STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155650	B. WI	ING		10/02/2015	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			IRGINIA ST		
LINCOLI	NSHIRE HEALTH 8	REHABILITATION CENTER			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		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	COMPLET	ION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F 0000							
Bldg. 00	State Licensure Survey dates: S October 1 and 2 Facility number Provider number AIM number: 1 Census bed type SNF/NF: 80 Total: 80 Census payor ty Medicare: 17 Medicaid: 58 Other: 5 Total: 80 These deficience	September 28 - 30, 2, 2015 :: 000577 er: 155650 100266950 e:	F 00	000	Lincolnshire Healthcare and Rehab Center 8380 Virginia S Merrillville, IN 46410-6231 Provider#: 155650 AIM Numb 100266950 Facility ID: 00057 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 gui liability by the facility and is submitted only in response to regulatory requirement. The facility formally request paper compliance for all citations identified regarding annual sur 10/2/15. Please feel free to contact me, Kenan Weekley, Administrator, with any question concerns. Thank you in advance. KENAN WEEKLEY	ot t or the	
	Quality review of October 8, 2015	completed by 26143, on					
F 0241 SS=D Bldg. 00		ESPECT OF promote care for residents in an environment that					

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLI	
		155650	B. Wl	ING		10/02/	2015
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDERIC N. AV OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	dignity and respect or her individuality Based on observe interview, the fat each resident's dearelated to waiting room after knock	ration, record review, and cility failed to ensure ignity was maintained g to enter a resident's king for 1 of 3 residents	F 02	241	F241 It is the practice of this fact to promote care for residents manner and in an environment that maintains or enhances earned antity and respect	in a it ach	10/16/2015
	reviewed for dignity. (Resident #88) Finding includes:				resident's dignity and respect full recognition of his or her individuality. What correc action(s) will be accomplished	tive	
	On 9/28/15 at 2:	25 p.m., the Resident			for those residents found to		
	Interview was in	nitiated with Resident			have been affected by the		
	#88. The intervi	iew was conducted in the			deficient practice? Resid #88 was interviewed and	ent	
	resident's room.	The door was closed to			indicated that staff are treating	,	
	the resident's roo				her with respect and dignity a	-	
		During the interview, the			are knocking and asking for		
		ed she felt some staff did			permission to enter her room.		
		h respect and dignity			How will you identify other	_	
		ould often open her room			residents having the potenti	al	
	_	*			to be affected by the same deficient practice and what		
	they could come	ocking and rarely asked if in. 48 p.m., during the			corrective action will be take All residents have the poten to be affected by the same	tial	
	Resident Intervie	ew, CNA #1 knocked on			alleged deficient practice. C.I #1 was in-serviced on maintai		
	the resident's clo	osed door. He did not			resident dignity by knocking o	~	
		nse from the resident. He			resident's door and waiting for		
	_	lent's room and set a			permission to enter the room.		
					What measures will be put in	nto	
	gown on the resi				place or what systemic		
		resident he would help			changes you will make to		
	her put on the go	own later and then left the			ensure that the deficient		
	room.				practice does not recur?		
					Facility staff have been		
	On 9/28/15 at 2:	54 p.m., during the			in-serviced on maintaining		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY IPLETED 12/2015
LINCOL		REHABILITATION CENTER	8380 V MERR	ADDRESS, CITY, STATE, ZI /IRGINIA ST ILLVILLE, IN 46410	P CODE	(V5)
(X4) ID PREFIX TAG	Resident Interview the resident's clowait for a responsentered the resident's clowait for a responsentered the resident something on the side of the room. The record for Freviewed on 9/3 Annual Minimulassessment, date resident had a B Status (BIMS) sindicated she was indicated she was indicated with the (DON) on 9/29/staff should wait	extratement of deficiencies accy must be preceded by full accidentifying information) ew, CNA #1 knocked on osed door. He did not use from the resident. He dent's room, searched for the resident's roommate's the and left the room. Resident #88 was 0/15 at 11:22 a.m. The the m Data Set (MDS) the d 7/15/15, indicated the trief Interview of Mental the core of 15, which the seconditively intact. The Director of Nursing the at 3:15 p.m., indicated the for the resident to the entering the room.	ID PREFIX TAG	PROVIDER'S PLAN OF CACHOCRRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY. resident's dignity by resident's door and opermission to enter the deficient will not recur, i.e., vasurance programminto place? The Administrator/design randomly observe 15 members weekly to staff on all shifts are permission from residentering. The Administrator/design present a summary to the Quality Assurance committee monthly formorths. Thereafter, determined by the Quarterly and present at the QA meeting. will be on going. Complian Date: Oct. 16, 2015	knocking on waiting for the room. ective tored to the practice what quality in will be put the ewill staff ensure that requesting idents prior to the audits ance for six, if Quality ee, auditing the done inted quarterly Monitoring	(XS) COMPLETION DATE
F 0250 SS=D	483.15(g)(1) PROVISION OF I	MEDICALLY RELATED				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155650	B. W	ING		10/02/	′2015
				CTREET	ADDRESS SITE STATE SID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LINICOLN	IOLIIDE LIEALTIL O	DELIADILITATION CENTED			IRGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER		MERKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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
Bldg. 00	SOCIAL SERVICE						
		rovide medically-related					
		attain or maintain the					
		e physical, mental, and					
	· ·	being of each resident.	F 0/				10/16/2015
		ation, record review and	F 02	250	Lincolnshire Health and Re	hah	10/16/2015
		cility failed to provide			Lincomsnii e Heattii aliu Ke	เเลย	
	medically-related	d social services to attain			Annual Survey 10/2/2015	5	
	or maintain the h	nighest practicable				-	
	mental and psycl	hosocial well-being of a			F 250 Provision of medica	lly	
		to a lack of behavior			related social services.		
	· ·	or a resident receiving					
		•					
		ces and psychoactive					
	medications, for				Please accept the following as the	2	
	reviewed for unr	necessary medications.			facility's plan of correction. This		
	(Resident #29)				plan of correction does not consti		
					an admission of guilt or liability b	-	
	Finding includes				the facility and is submitted only	ın	
	i mamg meraaes	•			response to the regulatory requirement.		
	00/20/15 -4 11	.41 D 1 1/20			requirement.		
		:41 a.m., Resident #29					
		ting in a wheelchair in					
	front of the nurse	es station. The resident			What corrective action which w	ill	
	was watching tel	evision with no			be accomplished for those		
	behaviors observ	red.			residents found to have been		
					affected by the deficient practice	e .	
	On 10/2/15 at 10	:00 a.m., Resident #29					
					R29 has been reassessed and the		
		ting in a wheelchair in			plan of care has been updated.	_	
		es station at a table. The			Resident has undergone a GDR o	f	
		ching television with no			psychotropic medication.		
	behaviors observ	ved.					
	Record review for	or Resident #29 was			How the facility will identify oth	ıer	
		29/15 at 2:21 p.m. The			residents having the potential to		
	-	-			affected by the same deficient		
	_	ses included, but were			practice and what corrective		
	not limited to, hy	pertension, dementia,			P		

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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	COMPI	LETED
		155650	B. W	ING		10/02	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			IRGINIA ST		
LINCOLN	ISHIRE HEALTH 8	REHABILITATION CENTER			LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIES		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	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 ,1 2	chotic disorder, and			actions will be taken.		
	anxiety.				All residents on Psychotropic		
					Medications have the potential t	o be	
	Review of the S	eptember 2015 POS			affected by the alleged deficient		
	(Physician Order Summary), indicated				practice. Clinical staff have been		
		eived Ativan (antianxiety			in-serviced regarding providing		
		mg (milligrams) BID			proper behavior documentation		
		y). The Ativan was			residents receiving psychoactive		
	started on 7/3/1:				medications and psychiatric serv		
	started on 7/3/1.	<i>3</i> .			Residents not exhibiting behavior will be referred to the physician		
	Danian, afa Dan	-shistais Dassassa Note			dose reduction.	101 a	
	1	ychiatric Progress Note			dose reduction.		
	-	/16/15, indicated per					
		and nursing the resident					
	• .	ods of agitation, but not			What measures will the facility		
	continuous. The	e residents current			take or systems the facility will		
	medications inc	luded Celexa (depression			alter to ensure that the problem	n	
	medication) 20	mg daily, Namenda XR			will be corrected and will not recur.		
	(dementia medi	cation) 28 mg daily,			recur.		
		sychotic medication) 50			Clinical staff will provide behave	vior	
		ng and 25 mg at night,			documentation for all current an		
		cation to treat symptoms			newly admitted residents receive	-	
		Disease) 1 mg daily. No			psychiatric services and psychoa	active	
		be made at the time since			medications.		
	_	ere not continuous.					
		idents moods and			How will the corrective action	be	
	behaviors and d	ocument.			monitored to ensure the deficie		
					practice will not recur, i.e., wh		
	Review of Socia	al Service Notes on:			quality assurance program wil	l be	
					put into place?		
	-4/17/15 at 8:30	a.m., indicated the					
	resident was see	en by Psych Services on					
		ncreased agitation. No			Social Service Director/Designe	ee	
		ived. Will continue to			will run the Point of Care		
	observe.				Compliance Report weekly to en	nsure	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2015	
	PROVIDER OR SUPPLIEI		8380 \	ADDRESS, CITY, STATE, ZIP CODE VIRGINIA ST CILLVILLE, IN 46410	10,02,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	followed on beh had been agitate continue to observe the fact that he tand he would be people bump into current medication mg daily, Name Seroquel 50 mg mg at night, Cog Continue current observe the resident and the would be people bump into current medication mg daily, Name Seroquel 50 mg mg at night, Cog Continue current observe the resident and the serogeneous continue current observe the resident and the serogeneous continue to the serogeneous continue current observe the resident and the serogeneous continue to observe the serogeneous continue current continue to observe the serogeneous continu	p.m., resident being avior program. Resident d and swearing. Will erve on behavior program. The chiatric Progress Note 15/15, indicated per esident had fallen due to ried to get up on his own, become agitated when to him. The residents ons included Celexa 20 and XR 28 mg daily, in the morning and 25 gentin 1 mg daily. It treatment plant dents moods and y and document.		that all residents receiving psychiatric services and psychoad medications have daily documentation. In addition the So Service Director will review all events created for behaviors. Residents not exhibiting behavior will be referred to the physician f dose reduction. Social Service/Designee will presa summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determine by the Quality Assurance committing further monitoring should contain and for what time period.	ocial rs or a sent ined ttee
	4/18/15 through resident was or y behaviors.	Social Service Notes from 5/15/15 to indicate the was not having any schiatric Progress Note		Completion Date: 10-16-15	
	completed on 7/ Services the resi on his own, and when people but there were no re The residents cu included Celexa	3/15, indicated per Social ident would try to get up would become agitated imp into him. Per nursing cent reported behaviors. The interported behaviors arrent medications 20 mg daily, Namenda The interported behavior in the			

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULT		NSTRUCTION 00	(X3) DATE : COMPL	
11112 12111	or condition	155650	B. WING		00	10/02/	
				TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			RGINIA ST		
LINCOLN	ISHIRE HEALTH &	REHABILITATION CENTER	N	/IERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	AG	DEFICIENCY)		DATE
		mg at night, Cogentin 1					
	mg daily. GDR	resident did not have					
	·	naviors therefore the					
		decreased to 25 mg BID.					
	•	mg BID for anxiety and					
	add diagnosis of	•					
	Review of the B	ehavior Charting for the					
	months of May 2	2015 through June 2015,					
	indicated there v	vere no behaviors					
	reported for Res	ident #29.					
		ng Notes from 5/5/15					
		indicated the resident did					
	not have any agi	tation or other behaviors.					
	Review of Progr	ress Notes from 4/18/15					
	through 7/3/15,	indicated there were no					
		lotes related to the					
		or not having any					
	behaviors.						
	Interview with the	he SSD (Social Service					
		0/15 at 11:30 a.m.,					
	· ·	d just started at the					
		onths ago. She indicated					
	if it was brought	to her attention a					
	resident was hav	ing behaviors then the					
		e followed by SS (Social					
	· ·	behaviors. She indicated					
		to ask the other SS staff					
		as having behaviors. She					
	further indicated	SS should have been					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL	
		155650	B. W	ING	<u> </u>	10/02/	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	<u> </u>	8380 VII	DDRESS, CITY, STATE, ZIP CODE RGINIA ST LVILLE, IN 46410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	_	cumenting if the resident aving any behaviors.					
	Nursing) on 10/2 indicated she coundication the reservent behaviors nursing staff were resident was have nursing or SS wees She further indicate been following a resident was or were staged to the stage of the sta	ald not find any sident was having any She indicated the re probably telling SS the ring behaviors but neither re documenting them. rated SS should have and documenting if the reas not having behaviors t was on a behavior					
F 0322 SS=D Bldg. 00	EATING SKILLS Based on the com a resident, the faci (1) A resident who enough alone or w by naso gastric tub clinical condition d naso gastric tube w (2) A resident who gastrostomy tube is treatment and servi	prehensive assessment of lity must ensure that has been able to eat with assistance is not fed be unless the resident 's emonstrates that use of a was unavoidable; and is fed by a naso-gastric or receives the appropriate wices to prevent aspiration ea, vomiting, dehydration, alities, and					

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STATEMEN	NT 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		10/02/	2015
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
LINIOOLA	JOHNDE HEALTH A	DELIADII ITATION CENTED			IRGINIA ST		
LINCOLI	NSHIRE HEALTH &	REHABILITATION CENTER		MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	, , ,	ulcers and to restore, if					
	possible, normal e	•					
	Based on observ	ration, record review and	F 03	322			10/16/2015
	interview, the fa	cility failed to ensure the			F322		
	placement of a P	Percutaneous Endoscopic				lity	
	-	EG) tube (a feeding tube)			It is the practice of this facilito ensure that placement of a	iity	
	• `	fore administering a			PEG tube is assessed prior to		
		•			administering medication.		
	•	n for 1 of 1 residents			What corrective action(s) wil	ı	
		observed during			be accomplished for those		
	medication pass.	. (Resident #48)			residents found to have beer	ı	
					affected by the deficient		
	Finding includes	3:			practice? Enteral tube		
					placement is being verified for		
	LPN #1 was obs	served on 9/29/15 at 5:03			resident #48. How will yo		
	p.m. during the				identify other residents having	-	
	-	f Resident # 48's			the potential to be affected b	-	
					the same deficient practice a		
		#1 washed hands,			what corrective action will be taken. All residents with an	9	
	applied gloves, a	applied 30 cc (cubic			enteral tube have the potentia	l to	
	centimeters) air	bolus to check for			be affected by the same allege		
	residual, saw no	residual, put 30 cc of			deficient practice. LPN #1	Ju	
	water into tube v	via syringe, then			was in-serviced on placement		
		uid valproic acid			checks for residents with a		
	_	dication), 5 cc of water,			feeding tube prior to medication	on	
	`				administration. What		
		rith the rest of the			measures will be put into pla		
		N #1 did not auscultate			or what systemic changes yo	ou	
	(listen with her s	stethoscope) after the air			will make to ensure that the		
	bolus was applie	ed.			deficient practice does not		
					recur? Licensed nurses have	_	
	Interview with I	LPN #1, at 5:20 p.m. on			been in-serviced on the policy titled "Enteral Tube Medication		
		d, she should have			Administration." How will t		
		*			corrective actions(s) be		
	_	cement of the PEG-tube			monitored to ensure the		
		before the administration			deficient practice will not rec	ur.	
	of the medicatio	ns.			i.e., what quality assurance	· · ,	
					program will be put into place	e?	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/02/2015
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	8380 \	ADDRESS, CITY, STATE, ZIP CO /IRGINIA ST ILLVILLE, IN 46410	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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, "ProceduresG8. With gloves on, check for proper tube placement using air and auscultation only" 3.1-44(a)(2)		Director of Nursing/de will observe 5 licensed r weekly to ensure entera placement is being verif to medication administra all shifts. The Directo Nursing/designee will pr summary of the audits to Quality Assurance commonthly for six months. Thereafter, if determined Quality Assurance commaditing and monitoring done quarterly and pres quarterly at the QA mee Monitoring will be on go	nurses al tube ied prior ation on or of resent a to the mittee d by the mittee, will be eented sting.		
				Compliance Date: Octo 16, 2015	
F 0329 SS=D Bldg. 00	from unnecessary drug is any drug w dose (including du excessive duration monitoring; or with for its use; or in th consequences wh				

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		155650	B. WI	_		10/02/	2015
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
LINICOLA	IQUIDE UEALTU Ø	REHABILITATION CENTER			RGINIA ST LLVILLE, IN 46410		
					LLVILLE, IN 404 IU		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG	combinations of th		+	IAG			DATE
		To reacone above.					
	Based on a comp	rehensive assessment of a					
resident, the facility must ensure that							
		enot used antipsychotic renthese drugs unless					
		therapy is necessary to					
		ndition as diagnosed and					
		e clinical record; and					
		e antipsychotic drugs					
		ose reductions, and entions, unless clinically					
		an effort to discontinue					
	these drugs.						
	Based on observ	ration, record review and	F 03	329			10/16/2015
	interview, the fa	cility failed to ensure a			F329		
	resident was free	e from unnecessary					
	medications, rela	ated to an antianxiety					
	medication give	n without indications for			It is the practice of this facility to		
	use, and a blood	pressure medication not			ensure that residents who have no	ot	
	given on multipl	le days for 1 of 5			used psychotropic drugs are not		
	residents review	ed for unnecessary			given these drugs unless necessar	y to	
	medications. (Re	esident #29)			treat a specific condition as diagnosed and documented in the		
					clinical record.		
	Findings include	2:					
	_						
	On 9/30/15 at 11	1:41 a.m., Resident #29					
		tting in a wheelchair in			What corrective action(s)		
	front of the nurs	es station. The resident			will be accomplished for		
	was watching tel	levision with no			those residents found to ha		
	behaviors observ				been affected by the deficion	ent	
					practice?		
	On 10/2/15 at 10	0:00 a.m., Resident #29					
		tting in a wheelchair in					
		es station at a table. The			Pagidant #20 physician		
		tching television with no			Resident #29 physician was		
	behaviors observ	_			updated on resident's		
	benaviors observ	vea.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/02/2015	
	OVIDER OR SUPPLIEF	REHABILITATION CENTER		8380 VI	ADDRESS, CITY, STATE, ZIP CODE RGINIA ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	completed on 9/2 residents diagno not limited to, hy depression, psycanxiety. The Quarterly Massessment compindicated the residents diagno not limited to, hy depression, psycanxiety.	or Resident #29 was 29/15 at 2:21 p.m. The ses included, but were ypertension, dementia, hotic disorder, and linimum Data Set (MDS) bleted on 9/20/15 ident had a BIMS (Brief intal Status) score of 3			behaviors, blood pressure results and hydralazine orders were received. How will you identify othe residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	er e
	cognitively impaindicated the residepression, no big psychosis. The antianxiety mediassessment period	ident had minimal ehaviors or indicators of resident received an acation 7 x in the 7 day			All residents prescribed antihypertensive medication psychotropic medication have the potential to be affected by the same alleged deficient practices.	ve
	(Physician Orde the resident rece medication) 0.5	r Summary), indicated ived Ativan (antianxiety mg (milligrams) BID). The Ativan was			Antihypertensive orders hav been reviewed for clarificati of parameters, as applicable	ion
	completed on 7/. Services the resi on his own, and when people but there were no re	chiatric Progress Note 3/15, indicated per Social dent would try to get up would become agitated mp into him. Per nursing cent reported behaviors. rrent medications			Psychotropic medications have been reviewed to ensure documentation is present for indication of use. What measures will be put	r

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING 00 COMPLETI B. WING 10/02/20			ETED	
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	20 mg daily, Na medication) 28 (antipsychotic morning and 25 (medication to the Parkinson's Disconsideration of the Parkinson's Disconsideration of the Parkinson's Disconsideration of the Parkinson's Disconsideration of May morning and 25 mg BID. It is a superior of the Parkinson's morning and parkinson's	in (depression medication) in menda XR (dementia in mg daily, Seroquel inedication) 50 mg in the image at night, Cogentin in reat symptoms of lease) 1 mg daily. GDR Reduction): The resident is reported behaviors in requel will be decreased Start Ativan 0.5 mg BID is add diagnosis of anxiety. In the resident was a start of the in the start of the control of the control of the in the start of the control of the control of the in the start of the control of the con			into place or what systemichanges 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 dose reduction.		
	Services Notes: 7/3/15, were no had any agitation. Interview with the Director on 9/3 indicated she had facility a few miffit was brough resident was had resident would be Service for the indicated she was SS staff if the resident was had resident would be service.	ing Notes and Social from 5/5/15 through indication the resident in or other behaviors. the SSD (Social Service 0/15 at 11:30 a.m., in digital just started at the conths ago. She indicated it to her attention a serving behaviors then the perfollowed by SS (Social behaviors. She further could have to ask the other resident was having icate the start of the			An in-service has been completed for nurses regard antihypertensive medication 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	ns f	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155650	B. W	NG		10/02/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			RGINIA ST		
LINCOLN	SHIRE HEALTH &	REHABILITATION CENTER		MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID		Т	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Ativan medication	on.			antihypertensive orders have		
					parameters for holding and		
	Interview with the	he DON (Director Of			physician notification as		
		2/15 at 9:58 a.m.,			applicableand new orders fo	r	
	indicated she con	-			psychotropic medications ha		
		sident was having any			an appropriate indication for		
		to indicate the start of			use.		
	the Ativan medic						
	Review of the Se	eptember 2015 POS					
	indicated, the res	-					
	· ·	ood pressure medication)					
	25 mg TID (thre	_					
	23 1118 1110 (till)	times a day).					
	Pavious of the Sa	eptember 2015 MAR			How will the corrective		
		dralazine medication was			actions(s) be monitored to		
	_				ensure the deficient praction	ce	
	neid on the folio	wing dates and times:			will not recur, i.e., what		
	0/2/15 / 1 00	37 / A 1			quality assurance program	1	
	•	o.m. = Not Administered:			will be put into place?		
		nent: BP (blood pressure)					
	117/72						
		o.m. = Not Administered:			DOM/designs : 11 '	1	
		n, Comment: BP 115/78	1		DON/designee will review t	ne	
		.m. = Not Administered:			Medication Administration		
	Due to condition				record for 5 residents with		
	-9/3/15 at 1:00 p	o.m. = Not Administered:			orders for antihypertensive		
	Due to condition	1			medications weekly to ensur		
	-9/4/15 at 9:00 a	.m. = Not Administered:			that physician orders are bei	ng	
	Due to condition	1			followed related to MD		
	-9/5/15 at 9:00 a	.m. = Not Administered:			notification parameters and		
	On Hold, Comm	nent: BP 117/83			medication held.		
	-9/10/15 at 5:00						
		Other, Comment: BP					
	result	, 					
	170410						

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) /			ľ		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN			00	COMPLETED		
		155650	B. W	ING		10/02/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					IRGINIA ST	
LINCOLNSHIRE HEALTH & REHABILITATION CENTER				MERRII	LLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		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)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	-9/11/15 at 5:00	•			Social Services	
	Administered: D	•			Director/designee will run th	ne
	Comment: BP to				Point of Care Compliance	
	-9/12/15 at 5:00	•			Report weekly to ensure that	t
	Administered: D	·			all residents receiving	
	Comment: BP to				psychiatric services and	
	-9/14/15 at 5:00	•			psychoactive medications ha	ive
	Administered: D	·			daily documentation. In	
	Comment: BP to				addition the Social Service	
-9/17/15 at 5:00 p.m. = Not					Director will review all ever	nts
Administered: Due to condition,				created for behaviors.		
	Comment: BP too low				Residents not exhibiting	
	-9/18/15 at 5:00	p.m. = Not			behaviors will be referred to	
	Administered: D	ue to condition			the physician for a dose	
	-9/21/15 at 5:00	p.m. = Not			reduction.	
	Administered: D	ue to condition,				
	Comment: BP lo	W				
	-9/28/15 at 5:00	p.m. = Not				
	Administered: D	ue to condition,				
	Comment: BP lo	W			The Director of nursing/Soc	ial
	-9/29/15 at 1:00	p.m. = Not administered:			Services/designee will prese	
	On Hold, Comm	ent: BP 118/72			a summary of the audits to t	
					Quality Assurance committee	
	Review of Nursi	ng Notes from 9/2/15			monthly for six months.	
	through 9/29/15	had no indication of why			Thereafter, if determined by	
	_	re medication was held			the Quality Assurance	
	_	had been notified.			committee, auditing and	
	-				monitoring will be done	
	Interview with th	ne DON on 9/30/15 at			quarterly and presented	
		ted the nurses were			quarterly at the QA meeting	
		dgement on the days the			Monitoring will be on going	
	1 0 03	nedication was held. She			will be on going	
	_	ysician should have been				
	· -	ays the medication was				
	1		1			I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		ì	JILDING	DNSTRUCTION 00	(X3) DATE SU COMPLET 10/02/20	ГЕD	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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 0371	BP parameter of medication. 3.1-48(a)(3)	lication should have a when to hold the			Compliance Date: Octobe 16, 2015	er	
SS=D Bldg. 00	The facility must - (1) Procure food fi considered satisfa local authorities; a (2) Store, prepare under sanitary cor Based on observ record review, th food in a sanitary trays carried dow uncovered food.	rom sources approved or ctory by Federal, State or nd distribute and serve food nditions ation, interview, and he facility failed to serve y manner related to room which hallway with This had the potential to dents who receive room (B wing)	F 03	371	F371 It is the practice of this facility to store, prepare, distribute and serv food under sanitary conditions.	,	10/16/2015
	During a lunch s wing on 9/28/15 the following wa The room tray ca and plugged in h hallway at 11:35	ervice observation on B beginning at 11:30 a.m.,			What corrective action(s) will be accomplished for those residents found to ha been affected by the defici practice? Meal trays transported outsi of enclosed carts now have	ent de	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO			COMPL	ETED
		155650	B. W	ING		10/02/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			RGINIA ST		
		REHABILITATION CENTER			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·	DATE	
	another empty cart and rolled to halfway				items covered.		
		way. At 11:43 a.m., CNA					
		m tray from the C					
		vn the hallway to Room			How will you identify othe	w	
	24 with the fruit	observed to be			residents having the	1	
	uncovered. At 1	1:46 a.m., CNA #3			potential to be affected by		
	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				^		
					the same deficient practice		
					and what corrective action	1	
					will be taken.		
	carried a room tray from the B hallway						
	cart all the way down the hall to Room						
	17 with the fruit	observed to be			All residents have the poten	tial	
	uncovered.				to be affected by the same	tiui	
					alleged deficient practice.		
	Interview with (CNA #2 on 9/28/15 at			aneged deficient practice.		
		cated she was unsure why					
		covered since all the					
		l covers and the unit			What measures will be put	t	
	didn't store extra				into place or what systemic		
	didii t store extra	i covers.			changes you will make to	_	
	Interview on 0/2	8/15 at 11:52 a.m. with	ensure that the deficient				
				practice does not recur?			
		sultant, indicated she had			practice does not recui.		
		was served uncovered on					
	-	nd should have been					
	covered.				Staff have been in-serviced	on	
					all food that is transported		
		Tray Service" was			outside of an enclosed cart	or	
		DON (Director of			outside of the dining room		
	υ /	9/15 at 3:10 p.m. and			must have all items covered		
	deemed as current. The policy indicated, " 7. Any trays transported outside of					-	
	the enclosed car	t or outside the dining					
	room will have a	all items covered"			How will the corrective		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2015
	PROVIDER OR SUPPLIER SHIRE HEALTH & REHABILITATION CENTER	8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	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/designeed will audit 5 meals weekly, including breakfast, lunch a dinner, to ensure that all foot transported outside of the enclosed meal carts and din room have all items covered will present a summary of the audits to the Quality Assurance committee month for six months. Thereafter, determined by the Quality Assurance committee, audit and monitoring will be done	nd od ing he he ing
			quarterly and presented quarterly at the QA meeting Monitoring will be on going Compliance Date: Octobe	g
			16, 2015	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/02/2015		
	PROVIDER OR SUPPLIER NSHIRE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION		
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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			ETED
		155650	B. Wl	NG		10/02/	2015
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID BROWINGB'S BLANGE CORRECT		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
	of infection.						
	Based on observ	ation and interview, the	F 04	141			10/16/2015
	facility failed to	ensure infection control		F441			
	was maintain rel	ated to a clean linen cart					
	not covered in th	ne A Wing, A Hallway.					
	(A Wing)						
	(A wing)						
	Finding includes:				What corrective action(s) will be accomplished for		
	During the initio	1 tour on 0/20/15 at 0:00		those residents found to been affected by the de		WA	
	_	1 tour on 9/28/15 at 9:08					
	· ·	en cart was observed			practice?		
	ı	transported down A			practice:		
	Wing, A Hallwa	y to the AC Hallway.					
	Interview with L	aundry/Housekeeping #1			Class lines and an array		
	on 9/28/15 at 9:1	0 a.m., indicated he did			Clean linen carts are now covered when being		
	not know the cle	an linens were to be					
	covered.				transported through the		
	00,0100.				hallways.		
	Interview with th	ne DON (Director of					
		9/15 at 2:30 p.m.,					
	•	ndry linens should have			11 .11 .1		
		-			How will you identify othe	r	
		ach linen cart had a flap			residents having the		
	to cover the line	ns.			potential to be affected by		
					the same deficient practice	•	
	3.1-19(g)(2)				and what corrective action	1	
					will be taken.		
					All residents have the poten	tial	
					to be affected by the same		
					alleged deficient practice.		
					_ ^		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155650	B. WING 10/02/2015			
			- CENTER	A DDDDGG GUTY GTATE TIP GODE		
NAME OF P	ROVIDER OR SUPPLIE	CR.		ADDRESS, CITY, STATE, ZIP CODE		
LINICOLN	IOLUDE LIEALTIL	DELIADII ITATION CENTED		/IRGINIA ST		
LINCOLN	ISHIRE HEALTH	REHABILITATION CENTER	MERR	ILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				Laundry/Housekeeping star	ff	
				#1 has been in-serviced on	the	
				importance of ensuring that		
				clean linen carts are covere		
					u	
				while being transported		
				through the hallway.		
				What measures will be pu	ıt	
				into place or what system	ic	
				changes you will make to		
				ensure that the deficient		
				practice does not recur?		
				practice does not recur:		
				Staff have been in-serviced		
				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 pract		
				_	100	
				will not recur, i.e., what		
				quality assurance program	n	
				will be put into place?		
				The Administrator/designed	e	
				will audit 5 linen deliveries		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUILDING 00 B. WING		COMPLETED 10/02/2015	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
				weekly to ensure that the lin carts are covered while bein transported through the hall.	g	
				The Administrator/designee will present a summary of the audits to the Quality Assurance committee months for six months. Thereafter, determined by the Quality Assurance committee, audition and monitoring will be done quarterly and presented quarterly at the QA meeting Monitoring will be on going	ne aly if ing	
				Compliance Date: Octobe 16, 2015	r	
F 0465 SS=E Bldg. 00	TABLE ENVIRON The facility must p	rovide a safe, functional, fortable environment for				
	facility failed to	ation and interview, the ensure the residents' s clean and in good repair	F 0465	Please accept the following a the facility's credible allegation of compliance. This plan of correction does not constitute	on	10/16/2015

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Event ID:

WRKJ11 Facility ID: 000577

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			COMPLETED
		155650	B. WI	NG		10/02/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R			RGINIA ST	
LINICOLN	ICUIDE LIENI TLI Ø	DEHABII ITATIONI CENTED			LLVILLE, IN 46410	
LINCOLNSHIRE HEALTH & REHABILITATION CENTER			MEKKI	LEVILLE, IN 404 10		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		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	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	related to marre	d and gouged doors, rust			an admission of guilt or liabi	-
	on bathroom dra	ains and broken floor tile			by the facility and is submitte	ed
	for 2 of 2 wings	and the front entrance			only in response to the	
	_	ing, B Wing and the front			regulatory requirement. F 4	
	entrance doorwa	-			What corrective action(s) will be	
	cittiance doorwa	iy)			accomplished for those reside found to have been affected by	
					the deficient practice; The	,
	Findings include	e:			broken and missing tile in the	
					front entrance doorway was	
	During the Envi	ronmental tour on			repaired. The marred wall in	
	10/1/15 at 3:15 p.m. until 3:45 p.m., with				room A2 was cleaned. The	
	the Administrator, Maintenance Director				marred wall in room A2 bathro	
	and Nurse Consultant, the following was				was cleaned. The marred wal	
					in A 14 bathroom was cleaned	
	observed:				Room A 14 door was cleaned	
					repaired. The wall beside the in room A20-2 was cleaned. 1	
	1. Front Lobby	•			door for room A20 was repaired	
					The flange bowl caps were	,u.
	a. Broken and r	nissing tile in the front			installed to the toilet in room A	.23.
	entrance doorwa	av.			The bathroom door for room A	. 23
		-5			was repaired. The hot water	
	2. A Wing, A H	Iollmon			faucet handle cap was replace	
	2. A wing, A i.	iaiiway			in room A26. The A wing cent	
					shower door was repaired. Th	ne
		2, there were black mars			base molding in room B5 was	t to
	on the wall behi	nd bed number two and			repaired. The corner wall nex the bathroom in room B5 was	110
	on the bathroom	walls. Two residents			repaired. The bathroom drain	
	resided in this ro	oom.			and plate on the sink in room I	
					was cleaned and the rust was	
	3. A Wing, AB	Hallway			removed. The bathroom door	in
	5. 11 ,, mg, 11D				room B7 was repaired. In room	
	a In Daam #A	14 the bothroom wells			11 the room and bathroom do	
		14, the bathroom walls			were repaired. In room B 11 t	
		d the outside of the room			bathroom door jam and bathro	DOITI
		d and marred. Two			corner wall were repaired. In room B 11the wood base mole	lina
	residents resided	d in this room.			below the radiator was repaire	_
					In room B12 the room and	
	4. A Wing, AC	Hallway			bathroom door was repaired.	In
	<i>S</i> ,	,	- 1		·	i

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	COMPLETED		
		155650	B. W	ING	00	10/02/2015	
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	IRGINIA ST		
LINCOLA	ICHIDE HEVI TH 0	REHABILITATION CENTER			LLVILLE, IN 46410		
	NOTHE HEALTH &	REHABILITATION CENTER		WERRI	LLVILLE, IIN 404 IU		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
					room B 13 the bathroom door		
	a. In Room # 20), the wall beside bed			was repaired. In room B14 th		
		s dirty and the room door			bathroom door, and corner wa		
		he inside. Two residents			was repaired. In room B16 th walls were cleaned and repair	I	
	resided in this ro				In room B 16 the bathroom do	I	
	resided ill tills IC	JUIII.			and the corner wall were clear		
					and repaired. In room B16 the		
		, the flange bowl caps			door jam was touched up with		
	were missing on	the toilet, and the			paint. How the facility will		
	bathroom door v	was gouged. Two			identify other residents having	ı the	
	residents resided				potential to be affected by the		
					same deficient practice and w		
	. In D Ψ2.6	the heather and best			corrective action will be taken	;	
		, the bathroom's hot			All facility residents have the		
		idle had part of the plastic			potential to be affected by the	I	
	top missing, the	bathroom and room			same alleged deficient practic		
	doors were marr	ed and gouged. Two			What measures will be put int place or what systemic chang	I	
	residents resided	l in this room.			will be made to ensure that the	I	
					deficient practice does not rec		
	d The Control 9	Shower door was gouged.			Housekeeping was in-service	I	
	u. The Central S	shower door was gouged.			proper room cleaning, includir		
					the walls, doors, and sink drai	-	
	5. B Wing, A H	allway			plates. Housekeeping will init		
					room cleaning checklist to ide	-	
	a. In Room #5,	the base molding next to			and document cleaning needs	5	
		as peeling off, the corner			and resultant resolution.	_	
		bathroom was gouged.			Maintenance Director/designe		
		ided in this room.			will conduct weekly room checand facility rounds to identify	JKS	
	One resident res	iucu III uiis 100III.			environmental concerns and t	rack	
					progression of resolution.	Idok	
	b. In Room #7,	the bathroom drain and			Schedule of preventative roon	n	
	plate on the sink	was rusted, and the			maintenance will be reviewed		
	bathroom door v	was gouged. One resident			weekly by Administrator to en		
	resided in this ro				rooms are tended to timely.		
	1351404 111 (1115 10				the corrective action(s) will be		
		-11 -			monitored to ensure the defici		
	6. B Wing, B Ha	anway			practice will not recur, i.e., wh		
					quality assurance programs w		
	a In Room #11	the room and the			be put into place; Housekeep	oing	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION				A. BUILDING <u>00</u>		COMPLETED			
		155650		ING		10/02/2015			
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIEF	8		1	RGINIA ST				
LINCOLNSHIRE HEALTH & REHABILITATION CENTER				MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX				PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION		
TAG			+	TAG	· ·		DATE		
	bathroom doors were gouged. The bathroom door jambs and the wall corner by the bathroom were gouged The wood				Supervisor will review 5 rooms a week to ensure proper cleaning takes place. Maintenance Supervisor will review				
	base molding below the radiator was			preventative maintenance					
	chipped. One resident resided in this			schedule weekly with					
				Administrator to ensure rooms					
	room.			are tended to timely.					
	b. In Room #12, the room and bathroom door were gouged. Two residents resided in this room.				Housekeeping Supervisor and				
					Administrator will summarize				
					tracking tool monthly and bring				
					Quality Assurance Committee				
					The results of the audit will be presented to the Quality				
	c. In Room # 13, the bathroom door was				Assurance committee monthly	for			
	·				nine months. Thereafter, if	101			
	gouged. Two residents resided in this room.				determined by the Quality				
					Assurance committee, auditing	a			
					and monitoring will be done				
	d. In room #14,	the bathroom door was			quarterly and present quarterly	y at			
	gouged, the corner wall between the first bed and the bathroom was gouged. One resident resided in this room.				the QA meeting. Date by wh	ich			
					systemic corrections will be				
					completed. 10/16/15.				
	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.								
	Consultant.								
	.								
		he 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.									
	1	2							

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 10/02/	ETED		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		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		
	3.1-19(f)							

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