

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/26/2015
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NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00173777.</p> <p>Complaint IN00173777- Substantiated. Federal/State deficiencies related to the allegation are cited at F282, F312, and F314.</p> <p>Survey date: May 26, 2015</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 6 Medicaid: 44 Other: 13 Total: 63</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>June 5, 2015</p> <p>Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006</p> <p>Dear Ms. Rhoades:</p> <p>Please reference the enclosed 2567L as "Plan of Correction"</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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			<p>for the May 26, 2015 Complaint (IN00173777) survey that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools June 5, 2015. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community.</p> <p>The Plan of Correction submitted on June 5, 2015 serves as our allegation of</p>	

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F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN		<p>compliance. The provider respectfully request a Desk review on or after June 25, 2015. Should you have any question or concerns regarding the Plan of Corrections, please contact me.</p> <p>Respectfully,</p> <p>Neysa Stewart, HFA</p>	

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to follow Physician orders related to preventative wound care treatments not completed as ordered by the Physician for 2 of 4 residents reviewed for pressure ulcers in the sample of 4. (Residents #B & #E)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 5/26/15 at 8:45 a.m., Resident #B was observed in bed. The resident was awake and alert. The Director of Nursing was present at this time. The resident had a dressing in place to the right heel. The right heel dressing was dated 5/22/15. There was no dressing in place to the resident's left heel or ankle area. The resident stated the dressing fell off over the weekend when staff put her sock on.</p> <p>On 5/26/15 at 11:05 a.m., the Wound Nurse was observed rendering wound care to the resident. The left heel area was observed. The resident's skin was dry and no open areas or discolored areas were noted. There was small intact scabbed area to the right outer ankle.</p> <p>The record for Resident #B was reviewed</p>	F 282	<p>F 282 PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident #B preventative treatment was completed by treatment nurse on 5/26/15. Preventative treatment orders were clarified. Resident #D preventative treatment was completed by treatment nurse on 5/26/15. Preventative treatment orders were clarified. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected by the alleged deficient practice. An audit was completed by the Wound nurse on 5/26/15 of all residents with preventative treatment orders to ensure they were being completed. No further deficiencies were identified. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: On 6/2/15 & 6/3/15 Nurses were reeducated</p>	06/04/2015

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	<p>on 5/26/15 at 12:50 p.m. The resident's diagnoses included, but were not limited to, paraplegia, diabetes mellitus, high blood pressure, and anemia.</p> <p>The 5/15/15 Minimum Data Set annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) was (15). A score of (15) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of one staff member for dressing, bed mobility, and personal hygiene. The assessment also indicated the resident was at risk for the development of pressure ulcers.</p> <p>The current Physician orders were reviewed. A Physician's order was written on 4/29/15 to apply skin protestant to the left heel and then apply a dry dressing every other day. Another order was written on 4/29/15 to apply skin protestant to the right lateral ankle and then apply a dry dressing, and wrap with a kerlix dressing every other day.</p> <p>When interviewed on 5/26/15 at 8:50 a.m., the Director of Nursing indicated a dressing should have been in place to the left heel and the dressing to the right ankle area was to be changed every other</p>		<p>regarding completion of all treatments by the DON. Employee #1 received disciplinary action and reeducated concerning completion of Preventative treatments. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor 3 residents daily 4 days a week for 4 weeks. Then 5 residents weekly for 4 weeks. Then 3 residents per week for 2 months to ensure MD orders are being followed. Any issues of noncompliance will be corrected immediately. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 6/4/15</p>	

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	<p>day as ordered by the Physician.</p> <p>2. During Orientation Tour on 5/26/15 at 8:19 a.m. Resident #D was observed in bed. A dressing was noted to the resident's left foot area. The dressing was dated 5/23/15.</p> <p>On 5/26/15 at 9:50 a.m., the Wound Nurse was observed completing a treatment to the resident's left heel area. No open areas were noted to the resident's left heel or ankle area. The skin on the left heel area was dry and flaky.</p> <p>The record for Resident #D was reviewed on 5/26/15 at 11:56 a.m. The resident's diagnoses included, but were not limited to, left heel pressure ulcer, insulin dependent diabetes mellitus, acute kidney failure, and weight loss.</p> <p>Review of the 3/18/15 Minimum Data Set Significant Change assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident was totally dependent on staff for personal hygiene and bed mobility.</p> <p>The current Physician orders were</p>			

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F 312 SS=D Bldg. 00	<p>reviewed. An order was written on 4/21/15 to apply skin protestant to the left heel and cover with a dry dressing every other day as preventative care.</p> <p>When interviewed on 5/26/15 at 8:26 a.m., LPN #1 indicated she worked yesterday and was assigned to care for Resident #D. LPN #1 indicated she did not complete the ordered treatment to the resident's left heel yesterday.</p> <p>When interviewed on 5/26/15 at 8:30 a.m., the Director of Nursing indicated the treatment to the resident's left heel area should have been completed every other day as ordered by the Physician.</p> <p>This Federal tag relates to Complaint IN00173777.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure nail care was provided for 1 of 3 residents who were dependent on staff for activities of daily living in the sample of</p>	F 312	F 312	06/04/2015			

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	<p>4. (Resident #D)</p> <p>Finding includes:</p> <p>On 5/26/15 at 9:50 a.m., Resident #D was observed in bed. The Wound Nurse was changing the dressing on the resident's left heel. The nails of the residents right and left great toes were long with tan colored build up behind the nails. The nail on the left great toe extended approximately 1 cm (centimeter) longer then the tip of the toe. The nail on the right great toe extended approximately .75 cm longer then the tip of the toe. The second toe of the left foot was also long. Two nails on the right foot were also long.</p> <p>The record for Resident #D was reviewed on 5/26/15 at 11:56 a.m. The resident's diagnoses included, but were not limited to, left heel pressure ulcer, insulin dependent diabetes mellitus, acute kidney failure, and weight loss.</p> <p>Review of the 3/18/15 Minimum Data Set Significant Change assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident was totally dependent on staff for personal hygiene and bed mobility.</p>		<p><i>PLAN OF CORRECTION</i></p> <p><i>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</i></p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>Resident #D received podiatry services on 6/2/15.</p> <p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>All residents requiring podiatry</p>	
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	<p>When interviewed on 5/26/15 at 2:00 p.m., the Director of Nursing indicated Resident #D was dependent on staff for activities of daily living and nail care. The Director of Nursing also indicated the residents toe nails were in need of trimming.</p> <p>When interviewed on 5/26/15 at 3:00 p.m., the Social Worker indicated the resident had not been seen by the Podiatrist in 2015. The Social worked indicated the resident's family or responsible party had signed consents prior to 2015 for the resident to receive Podiatry services. The Social Worker indicated the Podiatrist was in the facility on 1/23/15 and 5/19/15 and services were not provided to the resident on either of those visits.</p> <p>This Federal tag relates to Complaint IN00173777.</p> <p>3.1-38(a)(3)(E)</p>		<p>services are at risk for this alleged deficient practice.</p> <p>A "skin sweep" of all residents was completed on 5/15/15 where a list was generated for</p> <p>Podiatry services. All residents requiring services were seen by podiatrist on 6/2/15.</p> <p>An audit was completed on 6/5/15 to ensure that a referral has been made for all residents requesting podiatry services.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>Nursing staff were reeducated on 6/2/15 and 6/3/15 concerning podiatry services by the DON.</p> <p>Upon admission residents will be assessed and referral made to podiatry services as needed.</p>	

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F 314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a		<p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>DON / Designee will monitor 5 residents 4 days a week for 4 weeks, then 2 resident 4 days a week for 4 weeks and 3 residents weekly for 2 months. To ensure Podiatry services are provided as needed.</p> <p>Any issues identified will be corrected immediately.</p> <p>The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 6/4/15</p>	

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	<p>resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to provide the necessary treatment and services to promote wound ulcer healing related to dressing not changed as ordered by the Physician for 1 of 4 reviewed for pressure ulcers in the sample of 4. (Resident #E)</p> <p>Finding includes:</p> <p>During Orientation Tour on 5/26/15 at 8:36 a.m., Resident #E was observed in bed. The resident had dressings in place on both of his feet. The dressings were dated 5/24/15.</p> <p>On 5/26/15 at 10:30 a.m., the Wound Nurse was observed rendering wound care for the resident. There was a dressing in place to the resident's right ankle area. The dressing was dated 5/24/15. The Wound Nurse removed the dressing. There were two blacked areas to the resident's right ankle/foot area. One area measured approximately 3 cm x 1.5 cm and the second area measured approximately 3.5 cm in diameter. No</p>	F 314	<p>F 314</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice:</p> <p>Treatment nurse completed the treatment on 5/26/15 as ordered for Resident #E.</p>	06/04/2015

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	<p>drainage was noted to either area. The Wound Nurse wiped the above areas with Betadine, applied a gauze bandage, and wrapped the area with a kerlix dressing.</p> <p>The record for Resident #E was reviewed on 5/26/15 at 9:27 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, cancer, weight loss, and seizures.</p> <p>Review of the 5/11/15 Minimum Data Set Quarterly assessment indicated the resident required extensive assistance of two staff members for bed mobility. The assessment also indicated the resident was totally dependent on staff for dressing and personal hygiene. The assessment also indicated the resident was at risk for the development of pressure ulcers. The assessment also indicated the resident had two Unstageable (full thickness tissue loss with the base of the ulcer covered by slough or eschar (tan, brown, or black colored) pressure ulcers.</p> <p>The current Physician orders were reviewed. An order was written on 5/5/15 to wipe the right lateral heel with Betadine solution, apply a dry dressing and secure the dressing with tape daily. Another order was written on 5/5/15 to wipe the right medial heel area with</p>		<p>2. The corrective action for those residents having the potential to be affected by the same deficient practice:</p> <p>Treatment nurse completed an audit on 5/26/15 of all residents with wounds and treatment orders to ensure that MD orders were being followed. No further alleged deficiencies were identified.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur:</p> <p>Nursing staff were reeducated on following MD orders related to wound care.</p> <p>Employee LPN #1 received disciplinary action and received 1:1 reeducation 5/26/15.</p>	

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	<p>Betadine, apply a dry dressing, and secure the dressing with tape daily.</p> <p>The 5/19/15 Skin Integrity Condition assessment indicated the resident's right medial heel pressure ulcer measured 2.4 cm (centimeters) x 1.8 cm , with undetermined depth. The deepest tissue classification of the skin condition was noted to be a Unstageable. The color of the wound bed was black and the character of the wound bed was 100% eschar.</p> <p>The 5/19/15 Skin Integrity Condition assessment indicated the residents right lateral heel pressure ulcer measured 4.3 cm x 3.3 cm with the depth undetermined. The deepest tissue classification of the skin condition was noted to be Deep Tissue Injury. The color of the wound bed was black and the character of the wound bed was 100% eschar.</p> <p>When interviewed on 5/26/15 at 10:50 a.m., LPN #1 indicated she worked on 5/25/15 and was assigned to care for Resident #E. The LPN indicated she did not complete the Betadine treatments to the resident's right ankle area yesterday.</p> <p>This Federal tag relates to Complaint IN00173777.</p>		<p>4. To ensure the deficient practice does not reoccur, the monitoring system established is to:</p> <p>DON / Designee will monitor 3 residents daily with treatment orders 4 days per week for 4 weeks to ensure MD orders are being followed. <i>Then 5 residents weekly for 4 weeks.</i> Then 3 resident weekly for 2 months.</p> <p>Any identified issues will be corrected immediately</p> <p>The audits will be discussed during our monthly QA meeting.</p> <p>QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 6/4/15</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/26/2015
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3.1-40(a)(2)				