STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnshire Health & Rehabilitation Center	8380 Virginia St Merrillville, IN 46410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interview, the facility failed to ensure a resident had a clean and homelike environment, related to a resident lying on soiled bottom sheet on the bed for 1 random observation. (Resident C) Finding includes: During an observation 7/7/25 at 9:47 a.m., Resident C was lying on her back in bed. She indicated she needed to be changed and that she was in a mess. The resident's skin was scaly and shedding from the shoulders and arms. There were several pieces of dry skin, dark specks and dark discoloration spots on the bottom sheet of the bed under the resident's arms. The resident indicated she had not had any care since last night. During an observation on 7/7/25 at 10:03 a.m., CNA 1 and CNA 2 entered the room to provide care to the resident. CNA 1 indicated the resident had a skin condition. When the top sheet was removed, the resident's skin on her torso and legs were also scaly and shedding. There was a copious amount of dried skin flakes and discoloration areas from her skin on the bottom sheet. CNA 2 indicated she had started her shift at 7:00 a.m. and had not provided care to the resident prior to this observation. Resident C's record was reviewed on 7/7/25 at 1:46 p.m. The diagnoses included, but were not limited to, diabetes mellitus and psoriasiform dermatitis. A Quarterly Minimum Data Set assessment, dated 6/6/25, indicated an intact cognitive status, required maximum assistance for bathing, hygiene, and bed mobility. The CNA observation for incontinence task in the electronic medical record indicated the resident had been checked on 7/6/25 at 7:55 p.m. On 7/7/25 at 5:17 a.m., it was marked as not-applicable. This citation relates to Complaint IN00462425. 3.1-19(f)(5)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was implemented for a resident with a skin condition for 1 of 4 resident care plans reviewed. (Resident C) Finding includes: During an observation 7/7/25 at 9:47 a.m., Resident C was lying on her back in bed. She indicated she needed to be changed and that she was in a mess. The resident's skin was scaly and shedding from the shoulders and arms. There were several pieces of dry skin, dark specks and dark discoloration spots on the bottom sheet of the bed under the resident's arms. During an observation on 7/7/25 at 10:03 a.m., CNA 1 and CNA 2 entered the room to provide care to the resident. CNA 1 indicated the resident had a skin condition. When the top sheet was removed, the resident's skin on her torso and legs were also scaly and shedding. There was a copious amount of dried skin flakes and discoloration areas from the skin on the bottom sheet. Resident C's record was reviewed on 7/7/25 at 1:46 p.m. The diagnoses included, but were not limited to, diabetes mellitus and psoriasiform dermatitis. A Quarterly Minimum Data Set assessment, dated 6/6/25, indicated an intact cognitive status, required maximum assistance for bathing, hygiene, and bed mobility. A Physician's Order, dated 7/1/25, indicated Tacrolimus external cream 0.1% (treatment for dry, itching, and rashes of the skin), apply to affected areas every day and evening for skin impairment. Apply the cream to the bilateral upper and lower extremities, abdomen and the back. The record lacked a comprehensive care plan related to the psoriasiform dermatitis. The Director of Nursing was notified on 7/7/25 at 3:02 p.m. the record lacked a care plan for the psoriasiform dermatitis. No Care Plan had been received at the time of exiting the facility on 7/7/25 at 5:00 p.m. This citation relates to Complaint IN00462425. 3.1-35(b)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure a dependent resident received assistance with activities of daily living (ADLs) related to the timeliness of incontinence care for 1 of 3 residents reviewed for ADLs. (Resident C) Finding includes: During an observation 7/7/25 at 9:47 a.m., Resident C was lying on her back in bed. She indicated she needed changed and that she was in a mess and she had not had any care since last night. During an observation on 7/7/25 at 10:03 a.m., CNA 1 and CNA 2 entered the room to provide care to the resident. CNA 2 indicated she had started her shift at 7:00 a.m. and had not provided care to the resident prior to this observation. CNA 1 indicated the resident required assistance for bed mobility. There was a large amount of dried dark fluid with rings and reddish/pink drainage that covered the incontinent pad under the resident. The incontinent brief was saturated. CNA 2 indicated the resident's skin weeped and some of the drainage on the incontinent pad was from the skin. During the care, the resident moaned with pain and stated I can't do this no more. She indicated she wanted to be left alone. CNA 1 and CNA 2 attempted to comfort the resident and asked the resident if she would like to rest. She indicated she wanted to rest. The CNAs covered the resident with a sheet and assured her they would return. CNA 2 then reported the pain and the resident's request to LPN 3. During an interview on 7/7/25 at 10:30 a.m., LPN 3 indicated the resident received routine pain medication at 8:50 a.m. During an observation on 7/7/25 at 11:40 a.m., CNA 1 and CNA 2 were providing care. The resident was assisted to roll onto her right side. There was a copious amounts of dried dark drainage and reddish/pink drainage on the incontinence pad. The CNAs' indicated they were not sure if the drainage on the pad was from urine or from the uncovered left hip pressure ulcer. Resident C's record was reviewed on 7/7/25 at 1:46 p.m. The diagnoses included, but were not limited to, diabetes mellitus and psoriasiform dermatitis. A Care Plan, revised on 3/26/25, indicated a risk for complications, related to urinary incontinence. The interventions included incontinence care would be provided after each incontinence episode. The resident would be checked and the brief/incontinence pad would be changed with routine care rounds and as needed. A Quarterly Minimum Data Set assessment, dated 6/6/25, indicated an intact cognitive status, required maximum assistance for bathing, hygiene, and bed mobility and was dependent for toileting. She was frequently incontinent of bowel and bladder. The CNAs observation for incontinence task in the electronic medical record indicated she had been checked on 7/6/25 at 7:55 p.m. On 7/7/25 at 5:17 a.m., it was marked as not-applicable. During an interview on 7/7/25 at 3:00 p.m., the Wound Nurse indicated the resident's skin was not seeping and the pressure area on the left hip had drainage. The drainage on the left hip would not be enough to cover the whole incontinence pad. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incontinence policy, dated 2/12/21 and received from the Administrator as current, indicated the residents would be provided assistance with incontinence care routinely. Included in the incontinence care was brief changes, peri-care, clothing changes, and bed linen changes. This citation relates to Complaint IN00462425. 3.1-38(a)(2)(C)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure treatments for pressure ulcers were in place as ordered by the physician for 1 of 3 residents reviewed for pressure ulcers. (Resident C) Finding includes: During an observation on 7/7/25 at 11:40 a.m., CNAs 1 and CNAs 2 were providing care. The resident was rolled to her right side. There was a pressure ulcer observed on the left hip, and superficial open areas on the lower back/sacrum area and right buttock. The right buttock had bloody drainage present. There were no dressings on any of the open areas. CNAs 1 looked in the brief and linens being removed from under the resident and found no dressings. CNAs 1 and CNAs 2 indicated they had not been made aware the dressings were not present by the previous shift. During an interview on 7/7/25 at 11:45 a.m., the Wound Nurse indicated the treatments had been completed by her on 7/3/25. There were physician's orders to change the dressings if soiled or if the dressings came off. During an interview on 7/7/25 at 12:00 p.m., the Director of Nursing indicated she had spoken to the nurse who worked the night shift and was informed the nurse had completed the dressing changes on the night shift of 7/7/25. Resident C's record was reviewed on 7/7/25 at 1:46 p.m. The diagnoses included, but were not limited to, diabetes mellitus and psoriasiform dermatitis. Physician's Orders, dated 4/28/25, indicated the sacrum area and right buttock area was to be cleansed with normal saline, patted dry, and covered with a hydrocolloid dressing three times a week and as needed for dislodgement and/or if soiled. The treatment was to be completed on Mondays, Wednesdays, and Fridays. A Care Plan, revised on 5/1/25, indicated an infection of a pressure ulcer wound. The interventions included treatments would be administered as ordered. A Physician's Order, dated 5/30/25, indicated the left hip pressure ulcer was to be cleansed with normal saline, patted dry, packed with iodoform (antiseptic and antimicrobial wound treatment), and covered with a foam dressing daily and as needed for dislodgement and/or if soiled. A Care Plan, dated 6/5/25, indicated a pressure ulcer was present. The interventions included wound care would be provided as ordered by the Physician. A Quarterly Minimum Data Set assessment, dated 6/6/25, indicated an intact cognitive status, required maximum assistance for bathing, hygiene and bed mobility and was dependent for toileting. She was frequently incontinent of bowel and bladder. There was one stage three (full thickness skin loss) pressure ulcer and pressure ulcer care was provided. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication and Treatment Administration Records, dated 7/2025, indicated the left hip treatment had not been completed on 7/5/25 and 7/6/25 on day shift as scheduled. The hydrocolloid dressings had been documented as completed on 7/4/25. There were no as needed treatments documented as completed. During an interview on 7/7/25 at 3:00 p.m., the Wound Nurse indicated the hydrocolloid dressings were not on the resident and she had completed all the dressing treatments this morning. This citation relates to Complaint IN00462425. 3.1-40(a)(2)