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	02/26/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the required information and documents to the resident or their representative at the time of discharge for 1 of 3 residents reviewed for discharges. (Resident G)Finding includes: The closed record for Resident G was reviewed on 2/26/26 at 1:25 p.m. Diagnoses included, but were not limited to, hemiparesis (one-sided weakness) and hemiplegia (one-sided paralysis) following a cerebral vascular accident (stroke) and chronic obstructive pulmonary disease. The resident was admitted to the facility on [DATE] and discharged on 2/14/26.A Psychosocial Note, dated 2/11/26, indicated the resident had been notified their last covered day for their stay would be 2/13/26. There were no additional notes regarding the resident being discharged or what instructions the resident had received on discharge.A Discharge Planning Review, dated 2/14/26, was signed by the resident. The first two sections of the document were completed, however the remaining sections, including medications and follow up visits, were not completed. During an interview on 2/26/26 at 2:33 p.m., the Social Service Director (SSD) indicated the resident had been discharged to home and a referral had been made to home health. There was no documentation regarding the home health referral in the resident's record but there was an email related to the referral. During an interview on 2/26/26 at 2:40 p.m., the Director of Nursing indicated at discharge, residents should be given a discharge summary, a list of medications and any equipment orders and there should be a progress note completed in their record. The policy, Discharge summary, dated [DATE], was provided by the Administrator and indicated, .2. When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: a. A recapitulation of the resident's stay that includes, but is not limited to, diagnosis, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results c. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter. This citation relates to Intake 2745646.410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(3)

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 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 (ADL's) related to the timeliness of assistance with a breakfast meal for 1 of 3 residents observed for meal intake assistance. (Resident F)Finding includes:During an observation on 2/26/26 at 8:16 a.m., Resident F was lying in bed with her head up and a tray table over the bed. On the tray table was an uncovered breakfast tray which consisted of scrambled eggs, a hot cereal, a muffin, a carton of milk, and a glass of orange juice. There were no attempts made to feed herself.During an observation on 2/26/26 at 8:24 a.m., the breakfast tray remained in front of Resident F on the tray table. Her fingers of her left hand were in the scrambled eggs and there were tremors of the hand when she raised her fingers off the plate. She was unable to communicate if she required help to eat. There were no attempts to feed herself.During an observation on 2/26/26 at 8:45 a.m., the breakfast tray remained in front of her. The tremors of the hands continued. The scrambled eggs were now in in the hot cereal bowl. There were no attempts made to feed herself. CNA 1 indicated the resident was a new admission and required assistance with the meal intake and she would assist the resident.During an observation on 2/26/25 at 8:49 a.m., CNA 1 was at the bedside and attempted to feed the resident. She indicated the resident didn't seem like she wanted to eat and did take a sip of the orange juice. CNA 1 had not warmed up the food nor obtained a new breakfast tray for the resident.During an observation on 2/26/26 at 1:00 p.m., a family member was assisting the resident with her lunch meal and indicated the resident was dependent for meal intake.During an interview on 2/26/26 at 1:06 p.m., the Director of Nursing indicated the resident should have been fed when the tray arrived and CNA 1 should have obtained a new tray for the resident. Resident B's record was reviewed on 2/26/26 at 1:22 p.m. The diagnoses included, but were not limited to Parkinson's disease and dementia. She was admitted into the facility on 2/25/26.A Baseline Care Plan, dated 2/25/26 at 1:49 p.m., indicated the resident required physical assistance of one person for eating.The Functional Abilities and Goals assessment, dated 2/25/26 at 10:04 p.m., indicated the resident was dependent for eating.This Citation relates to Intake 2745646.410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)

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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 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 record review and interview, the facility failed to ensure a resident's pressure ulcer treatment was provided as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident D)Finding includes:Resident D's record was reviewed on 2/26/26 at 9:45 a.m. Diagnoses included, but were not limited to, adult failure to thrive. The resident had pressure ulcers on her coccyx and left heel and received hospice services.The Significant Change Minimum Data Set assessment, dated 11/27/25, indicated the resident had significant cognitive deficits and required substantial/maximum assistance for bed mobility.A Physician's Order, dated 12/20/25, indicated to cleanse the coccyx wound with normal saline, apply calcium alginate and cover with a dry dressing daily.The January 2026 Treatment Administration Record indicated the wound treatment was not signed out as completed on 1/5 and 1/7.A Physician's Order, dated 12/17/25, indicated to cleanse the left heal wound with normal saline, apply calcium alginate and secure with Kerlix every Monday, Wednesday and Friday. The order was discontinued on 1/6/26.A Physician's Order, dated 1/7/26, indicated to cleanse the left heal wound with normal saline, apply calcium alginate and cover with a dry dressing every Monday, Wednesday and Friday. The order was discontinued on 1/16/26.A Physician's Order, dated 1/24/26, indicated to cleanse the left heal wound with normal saline, pat dry, apply triple antibiotic ointment to peri-wound, apply calcium alginate and cover with a dry dressing. The order was discontinued on 1/30/26.A Physician's Order, dated 1/31/26, indicated to cleanse the left heal wound with normal saline, apply calcium alginate and cover with a dry dressing daily.The January and February 2026 Treatment Administration Records indicated the wound treatment was not signed out as completed on 1/5, 1/7, 1/25, 1/31, 2/9, 2/16 and 2/17.During an interview on 2/26/26 at 2:25 p.m., the Wound Nurse indicated she did not know why the treatments weren't completed on the above dates. The February dates corresponded with dates hospice staff visited and they may have changed the dressing. Hospice records were requested by the nurse, but not received. The policy, Wound Dressing Change, dated 5/20/24, was received from the Regional Wound Nurse indicated, .11. Document the completion of dressing change on the treatment record.This citation relates to Intake 2745676.410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure residents' records were completed in a timely manner related to nutritional assessments for 2 of 6 residents reviewed for medical records. (Residents B and C) Findings include:1. Resident B's closed record was reviewed on 2/26/26 at 9:58 a.m. The diagnoses included, but were not limited to, diabetes mellitus. The resident was admitted into the facility on 1/28/26 and discharged from the facility on 2/13/26.A Care Plan, dated 2/10/26, indicated a poor appetite and frequent refusals of meals.There was no documentation located in the record that indicated a nutritional assessment had been completed to evaluate the resident's nutritional needs. 2. Resident C's closed record was reviewed on 2/26/26 at 11:03 a.m. The diagnoses included, but were not limited to, dementia. The resident was admitted into the facility on 1/19/26 and discharged from the facility on 2/5/26.An admission Minimum Data Set assessment, dated 1/26/26, indicated a deep tissue injury pressure ulcer was present on admission.A Care Plan, dated 2/2/26, indicated there was difficulty chewing and swallowing some foods with a moderate appetite.There was no documentation located in the record that indicated a nutritional assessment had been completed to evaluate the resident's nutritional needs.During an interview on 2/26/26 at 2:43 p.m., the Registered Dietician indicated she was a little behind and did not have enough hours at the facility to ensure the assessments were completed timely.This citation relates to Intake 2745646.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)