STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	10/02/2015

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 28 - 30, October 1 and 2, 2015 Facility number: 000577 Provider number: 155650 AIM number: 100266950 Census bed type: SNF/NF: 80 Total: 80 Census payor type: Medicare: 17 Medicaid: 58 Other: 5 Total: 80 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on October 8, 2015.	F 0000	Lincolnshire Healthcare and Rehab Center 8380 Virginia ST Merrillville, IN 46410-6231 Provider#: 155650 AIM Number: 100266950 Facility ID: 000577 ANNUAL SURVEY 10/2/15 Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility formally request paper compliance for all citations identified regarding annual survey 10/2/15. Please feel free to contact me, Kenan Weekley, Administrator, with any questions or concerns. Thank you in advance. KENAN WEEKLEY	
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that			

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

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	maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to waiting to enter a resident's room after knocking for 1 of 3 residents reviewed for dignity. (Resident #88) Finding includes: On 9/28/15 at 2:25 p.m., the Resident Interview was initiated with Resident #88. The interview was conducted in the resident's room. The door was closed to the resident's room to maintain confidentiality. During the interview, the resident indicated she felt some staff did not treat her with respect and dignity because they would often open her room door without knocking and rarely asked if they could come in. On 9/28/15 at 2:48 p.m., during the Resident Interview, CNA #1 knocked on the resident's closed door. He did not wait for a response from the resident. He entered the resident's room and set a gown on the resident's desk. He indicated to the resident he would help her put on the gown later and then left the room. On 9/28/15 at 2:54 p.m., during the	F 0241	**F241** It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #88 was interviewed and indicated that staff are treating her with respect and dignity and are knocking and asking for permission to enter her room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the same alleged deficient practice. C.N.A. #1 was in-serviced on maintaining resident dignity by knocking on resident's door and waiting for permission to enter the room. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Facility staff have been in-serviced on maintaining	10/16/2015

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	Resident Interview, CNA #1 knocked on the resident's closed door. He did not wait for a response from the resident. He entered the resident's room, searched for something on the resident's roommate's side of the room, and left the room. The record for Resident #88 was reviewed on 9/30/15 at 11:22 a.m. The Annual Minimum Data Set (MDS) assessment, dated 7/15/15, indicated the resident had a Brief Interview of Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Interview with the Director of Nursing (DON) on 9/29/15 at 3:15 p.m., indicated staff should wait for the resident to respond before entering the room. 3.1-3(t)		resident's dignity by knocking on resident's door and waiting for permission to enter the room. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator/designee will randomly observe 15 staff members weekly to ensure that staff on all shifts are requesting permission from residents prior to entering. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going. **Compliance Date: October 16, 2015**	
F 0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED			

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Bldg. 00	SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of a resident, related to a lack of behavior documentation for a resident receiving psychiatric services and psychoactive medications, for 1 of 5 residents reviewed for unnecessary medications. (Resident #29) Finding includes: On 9/30/15 at 11:41 a.m., Resident #29 was observed sitting in a wheelchair in front of the nurses station. The resident was watching television with no behaviors observed. On 10/2/15 at 10:00 a.m., Resident #29 was observed sitting in a wheelchair in front of the nurses station at a table. The resident was watching television with no behaviors observed. Record review for Resident #29 was completed on 9/29/15 at 2:21 p.m. The residents diagnoses included, but were not limited to, hypertension, dementia,	F 0250	**Lincolnshire Health and Rehab** **Annual Survey 10/2/2015** **F 250 Provision of medically related social services.** Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.** R29 has been reassessed and the plan of care has been updated. Resident has undergone a GDR of psychotropic medication. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective**	10/16/2015

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	depression, psychotic disorder, and anxiety. Review of the September 2015 POS (Physician Order Summary), indicated the resident received Ativan (antianxiety medication) 0.5 mg (milligrams) BID (two times a day). The Ativan was started on 7/3/15. Review of a Psychiatric Progress Note completed on 4/16/15, indicated per Social Service and nursing the resident was having periods of agitation, but not continuous. The residents current medications included Celexa (depression medication) 20 mg daily, Namenda XR (dementia medication) 28 mg daily, Seroquel (antipsychotic medication) 50 mg in the morning and 25 mg at night, Cogentin (medication to treat symptoms of Parkinson's Disease) 1 mg daily. No changes would be made at the time since the behaviors were not continuous. Observe the residents moods and behaviors and document. Review of Social Service Notes on: -4/17/15 at 8:30 a.m., indicated the resident was seen by Psych Services on 4/16/15 due to increased agitation. No new orders received. Will continue to observe.		**actions will be taken.** All residents on Psychotropic Medications have the potential to be affected by the alleged deficient practice. Clinical staff have been in-serviced regarding providing proper behavior documentation for residents receiving psychoactive medications and psychiatric services. Residents not exhibiting behaviors will be referred to the physician for a dose reduction. **What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Clinical staff will provide behavior documentation for all current and newly admitted residents receiving psychiatric services and psychoactive medications. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Social Service Director/Designee will run the Point of Care Compliance Report weekly to ensure	

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	-4/17/15 at 3:43 p.m., resident being followed on behavior program. Resident had been agitated and swearing. Will continue to observe on behavior program. Review of a Psychiatric Progress Note completed on 5/15/15, indicated per Social Service resident had fallen due to the fact that he tried to get up on his own, and he would become agitated when people bump into him. The residents current medications included Celexa 20 mg daily, Namenda XR 28 mg daily, Seroquel 50 mg in the morning and 25 mg at night, Cogentin 1 mg daily. Continue current treatment plan. Observe the residents moods and behaviors closely and document. There were no Social Service Notes from 4/18/15 through 5/15/15 to indicate the resident was or was not having any behaviors. Review of a Psychiatric Progress Note completed on 7/3/15, indicated per Social Services the resident would try to get up on his own, and would become agitated when people bump into him. Per nursing there were no recent reported behaviors. The residents current medications included Celexa 20 mg daily, Namenda XR 28 mg daily, Seroquel 50 mg in the		that all residents receiving psychiatric services and psychoactive medications have daily documentation. In addition the Social Service Director will review all events created for behaviors. Residents not exhibiting behaviors will be referred to the physician for a dose reduction. Social Service/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period. **Completion Date: 10-16-15**	

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	morning and 25 mg at night, Cogentin 1 mg daily. GDR (Gradual Dose Reduction): The resident did not have any reported behaviors therefore the Seroquel will be decreased to 25 mg BID. Start Ativan 0.5 mg BID for anxiety and add diagnosis of anxiety. Review of the Behavior Charting for the months of May 2015 through June 2015, indicated there were no behaviors reported for Resident #29. Review of Nursing Notes from 5/5/15 through 7/3/15, indicated the resident did not have any agitation or other behaviors. Review of Progress Notes from 4/18/15 through 7/3/15, indicated there were no Social Service Notes related to the resident having or not having any behaviors. Interview with the SSD (Social Service Director) on 9/30/15 at 11:30 a.m., indicated she had just started at the facility a few months ago. She indicated if it was brought to her attention a resident was having behaviors then the resident would be followed by SS (Social Service) for the behaviors. She indicated she would have to ask the other SS staff if the resident was having behaviors. She further indicated SS should have been			

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	watching and documenting if the resident was or was not having any behaviors. Interview with the DON (Director Of Nursing) on 10/2/15 at 9:58 a.m., indicated she could not find any indication the resident was having any recent behaviors. She indicated the nursing staff were probably telling SS the resident was having behaviors but neither nursing or SS were documenting them. She further indicated SS should have been following and documenting if the resident was or was not having behaviors since the resident was on a behavior management program. 3.1-34(a)			
F 0322 SS=D Bldg. 00	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and			

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	nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review and interview, the facility failed to ensure the placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube (a feeding tube) was assessed before administering a liquid medication for 1 of 1 residents with a PEG tube observed during medication pass. (Resident #48) Finding includes: LPN #1 was observed on 9/29/15 at 5:03 p.m. during the medication administration of Resident # 48's PEG-tube. LPN #1 washed hands, applied gloves, applied 30 cc (cubic centimeters) air bolus to check for residual, saw no residual, put 30 cc of water into tube via syringe, then administered liquid valproic acid (anti-seizure medication), 5 cc of water, and continued with the rest of the medications. LPN #1 did not auscultate (listen with her stethoscope) after the air bolus was applied. Interview with LPN #1, at 5:20 p.m. on 9/29/15 indicated, she should have checked the placement of the PEG-tube via auscultation before the administration of the medications.	F 0322	**F322** It is the practice of this facility to ensure that placement of a PEG tube is assessed prior to administering medication. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Enteral tube placement is being verified for resident #48. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents with an enteral tube have the potential to be affected by the same alleged deficient practice. LPN #1 was in-serviced on placement checks for residents with a feeding tube prior to medication administration. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Licensed nurses have been in-serviced on the policy titled "Enteral Tube Medication Administration." **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	10/16/2015

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	The policy titled, "ENTERAL TUBE MEDICATION ADMINISTRATION," provided by the Director of Nursing on 9/30/15 at 3:04 p.m., as current and indicated, "...Procedures...G...8. With gloves on, check for proper tube placement using air and auscultation only...." 3.1-44(a)(2)		Director of Nursing/designee will observe 5 licensed nurses weekly to ensure enteral tube placement is being verified prior to medication administration on all shifts. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going. **Compliance Date: October 16, 2015**	
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any			

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	combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, record review and interview, the facility failed to ensure a resident was free from unnecessary medications, related to an antianxiety medication given without indications for use, and a blood pressure medication not given on multiple days for 1 of 5 residents reviewed for unnecessary medications. (Resident #29) Findings include: On 9/30/15 at 11:41 a.m., Resident #29 was observed sitting in a wheelchair in front of the nurses station. The resident was watching television with no behaviors observed. On 10/2/15 at 10:00 a.m., Resident #29 was observed sitting in a wheelchair in front of the nurses station at a table. The resident was watching television with no behaviors observed.	F 0329	**F329** It is the practice of this facility to ensure that residents who have not used psychotropic drugs are not given these drugs unless necessary to treat a specific condition as diagnosed and documented in the clinical record. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #29 physician was updated on resident's	10/16/2015

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	Record review for Resident #29 was completed on 9/29/15 at 2:21 p.m. The residents diagnoses included, but were not limited to, hypertension, dementia, depression, psychotic disorder, and anxiety. The Quarterly Minimum Data Set (MDS) assessment completed on 9/20/15 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 3 which indicated the resident was cognitively impaired. The assessment indicated the resident had minimal depression, no behaviors or indicators of psychosis. The resident received an antianxiety medication 7 x in the 7 day assessment period. Review of the September 2015 POS (Physician Order Summary), indicated the resident received Ativan (antianxiety medication) 0.5 mg (milligrams) BID (two times a day). The Ativan was started on 7/3/15. Review of a Psychiatric Progress Note completed on 7/3/15, indicated per Social Services the resident would try to get up on his own, and would become agitated when people bump into him. Per nursing there were no recent reported behaviors. The residents current medications		behaviors, blood pressure results and hydralazine order. New orders were received. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents prescribed antihypertensive medication or psychotropic medication have the potential to be affected by the same alleged deficient practices. Antihypertensive orders have been reviewed for clarification of parameters, as applicable. Psychotropic medications have been reviewed to ensure documentation is present for indication of use. **What measures will be put**	

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	included Celexa (depression medication) 20 mg daily, Namenda XR (dementia medication) 28 mg daily, Seroquel (antipsychotic medication) 50 mg in the morning and 25 mg at night, Cogentin (medication to treat symptoms of Parkinson's Disease) 1 mg daily. GDR (Gradual Dose Reduction): The resident did not have any reported behaviors therefore the Seroquel will be decreased to 25 mg BID. Start Ativan 0.5 mg BID for anxiety and add diagnosis of anxiety. Review of the Behavior Charting for the months of May 2015 through June 2015, indicated there were no behaviors reported for Resident #29. Review of Nursing Notes and Social Services Notes from 5/5/15 through 7/3/15, were no indication the resident had any agitation or other behaviors. Interview with the SSD (Social Service Director) on 9/30/15 at 11:30 a.m., indicated she had just started at the facility a few months ago. She indicated if it was brought to her attention a resident was having behaviors then the resident would be followed by SS (Social Service) for the behaviors. She further indicated she would have to ask the other SS staff if the resident was having behaviors to indicate the start of the		**into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Clinical staff have been in-serviced regarding providing proper behavior documentation for residents receiving psychoactive medications and psychiatric services. Residents not exhibiting behaviors will be referred to the physician for a dose reduction. An in-service has been completed for nurses regarding antihypertensive medications including MD notification of medications held and the importance of ensuring that parameters for holding medications are present in the physician order. The clinical team will review new orders in the morning meeting to ensure that	

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	Ativan medication. Interview with the DON (Director Of Nursing) on 10/2/15 at 9:58 a.m., indicated she could not find any indication the resident was having any recent behaviors to indicate the start of the Ativan medication. Review of the September 2015 POS indicated, the resident received Hydralazine (blood pressure medication) 25 mg TID (three times a day). Review of the September 2015 MAR indicated the Hydralazine medication was held on the following dates and times: -9/2/15 at 1:00 p.m. = Not Administered: On Hold, Comment: BP (blood pressure) 117/72 -9/2/15 at 5:00 p.m. = Not Administered: Due to condition, Comment: BP 115/78 -9/3/15 at 9:00 a.m. = Not Administered: Due to condition -9/3/15 at 1:00 p.m. = Not Administered: Due to condition -9/4/15 at 9:00 a.m. = Not Administered: Due to condition -9/5/15 at 9:00 a.m. = Not Administered: On Hold, Comment: BP 117/83 -9/10/15 at 5:00 p.m. = Not Administered: Other, Comment: BP result		antihypertensive orders have parameters for holding and physician notification as applicableand new orders for psychotropic medications have an appropriate indication for use. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will review the Medication Administration record for 5 residents with orders for antihypertensive medications weekly to ensure that physician orders are being followed related to MD notification parameters and medication held.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. BUILDING 00 B. WING	10/02/2015

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	-9/11/15 at 5:00 p.m. = Not Administered: Due to condition, Comment: BP too low -9/12/15 at 5:00 p.m. = Not Administered: Due to condition, Comment: BP too low -9/14/15 at 5:00 p.m. = Not Administered: Due to condition, Comment: BP too low -9/17/15 at 5:00 p.m. = Not Administered: Due to condition, Comment: BP too low -9/18/15 at 5:00 p.m. = Not Administered: Due to condition -9/21/15 at 5:00 p.m. = Not Administered: Due to condition, Comment: BP low -9/28/15 at 5:00 p.m. = Not Administered: Due to condition, Comment: BP low -9/29/15 at 1:00 p.m. = Not administered: On Hold, Comment: BP 118/72 Review of Nursing Notes from 9/2/15 through 9/29/15 had no indication of why the blood pressure medication was held or the Physician had been notified. Interview with the DON on 9/30/15 at 4:50 p.m., indicated the nurses were using nursing judgement on the days the blood pressure medication was held. She indicated the Physician should have been notified on the days the medication was		Social Services Director/designee will run the Point of Care Compliance Report weekly to ensure that all residents receiving psychiatric services and psychoactive medications have daily documentation. In addition the Social Service Director will review all events created for behaviors. Residents not exhibiting behaviors will be referred to the physician for a dose reduction. The Director of nursing/Social Services/designee will present a summary of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.	

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	155650	A. BUILDING 00 B. WING	10/02/2015

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	held and the medication should have a BP parameter of when to hold the medication. 3.1-48(a)(3)		**Compliance Date: October 16, 2015**	
F 0371 SS=D Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to serve food in a sanitary manner related to room trays carried down the hallway with uncovered food. This had the potential to affect the 22 residents who receive room trays on B wing. (B wing) Finding includes: During a lunch service observation on B wing on 9/28/15 beginning at 11:30 a.m., the following was observed: The room tray cart was brought to B wing and plugged in halfway down the C hallway at 11:35 a.m. At 11:39 a.m., trays for B hall were transferred to	F 0371	**F371** It is the practice of this facility to store, prepare, distribute and serve food under sanitary conditions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Meal trays transported outside of enclosed carts now have all	10/16/2015

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	155650	A. BUILDING 00 B. WING	10/02/2015

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	another empty cart and rolled to halfway down the B hallway. At 11:43 a.m., CNA #2 carried a room tray from the C hallway cart down the hallway to Room 24 with the fruit observed to be uncovered. At 11:46 a.m., CNA #3 carried a room tray from the B hallway cart back up the hall to the unit dining area with the fruit observed to be uncovered. At 11:49 a.m., CNA #2 carried a room tray from the B hallway cart all the way down the hall to Room 17 with the fruit observed to be uncovered. Interview with CNA #2 on 9/28/15 at 11:50 a.m., indicated she was unsure why the fruit was not covered since all the food usually had covers and the unit didn't store extra covers. Interview on 9/28/15 at 11:52 a.m. with the Dietary Consultant, indicated she had noticed the fruit was served uncovered on the room trays and should have been covered. A policy titled "Tray Service" was presented by the DON (Director of Nursing) on 9/29/15 at 3:10 p.m. and deemed as current. The policy indicated, " .... 7. Any trays transported outside of the enclosed cart or outside the dining room will have all items covered ...."		items covered. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff have been in-serviced on all food that is transported outside of an enclosed cart or outside of the dining room must have all items covered. **How will the corrective**	

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	3.1-21(i)(3)		**actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator/designee will audit 5 meals weekly, including breakfast, lunch and dinner, to ensure that all food transported outside of the enclosed meal carts and dining room have all items covered. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going. **Compliance Date: October 16, 2015**	

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F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread			

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	of infection. Based on observation and interview, the facility failed to ensure infection control was maintain related to a clean linen cart not covered in the A Wing, A Hallway. (A Wing) Finding includes: During the initial tour on 9/28/15 at 9:08 a.m., a clean linen cart was observed uncovered being transported down A Wing, A Hallway to the AC Hallway. Interview with Laundry/Housekeeping #1 on 9/28/15 at 9:10 a.m., indicated he did not know the clean linens were to be covered. Interview with the DON (Director of Nursing) on 9/29/15 at 2:30 p.m., indicated the laundry linens should have been covered. Each linen cart had a flap to cover the linens. 3.1-19(g)(2)	F 0441	**F441** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Clean linen carts are now covered when being transported through the hallways. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the same alleged deficient practice.	10/16/2015

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			Laundry/Housekeeping staff #1 has been in-serviced on the importance of ensuring that the clean linen carts are covered while being transported through the hallway. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff have been in-serviced on the importance of ensuring that the flaps are closed on the linen carts in hallway. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator/designee will audit 5 linen deliveries	

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LINCOLNSHIRE HEALTH & REHABILITATION CENTER	8380 VIRGINIA ST MERRILLVILLE, IN 46410

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			weekly to ensure that the linen carts are covered while being transported through the hall. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going. **Compliance Date: October 16, 2015**	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair	F 0465	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute**	10/16/2015

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	related to marred and gouged doors, rust on bathroom drains and broken floor tile for 2 of 2 wings and the front entrance doorway. (A Wing, B Wing and the front entrance doorway) Findings include: During the Environmental tour on 10/1/15 at 3:15 p.m. until 3:45 p.m., with the Administrator, Maintenance Director and Nurse Consultant, the following was observed: 1. Front Lobby a. Broken and missing tile in the front entrance doorway. 2. A Wing, A Hallway a. In Room # A2, there were black mars on the wall behind bed number two and on the bathroom walls. Two residents resided in this room. 3. A Wing, AB Hallway a. In Room #A-14, the bathroom walls were marred and the outside of the room door was gouged and marred. Two residents resided in this room. 4. A Wing, AC Hallway		**an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** F 465 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The broken and missing tile in the front entrance doorway was repaired. The marred wall in room A2 was cleaned. The marred wall in room A2 bathroom was cleaned. The marred walls in A 14 bathroom was cleaned. Room A 14 door was cleaned and repaired. The wall beside the bed in room A20-2 was cleaned. The door for room A20 was repaired. The flange bowl caps were installed to the toilet in room A23. The bathroom door for room A 23 was repaired. The hot water faucet handle cap was replaced in room A26. The A wing central shower door was repaired. The base molding in room B5 was repaired. The corner wall next to the bathroom in room B5 was repaired. The bathroom drain and plate on the sink in room B7 was cleaned and the rust was removed. The bathroom door in room B7 was repaired. In room B 11 the room and bathroom doors were repaired. In room B 11 the bathroom door jam and bathroom corner wall were repaired. In room B 11the wood base molding below the radiator was repaired. In room B12 the room and bathroom door was repaired. In	

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	a. In Room # 20, the wall beside bed number two was dirty and the room door had gouges on the inside. Two residents resided in this room. b. In Room #23, the flange bowl caps were missing on the toilet, and the bathroom door was gouged. Two residents resided in this room. c. In Room #26, the bathroom's hot water faucet handle had part of the plastic top missing, the bathroom and room doors were marred and gouged. Two residents resided in this room. d. The Central Shower door was gouged. 5. B Wing, A Hallway a. In Room #5, the base molding next to the entryway was peeling off, the corner wall next to the bathroom was gouged. One resident resided in this room. b. In Room #7, the bathroom drain and plate on the sink was rusted, and the bathroom door was gouged. One resident resided in this room. 6. B Wing, B Hallway a. In Room #11, the room and the		room B 13 the bathroom door was repaired. In room B14 the bathroom door, and corner wall was repaired. In room B16 the walls were cleaned and repaired. In room B 16 the bathroom door and the corner wall were cleaned and repaired. In room B16 the door jam was touched up with paint. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Housekeeping was in-serviced on proper room cleaning, including the walls, doors, and sink drain plates. Housekeeping will initiate room cleaning checklist to identify and document cleaning needs and resultant resolution. Maintenance Director/designee will conduct weekly room checks and facility rounds to identify environmental concerns and track progression of resolution. Schedule of preventative room maintenance will be reviewed weekly by Administrator to ensure rooms are tended to timely. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Housekeeping	

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	bathroom doors were gouged. The bathroom door jambs and the wall corner by the bathroom were gouged The wood base molding below the radiator was chipped. One resident resided in this room. b. In Room #12, the room and bathroom door were gouged. Two residents resided in this room. c. In Room # 13, the bathroom door was gouged. Two residents resided in this room. d. In room #14, the bathroom door was gouged, the corner wall between the first bed and the bathroom was gouged. One resident resided in this room. e. In Room # 16, the room walls were marred and gouged, the bathroom door and the corner wall by the bathroom were marred and gouged, and the bathroom door jamb had chipped paint. There was a resident who resided in this room, that resident was moved out per the Nurse Consultant. Interview with the Maintenance Director at end of the tour, on 10/1/15 at 3:45 p.m., indicated all of the above was in need of repair or cleaning.		Supervisor will review 5 rooms a week to ensure proper cleaning takes place. Maintenance Supervisor will review preventative maintenance schedule weekly with Administrator to ensure rooms are tended to timely. Housekeeping Supervisor and Administrator will summarize tracking tool monthly and bring to Quality Assurance Committee. The results of the audit will be presented to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed. 10/16/15.	

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	3.1-19(f)			