STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION (X3		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155650	B. WING		01/17/2018
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	ROVIDER OR SUPPLIE	R		IRGINIA ST	
LINCOLN	ISHIRE HEALTH 8	REHABILITATION CENTER	MERR	LLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00					
	This visit was fo	or the Investigation of	F 0000		
	Complaint IN00	-			
	- Compi u m 11 (00				
	Complaint IN00	250900 - Substantiated.			
	Federal/state de	ficiencies related to the			
	allegations are c	eited at F0609, F0610,			
	F0656, and F999				
	1 0000, 4114 1 99	,,,			
	Survey date: January 18, 2018				
	Facility number	: 000577			
	Provider numbe				
	AIM number: `				
	Anvi number.	00200730			
	Census Bed Typ	ne:			
	SNF/NF: 81				
	Total: 81				
	10tai. 81				
	Census Payor T	vne:			
	-	ypc.			
	Medicare: 17				
	Medicaid: 54				
	Other: 10				
	Total: 81				
	Those deficients	ios roflost Stata Findinas			
		ies reflect State Findings			
	cited in accorda	nce with 410 IAC 16.2-3.1.			
		1 . 1 . 1/10/10			
	Quality review of	completed on 1/19/18.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 7/2018			
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 0609 SS=D Bldg. 00	abuse, neglect, exthe facility must: §483.12(c)(1) Ensiviolations involving exploitation or misinjuries of unknown misappropriation or reported immediate hours after the allegation to the result in serious than 24 hours if the allegation do not in result in serious be administrator of the officials (including Agency and adult state law provides care facilities) in a through established §483.12(c)(4) Reginvestigations to the designated recofficials in accordance.	conse to allegations of exploitation, or mistreatment, sure that all alleged grabuse, neglect, streatment, including on source and of resident property, are tely, but not later than 2 egation is made, if the the allegation involve abuse is bodily injury, or not later the events that cause the involve abuse and do not odily injury, to the ine facility and to other to the State Survey protective services where is for jurisdiction in long-term accordance with State law						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/17/2018 155650 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8380 VIRGINIA ST LINCOLNSHIRE HEALTH & REHABILITATION CENTER MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. F 0609 Lincolnshire 01/26/2018 Based on record review and interview, the facility failed to report an injury of unknown Complaint Survey, 1/17/18 source in a timely and thorough manner to the ISDH (Indiana State Department of Health), related to a suspicious injury due to F609 the location and size of the bruise, for 1 of 3 residents reviewed for injuries of unknown Reporting of Alleged Violations source. (Resident B) Finding includes: Please accept the following as the Resident B's record was reviewed on facility's plan of correction. This 01/17/18 at 11:14 a.m. Diagnoses included, plan of correction does not constitute an admission of guilt or but were not limited to, Alzheimer's disease. liability by the facility and is submitted only in response to the A Quarterly Minimum Data Set assessment, regulatory requirement. Facility cordially requests paper dated 10/19/17, indicated the cognition compliance in regards to this plan status could not be assessed, no behaviors of correction. present, extensive assistance of two for bed mobility and transfers, and upper extremity impairment of one side. What corrective action will be accomplished for those residents A Nurse's Progress Note, dated 01/05/18 found to have been affected by the at 8:15 a.m., indicated the CNA found deficient practice? bruising of the chest during morning care. The bruising was across the chest with swelling to the upper chest. There was pain ISDH notified of injury of unknown with touch and range of motion. origin on 1/8/18. No further intervention possible for R1. The assessments of the areas indicated:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155650 B. WING 01/17/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8380 VIRGINIA ST LINCOLNSHIRE HEALTH & REHABILITATION CENTER MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 01/05/18 at 9:58 a.m., a bruise was found across the chest measuring 51 cm How will the facility identify (centimeters) by 6 cm, purplish/ black color other residents having the with swelling to right upper chest and mild potential to be affected by the pain. same deficient practice? 01/05/18 at 10:13 a.m., a bruise was found to the right upper inner arm, measuring 2 All residents are potentially at risk of the same alleged deficient cm by 1.5 cm, reddish/blue in color, and no practice. All current, pain. facility-acquired injuries have been reviewed to ensure that they did 01/05/18 at 10:16 a.m., a bruise was found not meet reportable criteria. on the right antecubital, measuring 1.4 cm by 2 cm, reddish/blue in color, and no swelling or pain. What measures will the facility take or what systems will the The ISDH Reportable Incident indicated the facility alter to ensure that the problem will be corrected and incident occurred on 01/08/18 at 1:10 p.m. will not recur? 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. Administrator educated on properly reporting injuries of The 5-day follow-up, dated 01/10/18, unknown origin and timely indicated multiple staff were interviewed investigation of reportable events. All department managers and, based on interviews, the facility in-serviced regarding properly believes the discoloration my have been reporting injuries of unknown caused by an inappropriate transfer. No origin. Staff in-serviced regarding further concerns identified. facility abuse prevention policy and investigating suspected events. There was no measurement of the chest bruise included on the initial or follow-up report to the ISDH.

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155650	B. WING		01/17/2018	
NAME OF	PROVIDER OR SUPPLIE	8		ADDRESS, CITY, STATE, ZIP COD		
LINCOL	NOUIDE LIEALTH 0	DELIADII ITATION CENTED		VIRGINIA ST		
LINCOL	NOTIRE TEALIT &	REHABILITATION CENTER	IVIERR	RILLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	How will the corrective action	5.112	
	D	. 01/17/10 / 1 22		monitored to ensure the defici		
		riew on 01/17/18 at 1:22		practice will not recur, i.e., wh		
	•	istrator indicated he did not		quality assurance program wi		
	-	se to be of an unknown		put into place?		
		e investigation indicated it				
		caused by an improper				
	transfer. He did	not think the bruise was in a		Administrator/designee will		
	suspicious spot.	It was reported on		immediately report injuries of		
	01/08/18 when t	he family voiced they		unknown origin to both the IS		
	wanted it reported. The bruise should have			and the Extended Clinical tea		
	been reported or	n 01/05/18.		ECC consulting team will revi	ew	
	1			injuries of unknown origin to ensure reporting procedure w	vas .	
	During an interv	riew on 01/17/18 at 2:11		conducted timely. ECC will pr		
	_	Nurse indicated she		summary of this review weekl		
	•	ninistrator and the Director		Additionally ECC will conduct	а	
	1	e bruise in the morning		random review of clinical		
	meeting on 01/0	-		documentation weekly for compliance. Any suspected		
	lineeting on 01/0	3/18.		events will be reported to ISD	н	
	A C:11:411: .	. 1.4. 1 1 1		following appropriate reportab		
		, undated and received from		criteria.		
		or on 01/17/18 at 1:30 p.m.,				
		revention Program",		DON/designee will present a summary of the ECC audit		
		injury should be classified		findings to the Quality Assura	nce	
	as an "injury of	unknown source" when both		Committee monthly for 6 mon		
	of the following	conditions are met: The		Thereafter, if determined		
	source of the inj	ury was no observed by any		necessary by the QA Commit		
	person or the so	urce of the injury could not		auditing and monitoring will be		
	be explained by	the resident; and The injury		done quarterly and presented quarterly at QA meeting.		
	is suspicious bed	cause of the extent of the		Monitoring will be ongoing.		
	injury or the loc	ation of the injuryThe				
	* *	tment of Public Health shall				
	1	soon as possible within 24		Data of Compiletters		
				Date of Completion:		

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hours, but no later than 2 hours if the abuse

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/G		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		00	COMPL	
		155650	B. WIN	G		01/17/	2018
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER			RGINIA ST LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION nt injury or harmThe	+	TAG	DEFFERRET		DATE
		•					
	1	ould containAny obvious			1/26/2018		
	injuries or compi	laints of injury"					
	This Federal tag	relates to Complaint					
	IN00250900.	•					
	- 1 20 (L) (2)						
	3.1-28(b)(2)						
F 0610	492 42(2)(2) (4)						
SS=D	483.12(c)(2)-(4) Investigate/Prever	nt/Correct Alleged Violation					
Bldg. 00	_	oonse to allegations of					
	_	oploitation, or mistreatment,					
	the facility must:						
		ve evidence that all alleged					
	violations are thore	oughly investigated.					
		vent further potential abuse,					
		on, or mistreatment while					
	the investigation is	in progress.					
	§483.12(c)(4) Rep	oort the results of all					
	_	he administrator or his or					
		presentative and to other					
		ance with State law,					
	· -	ate Survey Agency, within the incident, and if the					
	1	s verified appropriate					
	corrective action m						
		review and interview, the	F 061	0	Lincolnshire Health & Rehabilit	ation	01/26/2018
	facility failed to	investigate an injury of			Center		
		in a timely manner, for 1 of			Complaint Survey 1/17/18	1	
	3 residents with	injury of an unknown origin					
	reviewed. (Resid	lent B)					

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	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES							
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY LETED /2018	
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	Finding includes	s:			INFORMAL DISPUTE RESOLU	ITION		
	01/17/18 at 11:1 but were not lim A Quarterly Min dated 10/19/17, status could not present, extensive mobility and traimpairment of of A CNA care car Director of Nurse 2:10 p.m., indicated to the control of the cont	ord was reviewed on 4 a.m. Diagnoses included, aited to, Alzheimer's disease. nimum Data Set assessment, indicated the cognition be assessed, no behaviors we assistance of two for bed insfers, and upper extremity me side. d, received from the sing (DON) on 01/17/18 at ated the resident required a with two assistants for			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 manne for 1 of 3 residents with injury of a unknown origin reviewed. Lincolnshire Health &	r,		
	at 8:15 a.m., ind bruising of the c The bruising wa swelling to the u with touch and r The assessments 01/05/18 at 9:58	ess Note, dated 01/05/18 icated the CNA found thest during morning care. s across the chest with apper chest. There was pain range of motion. s of the areas indicated: a.m., a bruise was found measuring 51 cm			Rehabilitation Center contends the investigated the injury to R1 in a timely manner. On 1/5/18, facility Administrator was notified of a bruise to R1. Sta interviewed on 1/5/18 include: Shante Brown (LPN), Colleen Ahlei (LPN), Felicia Benson (LPN), Randi Croy (LPN), Patience Gray (CNA), a Lisa Mars (CNA). The 1/5/18 interview with Patience Gray, CNA indicated that R1 was observed or	ff rs nd		

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(centimeters) by 6 cm, purplish/ black color

with swelling to right upper chest and mild

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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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETI	
		155650	B. WI	ING		01/17/20	18
NAME OF P	DOMDED OF GUIDNI 155		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				RGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER		MERRII	LVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	Randi Croy, LPN it was stated that		DATE
	pain.				around 2pm on 1/4/18, R1 was		
					observed lying in bed. None of the		
	01/05/18 at 10:13 a.m., a bruise was found				staff interviewed indicated they had	i	
	to the right uppe	r inner arm, measuring 2			assisted transferring R1 from		
	cm by 1.5 cm, re	eddish/blue in color, and no			wheelchair to bed. Calls were placed to Deonte Cotton, CNA on		
	pain.				1/5/18 and on 1/9/18 Deonte		
					Cotton, the CNA assigned to R1 on		
	01/05/18 at 10·1	6 a.m., a bruise was found			1/4/18 admitted to transferring R1		
		cubital, measuring 1.4 cm by			without a mechanical lift or staff		
	•	ue in color, and no swelling			assistance. On 1/5/18, multiple calls were placed to Brianna		
	-	ue in color, and no swerning			Christman, contracted CNA through		
	or pain.				Nightingale Staffing that was		
					assigned to A Unit on 1/4/18.		
	A Resident Grie	vance/Complaint Form,			Facility was unable to reach Ms.		
	dated 01/08/18, i	indicated a bruise was			Christman despite multiple attempt and voicemails being left.	S	
	found on the resi	ident's chest on 01/05/18,			Nightingale Staffing was contacted		
	family was notif	ied and informed that			on 1/5/18 and notified of facility		
	_	r was suspected. Family			attempting to contact Ms.		
		ill investigation into the			Christman. Administrator spoke		
		ise would be conducted.			with R1's family in person on 1/5/18 and explained that the		
	Source of the oft	inse would be conducted.			source of bruising was suspected to		
	TI IODII D	. 11 * . 1			be an improper transfer. Family		
	•	rtable Incident, indicated			acknowledged that investigation		
		arred on 01/08/18 at 1:10			and staff interviews would be		
	p.m. The descrip	otion, dated 01/08/18,			ongoing. Administrator again spoke with family on 1/8/18 to follow up	•	
	indicated on 01/0	05/18 a bruise was found to			on interviews. It was during this		
	the chest. Type of	of injury was bruise to the			conversation that family indicated		
		ve measures 01/08/18,			they wanted ISDH notified of event.		
	investigation init				Facility immediately complied with		
	mivestigation iiii	inica.			this request and notified ISDH. On 1/10/18, Administrator informed		
	TPL . E J . C 11				family that CNA admitted to		
	The 5-day follow-up, dated 01/10/18, indicated multiple staff were interviewed				improperly transferring R1 on		
					1/4/18.		
	and based on interviews, the facility believes						
	the discoloration	my have been caused by			Although the facility did not report		
		-	1		the bruise on 1/5/2018, the facility		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLI	
		155650	B. WING	_		01/17/2	2018
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					RGINIA ST		
	IOMIKE MEALIM &	REHABILITATION CENTER		IVIEKKIL	LVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		transfer. No further		1710	has provided evidence that the ever	nt	DATE
	concerns identifi				was investigated both timely and		
	concerns identifi	cu.			thoroughly.		
	During on inters	iew on 01/17/18 at 1:22			In conclusion, after review of all the		
	_				facts, the facility respectfully		
	•	istrator indicated he did not e to be of an unknown			requests that F610 be eliminated		
	_				from the statement of deficiencies or at a minimum the scope and		
		e investigation indicated it			severity be reduced.		
		caused by an improper not think the bruise was in a					
	suspicious spot. It was reported on 01/08/18 when the family voiced they						
		•					
	wanted it reporte	ed.					
	_	iew on 01/17/18 at 2:11					
	* '	Nurse indicated she			Lincolnshire		
		ninistrator and the Director			Complaint Survey, 1/17/18		
	_	e bruise in the morning			F610		
	meeting on 01/0	5/18.			Investigate/Prevent/Correct All	eged	
					Violation		
		, undated and received from			Please accept the following as the		
		or on 01/17/18 at 1:30 p.m.,			facility's plan of correction. This		
	*	evention Program",			plan of correction does not		
	•	pervisors shall immediately			constitute an admission of guilt or		
	inform the admir	nistratorof all reports of			liability by the facility and is submitted only in response to the		
	•	learning of the report, the			regulatory requirement. Facility		
	administratorsl	hall initiate an incident			cordially requests paper		
	investigationA	n injury should be classified			compliance in regards to this plan of correction.		
	as an "injury of t	ınknown source" when both			3. 33116660111		
	of the following conditions are met: The source of the injury was no observed by any				What corrective action will be		
					accomplished for those reside		
	_	arce of the injury could not			found to have been affected by	y the	
	_	the resident; and The injury			deficient practice?		
	1 ^	<i>3</i> •	I				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		A. BUILDING B. WING	00 00	COMPLETED 01/17/2018	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP COD IRGINIA ST ILLVILLE, IN 46410	
	SUMMARY S (EACH DEFICIENT REGULATORY OR is suspicious bec injury or the loca		8380 V	IRGINIA ST	of en DATE of of en er to dent dent dent dent dent dent dent dent
				on facility abuse prevention program. How will the corrective action monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put into place? Administrator/designee will immediately report to ISDH ar initiate an investigation for any injuries of unknown origin to be the ISDH and the Extended	be ent at I be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/17/2018	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		8380 VI	NDDRESS, CITY, STATE, ZIP COD RGINIA ST LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					Clinical team. ECC consulting team will review the investigal for injuries of unknown origin ensure the investigation was conducted timely. ECC will pr summary of this review weekl	tions to ovide	
					DON/designee will present a summary of the ECC audit findings to the Quality Assura Committee monthly for 6 mon Thereafter, if determined necessary by the QA Commit auditing and monitoring will be done quarterly and presented quarterly at QA meeting. Monitoring will be ongoing. Date of Completion: 1/26/201	ths. tee, e	
F 0656 SS=D Bldg. 00	§483.21(b) Compi §483.21(b)(1) The implement a comp care plan for each the resident rights and §483.10(c)(3) objectives and tim resident's medical	nt Comprehensive Care Plan rehensive Care Plans facility must develop and prehensive person-centered resident, consistent with set forth at §483.10(c)(2), that includes measurable eframes to meet a, nursing, and mental and dis that are identified in the			Date of Completion: 1/26/201	8	
	comprehensive as						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/17/2018 155650 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8380 VIRGINIA ST LINCOLNSHIRE HEALTH & REHABILITATION CENTER MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. F 0656 Lincolnshire 01/26/2018 Based on record review and interview, the facility failed to ensure a resident's plan of Complaint Survey, 1/17/18 care was implemented, related to a mechanical lift for transfers, for 1 of 3 residents reviewed for plans of care. F 656 (Resident B)

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155650	B. WI	ING		01/17/	/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Finding includes:				Develop/Implement Comprehensive Care Pl	an	
	Resident B's reco	ord was reviewed on					
	01/17/18 at 11:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease.				Please accept the following as facility's plan of correction. The plan of correction does not	is	
	· · · · · ·	nimum Data Set assessment,			constitute an admission of gui	lt or	
	dated 10/19/17, indicated the cognition status could not be assessed, no behaviors				liability by the facility and is submitted only in response to	the	
					regulatory requirement. Facili		
	•	ve assistance of two for bed			cordially requests paper		
	_	nsfers, and upper extremity			compliance in regards to this p	olan	
	impairment of or	ne side.			of correction.		
	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				What corrective action will be accomplished for those reside found to have been affected b deficient practice?		
	` *	s, slings), and utilize			R1 is currently being transferr	ad	
		with transfers when needed.			R1 is currently being transferred by 2 people using a mechanic lift. Both the Care Card and th	al	
		d, received from the			Care Plan are accurate.		
		ing (DON) on 01/17/18 at					
		ated the resident required a					
		vith two assistants for			How will the facility identify		
	transfers. A Nurse's Progress Note, dated 01/05/18				other residents having the potential to be affected by th	е	
					same deficient practice?		
	at 8:15 a.m., ind	icated the CNA found					
	bruising of the chest during morning care						

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155650	B. WIN	NG		01/17/	2018
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LINCOLA	ICHIDE HEALTH 0	REHABILITATION CENTER			RGINIA ST LLVILLE, IN 46410		
					LLVILLE, IIN 404 IU		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1110		s across the chest with		1110	All residents that require		5.112
	swelling to the upper chest. There was pain				assistance from staff for transf	ers	
	with touch and range of motion.				are potentially at risk of the sa		
	with toden and i	ungo or motion.			alleged deficient practice. Aud		
	The accessments	of the areas indicated:			completed for residents needing mechanical lift transfers to ens	-	
		a.m., a bruise was found			clinical documentation matche		
		measuring 51 cm			resident need. CNA in questio	n	
		6 cm, purplish/ black color			educated on proper resident		
					transfer techniques		
	· ·	right upper chest and mild					
	pain.						
	01/05/10 -4 10:1	2 a ma			What measures will the facili	-	
		3 a.m., a bruise was found			take or what systems will the		
		r inner arm, measuring 2			facility alter to ensure that th problem will be corrected an		
		eddish/blue in color, and no			will not recur?	-	
	pain.						
	01/05/10 -4 10:1	6 a.m. a.hmisa					
		6 a.m., a bruise was found			Clinical staff have been educa	ted	
	_	cubital, measuring 1.4 cm by			regarding resident transfer	-	
		ue in color, and no swelling			techniques and following resid	ent	
	or pain.				plan of care.		
	The and to the	Y					
		f statements included in the					
	Investigation, re				How will the corrective action I		
		n 01/17/18 at 11:14 a.m.,			monitored to ensure the deficie	_	
		admitted to transferring			practice will not recur, i.e., what quality assurance program will		
		e without using the			put into place?	. 50	
	mechanical lift o	on the evening of 01/04/18.			,		
	D	. 01/17/10 + 12.07					
	_	iew on 01/17/18 at 12:07					
	1 ,	ndicated CNA 1 had said					
		chanical lift pad under the			DON/designee will observe 5		
	resident. CNA 1	transferred the resident by			residents requiring mechanica	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	00	COMPL	
		155650	B. W	ING		01/17/	/2018
NAME OF F	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP COD		
					IRGINIA ST		
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		written agreement. Such		IAU	Please accept the following as	the	DATE
	1	•			facility's plan of correction. Th		
	agreements pertaining to services furnished by outside resources must specify, in writing				plan of correction does not		
	that the facility assumes responsibility for				constitute an admission of gui	lt or	
	1	•			liability by the facility and is submitted only in response to	tho	
	1	ertinent facility policies and			regulatory requirement. Facili		
	residents to who	m they are responsible.			cordially requests paper	• 9	
					compliance in regards to this p	olan	
	This State rule v	vas not met as evidenced by:			of correction.		
	Based on record review and interview, the						
	facility failed to	ensure an Agency CNA			What corrective action will be		
	received Orienta	tion to the facility's pertinent			accomplished for those reside	nts	
	policies and pro-	cedures for 1 of 1 Agency			found to have been affected b	y the	
	CNA reviewed.	(Agency CNA 2)			deficient practice?		
	Finding includes	3:					
					Agency staff member in quest	ion	
	During an interv	riew on 01/17/18 at 2:26			is no longer assigned to this		
	p.m., the Admir	nistrator indicated Agency			facility. No further corrective action is possible.		
	CNA 2 had only	worked a few days at the			action is possible.		
	facility and there	e was no orientation record					
	1	ency CNA 2. Packets were					
	ı	cy electronically and they			How will the facility identify		
		e the orientation. There was			other residents having the potential to be affected by th	•	
	_	from the Agency this was			same deficient practice?	e	
	completed.	from the Agency this was			Came acrossor practices		
	Compicted.						
	The Director of	Nursing provided Agency			All providents of the C. P. C.	-i-1-	
	The Director of Nursing provided Agency				All residents are potentially at of the same alleged deficient	ΓISK	
	CNA 2's work schedule on 01/17/18 at 3:15 p.m., which indicated the CNA				practice. Agency staff member	er in	
					question is no longer assigned		
		mber 7, 11, 16, 17, 19,			this facility.		
	20, 23, 27, and 2	29, 2017 and January 4,					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	IER/CLIA (X2) MULTIPI		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED			
		155650	B. WING			01/17/2018			
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T.	COMPLETION		
TAG			TAG		DEFICIENCY)	DATE			
	2018. This State rule relates to Complaint IN00250900.				What measures will the facilitake or what systems will the facility alter to ensure that the problem will be corrected an will not recur?	e le			
					All agency staff members assigned to facility will be oried to facility prior to being given resident assignment. All agen 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.	ncies 3 on 3			
					How will the corrective action of monitored to ensure the deficie practice will not recur, i.e., who quality assurance program will put into place?	ent at			
					Administrator/designee will au all agency staff assignments weekly to ensure proper orientation has been provided the individual. Administrator/designee will present a summary of the aud	to			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/17/2018		
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 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 PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TE	(X5) COMPLETION DATE	
				to the Quality Assurance Committee monthly for 6 monthly f	ee,		

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