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	11/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a treatment to a surgical incision was completed as ordered, areas of bruising and scabbing were assessed and monitored, and interventions were in place for areas of dry scaly skin for 5 of 6 residents reviewed for skin conditions non-pressure related. (Residents D, H, J, F, and G)Findings include:1. The closed record for Resident D was reviewed on 11/19/25 at 3:22 p.m. Diagnoses included, but were not limited to, aortocoronary bypass graft, atherosclerotic heart disease, and type 2 diabetes mellitus. The Medicare 5-day Minimum Data Set (MDS) assessment, dated 8/9/25, indicated the resident had moderate cognitive impairment and required partial/moderate assistance with bathing and dressing. The resident was also identified as having a surgical wound. A Care Plan, dated 8/6/25, indicated the resident had actual impairment to the skin integrity of her chest related to a surgical incision. Interventions included, but were not limited to, follow facility protocols for treatment of injury and monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, and signs and symptoms of infections to physician. Physician's Orders, dated 8/3/25, indicated the incision could be left open to air and if drainage was observed, apply gauze 4 x 4's and change daily or as needed (PRN). The incision was to be cleansed with antiseptic soap and water as follows: start at the top of the chest incision, using a clean wash cloth wipe down the chest incision once with soap and water. Use another clean washcloth and rinse the incision starting at the top and going down the incision one time a day for treatment. The surgical incision was assessed by the Wound Nurse on 8/5/25 and measured 8.6 centimeters (cm) in length by 0.3 cm in width by undetermined in depth. There was no odor, no signs of infection, and no exudate (drainage). The August 2025 Medication and Treatment Administration records indicated the treatment was not listed on either form and the treatment had not been signed out as being completed. A Nurse's Note, dated 8/9/25 at 6:15 a.m., indicated while the resident's morning medications were being administered, the resident informed the writer that she felt some drainage and discomfort to her mid chest surgical area. The surgical wound appeared open with some light greenish colored skin noted. The resident requested to go to the emergency room. The Physician was notified and orders were obtained to transfer the resident to the hospital for evaluation. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/24/25 at 11:02 a.m., the Director of Nursing (DON) indicated the Wound Nurse stated she did complete the treatment to the resident's incision but she didn't document it on the medication or treatment records. The DON indicated the treatment to the surgical incision should have been signed out as ordered. 2. On 11/17/25 at 3:36 p.m. fading bruises that were purplish/brown in color were observed on top of Resident H's right hand. On 11/20/25 at 9:45 a.m., the fading bruises remained to the top of the resident's right hand. The record for Resident H was reviewed on 11/19/25 at 10:26 a.m. Diagnoses included, but were not limited to, Parkinson's disease and anemia. The admission Minimum Data Set (MDS) assessment, dated 8/19/25, indicated the resident was moderately impaired for daily decision making. The resident required partial to moderate assistance rolling from left to right and with chair to bed transfers. There was no current care plan related to the bruising. The November 2025 Physician's Order Summary (POS) indicated the resident's skin was to be assessed weekly. The November 2025 Medication Administration Record (MAR) indicated a skin assessment was to be completed on 11/18/25. The box was coded with a 6 which indicated the resident was hospitalized . The resident was not in the hospital on [DATE]. During an interview on 11/20/25 at 3:10 p.m., the B Wing Unit Manager indicated the bruising to the resident's right hand was most likely from a lab draw and the area should have been monitored. She also indicated the resident was not in the hospital on [DATE] and the weekly skin assessment should have been completed. 3. On 11/18/25 at 11:18 a.m., Resident J was observed with a fading reddish/purple discoloration to the top of her left hand. On 11/20/25 at 11:40 a.m., the resident was observed in her room in bed. The fading reddish/brown bruise remained to the top of her left hand and a scabbed area was observed to her right knee. The resident was unable to state how she obtained the areas. The record for Resident J was reviewed on 11/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, lack of coordination and history of falling. A Significant Change Minimum Data Set (MDS) assessment, dated 10/31/25, indicated the resident was moderately impaired for daily decision making. The resident required partial to moderate assistance with rolling left to right and chair to bed transfers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, dated 10/16/25, indicated the resident was at risk for complications such as bleeding or bruising secondary to anticoagulant (a blood thinner) therapy. Interventions included, but were not limited to, daily skin inspections and report abnormalities to the nurse and observe/document/report as needed (PRN) adverse reactions of anticoagulant therapy such bruising. A Physician's Order, dated 11/1/25, indicated the resident was to receive Xarelto (a blood thinner) 10 milligrams (mg) daily. The medication was discontinued on 11/15/25 and orders were received to start Aspirin 81 mg daily. A Weekly Skin Assessment, dated 11/18/25, indicated the resident had no new skin issues. During an interview on 11/20/25 at 3:10 p.m., the B Wing Unit Manager indicated the bruising to the resident's right hand and the scabbed area to her knee were most likely from a recent fall and the areas should have been assessed and monitored. 4. During random observations on 11/17/25 at 10:35 a.m. and 3:30 p.m., 11/19/25 at 9:09 a.m., and 11/20/25 at 9:32 a.m., Resident D was observed lying in bed. The skin on his legs appeared dry and scaly. There were many dark skin flakes on bed sheet. The record for Resident was reviewed on 11/19/25 at 10:03 a.m. Diagnoses included, but were not limited to, heart failure, pain, and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/11/25, indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs), and had 2 arterial ulcers to his lower extremities (wounds caused by poor blood flow). A Care Plan, initiated 6/5/25, indicated the resident had a pressure ulcer. Interventions included keeping skin clean and moisturized. The record lacked interventions or treatments for the dry, scaly skin. During an interview on 11/17/25 at 10:46 a.m., CNA 1 indicated she was not aware of any treatment for the resident's dry, flaking skin. During an interview on 11/21/25 at 1:07 p.m., the DON indicated the resident should have treatment for dry, scaly skin, and she would look into it. 5. During a random observation on 11/18/25 at 9:30 a.m., Resident G had dry, patchy, discolored skin to her elbows. At that time, the resident indicated she had psoriasis for years and had used a topical medication for it before she was admitted to the facility. She indicated the skin patches were itchy, and she was not receiving any treatment for them. The resident's record was reviewed on 11/20/25 at 2:57 p.m. Diagnoses included, but were not limited to, psoriasis. The record lacked assessments of or treatment for the resident's psoriasis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/25 1:24 p.m., LPN 3 indicated she did not know the resident had psoriasis. During an interview on 11/24/25 8:55 a.m., the DON indicated she observed the resident's psoriasis and she did not find any documentation of it being assessed or treated in the record. A policy, titled Skin Care, received as current from the Nurse Consultant on 11/21/25 at 1:59 p.m., indicated, . Weekly skin checks will be conducted by the licensed nurse. This will be documented in the resident's Electronic Medical Record (EMR). Daily, during routine care, the Certified Nursing Assistant (CNA) will observe the resident's skin. When abnormalities are noted this will be communicated to the licensed nurse . This citation relates to Intake 2585462. 3.1-37(a)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an intravenous (IV) access site was assessed upon admission and removed in a timely manner for 1 of 1 resident reviewed for parenteral/IV fluids. (Resident D)Finding includes:The closed record for Resident D was reviewed on 11/19/25 at 3:22 p.m. Diagnoses included, but were not limited to, aortocoronary bypass graft, atherosclerotic heart disease, and type 2 diabetes mellitus. The Medicare 5-day Minimum Data Set (MDS) assessment, dated 8/9/25, indicated the resident had moderate cognitive impairment. The admission Nursing Assessment, dated 8/3/25, indicated the resident did not have an IV (intravenous) present. The After Visit Summary from the hospital, dated 8/3/25, had no documentation related to an IV access site. A Nurse's Note, dated 8/3/25 at 12:40 p.m., indicated the resident had multiple areas of small bruising related to IV insertion. The note did not indicate if the IV access was still present. A Nurse's Note, dated 8/4/25 at 9:49 p.m., indicated the resident had multiple small bruising related to IV insertion. Again, the note did not indicate if the IV access was still present. A Physician's Progress note, dated 8/5/25 at 2:36 a.m., indicated the resident had a peripheral IV line from the hospital that the hospital did not remove. A Physician's Order, dated 8/6/25, indicated it was okay to remove the peripheral IV site. A Nurse's Note, dated 8/6/25 at 3:22 p.m., indicated the resident had a peripheral IV line from the hospital that the hospital did not remove. The hospital stated it was to come out there. The IV was removed per the physician's order and family was notified. A Physician's Discharge summary, dated [DATE] at 7:45 a.m., indicated the resident had draining and discomfort to her surgical area and she was discharged to the hospital for evaluation based on the resident's request. The resident was admitted to the facility on [DATE] with a peripheral IV line in from the hospital that the hospital did not remove. The IV was removed on 8/6/25 while in the facility. During an interview on 11/24/25 at 11:02 a.m., the Director of Nursing (DON) indicated the IV was an oversight on the admission assessment and it should have documented as being present. The facility policy titled, PICC (peripherally inserted central catheter) Line Maintenance, was provided by the Nurse Consultant on 11/24/25 at 4:02 p.m. and identified as current. The policy indicated the IV site should be checked for at least each shift for signs of infection, infiltration, or other complications. This citation relates to Intake 2585462.3.1-47(a)(2)