15 at 11:59 a.m., the Administrator indicated the Hospice Company were aware they had to report the allegation of abuse to the facility immediately. He indicated the Hospice Company knew the facility's expectations. A facility policy, dated 05/10/13, titled, "Reporting Reasonable Suspicion of a Crime in a LTC (Long Term Care) Facility...", received from the RN Corporate Nurse Consultant as current, indicated, "...The Facility shall annually train and provide in-service education to its operators, employees and managers. The facility shall take additional steps to ensure that Covered Individuals are notified annually of their duties to report...Notifications to Covered Individuals will require that all reasonable suspicions are communicated to The Facility Administrator			

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	immediately..." A facility policy, dated 08/08, titled, "Reporting Abuse to Facility Management", received from the RN Corporate Nurse Consultant as current, indicated, "It is the responsibility of our employees...visitors...to promptly report any incident or suspected incident of neglect or resident abuse...to facility management...must immediately report any suspected abuse or allegation...to the Director of Nursing Services/Administrator...Any staff member or person affiliated with this facility...shall immediately report, or cause a report to be made of, the mistreatment or offense..." This Federal Tag relates to Complaint IN00184006. 3.1-28(a)			