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	01/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00250900. Complaint IN00250900 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0609, F0610, F0656, and F9999. Survey date: January 18, 2018 Facility number: 000577 Provider number: 155650 AIM number: `00266950 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 17 Medicaid: 54 Other: 10 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/19/18.	F 0000		

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

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F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within			

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	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, the facility failed to report an injury of unknown source in a timely and thorough manner to the ISDH (Indiana State Department of Health), related to a suspicious injury due to the location and size of the bruise, for 1 of 3 residents reviewed for injuries of unknown source. (Resident B) Finding includes: Resident B's record was reviewed on 01/17/18 at 11:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 10/19/17, indicated the cognition status could not be assessed, no behaviors present, extensive assistance of two for bed mobility and transfers, and upper extremity impairment of one side. A Nurse's Progress Note, dated 01/05/18 at 8:15 a.m., indicated the CNA found bruising of the chest during morning care. The bruising was across the chest with swelling to the upper chest. There was pain with touch and range of motion. The assessments of the areas indicated:	F 0609	**Lincolnshire** **Complaint Survey, 1/17/18** **F609** **Reporting of Alleged Violations** 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. Facility cordially requests paper compliance in regards to this plan of correction. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? ISDH notified of injury of unknown origin on 1/8/18. No further intervention possible for R1.	01/26/2018

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	01/05/18 at 9:58 a.m., a bruise was found across the chest measuring 51 cm (centimeters) by 6 cm, purplish/ black color with swelling to right upper chest and mild pain. 01/05/18 at 10:13 a.m., a bruise was found to the right upper inner arm, measuring 2 cm by 1.5 cm, reddish/blue in color, and no pain. 01/05/18 at 10:16 a.m., a bruise was found on the right antecubital, measuring 1.4 cm by 2 cm, reddish/blue in color, and no swelling or pain. The ISDH Reportable Incident indicated the incident occurred on 01/08/18 at 1:10 p.m. The description, dated 01/08/18, indicated on 01/05/18 a bruise was found to the chest. Type of injury was bruise to the chest. The 5-day follow-up, dated 01/10/18, indicated multiple staff were interviewed and, based on interviews, the facility believes the discoloration my have been caused by an inappropriate transfer. No further concerns identified. There was no measurement of the chest bruise included on the initial or follow-up report to the ISDH.		**How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents are potentially at risk of the same alleged deficient practice. All current, facility-acquired injuries have been reviewed to ensure that they did not meet reportable criteria. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Administrator educated on properly reporting injuries of unknown origin and timely investigation of reportable events. All department managers in-serviced regarding properly reporting injuries of unknown origin. Staff in-serviced regarding facility abuse prevention policy and investigating suspected events.	

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	During an interview on 01/17/18 at 1:22 p.m., the Administrator indicated he did not suspect the bruise to be of an unknown source due to the investigation indicated it could have been caused by an improper transfer. He did not think the bruise was in a suspicious spot. It was reported on 01/08/18 when the family voiced they wanted it reported. The bruise should have been reported on 01/05/18. During an interview on 01/17/18 at 2:11 p.m., the Wound Nurse indicated she notified the Administrator and the Director of Nursing of the bruise in the morning meeting on 01/05/18. A facility policy, undated and received from the Administrator on 01/17/18 at 1:30 p.m., titled, "Abuse Prevention Program", indicated, "...An injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was no observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury...The resident's Department of Public Health shall be informed as soon as possible within 24 hours, but no later than 2 hours if the abuse		How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Administrator/designee will immediately report injuries of unknown origin to both the ISDH and the Extended Clinical team. ECC consulting team will review injuries of unknown origin to ensure reporting procedure was conducted timely. ECC will provide summary of this review weekly. Additionally ECC will conduct a random review of clinical documentation weekly for compliance. Any suspected events will be reported to ISDH following appropriate reportable criteria. DON/designee will present a summary of the ECC audit findings to the Quality Assurance Committee monthly for 6 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. **Date of Completion:**	

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	results in resident injury or harm...The written report should contain...Any obvious injuries or complaints of injury..." This Federal tag relates to Complaint IN00250900. 3.1-28(b)(2)		1/26/2018	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to investigate an injury of unknown origin in a timely manner, for 1 of 3 residents with injury of an unknown origin reviewed. (Resident B)	F 0610	**Lincolnshire Health & Rehabilitation Center** **Complaint Survey 1/17/18**	01/26/2018

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	Finding includes: Resident B's record was reviewed on 01/17/18 at 11:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 10/19/17, indicated the cognition status could not be assessed, no behaviors present, extensive assistance of two for bed mobility and transfers, and upper extremity impairment of one side. A CNA care card, received from the Director of Nursing (DON) on 01/17/18 at 2:10 p.m., indicated the resident required a mechanical lift with two assistants for transfers. A Nurse's Progress Note, dated 01/05/18 at 8:15 a.m., indicated the CNA found bruising of the chest during morning care. The bruising was across the chest with swelling to the upper chest. There was pain with touch and range of motion. The assessments of the areas indicated: 01/05/18 at 9:58 a.m., a bruise was found across the chest measuring 51 cm (centimeters) by 6 cm, purplish/ black color with swelling to right upper chest and mild		**INFORMAL DISPUTE RESOLUTION** **F610** It is the position of Lincolnshire Health and Rehabilitation Center that the findings reported in the Complaint Survey are incomplete and in places inaccurate. The facility is presenting compelling information to dispute the deficiency of F610 and respectfully requests the tag be deleted. On 1/17/18, ISDH completed a complaint survey citing the facility F610 at a "D" level alleging the facility failed to: · Investigate an injury of unknown origin in a timely manner, for 1 of 3 residents with injury of an unknown origin reviewed. Lincolnshire Health & Rehabilitation Center contends they investigated the injury to R1 in a timely manner. On 1/5/18, facility Administrator was notified of a bruise to R1. Staff interviewed on 1/5/18 include: Shante Brown (LPN), Colleen Ahlers (LPN), Felicia Benson (LPN), Randi Croy (LPN), Patience Gray (CNA), and Lisa Mars (CNA). The 1/5/18 interview with Patience Gray, CNA indicated that R1 was observed on 1/4/18 sitting up in wheelchair without a hoyer lift pad under her. During the 1/5/18 interview with	

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	pain. 01/05/18 at 10:13 a.m., a bruise was found to the right upper inner arm, measuring 2 cm by 1.5 cm, reddish/blue in color, and no pain. 01/05/18 at 10:16 a.m., a bruise was found on the right antecubital, measuring 1.4 cm by 2 cm, reddish/blue in color, and no swelling or pain. A Resident Grievance/Complaint Form, dated 01/08/18, indicated a bruise was found on the resident's chest on 01/05/18, family was notified and informed that improper transfer was suspected. Family was notified a full investigation into the source of the bruise would be conducted. The ISDH Reportable Incident, indicated the incident occurred on 01/08/18 at 1:10 p.m. The description, dated 01/08/18, indicated on 01/05/18 a bruise was found to the chest. Type of injury was bruise to the chest. Preventative measures 01/08/18, investigation initiated. The 5-day follow-up, dated 01/10/18, indicated multiple staff were interviewed and based on interviews, the facility believes the discoloration my have been caused by		Randi Croy, LPN it was stated that around 2pm on 1/4/18, R1 was observed lying in bed. None of the staff interviewed indicated they had assisted transferring R1 from wheelchair to bed. Calls were placed to Deonte Cotton, CNA on 1/5/18 and on 1/9/18 Deonte Cotton, the CNA assigned to R1 on 1/4/18 admitted to transferring R1 without a mechanical lift or staff assistance. On 1/5/18, multiple calls were placed to Brianna Christman, contracted CNA through Nightingale Staffing that was assigned to A Unit on 1/4/18. Facility was unable to reach Ms. Christman despite multiple attempts and voicemails being left. Nightingale Staffing was contacted on 1/5/18 and notified of facility attempting to contact Ms. Christman. Administrator spoke with R1's family in person on 1/5/18 and explained that the source of bruising was suspected to be an improper transfer. Family acknowledged that investigation and staff interviews would be ongoing. Administrator again spoke with family on 1/8/18 to follow up on interviews. It was during this conversation that family indicated they wanted ISDH notified of event. Facility immediately complied with this request and notified ISDH. On 1/10/18, Administrator informed family that CNA admitted to improperly transferring R1 on 1/4/18. Although the facility did not report the bruise on 1/5/2018, the facility	

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	an inappropriate transfer. No further concerns identified. During an interview on 01/17/18 at 1:22 p.m., the Administrator indicated he did not suspect the bruise to be of an unknown source due to the investigation indicated it could have been caused by an improper transfer. He did not think the bruise was in a suspicious spot. It was reported on 01/08/18 when the family voiced they wanted it reported. During an interview on 01/17/18 at 2:11 p.m., the Wound Nurse indicated she notified the Administrator and the Director of Nursing of the bruise in the morning meeting on 01/05/18. A facility policy, undated and received from the Administrator on 01/17/18 at 1:30 p.m., titled, "Abuse Prevention Program", indicated, "...Supervisors shall immediately inform the administrator...of all reports of incidents...Upon learning of the report, the administrator...shall initiate an incident investigation...An injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was no observed by any person or the source of the injury could not be explained by the resident; and The injury		has provided evidence that the event was investigated both timely and thoroughly. In conclusion, after review of all the facts, the facility respectfully requests that F610 be eliminated from the statement of deficiencies or at a minimum the scope and severity be reduced. Lincolnshire Complaint Survey, 1/17/18 F610 Investigate/Prevent/Correct Alleged Violation 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. Facility cordially requests paper compliance in regards to this plan of correction. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	

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	is suspicious because of the extent of the injury or the location of the injury..." This Federal tag relates to Complaint IN00250900. 3.1-28(d)		The investigation for the injury of unknown origin for R1 has been completed and has been submitted to ISDH. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are potentially at risk of the same alleged deficient practice. The facility has reviewed all residents. Any injury of unknown origin has been reported to ISDH. What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur? Administrator educated on the timely investigation for any injuries of unknown origin. Staff in-serviced on facility abuse prevention program. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Administrator/designee will immediately report to ISDH and initiate an investigation for any injuries of unknown origin to both the ISDH and the Extended	

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			Clinical team. ECC consulting team will review the investigations for injuries of unknown origin to ensure the investigation was conducted timely. ECC will provide summary of this review weekly. DON/designee will present a summary of the ECC audit findings to the Quality Assurance Committee monthly for 6 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. Date of Completion: 1/26/2018	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the			

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	following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure a resident's plan of care was implemented, related to a mechanical lift for transfers, for 1 of 3 residents reviewed for plans of care. (Resident B)	F 0656	**Lincolnshire** **Complaint Survey, 1/17/18** **F 656**	01/26/2018

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	Finding includes: Resident B's record was reviewed on 01/17/18 at 11:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 10/19/17, indicated the cognition status could not be assessed, no behaviors present, extensive assistance of two for bed mobility and transfers, and upper extremity impairment of one side. A care plan, dated 7/19/16 and revised on 11/16/17, indicated limited functional status in regards to the ability to transfer self. Interventions, dated 7/19/16, included ensure proper transfer technique and use appropriate equipment with any mechanical lift device (straps, slings), and utilize additional staff with transfers when needed. A CNA care card, received from the Director of Nursing (DON) on 01/17/18 at 2:10 p.m., indicated the resident required a mechanical lift with two assistants for transfers. A Nurse's Progress Note, dated 01/05/18 at 8:15 a.m., indicated the CNA found bruising of the chest during morning care.		**Develop/Implement Comprehensive Care Plan** 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. Facility cordially requests paper compliance in regards to this plan of correction. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R1 is currently being transferred by 2 people using a mechanical lift. Both the Care Card and the Care Plan are accurate. **How will the facility identify other residents having the potential to be affected by the same deficient practice?**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The bruising was across the chest with swelling to the upper chest. There was pain with touch and range of motion. The assessments of the areas indicated: 01/05/18 at 9:58 a.m., a bruise was found across the chest measuring 51 cm (centimeters) by 6 cm, purplish/ black color with swelling to right upper chest and mild pain. 01/05/18 at 10:13 a.m., a bruise was found to the right upper inner arm, measuring 2 cm by 1.5 cm, reddish/blue in color, and no pain. 01/05/18 at 10:16 a.m., a bruise was found on the right antecubital, measuring 1.4 cm by 2 cm, reddish/blue in color, and no swelling or pain. The undated staff statements included in the Investigation, received from the Administrator on 01/17/18 at 11:14 a.m., indicated CNA 1 admitted to transferring the resident alone without using the mechanical lift on the evening of 01/04/18. During an interview on 01/17/18 at 12:07 p.m., the DON indicated CNA 1 had said there was no mechanical lift pad under the resident. CNA 1 transferred the resident by		All residents that require assistance from staff for transfers are potentially at risk of the same alleged deficient practice. Audit completed for residents needing mechanical lift transfers to ensure clinical documentation matches resident need. CNA in question educated on proper resident transfer techniques **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Clinical staff have been educated regarding resident transfer techniques and following resident plan of care. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON/designee will observe 5 residents requiring mechanical	

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	155650	A. BUILDING 00 B. WING	01/17/2018

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	the waist of the pants and pivoted her to the bed. CNA 1 should not have transferred the resident back to bed by himself. Agency CNA 2 had worked on the day shift and they thought the resident was transferred to the wheelchair without the mechanical lift, but had not been able to verify this with Agency CNA 2 due to Agency CNA 2 had not returned calls. This Federal tag relates to Complaint IN00250900. 3.1-35(g)(2)		lift/staff assistance transfers weekly for 6 months to ensure proper resident transfer techniques are followed according to documented resident plan of care. Administrator/designee will present a summary of the audits to the Quality Assurance Committee monthly for 6 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. Date of Completion: 1/26/2018	
F 9999 Bldg. 00	STATE RULES: 3.1-13 Administration and Management If the facility does not employee a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the	F 9999	**Lincolnshire** **Complaint survey, 1/17/18** **State Rules: 3.1-13**	01/26/2018

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	facility under a written agreement. Such agreements pertaining to services furnished by outside resources must specify, in writing that the facility assumes responsibility for Orientation to pertinent facility policies and residents to whom they are responsible. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure an Agency CNA received Orientation to the facility's pertinent policies and procedures for 1 of 1 Agency CNA reviewed. (Agency CNA 2) Finding includes: During an interview on 01/17/18 at 2:26 p.m. , the Administrator indicated Agency CNA 2 had only worked a few days at the facility and there was no orientation record available for Agency CNA 2. Packets were sent to the Agency electronically and they were to complete the orientation. There was no signed proof from the Agency this was completed. The Director of Nursing provided Agency CNA 2's work schedule on 01/17/18 at 3:15 p.m., which indicated the CNA worked on December 7, 11, 16, 17, 19, 20, 23, 27, and 29, 2017 and January 4,		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. Facility cordially requests paper compliance in regards to this plan of correction. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Agency staff member in question is no longer assigned to this facility. No further corrective action is possible. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents are potentially at risk of the same alleged deficient practice. Agency staff member in question is no longer assigned to this facility.	

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	2018. This State rule relates to Complaint IN00250900.		**What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** All agency staff members assigned to facility will be oriented to facility prior to being given resident assignment. All agencies have been educated regarding need for proper staff orientation prior to accepting resident assignment. Staff educated regarding process of providing orientation to agency staff members prior to the individual accepting resident assignment. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Administrator/designee will audit all agency staff assignments weekly to ensure proper orientation has been provided to the individual. Administrator/designee will present a summary of the audits	

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			to the Quality Assurance Committee monthly for 6 months. Thereafter, if determined necessary by the QA Committee, auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. Date of Completion: 1/26/2018	