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	05/22/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure the physician and responsible party (RP) were notified of low blood sugars, behaviors, a transfer to a behavioral hospital, and change of condition, for 2 of 3 residents reviewed for notification of change. (Residents C and D)Findings include:1. Resident C's record was reviewed on 5/21/26 at 1:12 p.m. The diagnoses included, but were not limited to, bipolar, dementia, Alzheimer's disease, and violent behavior.A Quarterly Minimum Data Set (MDS) assessment, dated 3/2/26, indicated a severely impaired cognitive status.a) A Nurse's Progress Note, dated 3/17/26 at 10:24 p.m., indicated the resident was verbally and physically aggressive towards staff. The interventions attempted were unsuccessful.A Nurse's Progress Note, dated 3/18/26 at 9:42 p.m., indicated the resident was cursing and threatening staff with physical behaviors. The interventions were unsuccessful.A Nurse's Progress Note, dated 3/20/26 at 7:12 p.m., indicated the resident exhibited verbal and physical aggressiveness toward the staff. The interventions were unsuccessful.There was no documentation that indicated the responsible party had been notified of the increase in behaviors.A Social Service Progress Note, dated 3/23/26 at 2:19 p.m., indicated a referral had been sent to the Behavioral Hospital. The Responsible Party had not been notified of the behaviors or the referral prior to the referral being sent.A Social Service Progress Note, dated 3/24/26 at 4:09 p.m., indicated the resident had been accepted to the Behavioral Hospital. The responsible party was notified per voicemail.A Nurse's Progress Note, dated 3/24/26 at 6:14 p.m., indicated the resident was transferred to the behavioral hospital.During an interview on 5/21/26 at 2:39 p.m., the Director of Nursing (DON), indicated she was unsure why the responsible party had not been notified of the behaviors prior to the transfer.During an interview on 5/21/26 at 2:56 p.m., the Social Service Director indicated she had been on vacation and came back to work on 3/23/26 and could not notify the responsible party if she was not here. b) A Nurse's Note, dated 5/6/26 at 11:54 a.m., indicated there was swelling to the left wrist with complaints of pain. The physician was notified and orders for an X-ray of the left hand and wrist were received.There was no documentation that indicated the responsible party had been notified of the left wrist swelling and order for the X-ray. 2. Resident D's record was reviewed on 5/21/26 at 10:28 a.m. The diagnoses included, but were not limited to dementia and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, indicated a moderately impaired cognitive status.A Physician's Order, dated 10/6/25, indicated the physician was to be notified if the blood sugar was less than 60 or above 400.A Physician's Order, dated 10/20/25 and discontinued on 4/5/26, indicated the blood sugar was to be monitored by a glucometer before meals and at bedtime. Humalog insulin dose was to be given according to the results of the glucometer reading (sliding scale).A blood sugar result, dated 3/5/26 at 10:29 a.m., indicated the blood sugar was 44.There was no documentation that indicated the physician or Power of Attorney (POA) had been notified of the low blood sugar.A blood sugar result, dated 3/5/26 at 10:31 a.m., indicated the blood sugar was 189.During interviews on 5/21/26 at 2:23 p.m., the Regional Nurse Consultant indicated the blood sugar of 44 may have been an error in documentation. The DON indicated the Terminated LPN 1 who had completed the blood sugar testing and documentated the blood sugar result was no longer employed at the facility. An undated facility (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guideline for hypoglycemia, received from the DON as current on 5/21/26 at 3:22 p.m., indicated the physician was to be notified for a blood sugar below 60, unless ordered differently. The physician notification was to be documented in the clinical record.An undated facility change in condition policy, received as current from the DON on 5/21/26 at 3:22 p.m., indicated the physician and responsible party were to be notified when there was a change requiring a need to alter treatment, a significant change in a physical, mental, psychosocial status, or a decision to transfer the resident from the facility.This citation relates to Intakes 2985835 and 3005275.410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(2)410 IAC 16.2-3.1-5(a)(3)410 IAC 16.2-3.1-5(a)(4)

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. Based on record review and interview, the facility failed to ensure a resident received laboratory services as ordered by the physician for 2 of 3 residents reviewed for laboratory services. (Residents C and D)Findings include:1. Resident C's record was reviewed on 5/21/26 at 1:12 p.m. The diagnoses included, but were not limited to, dementia and Alzheimer's disease.A Physician's Order, dated 5/6/26, indicated a urinalysis (UA) with culture and sensitivity (C&S) test was to be completed.A Nurse's Progress Note, dated 5/6/26 at 9:44 p.m., indicated the resident had been incontinent and a urine sample was not obtained.There was no documentation a urine sample had been obtained or that the UA with C&S had been completed.During an interview on 5/22/26 at 8:15 a.m., the Director of Nursing (DON) indicated the UA with the C&S had not been completed. The physician had not been notified the test had not been completed. 2. Resident D's record was reviewed on 5/21/26 at 10:28 a.m. The diagnoses included, but were not limited to diabetes mellitus and chronic kidney disease.The Physician's Orders, dated 6/13/25, indicated a Comprehensive Metabolic Profile (CMP) (electrolytes) and a Complete Blood Count (CBC) was to be completed monthly on every third Tuesday. A lipid panel was to be completed every three months.The last CMP and CBC results located in the record were dated 1/27/26 and the lipid panel was dated 12/16/26.During an interview on 5/21/26 at 1:49 p.m., the DON indicated the laboratory tests had not been completed as ordered. The tests were supposed to be changed to every three months and the order was not put in by the Unit Manager.This citation relates to Intake 3005275.410 IAC (Indiana Administrative Code) 16.2-3.1-49(e)

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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 the medical record was complete and accurately documented related to treatment of low blood sugars for 1 of 3 residents reviewed for low blood sugars. (Resident D)Finding includes:Resident D's record was reviewed on 5/21/26 at 10:28 a.m. The diagnoses included, but were not limited to diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, indicated insulin and a hypoglycemic medication had been administered daily in the past seven days.A Physician's Order, dated 10/6/25, indicated the physician was to be notified if the blood sugar was less than 60 or above 400.A Physician's Order, dated 10/20/25 and discontinued on 4/5/26, indicated the blood sugar was to be monitored by a glucometer before meals and at bedtime. Humalog insulin dose was to be given according to the results of the glucometer reading (sliding scale).A Physician's Order, dated 6/3/25, indicated a glucagon (glucose) emergency kit one milligram (mg) was to be administered intramuscularly as needed for hypoglycemia, blood sugars less than 70, and if symptomatic and not awake and alert. The blood sugar was to be rechecked every 15 minutes. The Emergency Medical System (EMS) was to be notified if the resident did not despond to the first dose of glucagon. The physician was to be notified and all actions were to be documented.A Physician's Order, dated 11/16/25, indicated Glutose 15 Oral Gel 40% (dextrose), 15 grams by mouth was to be given every 24 hours for blood sugars less than 70 and the physician was to be notified.A blood sugar result, dated 3/5/26 at 10:29 a.m., indicated the blood sugar was 44.The Medication Administration Record (MAR), dated 3/2026, had not indicated the glucagon or Glutose gel was used for the treatment of the hypoglycemia.The treatment for the low blood sugar and the status of the resident had not been documented in the medical record.A follow up blood sugar, dated 3/5/26 and timed at 10:31 a.m., indicated the blood sugar was 189.During interviews on 5/21/26 at 2:23 p.m., the Regional Nurse Consultant indicated the blood sugar of 44 may have been an error in documentation. The DON indicated the Terminated LPN 1 who had completed the blood sugar and documented the blood sugar was no longer employed at the facility.During an interview on 5/22/26 at 8 a.m., the Unit Manager indicated the blood sugar had dropped a few times and it was always treated. Terminated LPN 1 had never reported the low blood sugar to her.A Physician's Order, dated 3/10/26, indicated Glucose Oral Gel 40%, one vial by mouth was to be used for hypoglycemia/blood sugars less than 60. The physician was to be notified.A Physician's Order, dated 3/12/26, indicated Glucose Oral Tablet Chewable, four tablets by mouth was to be given for blood sugars less than 70.A Nurse's Progress Note, dated 4/3/26 at 8:20 a.m., indicated the blood sugar was 44. The resident was awake but unable to follow commands. Attempts were made to raise the blood sugar per physician orders and were unsuccessful. The physician was notified and EMS was called. EMS arrived and were able to treat the hypoglycemia. The blood sugar was 166.The MAR, dated 4/2026, indicated none of the treatments for the hypoglycemia had been used.During an interview with Terminated LPN 2 on 5/21/26 at 1:49 p.m., she indicated the resident had not been able to hold anything in his mouth. The glucose tablets his family brought in were used. The family was not here. The family had brought the tablets in when his blood sugar was low the last time. He had checked the blood sugar after the treatment, but did not remember what it was. An undated facility guideline for hypoglycemia, received from the DON as current on 5/21/26 at 3:22 p.m., indicated If unable to swallow, notify the physician and prepare glucagon from the emergency drug kit for administration as ordered. Document findings, interventions, and physician contact in the resident's clinical record.This citation relates to Intake 3005275.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)410 IAC 16.2-3.1-50(a)(2)