CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
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		07/12/2024
		100000	B. WING _		0111212024
NAME OF B	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	KOVIDEK OK SUFFLIER		8380 \	/IRGINIA ST	
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER	MERF	ILLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000					
Bldg. 00					
9	This visit was for a	Recertification and State	F 0000		
			1 0000		
	Licensure Survey. This visit included the Investigation of Complaints IN00436382,				
	IN00437153, and II	-			
	110043/133, and 11	10043 / 140.			
	Commissint INIO0424	6382 - Federal/State deficiencies			
	•				
	_	ations are cited at F580, F657,			
	and F697.				
	-	7153 - No deficiencies related to			
	the allegations are o	cited.			
	-	7146 - No deficiencies related to			
	the allegations are of	cited.			
	Survey dates: July 8	8, 9, 10, 11, and 12, 2024			
	Facility number: 00				
	Provider number: 1				
	AIM number: 1002	266950			
	Census Bed Type:				
	SNF/NF: 74				
	Total: 74				
	Census Payor Type	:	1		
	Medicare: 3				
	Medicaid: 63		1		
	Other: 8		1		
	Total: 74		1		
			1		
	These deficiencies	reflect State Findings cited in			
	accordance with 41		1		
			1		
	Quality review com	unleted on 7/18/24			
	(aans) 10 (10 (001)				

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

Brittany Weaver Administrator 08/13/2024

Any defiency statement 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 disclodays 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 X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 07/12/2024 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 F 0554 483.10(c)(7) SS=D Resident Self-Admin Meds-Clinically Approp Bldg. 00 §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 F 0554 Lincolnshire Healthcare Center 08/02/2024 interview, the facility failed to ensure residents Annual Survey: 7/12/2024 had physician's orders for a medication, Please accept the following as the physician's orders for self-administration of facility's credible allegation of medications, and a self-administration of compliance. This plan of medications assessment completed for 1 of 2 correction does not constitute an residents reviewed for self-administration of admission of guilt or liability by the medication. (Resident 4) facility and is submitted only in response to the regulatory Finding includes: requirement. F554 Resident Self Admin On 7/8/24 at 11:51 a.m., there was a bottle of Meds-Clinically Appropriate fluticasone spray (nasal spray) observed on What corrective action(s) will be Resident 4's bedside table. At the time, the accomplished for those residents resident indicated that she took the nasal spray found to have been affected by the by herself whenever she felt that she needed it. deficient practice; A self-administration assessment On 7/10/24 at 11:54 a.m., the bottle of fluticasone was completed for Resident 4 and spray was still observed on the bedside table. an MD order was received for self-administration of Nasal spray. Resident 4's record was reviewed on 7/10/24 at How the facility will identify other 11:14 a.m. Diagnoses included, but were not residents having the potential to limited to, heart failure and adult failure to thrive. be affected by the same deficient practice and what corrective action The Quarterly MDS (Minimum Data Set) will be taken: assessment, dated 6/5/24, indicated the resident All facility residents with was cognitively intact for daily decision making. medication orders have the potential to be affected by the There were no physician's orders for the same alleged deficient practice. fluticasone spray. What measures will be put into place or what systemic changes There was no care plan for self-administration of will be made to ensure that the the fluticasone. deficient practice does not recur; Staff were educated on not leaving

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155650	B. W	ING		07/12/	2024
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	•	8380 V	ADDRESS, CITY, STATE, ZIP COD IRGINIA ST LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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 DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		administration of medication			medications at resident bedsid	de	
	assessments.				unless there is an order for		
	D	7/11/04 + 10.50 - 1			self-administration in place.		
	1	on 7/11/24 at 10:52 a.m., the			Licensed Nurses were also		
	and provided no fur	licated she would look into it			educated on the need for a	lion	
	and provided no fur	uici iiioiiiiauoii.			physician order and a medicate self-administration assessmer		
	A Policy, titled, "Se	elf-Administration of			when a resident self-administe		
	1	n," indicated "5. If a resident			medication.		
	1	ninister drugs, it is the			How the corrective action(s) w	ill be	
		IDT to determine that it is			monitored to ensure the defici		
		to self-administered rugs,			practice will not recur, i.e., wh	at	
		may exercise that right7. The			quality assurance programs w	ill be	
	_	lesignee will complete the			put into place;		
		of Medication Evaluation and			Facility Angel's will audit 5		
		to the Unit Manager or			residents 3 days per week to		
		he resident has been deemed			ensure no medication is		
	1	order will be obtained from the			improperly stored at the bedsi	de	
		or physician extender listing			and any medication noted at		
		hat may be self-administered, ons will be stored, who will be			bedside has orders for self-administration.		
		umentation and the location of			The Director of Nursing/design	200	
	_	Appropriate documentation of			will present a summary of the	ice	
		ations will be documented in			audits to the Quality Assurance	:e	
	the resident's care p				committee monthly for 6 mont		
	·				Thereafter, if determined by the		
	3.1-11(a)				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	483.10(g)(14)(i)-(i	v)(15)					
SS=D	1-71 717 1	(Injury/Decline/Room, etc.)					
Bldg. 00		otification of Changes.					
J. 22	_ ,_,,	mmediately inform the					
	resident; consult v	-					

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PRINTED: 08/16/2024
FORM APPROVED

ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155650	B. W	ING		07/12	/2024	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	R			RGINIA ST			
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		tify, consistent with his or						
	-	resident representative(s)						
	when there is-							
	, ,	volving the resident which						
		nd has the potential for						
	requiring physicia							
	, , -	hange in the resident's						
		or psychosocial status						
		ation in health, mental, or us in either life-threatening						
		cal complications);						
		er treatment significantly						
	` '	discontinue an existing						
	form of treatment	_						
		to commence a new form						
	of treatment); or							
	, ,	transfer or discharge the						
	` '	facility as specified in						
	§483.15(c)(1)(ii).							
	- ,,,,,	notification under paragraph						
	(g)(14)(i) of this se	ection, the facility must						
	ensure that all per	rtinent information specified						
	in §483.15(c)(2) is	s available and provided						
	upon request to the	ne physician.						
	, ,	ust also promptly notify the						
		esident representative, if						
	any, when there is							
	(A) A change in ro							
	-	ecified in §483.10(e)(6); or						
	, ,	esident rights under Federal						
		gulations as specified in						
	paragraph (e)(10)							
	, ,	ust record and periodically						
		ss (mailing and email) and						
	phone number of							
	representative(s).							
	§483.10(g)(15)							

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Admission to a composite distinct part. A facility that is a composite distinct part (as

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ΓED	
		155650	B. W.	ING		07/12/2	024	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF 1	PROVIDER OR SUPPLIE	R			IRGINIA ST			
LINCOLI	NSHIRE HEALTH &	REHABILITATION CENTER		MERRILLVILLE, 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	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	_) must disclose in its						
	admission agreen							
	_	luding the various locations						
		composite distinct part,						
		the policies that apply to						
	_	tween its different locations						
	under §483.15(c)	(9). on, record review and	EO	500	Lincolnshire Healthcare Cente	.	00/02/2024	
		ity failed to notify the	F 0:	380	Annual Survey: 7/12/2024	=1	08/02/2024	
		ve of new orders for			Please accept the following as	s the		
		of 5 residents reviewed for			facility's credible allegation of			
		ations. (Resident B)			compliance. This plan of			
					correction does not constitute	an		
	Finding includes:				admission of guilt or liability b			
					facility and is submitted only in			
	Resident B's record	l was reviewed on 7/9/24 at			response to the regulatory			
	11:18 a.m. Diagnos	ses included, but were not			requirement.			
	limited to, schizoaf	fective disorder, anxiety			F580 Notify of changes			
	disorder, dementia	with behavioral disturbance,			(Injuries/Decline/Room, Etc.)			
	and bipolar disorde	er without psychotic features.			What corrective action(s) will	be		
					accomplished for those reside	ents		
		imum Data Set (MDS)			found to have been affected b	y the		
	· ·	5/26/24, indicated the resident			deficient practice:			
		tively impaired for daily			Resident B and family were			
	_	Medications received while a			updated on medication orders			
		out were not limited to,			How the facility will identify other			
		routine basis, anti-anxiety			residents having the potential			
	medications, and of	pioids (pain medications).			be affected by the same defic			
	A Niuman-l Ni-4- 1	to d 5/22/2024 at 9:11			practice and what corrective a	action		
		ted 5/23/2024 at 8:11 p.m., ent complained of right hip			will be taken;			
		was placed for Icy Hot Patch			All residents with a change in	, ho		
	_	p and off at bedtime.			condition have the potential to	ne		
	daily to the light in	p and on at occume.			affected by the same alleged deficient practice.			
	A Nurses' Note da	ted 5/29/2024 at 3:58 p.m.,			What measures will be put int	_		
		niatric Nurse Practitioner placed			place or what systemic chang			
	-	traline (an antidepressant) 50			will be made to ensure that th			
		illy. The resident was aware.			deficient practice does not red	I .		
	l mg/ du	, 			Nurses were in-serviced on			
	A Nurses' Note. da	ted 6/12/2024 at 11:28 p.m.,			ensuring the physician, reside	ent.		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155650	B. W	ING		07/12/	
				_			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					RGINIA ST		
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated the Psych	iatric Nurse Practitioner placed			and resident responsible party	/ are	
	a new order for ario	cept (dementia treatment) 5 mg			notified of residents' change in	ı	
	at bedtime. The res	ident was aware.			condition, medication orders,		
					treatment orders and notificati	on is	
	A Nurses' Note, dat	ted 6/18/2024 at 3:01 p.m.,			documented in the resident's		
		ent requested a smoking patch.			medical record.		
		notified and new orders for a			How the corrective action(s) w	/ill be	
		e received. The resident was			monitored to ensure the defici		
	aware.				practice will not recur, i.e., who		
					quality assurance programs w		
	A Nurses' Note, dat	ted 7/9/2024 at 2:43 p.m.,			put into place;		
		iatric Nurse Practitioner placed			DON/Designee will randomly a	audit	
	1	continue sertraline 50 mg daily			5 residents with change in	addit	
		75 mg daily for anxiety. The			condition weekly to ensure		
	resident was aware.				resident/responsible party		
	resident was aware.	•			notification is completed timely	W	
	During an observat	ion on 7/10/24 at 12:10 p.m.,			and documented in the medical	-	
	_	served to be in her wheelchair			record.	ai	
		own the hallway. She was			The Director of Nursing/design	200	
	_	to LPN 1, but the conversation			will present a summary of the	166	
		indicated the resident often			audits to the Quality Assurance	20	
		she was doing at the time,			committee monthly for 6 mont		
		vas there right next to her and			Thereafter, if determined by the		
		onversation with them. LPN 1			-		
		ner "usual" state of mind.			Quality Assurance committee,		
	illulcated tills was i	iei usuai state of fiffid.			auditing and monitoring will be	;	
	During on integrican	v on 7/11/24 at 11:57 a.m., the			done quarterly and present		
		g indicated the resident was her			quarterly at the QA meeting.		
	· ·	rty. They had tried to call the			Monitoring will be on going.		
		in the past and never received			Date by which systemic		
	_	in the past and never received			corrections will be completed:		
	a response.				8/2/2024		
	A Policy titled "Cl	nange in Condition Process,"					
		cility must inform the resident,					
		sident's physician and notify					
	the resident's family member or legal						
	representative when there is a change requiring such notification. Situations requiring notification						
		to alter treatment significantly;					
	i mai is, a need to dis	scontinue an existing form of	1		İ		I

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· ´		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' A. BUILDING (00) COMPLETE				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLET B. WING 07/12/20					
		155650				07/12/	ZUZ4
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER		MERRILLVILLE, IN 46410			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY		DATE
		verse consequences, or to orm of treatment. This may					
		nuing a treatment or changing					
		: adverse consequences, acute					
		tion of a chronic condition."					
	condition, exacerba	tion of a chrome condition.					
	This citation was re	lated to Complaint IN00436382.					
	3.1-5(a)(3)						
F 0641	483.20(g)						
SS=A	Accuracy of Asses	ssments					
Bldg. 00		acy of Assessments.					
		nust accurately reflect the					
	resident's status.						
	Based on record rev	view and interview, the facility	F 064	1	Lincolnshire Healthcare Cente	r	08/02/2024
		Minimum Data Set (MDS)			Annual Survey: 7/12/2024		
	-	essments were accurately			Please accept the following as	the	
	_	o anticoagulant and diuretic			facility's credible allegation of		
		2 of 19 MDS assessments			compliance. This plan of		
	reviewed. (Resident	ts 33 and 220)			correction does not constitute		
	Eindines includes				admission of guilt or liability by		
	Findings include:				facility and is submitted only ir response to the regulatory	l	
	1. Resident 33's rec	cord was reviewed on 7/10/24 at			requirement.		
	11:13 a.m. Diagnos	es included, but were not			F641 Accuracy of Assessmen	t	
	_	ure, tachycardia, depression,			What corrective action(s) will b		
	and chronic obstruc	tive pulmonary disease.			accomplished for those reside		
					found to have been affected b		
	The Quarterly MDS	S assessment, dated 6/28/24,			deficient practice;		
	indicated the residen	nt was cognitively intact and			Resident 220's MDS Assessm	ent	
	took an anticoagula	nt medication. The MDS did			was modified for drug coding		
	not indicate the resi	dent took an antiplatelet			accuracy.		
	medication.				Resident 33's MDS Assessme	ent	
					was modified for drug coding		
	-	r, dated 4/8/24, indicated the			accuracy.		
	_	n 81 milligrams daily for			How the facility will identify oth		
	_	e was no order for an actual			residents having the potential		
	anticoagulant medic	cation.			be affected by the same defici		
					practice and what corrective a	ction	

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	LETED	
		155650	B. W	ING		07/12	/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	R			IRGINIA ST			
LINCOL	NISHIDE HEAT TH &	REHABILITATION CENTER			LLVILLE, IN 46410			
LINCOL	NOTINE HEALTH 6	REHABILITATION CENTER		MEKKI	LLVILLE, IN 404 IO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	w on 7/10/24 at 1:24 p.m., the			will be taken;			
		indicated the order for aspirin			All residents have the potentia	al to		
		s an anticoagulant instead of			be affected by this alleged			
	an antiplatelet. She indicated she would correct the MDS. 2. The record for Resident 220 was				deficient practice.			
					What measures will be put int			
		4 at 11:34 a.m. Diagnoses			place or what systemic chang			
		not limited to, hypertension,			will be made to ensure that th	е		
	coronary artery dis	ease, and anemia.			deficient practice does not rec	cur;		
					MDS was re-educated on:			
		OS assessment, dated 6/24/24,			· Drug classifications			
		ent had not received any			· Appropriately coding medica	itions		
	diuretic medication	s in the past seven days.			on the MDS assessment			
					How the corrective action(s) v			
	-	er, dated 6/17/24, indicated to			monitored to ensure the defici			
		rochlorothiazide (a diuretic			practice will not recur, i.e., wh			
	_	dication) 20-12.5 mg (milligrams)			quality assurance programs w	ill be		
	daily.				put into place;			
					DON/Designee will audit 5			
		lministration Record (MAR),			resident's MDS assessments			
		eated the resident had received			medication coding accuracy w			
	the diuretic blood p	pressure medication daily.			special focus on antiplatelets			
	D	7/10/24 + 1.24 + 1			diuretics weekly for 4 weeks,			
		w on 7/10/24 at 1:24 p.m., the indicated the MDS was			bi-weekly thereafter to ensure	!		
					compliance.			
	incorrect, and she v	vould modify it.			DON/designee will present a			
	2.1.21(;)				summary of the audits to the			
	3.1-31(i)				Quality Assurance committee	£4		
					monthly for 6 months. Therea	ner,		
					if determined by the Quality	~		
					Assurance committee, auditin and monitoring will be done	g		
					quarterly and present quarterl	v ot		
					the QA meeting. Monitoring w	-		
					on going.	III DC		
					Date by which systemic			
					corrections will be completed:			
					8/2/2024			
					S/2/2027			
F 0657	483.21(b)(2)(i)-(iii)						
SS=D	Care Plan Timing							

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	l í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		8380 VI	ADDRESS, CITY, STATE, ZIP COD IRGINIA ST LLVILLE, IN 46410		
(X4) ID PREFIX TAG Bldg. 00	SUMMARY (EACH DEFICIEN REGULATORY OF §483.21(b) Comp §483.21(b)(2) A c must be- (i) Developed with of the comprehen (ii) Prepared by an includes but is not (A) The attending (B) A registered n the resident.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION rehensive Care Plans omprehensive care plan sin 7 days after completion sive assessment. In interdisciplinary team, that t limited to		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	resident. (D) A member of the staff. (E) To the extent participation of the representative(s). included in a reside participation of the representative is of for the development plan. (F) Other appropring disciplines as determined or as requesing the representative is of the development of the dev	practicable, the eresident and the resident's An explanation must be dent's medical record if the eresident and their resident determined not practicable ent of the resident's care diate staff or professionals in ermined by the resident. revised by the resident, comprehensive and					
	Based on record rev failed to ensure qua completed and/or fa invited for 3 of 4 re planning. (Resident Findings include:	view and interview, the facility arterly care plan meetings were amily representatives were sidents reviewed for care	F 00	657	Lincolnshire Healthcare Cent Annual Survey: 7/12/2024 Please accept the following a facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability be facility and is submitted only response to the regulatory	es the ean by the	08/02/2024

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Resident D's Power of Attorney (POA)/ family

representative indicated she had not been invited

Event ID:

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requirement.

F657 Care Plan Timing and

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155650	B. W	ING		07/12	/2024
		<u> </u>	<u> </u>	CTREET	IDDREGG CHTV CT TO COP		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
LINICOLA	IOLUDE LIEALTIL O	DELIADII ITATION CENTED			RGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER		MERKII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to a care plan meeti	ing in a very long time. They			Revision		
	used to do phone co	onferences, but that had not			What corrective action(s) will b	ре	
	occurred recently.				accomplished for those reside	nts	
					found to have been affected b	y the	
	The resident's recor	d was reviewed on 7/9/24 at			deficient practice;		
	11:54 a.m. Diagno	ses included, but were not			A care conference was sched	uled	
	limited to, hemiples	gia (one sided weakness) and			for resident D and the respons	sible	
	hemiparesis (one si	ded paralysis) following a			party was invited.		
	cerebral vascular ac	ecident, dysphagia, and			A care conference was sched	uled	
	contracture of the ri	ight hand.			for resident E and the respons	sible	
					party was invited.		
		mum Data Set (MDS)			A care conference was sched	uled	
	assessment, dated 5	3/28/24, indicated the resident			for resident B and the respons	sible	
	had severe cognitiv	e impairment, required set up			party was invited.		
	assistance for meals	s, and extensive 2+ staff			How the facility will identify oth	ner	
	assistance for bed n	nobility.			residents having the potential	to	
					be affected by the same defici	ent	
		mentation a care plan meeting			practice and what corrective a	ction	
	had been completed	d in 2024.			will be taken;		
					All residents have the potentia	al to	
		ng Invitation, dated 5/5/24,			be affected by this alleged		
		nt was invited and noted, "the			deficient practice.		
		." The POA/representative			What measures will be put into		
	section was left bla	nk.			place or what systemic change	es	
					will be made to ensure that the		
		v on 7/9/24 at 2:43 p.m., the			deficient practice does not rec		
		ctor indicated a list was			Social Service was re-educate	ed	
	1 ^	eptionist monthly of care plan			on:		
		due and invitations were sent			· Scheduling Quarterly/Annual		
		If there was not a social			Care Conferences.		
		was no care plan meeting held.			· Ensuring the		
	1	d, there was no one with whom			resident/Responsible Party is		
	to have the meeting. She indicated they may not				invited to attend the conference		
	have the correct add	dress for the POA.			Documenting Conference Da		
		7/0/04 0.71			and Attendees in the resident'	S	
		iew on 7/8/24 at 8:51 a.m.,			medical record.		
		d he had not attended a care			How the corrective action(s) w		
		as not familiar with what that			monitored to ensure the defici		
	was.				practice will not recur, i.e., who		
					quality assurance programs w	ill be	

JIDK11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155650	B. W	ING		07/12/2	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			RGINIA ST		
LINCOLN	JSHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
LINOOLI	·	THE HABIETIATION CENTER		WILKIKI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		rd was reviewed on 7/11/24 at			put into place;		
	_	ses included, but were not			Administrator/Designee will au	I	
		e, metabolic encephalopathy,			care conferences scheduled for	or	
	and diabetes mellitus.				the week to ensure the		
					resident/responsible party was	S	
		S assessment, dated 6/24/24,			invited to attend and the		
	indicated the reside	ent was cognitively intact.			conference is documented in	the	
	l _, .				resident's medical record.		
		mentation a care plan meeting			The Administrator/designee w	I	
	had been completed	d in 2024.			present a summary of the aud	lits	
		7/11/04 : 10.05			to the Quality Assurance		
		w on 7/11/24 at 12:05 p.m., the			committee monthly for 6 mont		
		ector indicated she was unable			Thereafter, if determined by the		
		e plan meeting for the resident.			Quality Assurance committee,	I	
		invited and didn't want to			auditing and monitoring will be	9	
		ll be documented. She also			done quarterly and present		
		ent was due for a care plan			quarterly at the QA meeting.		
	-	and June, but had been in the			Monitoring will be on going.		
		ald have rescheduled the			Date by which systemic		
	_	ot.3. Resident B's record was			corrections will be completed:		
		at 11:18 a.m. The resident was			8/2/2024		
		ility on 4/18/24. Diagnoses					
		not limited to, schizoaffective isorder, depression, dementia					
		turbances, and bipolar disorder					
	without psychotic f	-					
	without psychotic i	catures.					
	The Quarterly Min	imum Data Set (MDS)					
		6/26/24, indicated the resident					
		tively impaired for daily					
		he required setup or clean-up					
		ing, oral hygiene, toileting					
		ng. She received scheduled					
		d antipsychotic medications on					
	_	yell as anti-anxiety medications.					
	a routino oubib us w	. In an anni annier, medications.					
	The record lacked	documentation of a care plan					
	meeting since admi						
	There was no docu	mentation of an invitation to a					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650			UILDING	nstruction 00	(X3) DATE : COMPL 07/12/	ETED		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION	
TAG		ent to the resident and/or the ive.		TAG	BEIGENCIT		DATE	
F 0677 SS=D Bldg. 00	During an interview Social Service Direction held a care plan meresident representate care plan meeting wadmission. She was documentation of a being sent to the resident policy, Centered Care Plan of the facility to produce our residents by util of care based on asservice and interver planning process with the resident and/or and The policy also indicare plan will bev participation of the representative(s). A included in the resident and/or and the resident and/or and the representative is detected by the development of the representative is detected by the representative i	on 7/11/24 at 1:52 p.m., the ctor indicated she had never eting with the resident and/or ive. It was expected to hold a within 72 hours after a new unable to provide any care plan meeting invitation dident and/or representative. "Comprehensive Resident", indicated, "It is the policy omote interdisciplinary care for izing the interdisciplinary plan dessment, planning, treatment, attion", and, "5. The ill: a. Facilitate the inclusion of resident representative" cated, "1. A comprehensive in the extent practicable, the resident and the resident's mexplanation must be indent's medical record if the						
	nutrition, grooming hygiene;	g, and personal and oral						

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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	COMPLETE	ED
		155650	B. W	NG		07/12/20	24
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			IRGINIA ST		
LINCOLI	VSHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
LINCOLI	·	CRETABLETATION CENTER		IVILIXIXI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		, observation, and record	F 0	677	Lincolnshire Healthcare Cente	er 0	08/02/2024
	-	failed to ensure residents			Annual Survey: 7/12/2024		
		sary care for activities of daily			Please accept the following as		
		ted to the lack of documentation			facility's credible allegation of		
		re and residents with long, dirty			compliance. This plan of		
	_	nails for 3 of 11 residents			correction does not constitute		
	reviewed for ADL	care. (Residents 10, 4 and C)			admission of guilt or liability by		
					facility and is submitted only in	n	
	Findings include:				response to the regulatory		
	1 0 7/0/04 : 11	00 P 11 . 10			requirement.		
		30 a.m., Resident 10 was			F677 ADL Care Provided for		
		resident indicated the staff			Dependent Residents		
		orief to see if he needed to be			What corrective action(s) will I		
	changed.				accomplished for those reside		
	D 1 . C	D 11 (10 1 1 1			found to have been affected b	y the	
		Resident 10 was completed on			deficient practice;		
	_	Diagnoses included, but were			ADL documentation is being		
		rtension, anxiety, depression,			completed accordingly for		
	bipolar, and psycho	oue disorder.			Resident's 4, C, and 10.		
	The Questerly Min	imum Data Set (MDS)			Nail care was provided for		
		4/12/24, indicated the resident			Resident's 4, C, and 10. How the facility will identify otl	nor	
		act. The resident required a			residents having the potential		
		ce for bed mobility and was			be affected by the same defic		
		sfers. The resident was always			practice and what corrective a		
	incontinent of blad				will be taken;	Clion	
					All residents requiring assista	nce	
	A Care Plan, dated	5/17/23, indicated the resident			with Activities of Daily Living h		
		er incontinence. An			the potential to be affected by		
	_	ed to check and change with			same alleged deficient practic		
	routine care rounds	•			What measures will be put int		
					place or what systemic chang		
	The Bladder Elimin	nation Task for the past 30 days			will be made to ensure that the		
		ontinence care was not			deficient practice does not rec		
	•	following dates and shifts:			· Staff were re-educated on		
	accumented on the following dates and sinits.				providing residents with		
	Days: 6/17/24 and	7/1/24			assistance with Activities of D	aily	
	Evenings: 6/13, 6/1	14, 6/16, 6/19, 6/21, 6/22, 6/23,			Living (ADL's) per plan of	-	
	6/24, 6/25, 6/26, 6/	729, 7/5, and 7/8/24.			care/preferences with a specia	al	
	Nights: 6/13, 6/14,	6/20, 6/23, 7/5, and 7/6/24.			focus on providing nail care.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155650	B. W	ING		07/12	/2024
		ı		STDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	₹			IRGINIA ST		
	ISHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
LINCOLIV	NOTHING HEALTH &	TELIABILITATION CENTER		IVILITATI	LL VILLE, IIN 404 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					· Staff were re-educated on		
During an interview on 7/10/24 at 11:48 a.m., CNA					documenting Activities of Dail	у	
		As worked 8 hour shifts. The			Living provided including		
	resident was incontinent of bladder and wore a				incontinence care in the medic	cal	
	brief. Staff were supposed to check residents				record.		
		acontinence care. They were			How the corrective action(s) w		
		ent at least once per shift if			monitored to ensure the defici		
		ntinent or incontinent and if			practice will not recur, i.e., wh		
	care was completed	l.			quality assurance programs w	ill be	
					put into place;		
	_	v on 7/10/24 at 1:46 p.m., the			DON/Designee will Audit 5		
	_	g (DON) indicated the CNAs			residents weekly, to ensure		
	-	neck the residents every 2			Activities of Daily Living with		
		nce care and document in the			special focus on incontinence	care	
		e per shift related to the			is documented in the medical		
		ce status and if care was			record.		
	completed.				Facility Angel's will observe 10	0	
		iew on 7/8/24 at 11:48 a.m.,			residents 2 times per week to		
		d the staff were not providing			ensure residents are groomed	l with	
		re timely. There were often			a special focus on nailcare.		
	_	ould come into her room and			Director of Nursing/designee v		
		ht and say they would come			present a summary of the aud	lits	
	_	e incontinence care, however it			to the Quality Assurance		
	would take them ho	ours to do so.			committee monthly for 6 mont		
		1 5/20/24			Thereafter, if determined by the		
		was reviewed on 7/10/24 at			Quality Assurance committee,		
	_	ses included, but were not			auditing and monitoring will be	9	
		lure, polyneuropathy (disease			done quarterly and present		
		l nerves), and adult failure to			quarterly at the QA meeting.		
	thrive.				Monitoring will be on going.		
		7			Date by which systemic		
		S assessment, dated 6/5/24,			corrections will be completed:		
		ent was cognitively intact for			8/2/2024		
	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						
		ll assistance for personal					
		lways incontinent of bladder					
	and frequently inco	ntinent of bowel continence.	1				I

JIDK11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVI			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155650	B. WING		07/12/2024
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
LINICOLA	JOHIDE MEVI AN O	REHABILITATION CENTER		IRGINIA ST ILLVILLE, IN 46410	
	NOTHRE HEALTH &	NEHADILHA HON CENTER	IVIERRI	LLVILLE, IIN 404 IU	
(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 APPROPRI DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION ressure ulcer that was present	TAG	BEFREERETT	DATE
	upon admission/ent	_			
	upon admission en	ly of reemily.			
	A Care Plan, dated	5/29/24, indicated the resident			
	required assistance	with activities of daily living			
	(ADLs) including b	· -			
		al lift device, and toileting.			
		led, but not limited to, assist			
	with bed mobility, I needed.	bathing, and toileting care as			
	necucu.				
	The Bowel and Bla	dder (B&B) - Bladder			
	Elimination Point of Care Task indicated there was				
	a frequency of ever	y shift. The documentation			
		e last 30 days and the resident			
		ntinent only twice per day on			
		20, 6/22, 6/23, 6/24, 6/26, 7/4, 7/6,			
		ident was marked as			
	incontinent once on	1 6/14 and 6/18/24.			
	During an interview	v on 7/11 at 11:15 a.m., the			
	_	indicated that it was expected			
	_	ng and changing the dependent			
	residents every two	hours and documenting at			
	least once a shift.				
	2 Danier 1 4	7/9/24 -4 0.21			
	_	iew on 7/8/24 at 9:31 a.m., d he needed his nails trimmed			
		nd feet and his fingernails			
		aning. He was having to			
		this stool and so his fingernails			
		s were observed to be long and			
		ls were long upon observation			
	at the time.				
	D 1 1	7/0/04 + 11 40			
		ion on 7/9/24 at 11:48 a.m., served lying in his bed. He had			
		ls and his toenails were long.			
	long unity imgerilar	is and instroctions were tong.			
	Resident C's record	was reviewed on 7/11/24 at			

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PRINTED: 08/16/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPL	ETED	
		155650	B. WING			07/12/	2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD RGINIA ST			
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER	М	ERRIL	LVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID)	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)	\\\L	DATE	
	9:28 a.m. Diagnoses to, hemiplegia and I dominant side and variety in the Annual Minima assessment, dated 5 was cognitively inta He had limited rang upper and lower extra assistance with toile transfers. He require assistance with personal frequently inconting incontinent of bower as resistive to care treatment. Intervent limited to, allow the about treatment regireceive care through options, and if residing reassure resident, le later and try again. The Bath and Skin I indicated the resident which included lotter nails trimmed. On 7	s included, but were not limited nemiparesis affecting the right vascular dementia. The part of the part of the right vascular dementia. The part of the part of the resident act for daily decision making. The part of motion on both sides on the tremities. He required total entire the part of						
	nails trimmed.	tion application, shaved, and nentation that the resident						

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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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155650		A. BU	A. BUILDING <u>00</u> COM			survey .eted /2024	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, 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)	TE	(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	documentation that that he had constipa received nail care a dirty. 3.1-38(a)(2)(C) 3.1-38(a)(3)(E) 483.25 Quality of Care § 483.25 Quality of						
	applies to all treat facility residents. It comprehensive as facility must ensure treatment and car professional stand comprehensive per and the residents. Based on observation interview, the facility received the necessate to administering a beginning of the prescribed parassessment and a trewith a bandage, and preventative heel progressidents reviewed (Resident 28) and 2	sessment of a resident, the re that residents receive e in accordance with lards of practice, the erson-centered care plan,	F 00	684	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F684 Quality of Care What corrective action(s) will be accomplished for those reside found to have been affected by	an the the	08/02/2024
	on 7/11/24 at 12:22 were not limited to,	r Resident 28 was completed p.m. Diagnoses included, but atrial fibrillation, heart failure, rthostatic hypotension.			deficient practice; Resident C- Heel protectors w applied. Resident 39- Skin was assess and treatment orders were		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155650	B. WI	NG		07/12/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF F	PROVIDER OR SUPPLIER	8			IRGINIA ST	
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE
					received.	
The Admission Minimum Data Set (MDS)					Resident 28's- physician was	
		/11/24, indicated the resident			notified and clarification was	
	was cognitively inta	act.			received for blood pressure	
	TI I 1 2024 DI				parameters.	
		sician's Order Summary			How the facility will identify oth	
		for midodrine hel (treats low			residents having the potential	
		mg (milligrams) twice a day for			be affected by the same defic	
		sion. Hold the medication if			practice and what corrective a	iction
		ressure (SBP) (top reading of			will be taken;	
	a blood pressure) w	as greater than 130.			All residents have the potentia	
	TO 1 1 1 1 1	202434 11 11			be affected by the same alleg	ed
	The June and July 2				deficient practice.	
		ords indicated the midodrine			What measures will be put int	
		ed on the following dates and			place or what systemic chang	
		P was out of parameters and			will be made to ensure that the	
	should not have bee				deficient practice does not rec	cur;
		edtime) the blood pressure (BP)			Nurses were re-educated on:	
	was 139/78	120/51			· Addressing and assessing	
	- 6/8/24 at HS the E				changes in skin condition,	
		I (morning) the BP was 132/69			notifying family and physician	
		I the BP was 133/72			obtaining orders for treatment	,
		I the BP was 131/72			implementation of treatment,	
	- 6/28/24 at HS the				treatments and interventions a	are in
	- 7/1/24 at HS the E				place per physician orders.	
	- 7/3/24 in the AM				· Interventions such as heel	
	- 7/4/24 in the AM				protectors, LAL mattresses,	
	- 7/5/24 in the AM				wedges, etc. are in place as	
	- 7/6/24 in the AM				ordered.	
	- 7/7/24 in the AM				· Administering/holding	la wa d
	- 7/8/24 in the AM				medications per physician ord	ered
	- 7/10/24 in the AM				parameters.	ill le a
	- //11/24 in the Alv	I the BP was 134/78			How the corrective action(s) w	
	Dumin a. a.: : '				monitored to ensure the defici	
	_	on 7/12/24 at 2:25 p.m., the			practice will not recur, i.e., wh	
	1	indicated the resident			quality assurance programs w	/III DE
		rine hel when his BP was out of			put into place;	
	_	should not have been			Nurse manager will audit 5	
		edication. She would			residents' clinical documentati	ion
I	I in-service the staff	on administering medications			weekly with focus on skin to	

JIDK11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155650	B. W	ING		07/12/	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			IRGINIA ST		
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
LINOOLI	·	TREMADIEMATION CENTER		IVILIXIXII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with prescribed par	rameters.			ensure assessments of chang	je in	
					condition is completed, treatm	ent	
					orders received, and intervent	ions	
		5 a.m., Resident 39 was			are in place per physician ord	ers.	
	_	the side of her bed. The			Nurse managers will randomly	y	
	_	e brown bandage with a smaller			audit 5 residents Medication		
	1	top of it above her right wrist.			Administration Record (MAR)		
		ted she had the bandage put			weekly to ensure medications	are	
		hospital after a blood			being administered/held per		
	transfusion.				physician parameters.		
					DON/designee will present a		
		5 a.m., the resident was			summary of the audits to the		
		n a wheelchair down the			Quality Assurance committee		
	1	n bandage with the yellow			monthly for 6 months. Therea	fter,	
	bandage was still o	bserved above her right wrist.			if determined by the Quality		
					Assurance committee, auditin	g	
		a.m., the resident was sitting in			and monitoring will be done		
		room eating breakfast. The			quarterly and present quarterl	-	
	_	h the yellow bandage was still			the QA meeting. Monitoring w	ill be	
	observed above her	right wrist.			on going.		
					Date by which systemic		
		Resident 39 was completed on			corrections will be completed:		
		m. Diagnoses included, but			8/2/2024		
		, anemia, heart failure,					
		stage renal disease, diabetes					
	mellitus, and deme	ntia.					
	m o o	NO 1 DE CESTOS					
		ange Minimum Data Set (MDS)					
	· ·	5/13/24, indicated the resident					
		act. The resident required					
	*	ssing, substantial maximum					
	_	sonal hygiene, and partial					
		e for transfers. The resident					
		gulant (blood thinning)					
	medication.						
	A Comp D1 1 4 1	5/10/22 :1:4-1:1 :1 :					
		5/19/23, indicated the resident					
		ormal bleeding/bruising related					
		agulant medications. An					
	I intervention includ	ed to monitor for side effects				Ų	l

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ENTERS FO	R MEDICARE & MEDI	CAID SERVICES			OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		155650	B. WING		07/12/	/2024
NAME OF	DDOLUDED OD CLIDDI H		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ER .	8380 VI	RGINIA ST		
LINCOL	NSHIRE HEALTH	& REHABILITATION CENTER	MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	+	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	and effectiveness	which included bruising.				
	The July 2024 Phy	ysician's Order Summary (POS)				
	indicated the follo	- · · · · · · · · · · · · · · · · · · ·				
		thinner) 2.5 mg (milligrams)				
		itor resident for signs and				
	-	erse effects, including bruising,				
		changes every shift.				
	_	-				
	- Blood Infusion Appointment on 7/3/24 at 1:15 p.m., at the hospital.					
	p.m., at the hospita					
	The record lacked any documentation related to					
		onitoring, or physician's order				
	for the resident's bandage, including the reason					
	for the bandage.					
	During an intervie	ew on 7/11/24 at 11:15 a.m., the				
	_	ng (DON) indicated the resident				
		usion at the hospital the prior				
		dage was put on there. She was				
		any documentation related to				
		or monitoring of the area and				
		d have been removed. 3. During				
	_	7/8/24 at 9:34 a.m., Resident C				
		e in bed. He had no heel				
	protector or offloa	iding in place on his right foot.				
	_	discoloration noted to his right				
	big toe.	-				
	On 7/0/24 at 11:49	8 a.m., Resident C was observed				
		ad no heel protector or				
		e on his right foot and an area of				
		observed to his right big toe.				
	discoloration was	ouserved to his right big toe.				
	Resident C's recor	rd was reviewed on 7/11/24 at				
	9:28 a.m. Diagnos	ses included, but were not limited				
		hemiparesis affecting the right				
		l vascular dementia.				

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The Annual Minimum Data Set (MDS)

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If continuation sheet

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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 07/12/2024	
	PROVIDER OR SUPPLIER	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 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
IAU	assessment, dated 5 was cognitively into He had limited rang upper and lower ext assistance with toile transfers and substa personal hygiene. H of bladder and alwa A Physician's Order protector to right he prophylaxis. A Care Plan, dated had an abrasion to t second toe. Interver limited to, encourag provide treatment p resident refuses hee The record lacked d whether the heel pro refused. During an interview Unit B Manager ind a place to document were on, off, or refu A Policy titled, "We "3c) Pressure relice	indicated the resident are for daily decision making. The see of motion on both sides on tremities. He required total eting hygiene, bathing, and antial/maximal assistance with the was frequently incontinent may incontinent of bowel. In dated 5/1/24, indicated heel et while in bed every shift for the right great toe and right entions included, but were not get turning and repositioning, the protectors. Indicated the resident the resident the right great toe and right entions included, but were not get turning and repositioning, the protectors. Indicated the resident the electron of monitoring of the protectors were on, off, or the dicated there should have been the whether the heel protectors used. The protectors indicated, the resident the electron of monitoring of the protectors were on, off, or the dicated there should have been the whether the heel protectors used. The protectors indicated, the protectors used in the protectors and the electron, indicated, the protectors in the protectors and the protectors and the protectors used.		TAU			DATE
F 0685 SS=D Bldg. 00	§483.25(a) Vision	s to Maintain Hearing/Vision and hearing sidents receive proper					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETE			
		155650	B. WING			07/12	/2024
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	8	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY		DATE
	reatment and assivision and hearing if necessary, assis §483.25(a)(1) In n §483.25(a)(2) By to and from the of specializing in the hearing impairment professional specivision or hearing a Based on record revision or hearing a Based on record revision or hearing impairment professional specivision or hearing a Based on record revision or hearing a Based on record revision or hearing includes: During an interview Resident C indicate aids. He was observed the service of the service o	R LSC IDENTIFYING INFORMATION sistive devices to maintain g abilities, the facility must, st the resident- making appointments, and arranging for transportation fice of a practitioner treatment of vision or nt or the office of a ializing in the provision of assistive devices. view and interview, the facility idents with impaired hearing ary services for 1 of 1 resident		AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	er s the an / the	
	9:28 a.m. Diagnose	s included, but were not limited			found to have been affected b		
	to, hemiplegia and l dominant side and v	hemiparesis affecting the right vascular dementia.			deficient practice; Audiology consents were rece for Resident C and the resider		
	The Annual Minim	um Data Set (MDS)			was placed on the audiology v		
	assessment, dated 5	5/3/24, indicated the resident			list.		
	was cognitively inta	act for daily decision making			How the facility will identify oth	ner	
	and had adequate he	earing.			residents having the potential		
		plans related to hearing loss.			be affected by the same defici practice and what corrective a will be taken;		
	~	v on 7/11/24 at 1:54 p.m., the			All facility residents requiring		
		ctor indicated she was never			audiology services have the		
	informed that the re	esident wanted to see an	1		potential to be affected by the		İ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f '	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		00	COMPL	
		155650	B. WIN	G		07/12/	2024
NAME OF E	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP COD		
					RGINIA ST		
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER		MERRII	LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		er he was hard of hearing. She			same alleged deficient practic		
		further information or prior			What measures will be put into		
	visits from an audiologist.				place or what systemic change		
	D	7/11/24 4 4 00 41			will be made to ensure that the		
	During an interview on 7/11/24 at 4:09 p.m., the Director of Nursing indicated the resident had				deficient practice does not rec		
	_				· Staff were educated on ensu	_	
		f hearing as far as she knew.			residents with impaired hearin	-	
	She provided no fur	rtner information.			are referred to social services.		
	During on intermi	y on 7/12/24 at 0.21 a ma I DM 1			· Social service was educated		
	_	on 7/12/24 at 9:31 a.m., LPN 1 on seemed like he would be			obtaining consents for ancillar	У	
					services upon admission and	ls. r	
	reading her lips when they were in the middle of				reviewing them at least quarte	-	
	conversation.				How the corrective action(s) w		
	During on intervious	v on 7/12/24 at 10:07 a.m., CNA			monitored to ensure the defici		
	_	dent was hard of hearing. She			practice will not recur, i.e., who		
		oach the resident very close in			quality assurance programs w	ili be	
		oach the resident very close in ar her, and it seemed like he was		put into place;			
		ps to understand her. He often			Administrator/designee will au		
		udly that he could not hear you			weekly to ensure new admissi and residents are referred to	UIIS	
	as you tried to enter				audiology services and those	with	
	as you tried to enter	ins room.			consents and are added to the		
	During an interview	on 7/12/24 at 9:54 a.m., the			visit list accordingly.	·	
	_	had set up an appointment for			Director of Nursing /designee	will	
		ervices for the following week.			present a summary of the aud		
	Saiside addiology s	or rices for the following week.			to the Quality Assurance	11.3	
	A Policy titled "Tro	eatment/Devices to Maintain			committee monthly for 6 mont	hs	
	-	dicated "1. The facility will			Thereafter, if determined by the		
		s receive proper treatment and			Quality Assurance committee,		
		maintain vision and hearing			auditing and monitoring will be		
		will, if necessary, assist the			done quarterly and present		
		ng appointments, and b. By			quarterly at the QA meeting.		
		portation to and from the office			Monitoring will be on going.		
		ecializing in the treatment of			Date by which systemic		
		ppairment or the office of a			corrections will be completed:		
		lizing in the provision of vision			8/2/2024		
		devices3. When identified,					
	_	earing needs of a resident will					
		o the Director of Social					
	Services or Designe						

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	8380	ET ADDRESS, CITY, STATE, ZIP COD O VIRGINIA ST RRILLVILLE, 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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
F 0688 SS=D Bldg. 00	§483.25(c) Mobiliti §483.25(c)(1) The resident who enter range of motion deduction in range resident's clinical that a reduction in unavoidable; and §483.25(c)(2) A remotion receives a services to increat prevent further defended §483.25(c)(3) A refere event further defended §483.25(c)(3) A refere event further defended §483.25(c)(3) A refere event further defended event further defended event further defended event further defended event further defended event further defended event further defended event further	e facility must ensure that a rs the facility without limited oes not experience of motion unless the condition demonstrates a range of motion is esident with limited range of ppropriate treatment and se range of motion and/or to crease in range of motion. esident with limited mobility ate services, equipment, and intain or improve mobility in practicable independence in in mobility is	F 0688	Lincolnshire Healthcare Cen Annual Survey: 7/12/2024 Please accept the following facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability facility and is submitted only response to the regulatory requirement. F688 Increase/Prevent Decr in ROM/Mobility What corrective action(s) will accomplished for those reside	as the of te an by the rease	

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Event ID:

on 7/9/24 at 11:26 a.m., 7/10/24 at 8:49 a.m., and

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If continuation sheet

found to have been affected by the

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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 00 COMPLETED B. WING 07/12/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 7/11/24 at 8:47 a.m. lying in bed without the hand deficient practice; splint in place. Resident D – order received for splint and care plan has been The resident's record was reviewed on 7/9/24 at implemented. 11:54 a.m. Diagnoses included, but were not How the facility will identify other limited to, hemiplegia (one sided weakness) and residents having the potential to hemiparesis (one sided paralysis) following a be affected by the same deficient cerebral vascular accident, dysphagia, and practice and what corrective action contracture of the right hand. will be taken: All residents with splints have the The Ouarterly Minimum Data Set assessment. potential to be affected by the dated 5/28/24, indicated the resident had severe same alleged deficient practice. cognitive impairment, required set up assistance What measures will be put into for meals, and extensive 2+ staff assistance for place or what systemic changes bed mobility. will be made to ensure that the deficient practice does not recur: There was not a current or discontinued Nurses were re-educated on: physician's order for a splint to be applied to the · Implementation of splint right hand. · Slint in place per care plan/therapy recommendations An Occupational Therapy (OT) Discharge · Care plan is updated accordingly Summary, dated 10/12/23, indicated How the corrective action(s) will be recommendations were the resident required monitored to ensure the deficient 24-hour care related to assistance needed for practice will not recur, i.e., what ADLs (activities of daily living) and to wear a quality assurance programs will be splint to the right hand with established wearing put into place; time. The resident had met the goal of safely Nurse manager/designee will wearing least restrictive splinting/orthotic device randomly audit 2 residents with for 4 hours on and 4 hours off. splints weekly to ensure splint is in place per During an interview on 7/9/24 at 2:35 p.m., the orders/recommendations. Therapy Director indicated the discharge DON/designee will present a summary indicated the resident should be wearing summary of the audits to the a splint and he would look into it. Quality Assurance committee monthly for 6 months. Thereafter, During a follow up interview on 7/10/24 at 10:15 if determined by the Quality a.m., the Therapy Director indicated the Assurance committee, auditing recommendation had been made by a PRN (as and monitoring will be done needed) Occupational Therapist and must have quarterly and present quarterly at

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been missed. Recommendations were normally

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the QA meeting. Monitoring will be

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AND PLAN OF CORRECTION ID		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/12/2024	
		155650	B. WI	NG	_	07/12/	2024
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	VIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	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 §483.25(g) Assiste (Includes naso-ga tubes, both percut gastrostomy and p jejunostomy, and oresident's comprel facility must ensur §483.25(g)(1) Mai parameters of nutu usual body weight range and electrol resident's clinical of that this is not pos preferences indical §483.25(g)(2) Is or to maintain proper §483.25(g)(3) Is or when there is a nu health care provid Based on observation interview, the facility with dysphagia (diffinadaptive equipment of 2 residents review Finding includes:	ntains acceptable ritional status, such as or desirable body weight yte balance, unless the condition demonstrates sible or resident	F 06	592	Lincolnshire Healthcare Cente Annual Survey: 7/12/2024 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute a admission of guilt or liability by facility and is submitted only in response to the regulatory	the an	08/02/2024
		ast. There was Styrofoam cup			requirement.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	ING	00	COMPL	ETED
		155650	B. WING			07/12/	2024
		<u> </u>	ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			RGINIA ST		
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER	М	ERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		raw, a cup of juice, and a cup of			F692 Nutrition/Hydration Statu	IS	
		to 2 handled mug present on			Maintenance		
	-	At 10:15 a.m., the resident was			What corrective action(s) will be		
	_	ed. The cup with the straw			accomplished for those reside		
		had been removed and there			found to have been affected b	y the	
	was a 2 handled mu	ig on her table.			deficient practice;		
	0.7/10/04 10.00				Resident D's – tray was		
		a.m., CNA 1 was observed			immediately corrected. Straw		
	_	ent's breakfast tray from her			removed and two handled cup	was	
		cup of juice with a straw and a			provided.		
	_	re was no 2 handled mug on			How the facility will identify oth		
	-	indicated she had not put the			residents having the potential		
	•	d it must have come from the			be affected by the same defici		
		a tray ticket on her tray that			practice and what corrective a	ction	
	indicated no straws	and to use a 2 handled mug.			will be taken;		
					All residents have the potentia		
		d was reviewed on 7/9/24 at			be affected by the same allege	ed	
	_	ses included, but were not			deficient practice.		
		gia (one sided weakness) and			What measures will be put into		
		ded paralysis) following a			place or what systemic change		
		ccident, dysphagia, and			will be made to ensure that the		
	contracture of the ri	ight hand.			deficient practice does not rec	ur;	
		D			Staff were re-educated on:		
	•	mum Data Set (MDS)			The tray pass process and		
		/28/24, indicated the resident			ensuring residents receive the		
		e impairment and required set			meals as per tray ticket/order.		
	up assistance for me	eals.			How the corrective action(s) w		
					monitored to ensure the defici		
	I -	an's Order Summary indicated			practice will not recur, i.e., who		
		a regular, mechanical soft diet,			quality assurance programs w	III be	
	no straws, and use a	a 2 handled mug.			put into place;		
	TI D' C D	1 1 1 4 14 14			Department heads will randon	าเy	
	· ·	lan indicated to provide			audit 5 tray tickets weekly at		
		as ordered to aid in self			alternating meals to ensure		
	feeding.				residents receive their meals a		
	21.46				per tray ticket/order with a spe	cial	
	3.1-46				focus on no straw orders and		
					adaptive equipment.		
					The Director of Nursing/design	nee	
l	I				will present a summary of the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 \	ADDRESS, CITY, STATE, ZIP COD VIRGINIA ST RILLVILLE, 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)	(X5) COMPLETION DATE
				audits to the Quality Assurance committee monthly for 6 mont. 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	hs. ne
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must e needs respiratory tracheostomy care is provided such o professional stand comprehensive pe the residents' goal 483.65 of this sub	e and tracheal suctioning, are, consistent with lards of practice, the erson-centered care plan, s and preferences, and part.			
	interview, the facility received proper treatoxygen administratify for respiratory care. Finding includes: On 7/8/24 at 9:08 at lying in bed with he oxygen concentrato and set at 2 liters (L.	m. Resident 1 was observed or eyes closed. She had an r at her bedside that was on). A nasal cannula was entrator and was laying on	F 0695	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F695 Respiratory/Tracheostor Care and Suctioning What corrective action(s) will accomplished for those reside found to have been affected by	an y the n my oe ents

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JIDK11

Facility ID: 000577

If continuation sheet

Page 28 of 39

AND PLAN OF CORRECTION A BUILDING B. WING	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH & REHABILITATION CENTER BUNDARRY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG On 7/19/24 at 13.37 am. Resident I 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 I 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 I was completed on 7/10/24 at 9.07 a.m. Diagnoses included, but were not limited to, strial 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 STRECT ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN 46410 MERRILLVILLE, IN 46410 MERRILLVILLE, IN 46410 PREFIX TAG MERRILLVILLE, IN 46410 (X5) COMPLETION DATE RECULATORY OR LSC IDBENTIFYING INFORMATION REGULATORY OR LSC IDBENTIFYING INFORMATION DATE On 7/10/24 at 2.12. The Instance of Control of Completion of Com	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
Sample of Provider of Suppling Suppling			155650	B. W	ING		07/12/	2024
Sample of Provider of Suppling Suppling					CTREET	ADDRESS CITY STATE ZID COD		
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lacked any orders for oxygen. residents requiring supplemental oxygen to ensure oxygen orders are in place. Director of Nursing/designee will		TEL DI LO	1 6 1.4 1.7/2024			1 -		
The Medication Administration Record (MAR), dated 7/2024, lacked any documentation that oxygen to ensure oxygen orders are in place. Director of Nursing/designee will		•	•			_		
The Medication Administration Record (MAR), dated 7/2024, lacked any documentation that are in place. Director of Nursing/designee will		lacked any orders to	or oxygen.					
dated 7/2024, lacked any documentation that Director of Nursing/designee will		m at it it is	1 (1 (1 P)			1 , 5	rs	
						T		
Loyvoen was administered								
		oxygen was admini	stered.			present a summary of the aud	its	
to the Quality Assurance						-		
During an interview on 7/11/24 at 11:03 a.m., the committee monthly for 6 months.		-				_		
Director of Nursing indicated she was unsure Thereafter, if determined by the		_				-		
what the resident's oxygen orders were, but she Quality Assurance committee,						<u> </u>		
would have the Unit Manager look into it. auditing and monitoring will be		would have the Uni	t Manager look into it.				;	
done quarterly and present						done quarterly and present		
During an interview on 7/11/24 at 11:05 a.m., the quarterly at the QA meeting.		_				quarterly at the QA meeting.		
A-Wing Unit Manager indicated there were no Monitoring will be on going.		A-Wing Unit Mana	ger indicated there were no			Monitoring will be on going.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155650	B. WI	NG		07/12/	2024
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		8380 VI	ADDRESS, CITY, STATE, ZIP COD RGINIA ST LLVILLE, IN 46410	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
	current oxygen orde				Date by which systemic		
	received as current, required when admi oxygen. The order				corrections will be completed: 8/2/2024		
F 0697 SS=D Bldg. 00	require such serving professional stand comprehensive per and the residents' Based on record revisited to ensure pair and administered to orders for 1 of 2 resident C) Finding includes: During an interview Resident C indicate pain medications, he due to the medication facility. Resident C's record 9:28 a.m. Diagnoses	lanagement. Pensure that pain Provided to residents who ces, consistent with lards of practice, the erson-centered care plan, goals and preferences. Priew and interview, the facility in medications were available a resident per the physician's idents reviewed for pain. From 7/8/24 at 9:37 a.m., d that he received scheduled owever he often missed doses ons not being available in the was reviewed on 7/11/24 at as included, but were not limited nemiparesis affecting the right	F 06	597	Lincolnshire Healthcare Center Annual Survey: 7/12/2024 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F697 Pain Managment What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: Resident C 's pain medication available and is being administered per physician or those the facility will identify other the second content of the sec	an y the n oe ents y the is ders.	08/02/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JIDK11

Facility ID: 000577

If continuation sheet Page 30 of 39

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155650	B. W	ING		07/12	/2024
		l .	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			RGINIA ST		
LINCOLV	JSHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
	- IIIC IILALIII Q	TELIADIELIATION CENTER	,	WENN			
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		um Data Set (MDS)			residents having the potential		
	assessment, dated 5/3/24, indicated the resident				be affected by the same defici		
	was cognitively intact for daily decision making.				practice and what corrective a	ction	
	He received opioid pain medications.				will be taken;		
	to M to t	5/4/04 * 12 1.1			All residents that require pain		
		7/4/24, indicated the resident			medication have the potential		
		plaints of pain. Interventions			be affected by the same allege	ed	
		not limited to, administer			deficient practice.		
	analgesia as per ord	iers.			What measures will be put into		
	4 PM - 1 - 1 - 0 - 1	1 . 15/1/04 : 1: 1			place or what systemic change		
	•	r, dated 5/1/24, indicated			will be made to ensure that the		
		minophen 10-325 milligrams			deficient practice does not rec	ur:	
	(mg) tablet, I tablet	by mouth every 6 hours.			Nurses were re-educated on:		
	TI I 2024 M	ir ar Addirina ar Događ			· Ensuring pain medication is		
		lication Administration Record			administered as per orders.		
		e resident did not receive the			· If pain medication is unavaila		
	-	minophen tablet on the			Nurses are to pull medication	īrom	
	following dates and				EDK (if possible) call the		
	- 6/1/24 at 6:00 p.m				physician and obtain a tempor	-	
		m., 6:00 a.m., 12:00 p.m., and 6:00			order for an alternative medica		
	p.m. - 6/3/24 at 12:00 a.ı	n and 6:00 a m			ensure scripts are obtained pr	IOI	
	- 6/4/24 at 12:00 a.i				to depletion of medication on hand.		
	- 6/4/24 at 12:00 a.f				How the corrective action(s) w	ill be	
	- 6/22/24 at 6:00 p.i				monitored to ensure the defici		
		.m., 6:00 a.m., and 12:00 p.m.			practice will not recur, i.e., who		
	- 6/28/24 at a 12:00 a	_			quality assurance programs w		
	- 6/30/24 at 6:00 a.i				put into place;	50	
	0.50,21 at 0.00 a.i				DON/Designee will audit 5		
	The July 2024 Med	ication Administration Record			residents 2 times per week		
		e resident did not receive the			receiving pain medication to		
		ninophen tablet on the			ensure the medication is avail-	able	
	following dates and	•			and being administered per		
	- 7/1/24 at 8:00 a.m				physician orders.		
	- 7/5/24 at 12:00 a.r				The Director of Nursing/design	nee	
	- 7/5/24 at 12:00 a.m. and 6:00 p.m.				will present a summary of the	. =	
	- 7/7/24 at 12:00 a.i				audits to the Quality Assurance	e	
	- 7/10/24 at 6:00 a.ı				committee monthly for 4 mont		
					Thereafter, if determined by the		
	A Progress Note de	ated 6/1/2024 at 8:24 n m			Quality Assurance committee		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155650	B. W	NG		07/12/	2024
		<u> </u>	<u> </u>	CTDEET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			RGINIA ST		
LINCOLA	ISHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
LINCOLIV	OF HINE HEALITI &	NETABILITATION CENTER		INIELZIZII	VILLE, IIN 404 IO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	codone-acetaminophen			auditing and monitoring will be)	
		pt and the doctor was made			done quarterly and present		
	aware.				quarterly at the QA meeting.		
	A Progress Note, dated 6/2/2024 at 12:38 a.m.,				Monitoring will be on going.		
					Date by which systemic		
	_	codone-acetaminophen tablets			corrections will be completed:		
	were to be delivered	a by pharmacy.			8/2/2024		
	A Drogress Note J	ated 6/2/2024 at 6:53 a.m.,					
	_	was called to re-order the					
		minophen tablets and a new					
	-	rom the doctor. The doctor					
	was made aware.	ion me doctor. The doctor					
	ab iliado amaro.						
	A Progress Note. da	ated 6/2/2024 at 11:34 a.m.,					
	_	nacy was to deliver the					
	-	minophen, a new script was					
	needed, and the doc						
	A Progress Note, da	ated 6/27/2024 at 6:31 a.m.,					
	indicated the hydro	codone-acetaminophen tablets					
	were unavailable ar	nd pharmacy was made aware.					
	_	ated 7/5/2024 at 12:21 a.m.,					
	-	codone-acetaminophen tablets					
		The pharmacy was aware and					
		y they only had a script to send					
		ired a new script from the					
	doctor.						
	.	7/10/04 + 1.22					
		v on 7/12/24 at 1:33 p.m., the					
	_	indicated the facility had					
		tions from the pharmacy and					
	•	use they were waiting on a new					
	script from the doct	OF.					
	This citation was to	elated to Complaint IN00436382.					
	This chanon was re	nated to Complaint 11100430362.					
	3.1-37(a)						
	5.1 5 / (w)						
	•		•		•		•

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Event ID:

JIDK11 Facility ID: 000577

If continuation sheet Page 32 of 39

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155650	B. W	ING _		07/12	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			IRGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0805	483.60(d)(3)						
SS=E	Food in Form to M	leet Individual Needs					
Bldg. 00	§483.60(d) Food a	and drink					
	Each resident rec	eives and the facility					
	provides-						
	\$483.60(d)(3) Foo	od prepared in a form					
	designed to meet						
		on, interview, and record	F 0	805	Lincolnshire Healthcare Cente	er	08/02/2024
		failed to ensure food was			Annual Survey: 7/12/2024		
		meet individual needs related			Please accept the following as	s the	
	to not following a re	ecipe for pureed food and not			facility's credible allegation of		
	making pureed food	the correct consistency. This			compliance. This plan of		
	had the potential to	affect all 5 residents who			correction does not constitute	an	
	received a pureed d	iet. (Main Kitchen)			admission of guilt or liability by	y the	
	_				facility and is submitted only in	-	
	Finding includes:				response to the regulatory		
					requirement.		
	On 7/10/24 at 10:29	a.m., Cook 1 was observed			F805 Food in Form to Meet		
	preparing pureed fo	od. She indicated she was			Individual Needs		
		vings of broccoli. The cook			What corrective action(s) will be	эе	
	had a recipe titled, '	'Pureed Broccoli".			accomplished for those reside	nts	
					found to have been affected b	y the	
	-	ccoli with an unknown amount			deficient practice;		
	of liquid into the blo				Dietary manager immediately		
	_	ckening powder to the blender			corrected the consistency of the	ne	
		She then added 2 more			puree broccoli.		
		kener and blended again. She			How the facility will identify oth		
	_	out of the blender into a			residents having the potential		
	-	The cook indicated the puree			be affected by the same defici		
		orrect consistency, and ready			practice and what corrective a	ction	
	_	ureed broccoli was observed			will be taken;		
	-	o thickened consistency. The			All residents have the potentia		
		DM) indicated the puree was			be affected by the alleged def	cient	
		cook to add more thickener.			practice.	_	
		d 2 more tablespoons into the			What measures will be put into		
		a whisk to stir up the puree.			place or what systemic change		
	_	aree was finished and at the			will be made to ensure that the		
		and handed the puree to the			deficient practice does not rec		
	ווע וווע בווע וווען. דוופ בווע	cated the puree was still too	1		Dietary managers/dietary staff	i	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155650	B. W	'ING		07/12/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			IRGINIA ST		
LINCOLN	NSHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	ed an unknown amount of			were re-educated on:		
	thickener into the co	ontainer until it was thickened.			· Following the recipes when		
					preparing altered consistency		
	1	after the puree observation,			diets		
		ne cook should have added			How the corrective action(s) w		
	_	agent. The puree was too thin			monitored to ensure the defici		
		consistency. He would			practice will not recur, i.e., who		
	in-service the staff of	on preparing pureed foods.			quality assurance programs w	'iii be	
	The recipe titled "T	Pureed Broccoli", indicated to			put into place;	ıı	
	_	e ingredients were to add "2			Dietary Manager/Designee will audit altered diets preparation		
	1	e nigredients were to add2			times per week to ensure the	۷	
		" "Place prepared vegetables			recipe is followed and consiste	encv	
		washed and sanitized food			is accurate.	ысу	
	_	til smooth" "2. If the			Administrator/designee will		
	1 ~	ening, gradually add a			present a summary of the aud	its	
	1 ~	ral food thickener (ex, potato			to the Quality Assurance	110	
		cereal) to achieve a smooth,			committee monthly for 4 mont	hs.	
		shed potato consistency"			Thereafter, if determined by the		
		1			Quality Assurance committee,		
	A facility policy, tit	led "Pureed Diet" and received			auditing and monitoring will be		
	as current from the	facility, indicated, "8. c. Drain			done quarterly and present		
	liquid from portions	s needed for pureed			quarterly at the QA meeting.		
	preparation. Reserv	ve liquid in case additional			Date by which systemic		
	liquid is needed wh	en pureeing to the correct			corrections will be completed:		
	· ·	If the recipe does not yield			8/2/2024		
		add a measured amount of					
		agent to yield the desired					
	consistency"						
	3.1-21(a)(3)						
F 0880	483.80(a)(1)(2)(4)	(e)(f)					
SS=E	Infection Prevention	on & Control					
Bldg. 00	§483.80 Infection						
	1	establish and maintain an					
	1	on and control program					
		de a safe, sanitary and					
		onment and to help prevent					
	the development a	and transmission of					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155650	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD /IRGINIA ST)
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER		RILLVILLE, IN 46410	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	
TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE COMPLETION DATE
		eases and infections.			
	program. The facility must e prevention and co	establish an infection ntrol program (IPCP) that minimum, the following			
	identifying, reporticontrolling infection diseases for all revisitors, and other services under a conducted according reports.	ystem for preventing, ng, investigating, and ons and communicable sidents, staff, volunteers, individuals providing contractual arrangement cility assessment ing to §483.70(e) and d national standards;			
	and procedures for include, but are not (i) A system of suridentify possible or infections before the persons in the fact (ii) When and to work communicable distributed be reported; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; include (A) The type and of depending upon the organism involved (B) A requirement.	rveillance designed to ommunicable diseases or hey can spread to other illity; whom possible incidents of lease or infections should transmission-based followed to prevent spread visolation should be used uding but not limited to: duration of the isolation, ne infectious agent or l, and that the isolation should be e possible for the resident			

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPI	LETED
		155650	B. W	NG		07/12	/2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	₹			IRGINIA ST		
LINICOLE	VICUIDE NEVI TH 0	REHABILITATION CENTER			LLVILLE, IN 46410		
LINCOLI	NOTINE HEALTH &	REHABILITATION CENTER		MEKKI	LLVILLE, IN 404 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(v) The circumsta	nces under which the facility					
	must prohibit emp	oloyees with a					
	communicable dis	sease or infected skin					
	lesions from direc	t contact with residents or					
	their food, if direct	t contact will transmit the					
	disease; and						
	(vi)The hand hygi	ene procedures to be					
	followed by staff i	nvolved in direct resident					
	contact.						
		ystem for recording					
		d under the facility's IPCP					
		e actions taken by the					
	facility.						
	0.400.00/						
	§483.80(e) Linens						
		andle, store, process, and					
		o as to prevent the spread					
	of infection.						
	\$402.00/f\ Ammus	Landani					
	§483.80(f) Annua						
	1	nduct an annual review of ate their program, as					
	necessary.	ate their program, as					
		on, record review and	F 08	280	Lincolnshire Healthcare Cente	ar.	08/02/2024
		ity failed to ensure infection	1 00	300	Compliant Survey: 7/12/2024	÷1	06/02/2024
	· ·	ere in place and implemented			Please accept the following as	the	
		clothing protector used when			facility's credible allegation of	, 1110	
		lry, incorrect signage posted			compliance. This plan of		
	_	ntact isolation, and not			correction does not constitute	an	
		lood pressure cuff between			admission of guilt or liability by		
		e 1, QMA 1, and Resident 23)			facility and is submitted only in		
		, ,			response to the regulatory	-	
	Findings include:				requirement.		
					F880 Infection Prevention &		
	1. On 7/12/24 at 10	:50 a.m., the laundry room was			Control		
	observed with Laundry Aide 1. In the dirty				What corrective action(s) will be	ре	
		a, there were no aprons or			accomplished for those reside		
	clothing coverings	-			found to have been affected b		
					deficient practice;	,	

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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 00 COMPLETED B. WING 07/12/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE During an interview at that time, the Laundry Aide Resident 23's contact isolation indicated she wore gloves when sorting the dirty sign was updated with CDC laundry. She did not wear any type of clothing approved contact isolation sign. protector and indicated she had never been QMA 1 -was educated on instructed to do so. sanitizing blood pressure equipment between resident use. The Laundry Policy was received and did not Laundry Aide 1- was educated on address the above issue. 2. On 7/11/24 at 9:16 wearing clothing protection when a.m., QMA 1 was observed preparing medications sorting/handling soiled clothes and for the resident in Room B 5-1. QMA 1 indicated linen. she was going to check the resident's blood How the facility will identify other pressure prior to administering the medications, residents having the potential to but needed the blood pressure cuff, which was on be affected by the same deficient A-Wing. She asked the Director of Nursing to practice and what corrective action bring her the blood pressure cuff/rolling cart. She will be taken; took the cart with the blood pressure cuff on it All facility residents have the and entered the resident's room. She placed the potential to be affected by the blood pressure cuff on the resident's arm and same alleged deficient practice. checked her blood pressure. She took the What measures will be put into machine out of the room and set it in the hallway place or what systemic changes next to the medication cart. She then administered will be made to ensure that the the resident's medications. She did not clean or deficient practice does not recur; disinfect the blood pressure cuff. Staff were re-educated: · Posting the appropriate Isolation QMA 1 then began preparing the medications for precaution signage. the resident in Room B 1-2. She took the cart with · Wearing clothing protectors while the blood pressure cuff on it and entered the sorting soiled clothes and linen resident's room. She placed the blood pressure · Cleaning blood cuff on the resident's arm and checked her blood pressure/re-usable medical pressure. She took the machine out of the room equipment between resident use. and set it in the hallway next to the medication How the corrective action(s) will be cart. She then administered the resident's monitored to ensure the deficient medications. She did not clean or disinfect the practice will not recur, i.e., what blood pressure cuff. quality assurance programs will be put into place; During an interview on 7/11/24 at 9:56 a.m., QMA DON/designee will randomly audit 1 indicated she should have cleaned the blood 3 residents requiring Contact pressure cuff with a sani wipe in between Isolation Precautions weekly to residents. confirm correct precaution signage is posted.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155650	B. WI	NG		07/12/	2024
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			RGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER			LLVILLE, IN 46410		
	-				,	1	
(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	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG		-1-66	DATE
		ceived as current, titled on and Control Program,"			DON/Designee will observe 5 members clean/sanitize medic		
		eaning and disinfection of			equipment between resident u		
	environmental surfa	_			weekly to ensure compliance.	SE	
		facility cleaning/disinfection			Administrator/Designee will		
		ndling of equipment shared			randomly audit 2 laundry staff		
	-	blood pressure cuffs] c.			members weekly to ensure		
	-	s and procedures to ensure that			compliance with utilizing clothi	na	
		levices are cleaned and			protectors when sorting soiled	-	
		riately prior to use on another			linen.		
		es necessary for appropriate			The Director of Nursing/design	nee	
		ection proceduresare			will present a summary of the		
	available and used a	according to manufacturer			audits to the Quality Assuranc	е	
	instructions for use.	"			committee monthly for 6 mont	hs.	
					Thereafter, if determined by th	e	
	-	observation on 7/9/24 at 11:46			Quality Assurance committee,		
		door had a sign next to the			auditing and monitoring will be)	
		ee nursing staff prior to			done quarterly and present		
		n. There were no other signs			quarterly at the QA meeting.		
	on or near the door	way.			Monitoring will be on going.		
	0 7/10/04 : 11 50	D 11 . 221 1 1 1			Date by which systemic		
		a.m., Resident 23's door had a			corrections will be completed:		
		paper that said "Contact			8/2/2024		
		a large font which was					
		sign indicating to see nursing					
	_	ce to the room. There were no mation on or near the door.					
	outer signs of infort	mation on or hear the door.					
	Resident 23's record	d was reviewed on 7/11/24 at					
		es included, but were not					
	_	eneration and generalized					
	anxiety disorder.	<u>8</u>					
	A Physician's Order	r, dated 7/7/24 at 7:00 p.m.,					
		ycin ointment (antibiotic) 5					
		ibbon in both eyes twice daily					
	for conjunctivitis.	·					
	A Physician's Order	r, dated 7/8/24 at 8:49 a.m.,					
	indicated contact is	olation (gown and glove) due					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTERSTON	WEDICAKE & WEDIC	AID SERVICES				OM	D 110. 0750-057	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	A. BUILDING <u>00</u> COMPLET			ETED	
		155650	B. WING	G		07/12/	/2024	
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				(X5)				
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE	
	indicated Resident 2 precautions currentl signage to see nursi being on an antibiot It had not been cont was not under any t yet. During an interview Unit B Manager ind updating signage or on Monday morning contact isolation that	on 7/8/24 at 9:53 a.m., LPN 1 23 was not under isolation by, but the staff had posted the ing before entrance due to her tic ointment for eye drainage. Firmed as conjunctivitis so she type of isolation precautions of on 7/11/24 at 10:52 a.m., the dicated she was responsible for in the doors when she came in the doors when she came in the doors what personal int was required to enter the						

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