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	07/12/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00436382, IN00437153, and IN00437146. Complaint IN00436382 - Federal/State deficiencies related to the allegations are cited at F580, F657, and F697. Complaint IN00437153 - No deficiencies related to the allegations are cited. Complaint IN00437146 - No deficiencies related to the allegations are cited. Survey dates: July 8, 9, 10, 11, and 12, 2024 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census Bed Type: SNF/NF: 74 Total: 74 Census Payor Type: Medicare: 3 Medicaid: 63 Other: 8 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/18/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brittany Weaver	Administrator	08/13/2024

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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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for a medication, physician's orders for self-administration of medications, and a self-administration of medications assessment completed for 1 of 2 residents reviewed for self-administration of medication. (Resident 4) Finding includes: On 7/8/24 at 11:51 a.m., there was a bottle of fluticasone spray (nasal spray) observed on Resident 4's bedside table. At the time, the resident indicated that she took the nasal spray by herself whenever she felt that she needed it. On 7/10/24 at 11:54 a.m., the bottle of fluticasone spray was still observed on the bedside table. Resident 4's record was reviewed on 7/10/24 at 11:14 a.m. Diagnoses included, but were not limited to, heart failure and adult failure to thrive. The Quarterly MDS (Minimum Data Set) assessment, dated 6/5/24, indicated the resident was cognitively intact for daily decision making. There were no physician's orders for the fluticasone spray. There was no care plan for self-administration of the fluticasone.	F 0554	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F554 Resident Self Admin Meds-Clinically Appropriate What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A self-administration assessment was completed for Resident 4 and an MD order was received for self-administration of Nasal spray. 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 with medication orders 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; Staff were educated on not leaving	08/02/2024

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	There were no self-administration of medication assessments. During an interview on 7/11/24 at 10:52 a.m., the Unit B Manager indicated she would look into it and provided no further information. A Policy, titled, "Self-Administration of Medication Program," indicated "...5. If a resident requests to self-administer drugs, it is the responsibility of the IDT to determine that it is safe for the resident to self-administered rugs, before the resident may exercise that right...7. The admitting nurse or designee will complete the Self-Administration of Medication Evaluation and report the findings to the Unit Manager or designee...9. Once the resident has been deemed safe by the IDT an order will be obtained from the resident's physician or physician extender listing the medications(s) that may be self-administered, where the medications will be stored, who will be responsible for documentation and the location of administration...10. Appropriate documentation of the above determinations will be documented in the resident's care plan." 3.1-11(a)		medications at resident bedside unless there is an order for self-administration in place. Licensed Nurses were also educated on the need for a physician order and a medication self-administration assessment when a resident self-administers medication. 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; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside and any medication noted at bedside has orders for self-administration. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's			

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	physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as			

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	defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on observation, record review and interview, the facility failed to notify the family/representative of new orders for medications for 1 of 5 residents reviewed for unnecessary medications. (Resident B) Finding includes: Resident B's record was reviewed on 7/9/24 at 11:18 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, anxiety disorder, dementia with behavioral disturbance, and bipolar disorder without psychotic features. The Quarterly Minimum Data Set (MDS) assessment, dated 6/26/24, indicated the resident was severely cognitively impaired for daily decision making. Medications received while a resident included, but were not limited to, antipsychotics on a routine basis, anti-anxiety medications, and opioids (pain medications). A Nurses' Note, dated 5/23/2024 at 8:11 p.m., indicated the resident complained of right hip pain. A new order was placed for Icy Hot Patch daily to the right hip and off at bedtime. A Nurses' Note, dated 5/29/2024 at 3:58 p.m., indicated the Psychiatric Nurse Practitioner placed a new order for sertraline (an antidepressant) 50 milligrams (mg) daily. The resident was aware. A Nurses' Note, dated 6/12/2024 at 11:28 p.m.,	F 0580	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F580 Notify of changes (Injuries/Decline/Room, Etc.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B and family were updated on medication orders. 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 residents with a change in condition 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: Nurses were in-serviced on ensuring the physician, resident,	08/02/2024

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	indicated the Psychiatric Nurse Practitioner placed a new order for aricept (dementia treatment) 5 mg at bedtime. The resident was aware. A Nurses' Note, dated 6/18/2024 at 3:01 p.m., indicated the resident requested a smoking patch. The physician was notified and new orders for a smoking patch were received. The resident was aware. A Nurses' Note, dated 7/9/2024 at 2:43 p.m., indicated the Psychiatric Nurse Practitioner placed new ordered to discontinue sertraline 50 mg daily and start sertraline 75 mg daily for anxiety. The resident was aware. During an observation on 7/10/24 at 12:10 p.m., Resident B was observed to be in her wheelchair wheeling herself down the hallway. She was observed speaking to LPN 1, but the conversation was unclear. LPN 1 indicated the resident often hallucinated, which she was doing at the time, saying her family was there right next to her and she was having a conversation with them. LPN 1 indicated this was her "usual" state of mind. During an interview on 7/11/24 at 11:57 a.m., the Director of Nursing indicated the resident was her own responsible party. They had tried to call the resident's daughter in the past and never received a response. A Policy titled, "Change in Condition Process," indicated ..."The facility must inform the resident, consult with the resident's physician and notify the resident's family member or legal representative when there is a change requiring such notification. Situations requiring notification include:...3. A need to alter treatment significantly; that is, a need to discontinue an existing form of		and resident responsible party are notified of residents' change in condition, medication orders, treatment orders and notification is documented in the resident's medical record. 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; DON/Designee will randomly audit 5 residents with change in condition weekly to ensure resident/responsible party notification is completed timely and documented in the medical record. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	

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	treatment due to adverse consequences, or to commence a new form of treatment. This may include: b. Discontinuing a treatment or changing a medication due to: adverse consequences, acute condition, exacerbation of a chronic condition." This citation was related to Complaint IN00436382. 3.1-5(a)(3)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessments were accurately completed related to anticoagulant and diuretic medication use for 2 of 19 MDS assessments reviewed. (Residents 33 and 220) Findings include: 1. Resident 33's record was reviewed on 7/10/24 at 11:13 a.m. Diagnoses included, but were not limited to, heart failure, tachycardia, depression, and chronic obstructive pulmonary disease. The Quarterly MDS assessment, dated 6/28/24, indicated the resident was cognitively intact and took an anticoagulant medication. The MDS did not indicate the resident took an antiplatelet medication. A Physician's Order, dated 4/8/24, indicated the resident took aspirin 81 milligrams daily for anticoagulant. There was no order for an actual anticoagulant medication.	F 0641	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F641 Accuracy of Assessment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 220's MDS Assessment was modified for drug coding accuracy. Resident 33's MDS Assessment was modified for drug coding accuracy. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	08/02/2024

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	During an interview on 7/10/24 at 1:24 p.m., the MDS Coordinator indicated the order for aspirin had been entered as an anticoagulant instead of an antiplatelet. She indicated she would correct the MDS. 2. The record for Resident 220 was reviewed on 7/10/24 at 11:34 a.m. Diagnoses included, but were not limited to, hypertension, coronary artery disease, and anemia. The Admission MDS assessment, dated 6/24/24, indicated the resident had not received any diuretic medications in the past seven days. A Physician's Order, dated 6/17/24, indicated to give lisinopril-hydrochlorothiazide (a diuretic blood pressure medication) 20-12.5 mg (milligrams) daily. The Medication Administration Record (MAR), dated 6/2024, indicated the resident had received the diuretic blood pressure medication daily. During an interview on 7/10/24 at 1:24 p.m., the MDS Coordinator indicated the MDS was incorrect, and she would modify it. 3.1-31(i)		will be taken; All residents have the potential to be affected by this 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; MDS was re-educated on: · Drug classifications · Appropriately coding medications on the MDS assessment 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; DON/Designee will audit 5 resident's MDS assessments for medication coding accuracy with special focus on antiplatelets and diuretics weekly for 4 weeks, then bi-weekly thereafter to ensure compliance. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure quarterly care plan meetings were completed and/or family representatives were invited for 3 of 4 residents reviewed for care planning. (Residents D, E and B) Findings include: 1. During an interview on 7/8/24 at 11:05 a.m., Resident D's Power of Attorney (POA)/ family representative indicated she had not been invited	F 0657	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F657 Care Plan Timing and	08/02/2024

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	to a care plan meeting in a very long time. They used to do phone conferences, but that had not occurred recently. The resident's record was reviewed on 7/9/24 at 11:54 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) and hemiparesis (one sided paralysis) following a cerebral vascular accident, dysphagia, and contracture of the right hand. The Quarterly Minimum Data Set (MDS) assessment, dated 5/28/24, indicated the resident had severe cognitive impairment, required set up assistance for meals, and extensive 2+ staff assistance for bed mobility. There was no documentation a care plan meeting had been completed in 2024. A Care Plan Meeting Invitation, dated 5/5/24, indicated the resident was invited and noted, "the resident was sleepy." The POA/representative section was left blank. During an interview on 7/9/24 at 2:43 p.m., the Social Service Director indicated a list was provided to the receptionist monthly of care plan meetings that were due and invitations were sent out to the families. If there was not a social service note, there was no care plan meeting held. If no one responded, there was no one with whom to have the meeting. She indicated they may not have the correct address for the POA. 2. During an interview on 7/8/24 at 8:51 a.m., Resident E indicated he had not attended a care plan meeting and was not familiar with what that was.		Revision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A care conference was scheduled for resident D and the responsible party was invited. A care conference was scheduled for resident E and the responsible party was invited. A care conference was scheduled for resident B and the responsible party was invited. 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 residents have the potential to be affected by this 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; Social Service was re-educated on: · Scheduling Quarterly/Annual Care Conferences. · Ensuring the resident/Responsible Party is invited to attend the conference. · Documenting Conference Date and Attendees in the resident's medical record. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be	

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	The resident's record was reviewed on 7/11/24 at 11:09 a.m. Diagnoses included, but were not limited to, gangrene, metabolic encephalopathy, and diabetes mellitus. The Quarterly MDS assessment, dated 6/24/24, indicated the resident was cognitively intact. There was no documentation a care plan meeting had been completed in 2024. During an interview on 7/11/24 at 12:05 p.m., the Social Service Director indicated she was unable to find a recent care plan meeting for the resident. If the resident was invited and didn't want to attend, it should still be documented. She also indicated the resident was due for a care plan meeting in March and June, but had been in the hospital. They should have rescheduled the meetings, but did not.3. Resident B's record was reviewed on 7/9/24 at 11:18 a.m. The resident was admitted to the facility on 4/18/24. Diagnoses included, but were not limited to, schizoaffective disorder, anxiety disorder, depression, dementia with behavioral disturbances, and bipolar disorder without psychotic features. The Quarterly Minimum Data Set (MDS) assessment, dated 6/26/24, indicated the resident was severely cognitively impaired for daily decision making. She required setup or clean-up assistance with eating, oral hygiene, toileting hygiene, and bathing. She received scheduled pain medication and antipsychotic medications on a routine basis as well as anti-anxiety medications. The record lacked documentation of a care plan meeting since admission. There was no documentation of an invitation to a		put into place; Administrator/Designee will audit care conferences scheduled for the week to ensure the resident/responsible party was invited to attend and the conference is documented in the resident's medical record. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	

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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
	care plan meeting sent to the resident and/or the resident representative. During an interview on 7/11/24 at 1:52 p.m., the Social Service Director indicated she had never held a care plan meeting with the resident and/or resident representative. It was expected to hold a care plan meeting within 72 hours after a new admission. She was unable to provide any documentation of a care plan meeting invitation being sent to the resident and/or representative. The current policy, "Comprehensive Resident Centered Care Plan", indicated, "...It is the policy of the facility to promote interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention....", and, "...5. The planning process will: a. Facilitate the inclusion of the resident and/or resident representative...." The policy also indicated, "...1. A comprehensive care plan will be...v. To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in the resident's medical record if the participation of the resident and their representative is determined not practicable for the development of the resident's care plan...." This citation was related to Complaint IN00436382. 3.1-35(b)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			

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	155650	A. BUILDING 00 B. WING	07/12/2024

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	Based on interview, observation, and record review, the facility failed to ensure residents received the necessary care for activities of daily living (ADLs) related to the lack of documentation of incontinence care and residents with long, dirty fingernails and toenails for 3 of 11 residents reviewed for ADL care. (Residents 10, 4 and C) Findings include: 1. On 7/8/24 at 11:30 a.m., Resident 10 was interviewed. The resident indicated the staff "never" check his brief to see if he needed to be changed. Record review for Resident 10 was completed on 7/9/24 at 1:53 p.m. Diagnoses included, but were not limited to hypertension, anxiety, depression, bipolar, and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 4/12/24, indicated the resident was cognitively intact. The resident required a substantial assistance for bed mobility and was dependent for transfers. The resident was always incontinent of bladder. A Care Plan, dated 5/17/23, indicated the resident experienced bladder incontinence. An intervention included to check and change with routine care rounds and as needed. The Bladder Elimination Task for the past 30 days indicated urinary continence care was not documented on the following dates and shifts: Days: 6/17/24 and 7/1/24 Evenings: 6/13, 6/14, 6/16, 6/19, 6/21, 6/22, 6/23, 6/24, 6/25, 6/26, 6/29, 7/5, and 7/8/24. Nights: 6/13, 6/14, 6/20, 6/23, 7/5, and 7/6/24.	F 0677	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F677 ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ADL documentation is being completed accordingly for Resident's 4, C, and 10. Nail care was provided for Resident's 4, C, and 10. 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 residents requiring assistance with Activities of Daily Living 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; · Staff were re-educated on providing residents with assistance with Activities of Daily Living (ADL's) per plan of care/preferences with a special focus on providing nail care.	08/02/2024

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	During an interview on 7/10/24 at 11:48 a.m., CNA 2 indicated the CNAs worked 8 hour shifts. The resident was incontinent of bladder and wore a brief. Staff were supposed to check residents every 2 hours for incontinence care. They were supposed to document at least once per shift if the resident was continent or incontinent and if care was completed. During an interview on 7/10/24 at 1:46 p.m., the Director of Nursing (DON) indicated the CNAs were expected to check the residents every 2 hours for incontinence care and document in the Tasks at least 1 time per shift related to the residents' continence status and if care was completed. 2. During an interview on 7/8/24 at 11:48 a.m., Resident 4 indicated the staff were not providing her incontinence care timely. There were often times when they would come into her room and turn off her call light and say they would come back to perform the incontinence care, however it would take them hours to do so. Resident 4's record was reviewed on 7/10/24 at 11:14 a.m. Diagnoses included, but were not limited to, heart failure, polyneuropathy (disease affecting peripheral nerves), and adult failure to thrive. The Quarterly MDS assessment, dated 6/5/24, indicated the resident was cognitively intact for daily decision making. She had functional limitation in range of motion on both lower extremities. She was dependent for toileting hygiene and bathing and required substantial/maximal assistance for personal hygiene. She was always incontinent of bladder and frequently incontinent of bowel continence.		· Staff were re-educated on documenting Activities of Daily Living provided including incontinence care in the medical record. 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; DON/Designee will Audit 5 residents weekly, to ensure Activities of Daily Living with special focus on incontinence care is documented in the medical record. Facility Angel's will observe 10 residents 2 times per week to ensure residents are groomed with a special focus on nailcare. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	

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She had 1 stage 4 pressure ulcer that was present upon admission/entry or reentry.

A Care Plan, dated 5/29/24, indicated the resident required assistance with activities of daily living (ADLs) including bed mobility, eating, transfers/mechanical lift device, and toileting. Interventions included, but not limited to, assist with bed mobility, bathing, and toileting care as needed.

The Bowel and Bladder (B&B) - Bladder Elimination Point of Care Task indicated there was a frequency of every shift. The documentation was reviewed for the last 30 days and the resident was marked as incontinent only twice per day on 6/11, 6/15, 6/16, 6/20, 6/22, 6/23, 6/24, 6/26, 7/4, 7/6, and 7/9/24. The resident was marked as incontinent once on 6/14 and 6/18/24.

During an interview on 7/11 at 11:15 a.m., the Director of Nursing indicated that it was expected CNAs were checking and changing the dependent residents every two hours and documenting at least once a shift.

3. During an interview on 7/8/24 at 9:31 a.m., Resident C indicated he needed his nails trimmed on both his hands and feet and his fingernails were in need of cleaning. He was having to manually disimpact his stool and so his fingernails were dirty. His nails were observed to be long and dirty and his toenails were long upon observation at the time.

During an observation on 7/9/24 at 11:48 a.m., Resident C was observed lying in his bed. He had long dirty fingernails and his toenails were long.

Resident C's record was reviewed on 7/11/24 at

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	9:28 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the right dominant side and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 5/3/24, indicated the resident was cognitively intact for daily decision making. He had limited range of motion on both sides on upper and lower extremities. He required total assistance with toileting hygiene, bathing, and transfers. He required substantial/maximal assistance with personal hygiene. He was frequently incontinent of bladder and always incontinent of bowel. A Care Plan, dated 4/4/24, indicated the resident was resistive to care as evidenced by refusing treatment. Interventions included, but were not limited to, allow the resident to make decisions about treatment regimen, encourage resident to receive care throughout the shift while providing options, and if resident resists with ADL care, reassure resident, leave and return 5-10 minutes later and try again. The Bath and Skin Report Sheet for July 2024 indicated the resident had a shower on 7/1/24 which included lotion application, shaving, and nails trimmed. On 7/4/24, he had a bed bath, lotion application, shaving, and nails trimmed. On 7/8/24, he had a shower, lotion application, shaved, and nails trimmed. There was no documentation that the resident received toenail care. During an interview on 7/11/24 at 4:09 p.m., the Director of Nursing indicated the resident required assistance for nail care. The nurses were to take care of his toenails. Staff should document nail			

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	care on the shower sheets. The resident had no documentation that he was digging stool out or that he had constipation, but he should have received nail care as needed if his fingernails were dirty. 3.1-38(a)(2)(C) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary care and treatment, related to administering a blood pressure medication out of the prescribed parameters, the lack of assessment and a treatment order for a resident with a bandage, and a resident not wearing preventative heel protectors as ordered, for 1 of 5 residents reviewed for unnecessary medications (Resident 28) and 2 of 4 residents reviewed for non-pressure skin conditions. (Residents 39 and C) Findings include: 1. Record review for Resident 28 was completed on 7/11/24 at 12:22 p.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, hypertension, and orthostatic hypotension.	F 0684	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C- Heel protectors were applied. Resident 39- Skin was assessed and treatment orders were	08/02/2024

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	The Admission Minimum Data Set (MDS) assessment, dated 6/11/24, indicated the resident was cognitively intact. The July 2024 Physician's Order Summary indicated an order for midodrine hcl (treats low blood pressure) 2.5 mg (milligrams) twice a day for orthostatic hypotension. Hold the medication if the systolic blood pressure (SBP) (top reading of a blood pressure) was greater than 130. The June and July 2024 Medication Administration Records indicated the midodrine hcl was administered on the following dates and times when the SBP was out of parameters and should not have been administered. - 6/7/24 at HS (at bedtime) the blood pressure (BP) was 139/78 - 6/8/24 at HS the BP was 139/71 - 6/23/24 in the AM (morning) the BP was 132/69 - 6/26/24 in the AM the BP was 133/72 - 6/27/24 in the AM the BP was 131/72 - 6/28/24 at HS the BP was 132/76 - 7/1/24 at HS the BP was 135/71 - 7/3/24 in the AM the BP was 136/78 - 7/4/24 in the AM the BP was 138/76 - 7/5/24 in the AM the BP was 132/70 - 7/6/24 in the AM the BP was 131/68 - 7/7/24 in the AM the BP was 132/75 - 7/8/24 in the AM the BP was 132/76 - 7/10/24 in the AM the BP was 134/71 - 7/11/24 in the AM the BP was 134/78 During an interview on 7/12/24 at 2:25 p.m., the Director of Nursing indicated the resident received the midodrine hcl when his BP was out of parameters and he should not have been administered the medication. She would in-service the staff on administering medications		received. Resident 28's- physician was notified and clarification was received for blood pressure parameters. 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 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; Nurses were re-educated on: · Addressing and assessing changes in skin condition, notifying family and physician, obtaining orders for treatment, implementation of treatment, treatments and interventions are in place per physician orders. · Interventions such as heel protectors, LAL mattresses, wedges, etc. are in place as ordered. · Administering/holding medications per physician ordered parameters. 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; Nurse manager will audit 5 residents' clinical documentation weekly with focus on skin to	

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	with prescribed parameters. 2. On 7/9/24 at 9:05 a.m., Resident 39 was observed sitting on the side of her bed. The resident had a large brown bandage with a smaller yellow bandage on top of it above her right wrist. The resident indicated she had the bandage put on last week in the hospital after a blood transfusion. On 7/10/24 at 11:45 a.m., the resident was propelling herself in a wheelchair down the hallway. The brown bandage with the yellow bandage was still observed above her right wrist. On 7/11/24 at 9:43 a.m., the resident was sitting in a wheelchair in her room eating breakfast. The brown bandage with the yellow bandage was still observed above her right wrist. Record review for Resident 39 was completed on 7/10/24 at 11:47 a.m. Diagnoses included, but were not limited to, anemia, heart failure, hypertension, end stage renal disease, diabetes mellitus, and dementia. The Significant Change Minimum Data Set (MDS) assessment, dated 5/13/24, indicated the resident was cognitively intact. The resident required supervision for dressing, substantial maximum assistance with personal hygiene, and partial moderate assistance for transfers. The resident received an anticoagulant (blood thinning) medication. A Care Plan, dated 5/19/23, indicated the resident was at risk for abnormal bleeding/bruising related to the use of anticoagulant medications. An intervention included to monitor for side effects		ensure assessments of change in condition is completed, treatment orders received, and interventions are in place per physician orders. Nurse managers will randomly audit 5 residents Medication Administration Record (MAR) weekly to ensure medications are being administered/held per physician parameters. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	

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	and effectiveness which included bruising. The July 2024 Physician's Order Summary (POS) indicated the following orders: - apixaban (blood thinner) 2.5 mg (milligrams) twice a day. Monitor resident for signs and symptoms of adverse effects, including bruising, bleeding, and skin changes every shift. - Blood Infusion Appointment on 7/3/24 at 1:15 p.m., at the hospital. The record lacked any documentation related to an assessment, monitoring, or physician's order for the resident's bandage, including the reason for the bandage. During an interview on 7/11/24 at 11:15 a.m., the Director of Nursing (DON) indicated the resident had a blood transfusion at the hospital the prior week and the bandage was put on there. She was unable to provide any documentation related to physician's orders or monitoring of the area and the bandage should have been removed. 3. During an observation on 7/8/24 at 9:34 a.m., Resident C was observed to be in bed. He had no heel protector or offloading in place on his right foot. He had an area of discoloration noted to his right big toe. On 7/9/24 at 11:48 a.m., Resident C was observed to be in bed. He had no heel protector or offloading in place on his right foot and an area of discoloration was observed to his right big toe. Resident C's record was reviewed on 7/11/24 at 9:28 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the right dominant side and vascular dementia. The Annual Minimum Data Set (MDS)			

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	assessment, dated 5/3/24, indicated the resident was cognitively intact for daily decision making. He had limited range of motion on both sides on upper and lower extremities. He required total assistance with toileting hygiene, bathing, and transfers and substantial/maximal assistance with personal hygiene. He was frequently incontinent of bladder and always incontinent of bowel. A Physician's Order, dated 5/1/24, indicated heel protector to right heel while in bed every shift for prophylaxis. A Care Plan, dated 7/10/24, indicated the resident had an abrasion to the right great toe and right second toe. Interventions included, but were not limited to, encourage turning and repositioning, provide treatment per Physician's Order and the resident refuses heel protectors. The record lacked documentation of monitoring whether the heel protectors were on, off, or refused. During an interview on 7/11/24 at 2:12 p.m., the Unit B Manager indicated there should have been a place to document whether the heel protectors were on, off, or refused. A Policy titled, "Wound Prevention," indicated, "3...c) Pressure relief...iii. As needed position and reposition the resident with pillows and other supportive devices" 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper			

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	treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to ensure residents with impaired hearing received the necessary services for 1 of 1 resident reviewed for hearing. (Resident C) Finding includes: During an interview on 7/8/24 at 9:31 a.m., Resident C indicated he was in need of hearing aids. He was observed to be hard of hearing, was yelling out, and was reading lips while in conversation. Resident C's record was reviewed on 7/11/24 at 9:28 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the right dominant side and vascular dementia. The Annual Minimum Data Set (MDS) assessment, dated 5/3/24, indicated the resident was cognitively intact for daily decision making and had adequate hearing. There were no care plans related to hearing loss. During an interview on 7/11/24 at 1:54 p.m., the Social Service Director indicated she was never informed that the resident wanted to see an	F 0685	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F685 Treatment /Devices to Maintain Hearing/Vision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Audiology consents were received for Resident C and the resident was placed on the audiology visit list. 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 requiring audiology services have the potential to be affected by the	08/02/2024

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	audiologist, however he was hard of hearing. She did not provide any further information or prior visits from an audiologist. During an interview on 7/11/24 at 4:09 p.m., the Director of Nursing indicated the resident had always been hard of hearing as far as she knew. She provided no further information. During an interview on 7/12/24 at 9:31 a.m., LPN 1 indicated the resident seemed like he would be reading her lips when they were in the middle of conversation. During an interview on 7/12/24 at 10:07 a.m., CNA 3 indicated the resident was hard of hearing. She would have to approach the resident very close in order for him to hear her, and it seemed like he was trying to read her lips to understand her. He often would yell really loudly that he could not hear you as you tried to enter his room. During an interview on 7/12/24 at 9:54 a.m., the SSD indicated they had set up an appointment for outside audiology services for the following week. A Policy titled, "Treatment/Devices to Maintain Hearing/Vision," indicated "...1. The facility will ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility will, if necessary, assist the resident: a. In making appointments, and b. By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices...3. When identified, the vision and or hearing needs of a resident will be communicated to the Director of Social Services or Designee."		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; · Staff were educated on ensuring residents with impaired hearing are referred to social services. · Social service was educated on obtaining consents for ancillary services upon admission and reviewing them at least quarterly. 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; Administrator/designee will audit weekly to ensure new admissions and residents are referred to audiology services and those with consents and are added to the visit list accordingly. Director of Nursing /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	

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	155650	A. BUILDING 00 B. WING	07/12/2024

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	3.1-39(a)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment to prevent decreased range of motion, related to a splint not in place as recommended for 1 of 3 residents reviewed for range of motion. (Resident D) Finding includes: On 7/8/24 at 11:07 a.m., Resident D was observed lying in bed. Her right hand was contracted (fixed tightening of muscle, tendon, ligament or skin) and there was a hand splint hanging on the wall next to her bed. The resident was observed again on 7/9/24 at 11:26 a.m., 7/10/24 at 8:49 a.m., and	F 0688	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F688 Increase/Prevent Decrease in ROM/Mobility What corrective action(s) will be accomplished for those residents found to have been affected by the	08/02/2024

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	7/11/24 at 8:47 a.m. lying in bed without the hand splint in place. The resident's record was reviewed on 7/9/24 at 11:54 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) and hemiparesis (one sided paralysis) following a cerebral vascular accident, dysphagia, and contracture of the right hand. The Quarterly Minimum Data Set assessment, dated 5/28/24, indicated the resident had severe cognitive impairment, required set up assistance for meals, and extensive 2+ staff assistance for bed mobility. There was not a current or discontinued physician's order for a splint to be applied to the right hand. An Occupational Therapy (OT) Discharge Summary, dated 10/12/23, indicated recommendations were the resident required 24-hour care related to assistance needed for ADLs (activities of daily living) and to wear a splint to the right hand with established wearing time. The resident had met the goal of safely wearing least restrictive splinting/orthotic device for 4 hours on and 4 hours off. During an interview on 7/9/24 at 2:35 p.m., the Therapy Director indicated the discharge summary indicated the resident should be wearing a splint and he would look into it. During a follow up interview on 7/10/24 at 10:15 a.m., the Therapy Director indicated the recommendation had been made by a PRN (as needed) Occupational Therapist and must have been missed. Recommendations were normally		deficient practice; Resident D – order received for splint and care plan has been implemented. 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 residents with splints 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; Nurses were re-educated on: · Implementation of splint · Slint in place per care plan/therapy recommendations · Care plan is updated accordingly 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; Nurse manager/designee will randomly audit 2 residents with splints weekly to ensure splint is in place per orders/recommendations. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be	

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	communicated to nursing verbally or by a communication form. He indicated the resident would be reevaluated by therapy. 3.1-42(a)(2)		on going. Date by which systemic corrections will be completed: 8/2/2024	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure a resident with dysphagia (difficulty swallowing) received adaptive equipment as ordered during meals for 1 of 2 residents reviewed for nutrition. (Resident D) Finding includes: On 7/10/24 at 8:49 a.m., Resident D was observed in bed eating breakfast. There was Styrofoam cup	F 0692	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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.	08/02/2024

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	with water and a straw, a cup of juice, and a cup of coffee. There was no 2 handled mug present on the breakfast tray. At 10:15 a.m., the resident was observed again in bed. The cup with the straw and beverage cups had been removed and there was a 2 handled mug on her table. On 7/12/24 at 9:20 a.m., CNA 1 was observed removing the resident's breakfast tray from her table. There was a cup of juice with a straw and a cup of coffee. There was no 2 handled mug on the tray. The CNA indicated she had not put the straw in the cup and it must have come from the kitchen. There was a tray ticket on her tray that indicated no straws and to use a 2 handled mug. The resident's record was reviewed on 7/9/24 at 11:54 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) and hemiparesis (one sided paralysis) following a cerebral vascular accident, dysphagia, and contracture of the right hand. The Quarterly Minimum Data Set (MDS) assessment, dated 5/28/24, indicated the resident had severe cognitive impairment and required set up assistance for meals. The current Physician's Order Summary indicated the resident was on a regular, mechanical soft diet, no straws, and use a 2 handled mug. The Dietary Care Plan indicated to provide adaptive equipment as ordered to aid in self feeding. 3.1-46		F692 Nutrition/Hydration Status Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D's – tray was immediately corrected. Straw was removed and two handled cup was provided. 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 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; Staff were re-educated on: · The tray pass process and ensuring residents receive their meals as per tray ticket/order. 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; Department heads will randomly audit 5 tray tickets weekly at alternating meals to ensure residents receive their meals as per tray ticket/order with a special focus on no straw orders and adaptive equipment. The Director of Nursing/designee will present a summary of the	

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			audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 7/26/24	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration for 1 of 1 resident reviewed for respiratory care. (Resident 1) Finding includes: On 7/8/24 at 9:08 a.m. Resident 1 was observed lying in bed with her eyes closed. She had an oxygen concentrator at her bedside that was on and set at 2 liters (L). A nasal cannula was attached to the concentrator and was laying on the floor beside the bed.	F 0695	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F695 Respiratory/Tracheostomy Care and Suctioning What corrective action(s) will be accomplished for those residents found to have been affected by the	08/02/2024

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	On 7/9/24 at 11:37 a.m. Resident 1 was observed lying in bed with her eyes closed. She had the nasal cannula in place and the oxygen was running at 2 L. On 7/10/24 at 2:52 p.m. Resident 1 was observed lying in bed with her eyes closed. The oxygen concentrator was on and set at 2 L. The nasal cannula was hanging on the tube feeding pole beside the resident's bed. On 7/11/24 at 8:35 a.m. Resident 1 was observed lying in bed with her eyes closed. She had the nasal cannula in place and the oxygen was running at 2 L. Record review for Resident 1 was completed on 7/10/24 at 9:07 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 4/15/24, indicated the resident was cognitively impaired and had not used oxygen. The Physician's Order Summary, dated 7/2024, lacked any orders for oxygen. The Medication Administration Record (MAR), dated 7/2024, lacked any documentation that oxygen was administered. During an interview on 7/11/24 at 11:03 a.m., the Director of Nursing indicated she was unsure what the resident's oxygen orders were, but she would have the Unit Manager look into it. During an interview on 7/11/24 at 11:05 a.m., the A-Wing Unit Manager indicated there were no		deficient practice; Oxygen orders were received from Resident 1's physician and the plan of care was updated. 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 residents requiring oxygen and tracheostomy care 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; Staff were re-educated on: · Ensuring oxygen orders are obtained for residents requiring supplemental oxygen therapy. 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; Nurse managers will audit 3 residents requiring supplemental oxygen to ensure oxygen orders are in place. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	current oxygen orders for the resident. A facility policy, titled, "Oxygen Administration," received as current, indicated "...an order is required when administering supplemental oxygen. The order should include the oxygen liter flow, delivery device [nasal cannula, mask, high flow nasal cannula] as well as the diagnosis/indication for use..." 3.1-47(a)(6)		Date by which systemic corrections will be completed: 8/2/2024	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure pain medications were available and administered to a resident per the physician's orders for 1 of 2 residents reviewed for pain. (Resident C) Finding includes: During an interview on 7/8/24 at 9:37 a.m., Resident C indicated that he received scheduled pain medications, however he often missed doses due to the medications not being available in the facility. Resident C's record was reviewed on 7/11/24 at 9:28 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the right dominant side and vascular dementia.	F 0697	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F697 Pain Managment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident C 's pain medication is available and is being administered per physician orders. How the facility will identify other	08/02/2024

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	The Annual Minimum Data Set (MDS) assessment, dated 5/3/24, indicated the resident was cognitively intact for daily decision making. He received opioid pain medications. A Care Plan, dated 7/4/24, indicated the resident was at risk for complaints of pain. Interventions included, but were not limited to, administer analgesia as per orders. A Physician's Order, dated 5/1/24, indicated hydrocodone-acetaminophen 10-325 milligrams (mg) tablet, 1 tablet by mouth every 6 hours. The June 2024 Medication Administration Record (MAR) indicated the resident did not receive the hydrocodone-acetaminophen tablet on the following dates and times: - 6/1/24 at 6:00 p.m. - 6/2/24 at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. - 6/3/24 at 12:00 a.m. and 6:00 a.m. - 6/4/24 at 12:00 a.m. - 6/17/24 at 6:00 p.m. - 6/22/24 at 6:00 a.m. - 6/27/24 at 12:00 a.m., 6:00 a.m., and 12:00 p.m. - 6/28/24 at a 12:00 a.m. - 6/30/24 at 6:00 a.m. The July 2024 Medication Administration Record (MAR) indicated the resident did not receive the hydrocodone-acetaminophen tablet on the following dates and times: - 7/1/24 at 8:00 a.m. - 7/5/24 at 12:00 a.m. and 6:00 p.m. - 7/6/24 at 12:00 a.m. and 6:00 p.m. - 7/7/24 at 12:00 a.m. - 7/10/24 at 6:00 a.m. A Progress Note, dated 6/1/2024 at 8:24 p.m.,		residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents that require pain medication 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: Nurses were re-educated on: · Ensuring pain medication is administered as per orders. · If pain medication is unavailable: Nurses are to pull medication from EDK (if possible) call the physician and obtain a temporary order for an alternative medication, ensure scripts are obtained prior to depletion of medication on hand. 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; DON/Designee will audit 5 residents 2 times per week receiving pain medication to ensure the medication is available and being administered per physician orders. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee,	

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	indicated the hydrocodone-acetaminophen required a new script and the doctor was made aware. A Progress Note, dated 6/2/2024 at 12:38 a.m., indicated the hydrocodone-acetaminophen tablets were to be delivered by pharmacy. A Progress Note, dated 6/2/2024 at 6:53 a.m., indicated pharmacy was called to re-order the hydrocodone-acetaminophen tablets and a new script was needed from the doctor. The doctor was made aware. A Progress Note, dated 6/2/2024 at 11:34 a.m., indicated the pharmacy was to deliver the hydrocodone-acetaminophen, a new script was needed, and the doctor was aware. A Progress Note, dated 6/27/2024 at 6:31 a.m., indicated the hydrocodone-acetaminophen tablets were unavailable and pharmacy was made aware. A Progress Note, dated 7/5/2024 at 12:21 a.m., indicated the hydrocodone-acetaminophen tablets were unavailable. The pharmacy was aware and informed the facility they only had a script to send in 1 tablet and required a new script from the doctor. During an interview on 7/12/24 at 1:33 p.m., the Director of Nursing indicated the facility had ordered the medications from the pharmacy and the delay was because they were waiting on a new script from the doctor. This citation was related to Complaint IN00436382. 3.1-37(a)		auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	

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F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was prepared in form to meet individual needs related to not following a recipe for pureed food and not making pureed food the correct consistency. This had the potential to affect all 5 residents who received a pureed diet. (Main Kitchen) Finding includes: On 7/10/24 at 10:29 a.m., Cook 1 was observed preparing pureed food. She indicated she was going to puree 5 servings of broccoli. The cook had a recipe titled, "Pureed Broccoli". She poured the broccoli with an unknown amount of liquid into the blender. She added 3 tablespoons of a thickening powder to the blender and began to blend. She then added 2 more tablespoons of thickener and blended again. She poured the broccoli out of the blender into a separate container. The cook indicated the puree was finished, the correct consistency, and ready to be served. The pureed broccoli was observed to be watery with no thickened consistency. The Dietary Manager (DM) indicated the puree was too thin and for the cook to add more thickener. The cook then added 2 more tablespoons into the container and used a whisk to stir up the puree. She indicated the puree was finished and at the correct consistency and handed the puree to the DM. The DM indicated the puree was still too	F 0805	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 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. F805 Food in Form to Meet Individual Needs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Dietary manager immediately corrected the consistency of the puree broccoli. 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 residents have the potential to be affected by the 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; Dietary managers/dietary staff	08/02/2024

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	155650	A. BUILDING 00 B. WING	07/12/2024

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	thin. He then poured an unknown amount of thickener into the container until it was thickened. During an interview after the puree observation, the DM indicated the cook should have added more of thickening agent. The puree was too thin and not the correct consistency. He would in-service the staff on preparing pureed foods. The recipe titled, "Pureed Broccoli", indicated to make 5 servings the ingredients were to add "...2 and 1/2 cups of Broccoli and 2 tablespoons of Margarine, Solids..." "...Place prepared vegetables and margarine in a washed and sanitized food processor; blend until smooth..." "...2. If the product needs thickening, gradually add a commercial or natural food thickener (ex, potato flakes or baby rice cereal) to achieve a smooth, pudding or soft mashed potato consistency..." A facility policy, titled "Pureed Diet" and received as current from the facility, indicated, "...8. c. Drain liquid from portions needed for pureed preparation. Reserve liquid in case additional liquid is needed when pureeing to the correct consistency..." "...i. If the recipe does not yield the correct texture, add a measured amount of fluid or thickening agent to yield the desired consistency..." 3.1-21(a)(3)		were re-educated on: · Following the recipes when preparing altered consistency diets 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; Dietary Manager/Designee will audit altered diets preparation 2 times per week to ensure the recipe is followed and consistency is accurate. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 8/2/2024	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review and interview, the facility failed to ensure infection control measures were in place and implemented related to lack of a clothing protector used when sorting soiled laundry, incorrect signage posted for a resident on contact isolation, and not cleaning a shared blood pressure cuff between uses. (Laundry Aide 1, QMA 1, and Resident 23) Findings include: 1. On 7/12/24 at 10:50 a.m., the laundry room was observed with Laundry Aide 1. In the dirty laundry sorting area, there were no aprons or clothing coverings observed hanging.	F 0880	Lincolnshire Healthcare Center Compliant Survey: 7/12/2024 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. F880 Infection Prevention & Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	08/02/2024

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	During an interview at that time, the Laundry Aide indicated she wore gloves when sorting the dirty laundry. She did not wear any type of clothing protector and indicated she had never been instructed to do so. The Laundry Policy was received and did not address the above issue. 2. On 7/11/24 at 9:16 a.m., QMA 1 was observed preparing medications for the resident in Room B 5-1. QMA 1 indicated she was going to check the resident's blood pressure prior to administering the medications, but needed the blood pressure cuff, which was on A-Wing. She asked the Director of Nursing to bring her the blood pressure cuff/rolling cart. She took the cart with the blood pressure cuff on it and entered the resident's room. She placed the blood pressure cuff on the resident's arm and checked her blood pressure. She took the machine out of the room and set it in the hallway next to the medication cart. She then administered the resident's medications. She did not clean or disinfect the blood pressure cuff. QMA 1 then began preparing the medications for the resident in Room B 1-2. She took the cart with the blood pressure cuff on it and entered the resident's room. She placed the blood pressure cuff on the resident's arm and checked her blood pressure. She took the machine out of the room and set it in the hallway next to the medication cart. She then administered the resident's medications. She did not clean or disinfect the blood pressure cuff. During an interview on 7/11/24 at 9:56 a.m., QMA 1 indicated she should have cleaned the blood pressure cuff with a sani wipe in between residents.		Resident 23's contact isolation sign was updated with CDC approved contact isolation sign. QMA 1 -was educated on sanitizing blood pressure equipment between resident use. Laundry Aide 1- was educated on wearing clothing protection when sorting/handling soiled clothes and linen. 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; Staff were re-educated: · Posting the appropriate Isolation precaution signage. · Wearing clothing protectors while sorting soiled clothes and linen · Cleaning blood pressure/re-usable medical equipment between resident use. 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; DON/designee will randomly audit 3 residents requiring Contact Isolation Precautions weekly to confirm correct precaution signage is posted.	

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	A facility policy received as current, titled "Infection Prevention and Control Program," indicated, "...15. Cleaning and disinfection of environmental surfaces and reuseable equipment...b. The facility cleaning/disinfection policies include handling of equipment shared among residents [...blood pressure cuffs...] c. Facility has policies and procedures to ensure that reuseable medical devices are cleaned and reprocessed appropriately prior to use on another resident...e. Supplies necessary for appropriate cleaning and disinfection procedures...are available and used according to manufacturer instructions for use..." 3. During a random observation on 7/9/24 at 11:46 a.m., Resident 23's door had a sign next to the door indicating to see nursing staff prior to entrance to the room. There were no other signs on or near the doorway. On 7/10/24 at 11:50 a.m., Resident 23's door had a plain white piece of paper that said "Contact Isolation" typed in a large font which was hanging below the sign indicating to see nursing staff prior to entrance to the room. There were no other signs or information on or near the door. Resident 23's record was reviewed on 7/11/24 at 11:31 a.m. Diagnoses included, but were not limited to, disc degeneration and generalized anxiety disorder. A Physician's Order, dated 7/7/24 at 7:00 p.m., indicated erythromycin ointment (antibiotic) 5 milligram/gram, 1 ribbon in both eyes twice daily for conjunctivitis. A Physician's Order, dated 7/8/24 at 8:49 a.m., indicated contact isolation (gown and glove) due		DON/Designee will observe 5 staff members clean/sanitize medical equipment between resident use weekly to ensure compliance. Administrator/Designee will randomly audit 2 laundry staff members weekly to ensure compliance with utilizing clothing protectors when sorting soiled linen. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/2/2024	

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	to conjunctivitis. During an interview on 7/8/24 at 9:53 a.m., LPN 1 indicated Resident 23 was not under isolation precautions currently, but the staff had posted the signage to see nursing before entrance due to her being on an antibiotic ointment for eye drainage. It had not been confirmed as conjunctivitis so she was not under any type of isolation precautions yet. During an interview on 7/11/24 at 10:52 a.m., the Unit B Manager indicated she was responsible for updating signage on the doors when she came in on Monday mornings. She had no other signs for contact isolation that included what personal protective equipment was required to enter the room. 3.1-18(b)			