

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  07/07/2011
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN46312		
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F0000	<p>This visit was for the Investigation of Complaint IN00092868 and IN00093070.</p> <p>Complaint IN00092868-Substantiated, Federal/State deficiencies related to the allegation are cited at F203 and F205.</p> <p>Complaint IN00093070-Substantiated, Federal/State deficiency related to the allegation is cited at F371.</p> <p>Survey dates: July 6 and 7, 2011</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Survey team: Janelyn Kulik, RN</p> <p>Census bed type: SNF/NF: 68 Total: 68</p> <p>Census payor type: Medicare: 5 Medicaid: 55 Other: 8 Total: 68</p> <p>Sample: 6</p>	F0000	The Lake County Nursing and Rehab Center is requesting a "desk review". Please contact Karen Ball, Administrator 219-397-0380 for further information. Inservices have been conducted, monitors and audits have been initiated and completed. Please give instructions on what documents you need for a desk review.Thank you very much.Karen L. Ball HFA		

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.

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

PRINTED: 07/29/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 11, 2011 by Bev Faulkner, RN</p>				

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F0203 SS=D	<p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone</p>						

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	<p>number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interview, the facility failed to ensure residents or legal representatives were provided the Notice of Transfer/Discharge prior to the resident being transferred or discharged to the hospital for 2 of 3 residents reviewed who were transferred or discharged to the hospital. (Residents #B and #D)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 7/6/11 at 1:10 p.m. A nursing note, dated 6/13/11 at 7:40 p.m., indicated the resident came to the facility as a new admit from the hospital. The resident was alert and verbally responsive to care. The resident was demanding to leave the facility and go back to the hospital. The resident indicated her wound vac should be on and it should not have been taken off. The nurse explained to the resident the wound vac will be put on tomorrow and her leg had to be assessed. The nurse explained a wet to dry dressing was to be</p>	F0203	<p>Please accept the following as the facility's credible allegation of compliance. 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. The Notice of Transfer or Discharge was mailed to Resident B. The Notice of Transfer or Discharge was mailed to Resident D. All facility residents who are transferred or discharged out of the facility have the potential to be affected by the same alleged deficient practice. The HIMC Consultant inserviced the nursing staff and the HIMC Director on the Notice of Transfer or Discharge. Nursing staff and the HIMC Director were inserviced regarding when to send the notice and how to document the notice was sent. The Director of Nursing inserviced the nurse who cared for Resident B on the procedure of correctly completing the Notice of Transfer or Discharge forms. The HIMC Director will ensure that a copy of the current</p>	08/05/2011	

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	<p>applied to her wound. The resident was acting delusional and started crying and yelling. The resident called 911 to take her back to the hospital. The physician was notified and indicated the resident was to arrive tomorrow when the wound vac and IV (intravenous) antibiotics were available. The resident's family was notified the resident was going to the hospital.</p> <p>Interview with the Health Information Manager on 7/7/11 at 11:50 a.m., indicated Resident #B was admitted to the facility and discharged to the hospital on 6/13/11.</p> <p>Interview with the Nurse Consultant on 7/7/11 at 1:30 p.m., indicated a Patient Transfer Form with the Notice of Transfer or Discharge form should have been completed.</p> <p>Interview with the Director of Nursing on 7/7/11 at 2:15 p.m., indicated the resident called 911, the physician was notified and it was determined it would be best to send the resident back to the hospital. The Director of Nursing indicated no determination had been made as to whether the facility would or would not accept the resident back once she was discharged from the hospital.</p>		<p>Notice of Discharge is sent with each transfer. If the HIMC Director notes that the Notice of Transfer or Discharge form was not sent she would promptly ensure one is delivered. The HIMC Director/designee will audit 10 charts per month to ensure that the form titled Notice of Transfer or Discharge was provided. Any non-compliance issues will be promptly addressed by the HIMC Director and then communicated by providing a copy of the audit to the Director of Nursing. A summary of the monthly audits will be presented to the Quality Assurance Committee monthly by the HIMC Director/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and presented quarterly at the Quality Assurance Committee meeting. Monitoring will continue on going.</p>		

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	<p>Interview with the Nursing Consultant on 7/7/11 at 3:20 a.m., indicated that the resident or resident's responsible party had not received the Notice of Transfer or Discharge form. She further indicated the Health Information Manager was not aware that if the resident did not receive the information when being sent to the hospital it needed to be mailed to the responsible party in this situation.</p> <p>2. Resident #D's record was reviewed on 7/6/11 at 1:10 p.m. He was admitted to the facility on 4/15/11.</p> <p>A physician order, dated 4/15/11, indicated may send out due to being combative and fall risk.</p> <p>Interview with the Health Information Manager on 7/7/11 at 11:50 a.m., indicated Resident #D was admitted to the facility and discharged to the hospital on 4/15/11.</p> <p>Interview with the Nurse Consultant on 7/7/11 at 1:30 p.m., indicated a Patient Transfer Form with the Notice of Transfer or Discharge form should have been completed.</p> <p>Interview the Administrator on 7/7/11 at 2:00 p.m., indicated when the resident arrived at the facility he was thrashing</p>			

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	<p>around to the point she thought he was going to fall and possible obtain an injury. The family was aware of the resident's behavior and it was decided for the resident's safety it would be best for him to be sent back to the hospital. The Administrator further indicated the facility was willing to take the resident back once his behaviors were more manageable in order to keep the resident safe.</p> <p>Interview with the Director of Nursing on 7/7/11 at 2:15 p.m., indicated the resident would have been accepted back to the facility when his behavior was more manageable for his safety.</p> <p>Interview with the Nursing Consultant on 7/7/11 at 3:20 a.m., indicated that the resident or resident's responsible party had not received the Notice of Transfer or Discharge form. She further indicated the Health Information Manager was aware the resident had not received the information when he was sent to the hospital. She caught it on the audit; however, she never sent the resident or the responsible party the Notice of Transfer or Discharge form.</p> <p>This Federal tag relates to complaint IN00092868.</p> <p>3.1-12(a)(6)(A)(i)</p>				

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	3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii) 3.1-12(a)(6)(A)(iv) 3.1-12(a)(8)(A) 3.1-12(a)(8)(E)				

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F0205 SS=D	<p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure residents or legal representatives were provided the bed -hold policy prior to the resident being transferred or discharged to the hospital for 2 of 3 residents reviewed who were transferred or discharged to the hospital. (Residents #B and #D)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 7/6/11 at 1:10 p.m. A nursing note, dated 6/13/11 at 7:40 p.m., indicated the resident came to the facility as a new admit from the hospital. The resident was alert and verbally responsive to care. The</p>	F0205	Please accept the following as the facility's credible allegation of compliance. 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. The Bedhold Policy was mailed to Resident B. The Bedhold Policy was mailed to Resident D. All facility residents who are transferred or discharged out of the facility have the potential to be affected by the same alleged deficient practice. The nursing staff and the HIMC Director were inserviced regarding when to send the notice and how to document that the notice was sent. The DON inserviced the nurse who cared	08/05/2011	

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	<p>resident was demanding to leave the facility and go back to the hospital. The resident indicated her wound vac should be on and it should not have been taken off. The nurse explained to the resident the wound vac will be put on tomorrow and her leg had to be assessed. The nurse explained a wet to dry dressing was to be applied to her wound. The resident was acting delusional and started crying and yelling. The resident called 911 to take her back to the hospital. The physician was notified and indicated the resident was to arrive tomorrow when the wound vac and IV (intravenous) antibiotics were available. The resident's family was notified the resident was going to the hospital.</p> <p>Interview with the Health Information Manager on 7/7/11 at 11:50 a.m., indicated Resident #B was admitted to the facility and discharged to the hospital on 6/13/11.</p> <p>Interview with the Nurse Consultant on 7/7/11 at 1:30 p.m., indicated a Patient Transfer Form with the Bed hold information should have been completed and none of the forms in the packet had been completed for Resident #B. The Nurse Consultant provided the Patient Transfer Form Packet on 7/7/11 at 3:15 a.m., the packet included the bed hold</p>		<p>for Resident B regarding Bedhold forms. The facility has a transfer form that includes a place to document that the Bedhold form was sent. The HIMC Director will ensure that a copy of the Bedhold Policy is sent with each transfer. If thr HIMC Director notes that the notice of Bedhold policy was not sent she will promptly ensure ne is delivered. The HIMC Director/designee will audit 10 residents per month to ensure that the Bedhold Policy was provided. Any non-compliant issues will be promptly addressed by the HIMC Director and then communicated to the DON. A summary of the monthly audits will be presented to the Q.A. Committee monthly by the HIMC Diretor/designee for 3 months. Thereafter, if determined by the QA Commitee, auditing and monitoring will be completed quarterly.</p>		

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	<p>policy.</p> <p>Interview with the Director of Nursing on 7/7/11 at 2:15 p.m., indicated the resident called 911, the physician was notified and it was determined it would be best to send the resident back to the hospital. The Director of Nursing indicated no determination had been made as to whether the facility would or would not accept the resident back once she was discharged from the hospital.</p> <p>Interview with the Nursing Consultant on 7/7/11 at 3:20 a.m., indicated that the resident or resident's responsible party had not received the Notice of Transfer or Discharge form due to none of the forms in the Patient transfer packet had been completed which included the Bed Hold Policy. She further indicated the Health Information Manager was not aware that if the resident did not receive the information when being sent to the hospital it needed to be mailed to the responsible party in this situation.</p> <p>2. Resident #D's record was reviewed on 7/6/11 at 1:10 p.m. He was admitted to the facility on 4/15/11.</p> <p>A physician order, dated 4/15/11, indicated may send out due to being combative and fall risk.</p>						

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	<p>Interview with the Health Information Manager on 7/7/11 at 11:50 a.m., indicated Resident #D was admitted to the facility and discharged to the hospital on 4/15/11.</p> <p>Interview with the Nurse Consultant on 7/7/11 at 1:30 p.m., indicated a Patient Transfer Form with the Notice of Transfer or Discharge form should have been completed and none of the forms in the packet had been completed for Resident #D. The Nurse Consultant provided the Patient Transfer Form Packet on 7/7/11 at 3:15 a.m., the packet included the Bed Hold Policy.</p> <p>Interview the Administrator on 7/7/11 at 2:00 p.m., indicated when the resident arrived at the facility he was thrashing around to the point she thought he was going to fall and possible obtain an injury. The family was aware of the resident's behavior and it was decided for the resident's safety it would be best for him to be sent back to the hospital. The Administrator further indicated the facility was willing to take the resident back once his behaviors were more manageable in order to keep the resident safe.</p> <p>Interview with the Director of Nursing on 7/7/11 at 2:15 p.m., indicated the resident</p>			

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	<p>would have been accepted back to the facility when his behavior was more manageable for his safety.</p> <p>Interview with the Nursing Consultant on 7/7/11 at 3:20 a.m., indicated that the resident or resident's responsible party had not received the Notice of Transfer or Discharge form due to none of the forms in the Patient transfer packet had been completed which included the Bed Hold Policy. She further indicated the Health Information Manager was aware the resident had not received the information when he was sent to the hospital. She caught it on the audit; however, she never sent the resident or the responsible party the Notice of Transfer or Discharge form or any of the information in the Patient Transfer packet.</p> <p>This Federal tag relates to complaint IN00092868.</p> <p>3.1-12(a)(25)(A)</p>				

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F0371 SS=E	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to ensure foods were stored under sanitary conditions in 1 of 1 walk in refrigerators in the kitchen related to prepared foods left in the refrigerator over 72 hours and food being stored on the floor. This deficient practice affected 1 of 6 sampled residents and had the potential to affect 63 of 68 residents who received meals from the facility kitchen. (Resident #E)</p> <p>Findings include:</p> <p>1. On 7/6/11 at 10:30 a.m., a metal container covered in foil, two plastic bowls covered in plastic wrap, and two watermelon in a cardboard box were observed in the kitchen walk-in refrigerator. The container with the foil indicated mixed vegetable and was dated 6/29/11. The two bowls indicated Resident #E's name and were dated 5/27/11. The cardboard box containing the two watermelon was on the floor of the refrigerator.</p> <p>The Food Borne Illness Control for Storage of Dry Food &amp; Supplies Policy</p>	F0371	<p>Please accept the following as the facility's credible allegation of compliance. 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. Inservices have been held for all dietary employees regarding the appropriate storage, preparation and distribution of food under sanitary conditions. All foods will be labeled with common name and dated with a "use by date". Refrigerated "leftovers" will be stored at 41 degrees in the refrigerator for up to three days and then discarded.</p> <p>All refrigerated food will be stored 6 inches from the refrigerator floor. All residents have the potential to be affected by this alleged deficient practice. The Dietary Manager has designated a dietary employee to monitor all leftover food on a daily basis and discard when evidence of compliance is not met. Corrective action by Dietary Manager and/or designee will be taken when monitoring is not complete. The Dietary Manager has developed an audit tool to assess "storage of foods". In services have been completed addressing the areas</p>	08/04/2011			

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  07/07/2011	
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	<p>was provided by the Dietary Manager on 7/6/11 at 3:15 p.m. The purpose of the policy was,"To reduce the risk of food borne illness." The procedure included, but was not limited to, "Raw food products will be stored below ready to eat products. Food will not be stored on the floor."</p> <p>The Food Borne Illness Control for Leftover Food Policy was provided by the Dietary Manager on 7/6/11 at 3:15 p.m. The purpose of the policy was, "To reduce the risk of food borne illness." The procedure included, but was not limited to, "Leftover food may be stored at 41 degrees F (Fahrenheit) in the refrigerator for up to 3 days and then must be discarded."</p> <p>When interviewed at the time of the observations, the Dietary Manager indicated the watermelon should not be on the floor, the mixed vegetables should not be in the refrigerator, and he was not sure what was in the two bowls they were being kept for Resident # E, but they should not be in the refrigerator. He then removed the two bowls and the mixed vegetables from the refrigerator.</p> <p>This Federal tag relates to complaint IN00093070</p>		<p>identified to Dietary employees. Monitoring will be completed daily and the audit tool completed on a weekly basis. Additional training by Dietary Manager and/or designee will be done if and when issues arise.A summary of results of the audits will be presented to the Quality Assurance Committee on a monthly basis and reviewed by the Administrator each month for six months, until such time as is deemed necessary.</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-21(i)(3)				