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 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	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
F000000	This visit was for the Investigation of Complaints IN00126777 and IN00126780. Complaint IN00126777-Substantiated. Federal/state deficiency related to the allegation cited at F202. Complaint IN00126780-Substantiated. Federal/state deficiencies related to the allegation are cited at F157, F323, F328, and F9999. Survey dates: April 11 & 12, 2013 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Survey team: Janet Adams, RN, TC Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 6 Medicaid: 70 Other: 1	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review be considered on or after May 9th, 2012.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	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
	Total: 77 Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on 4/18/13, by Brenda Meredith, R.N.			

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 04/12/2013
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
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify the Physician of a resident removing his tracheostomy tube on repeated occasions for 1 of 2 residents	F000157	**F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC)** **§483.10(b)(11) -- Notification of changes. (i) A facility must**	05/09/2013

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 04/12/2013
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
	reviewed with tracheostomies in the sample of 10. (Resident #E) Findings include: The closed record for Resident #E was reviewed on 4/11/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, acute respiratory distress, pneumonia, malnutrition, tracheostomy (surgical opening of the trachea), and diabetes mellitus. The resident was admitted to the facility on 3/21/13. The 3/21/13 Nursing Progress Notes indicated the resident was admitted with a tracheostomy tube in place with 10 liters of oxygen. The Nursing Progress note also indicated the resident was alert and his respirations were unlabored. Review of the Nursing Progress Notes, dated 3/22/13, indicated the following: At 3:39 a.m., the resident was in bed and was alert with periods of confusion. Trach (tracheostomy) care was given and the resident "continually takes off trach collar et [and] states he can't breath." The resident also indicated he wanted to leave.		**immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is-- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).** **(ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is-- (A) A change in room or roommate assignment as specified in §483.15(e)(2); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.** **(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.** **What corrective action(s) will be accomplished for those**	

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 04/12/2013
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
	At 4:30 a.m., the resident was observed attempting to remove the trach and the trach was observed "sticking half way out." At 7:36 p.m., the resident was very agitated and taking the oxygen off. At 8:30 p.m., the resident continued to remove the oxygen mask. At 9:15 p.m., the resident pulled out his trach and nursing was able to reinsert trach and maintained the airway with an oxygen saturation level of 89-90% (normal 100%) and continued to try and remove the trach mask. At 10:45 p.m., the resident remained restless and was trying to pull the trach out and was pulling the trach mask off. At 11:45 p.m., the DON (Director of Nursing) was notified of the resident's condition. There were no further entries made on 3/22/13. There was no documentation of the Physician being notified of the resident continued attempts to remove the oxygen and pulling or attempting to pull the trach out at 9:15 p.m. and 10:45 p.m. The Nursing Progress Notes, dated 3/23/13, indicated the following: At 12:30 a.m., the resident continued to take the trach out and the writer		**residents found to have been affected by the deficient practice** · Resident #E's physician was notified on 3/23/13 at 1:30am. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Residents who currently reside at the facility with trachs are at risk to be affected by the same alleged deficient practice. Records were reviewed for the last four months of the residents who currently reside in the facility who have trachs. No further deficiencies were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The Director of Nursing and/or designee will continue to audit the progress notes of the residents with trachs daily x 5 weeks for proper placement and physician notification. The charge nurses at the facility were re-in serviced on 4/30/2013 and 5/1/2013 on the facility policy "Guidelines for Notifying	

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 04/12/2013
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
	reinserted the trach and reapplied oxygen via a trach collar. At 1:30 a.m., the resident was observed pulling out the trach and the trach was inserted again. The resident's oxygen saturation levels were 87 %. At 1:52 a.m., the resident continued to be non compliant, the Physician was notified, and an ambulance was called to transport the resident to the hospital. The facility policy titled "Guidelines for Notifying Physicians of Clinical Problems" was reviewed on 4/12/13 at 10:00 a.m. The policy was dated with a revised date of April 2007. The policy was received from the facility Administrator and was identified as a current policy. The policy indicated medical care problems are to be communicated to the medical staff in a timely, efficient, and effective manner. When interviewed on 4/12/13 at 11:00 a.m., the Director of Nursing indicated the Nursing staff sent her a text on the late evening of 3/22/13, and she sent the Physician a text but did not get a response at that time. This federal tag relates to Complaint IN00126780.		Physician of Clinical Problems". **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** The Director of Nursing and/ or designee will use the trach position / physician notification audit tool ongoing to ensure continued compliance. Any issues found will be immediately corrected during the review. · The audits will be submitted to the QA Committee for review as indicated. An action plan may be developed for identified issues. § Noncompliance with facility procedures will result in education and/or disciplinary action.	

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 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	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
	3.1-5(a)(2) 3.1-5(a)(3)			

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 04/12/2013
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
F000202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. Based on record review and interview, the facility failed to ensure the Physician documentation was complete related to the need for Involuntary discharges for 2 of 3 residents reviewed for discharge from the facility. (Residents #B and #C) Findings include: 1. The closed record for Resident #B was reviewed on 4/11/13 at 1:45 p.m. The resident was originally admitted to the facility on 12/29/2008. The resident's diagnoses included, but were not limited to, paraplegia, anxiety state, high blood pressure, and depressive disorder. A Physician's order was written, on 3/28/13, to send the resident to the hospital for a mental status change. There were no Physician Progress Notes related to the discharge note	F000202	**F202** **§483.12(a)(3) Documentation** **When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--** **(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and** **(ii) A physician when transfer or discharge is necessary under**	05/09/2013

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 04/12/2013
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
	when the resident's electronic record was reviewed. No written Progress Notes were available at this time either. A "Notice of Transfer or Discharge" form was initiated on 3/28/13. The form indicated the resident was being transferred to the hospital. The "Reason for Transfer or Discharge" section indicated the reason checked on the form was "The health of the individuals in the facility would otherwise be endangered." On top of the form "Immediate Discharge- Not able to return" was hand written. When interviewed on 4/11/13 at 10:00 a.m., the facility Administrator indicated the resident was issued an discharge after an investigation of several events was initiated. The Administrator indicated she received a phone earlier in the week of 3/20/13, questioning her about a male resident that had been sent out to the hospital noted to have had been drinking alcohol. The facility investigation noted that there was beer in his water pitcher. Another resident was also noted to have alcohol bottles in his room. Ongoing investigations concluded the facility determined Resident #B was supplying the alcohol to the residents.		**paragraph (a)(2)(iv) of this section.** **Interpretive Guidelines** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident's #B and #C's physician has documented the need for the involuntary discharge in the residents record on 4/12/13. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** No other Residents who currently reside at the facility are at risk to be affected by the same alleged deficient practice since no other involuntary discharges have been issued. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The Social Service Director has been in serviced on the proper way to complete an involuntary	

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 04/12/2013
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
	The Administrator indicated based on the investigation a notice of discharge was given to Resident #B and the resident was sent to the hospital. The facility then attempted to find placement at other long term care facilities in the area without success and Resident #B was discharged home with family from the hospital. On 4/12/13 at 11:00 a.m., the Assistant Director of Nursing indicated the Physician had been contacted regarding the lack of Progress Notes related to the resident's discharge. A Progress Note was entered into the resident's closed record on 4/12/13 at 9:39 a.m. The Progress note indicated the Physician was aware of the immediate discharge of Resident #B and the resident will not be able to return to the facility. 2. The closed record for Resident #C was reviewed on 4/11/13 at 2:30 p.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis, pain, high blood pressure, depressive disorder, and alcohol abuse. The resident was admitted to the facility on 12/14/12. The resident was discharged from the facility on 4/1/13.		discharge which included ensuring the physician completes a progress note at the time the involuntary discharge is issued on 4/30/2013. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** The Administrator and/ or designee will review 100 % of the resident's records who have been given an involuntary discharge ongoing to ensure all the documentation is in place at the time it is issued. Any issues will be immediately corrected. . Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going.	

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 04/12/2013
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
	A "Notice of Transfer or Discharge" form was issued on 3/20/13. The form indicated the reason for the resident's discharge was listed as "The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing facility." The 3/12/13, Social Service Progress Note indicated the resident was issued a discharge notice in his room and the resident threw the paper in his wheelchair. The 3/19/13, Social Service Progress Note indicated the Social Worker met with the resident regarding the 30 day discharge related to not meeting the level of care per the Indiana Screening and the paperwork was sent to the Ombudsman office. Review of the Physician Progress notes indicated there were no Progress Notes related to the 3/20/13 Notice of Transfer or Discharge. When interviewed on 4/11/13 at 11:00 a.m., the facility Administrator indicated the resident had previously been issued a first discharge order in December 2012 for not meeting level of care for stay at the facility. The			

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 04/12/2013
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
	Administrator indicated the case was set to go to court and was changed due to scheduling conflicts with the court. The Administrator indicated another Discharge was initiated due to not meting level of care on 3/20/13. The Administrator indicated the resident was discharged home with his family on 4/1/13. This federal tag relates to Complaint IN00126777. 3.1-12(a)(5)(A) 3.1-12(a)(5)(B)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155653		04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	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
F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure adequate supervision was provided for a resident with repeated attempts to and removal of a tracheostomy tube and oxygen who subsequently sustained a fall, for 1 of 3 residents reviewed for falls in the sample of 10. (Resident #E) Findings include: The closed record for Resident #E was reviewed on 4/11/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, acute respiratory distress, pneumonia, malnutrition, tracheostomy (surgical opening of the trachea), and diabetes mellitus. The resident was admitted to the facility on 3/21/13. Review of a Fall Risk Observation note, dated 3/21/13, indicated the resident's total score was 17. This score indicated the resident was at high risk for falls.	F000323	**F323 FREE OF ACCIDENTS/HAZARDS/ SUPERVISION/ DEVICES** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Resident #E is no longer a resident at the facility but while he was here several things were put into place. Upon admission Resident # E was placed close to the nurse's station due to his current medical state and the need for close supervision. After his first fall he was placed in a bariatric bed with the bed in the lowest position to the floor with a mat. He was placed on 1 on 1 supervision, and then sat up in a recliner at the	05/09/2013

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 04/12/2013
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
	Review of the Nursing Progress Notes, dated 3/21/12 at 12:00 p.m., indicated the resident was admitted to the facility with a tracheostomy tube (breathing tube) and was receiving oxygen at 10 liters. Review of the Nursing Progress Notes, dated 3/22/13 indicated the following: At 3:39 a.m., the resident continually takes off his oxygen trach (tracheostomy) collar and had periods of confusion. The resident's pulse oxygen saturation was 89% (low level) when the oxygen was off. At 4:30 a.m., the resident was observed attempting to remove his trach and the trach was sticking 1/2 out and replaced by the LPN. At 5:10 a.m., an LPN heard the resident saying help me and the LPN entered the resident's room and the resident was again attempting to remove the trach and trach care was given. The resident was reminded to use the call light. At 11:10 a.m., the resident was observed pulling off the oxygen and he was redirected. At 1:50 p.m., the resident was observed on the floor on the side of the bed and was laying on his stomach. Blood was on the floor.		nurses' station. The staff was exceptionally diligent with his care. When all the interventions we had tried were unsuccessful, he was transferred to the emergency room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Residents who have a trach and are at a high risk for falls have the potential to be affected by this deficient practice. The DON and/or designee reviewed the records of the admissions who admitted to the facility in April to ensure that the all the fall assessments had been completed and interventions had been added for falls prevention. The DON and/or designee reviewed the record of the other resident who has a trach from April on and ensured this alleged deficient practice did not occur. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** Nursing staff were in serviced on Falls Management and fall prevention measures by the DON on 4/30/2013 and 5/1/2013. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The DNS/designee	

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 04/12/2013
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
	At 2:00 p.m., the resident was transported to the hospital. At 6:00 p.m., the resident returned to the facility with 5 sutures to the face and a broken nose. Review of the Nursing Progress Notes, dated 3/22/13 indicated the following: At 7:36 p.m., the resident was agitated and taking the oxygen off and the resident stated " I want to get in my car." The resident was moving around in bed and was placed in a large bed, redirected, continued to take his oxygen off, and was given Xanax (Antianxiety medication). At 8:30 p.m., the resident still continued to take his trach oxygen mask off "despite redirection." At 9:15 p.m., the resident was observed with the trach in his hand and was put into the recliner with CNA 1:1. At 10:37 p.m., the resident pulled the trach out of his trachea and nursing was able to reinsert trach and maintain oxygen saturation levels of 88-90%, continued to remove the trach mask with oxygen. At 10:45 p.m., the resident remained restless and trying to pull the trach out and staff were frequently monitoring. At 11:45 p.m., the DON was made		will audit the records of the new admissions ongoing to ensure compliance is met using the new admission audit tool. Any issues found will be immediately corrected. **Residents who are at high risk for falls will be reviewed by the DON and/or designee following the MDS assessment schedule to ensure this alleged deficient practice does not reoccur.**· Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going.	

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 04/12/2013
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
	aware of the resident's condition and measures taken. This was the last entry made on 3/22/13. There was no documentation to indicate how long the 1:1 CNA monitoring lasted or any other supervision provided to the resident during the above times. Review of the Nursing Progress Notes, dated 3/23/13, indicated the following: At 12:30 a.m., the resident continued to take his trach out and the writer reinserted the trach and the resident was reeducated. At 1:30 a.m., and indicated the resident was observed pulling out his trach and staff had to re insert the trach again, the resident's oxygen saturation level was 87% then increased to 92% when oxygen was reapplied. The entry also indicated numerous attempts at redirection had been unsuccessful. At 1:52 a.m., the staff called for an ambulance transport and the resident was sent to the hospital at 2:10 a.m. At 12:42 p.m., the resident returned from the hospital Emergency Room. At 4:28 p.m., a skin assessment was completed. At 5:29 p.m. the resident was observed on the floor and orders were obtained to transport the resident to the hospital. The resident			

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 04/12/2013
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
	did not return to the facility. There was no documentation of any interventions other then redirection and instructing the resident to leave the oxygen on during the above times. When interviewed, on 4/11/13 at 12:42 p.m., the Restorative Nurse indicated the resident had no history of falls and admission Nursing Notes did not indicate the resident attempted to get out of bed. The Restorative Nurse indicated a floor mat was not put in place until when the resident returned from the hospital. When interviewed on 4/11/13 at 3:00 p.m., the Director of Nursing indicated the resident was a fall risk and was admitted to a room across from the Nurses Station to be monitored. This federal tag relates to Complaint IN00126780. 3.1-45(a)(2)			

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 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	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

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 04/12/2013
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
F000328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on record review and interview, the facility failed to ensure the necessary treatment and services were provided for tracheostomy care related to staff Nurses reinserting tracheostomy tubes without evidence of proper training for 1 of 2 residents reviewed for tracheotomies in the sample of 10. (Resident #E) Findings include: The closed record for Resident #E was reviewed on 4/11/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, acute respiratory distress, pneumonia, malnutrition, tracheostomy (surgical opening of the trachea), and diabetes mellitus. The resident was admitted to the facility on 3/21/13. The 3/21/13	F000328	**F328 §483.25(k) Special Needs The facility must ensure that residents receive proper treatment and care for the following special services: Injections, Parenteral and enteral fluids, Colostomy, ureterostomy, or ileostomy care, Tracheostomy care, Tracheal suctioning, Respiratory care, Foot care, and Prostheses. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**Resident # E no longer resides at the facility. Resident was placed close to the nurses station and recieved frequent nursing assessments and interventions. When all the interventions were unsuccessfull he was sent out to the Emergency Room for an evaluation.**How will you identify other residents having the potential to be affected by the**	05/09/2013

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 04/12/2013
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
	Nursing Progress Notes indicated the resident was admitted with a tracheostomy tube in place with 10 liters of oxygen. The Nursing Progress note also indicated the resident was alert and his respirations were unlabored. Review of the Nursing Progress Notes, dated 3/22/13, indicated the following: at At 3:39 a.m., the resident was in bed and was alert with periods of confusion. Trach (tracheostomy) care was given and the resident "continually takes off trach collar et [and] states he can't breath." The resident also stated he wanted to leave. At 4:30 a.m., the resident was observed attempting to remove the trach and the trach was observed "sticking half way out." At 7:36 p.m., the resident was very agitated and taking the oxygen off. At 8:30 p.m., the resident continued to remove the oxygen mask. At 9:15 p.m., the resident pulled out his trach and nursing was able to reinsert trach and maintained the airway with an oxygen saturation level of 89-90% (normal 100%) and continued to try and remove the trach mask. At 10:37 p.m., the resident pulled out his trach and LPN #1 noted nursing		**same deficient practice and what corrective action will be taken** Residents residing at the facility currently that have a trach have the potential to be affected by this alleged deficient practice. Nurses were in serviced on 4/16/13 and 4/24/13 on trach reinsertion and performed skills check off for this procedure. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The trach resident's records will be reviewed 5 days a week to ensure this alleged deficient practice does not reoccur. **New Nurses who started employement after 4/23/13 will have their job specific orientation and skills check off's completed prior to finishing orientation. Any new clinical skills beyond the basic skills checklist would be in serviced by the DON and/or designee and a skills competency will be completed.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** The Director of Nursing and/ or designee will use the trach position/ physician notification audit tool ongoing to ensure continued compliance. Any issues found will be immediately corrected during the	

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 04/12/2013
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
	reinserted the trach. Review of the Nursing Progress Notes, dated 3/23/13, indicated the following: At 12:30 a.m., the resident continued to take the trach out and the writer reinserted the trach and reapplied oxygen via a trach collar. At 1:30 a.m., the resident was observed pulling out the trach and the trach was inserted again. The resident's oxygen saturation levels were 87 % (low level). The facility policy, titled "Tracheostomy Care," was reviewed on 4/11/13 at 12:35 p.m. The policy had a revised date of June 2005. The policy was provided by the facility Administrator and identified as the current. The policy indicated disposable tracheostomy tubes were to be changed in accordance with established policies. No policy related to the procedure to change tracheostomy tubes was provided. The facility Employee Files were reviewed on 4/12/13 at 9:10 a.m. The Employee File for LPN #1 was reviewed. The LPN was hired on 1/29/13. There was no Job Specific Orientation forms or checklist in the file. There was no documentation		review. · The audits will be submitted to the QA Committee for review as indicated. An action plan may be developed for identified issues. § Noncompliance with facility procedures will result in education and/or disciplinary action.	

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 04/12/2013
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
	indicating LPN had received training or inservicing on inserting tracheostomy tubes. When interviewed on 4/12/13 at 10:10 a.m., the Director of Nursing indicated she could not locate a facility policy related to changing tracheostomy tubes. The Director of Nursing also indicated there was no documentation to verify LPN #1 had received training in tracheostomy tube replacement. This federal tag relates to Complaint IN00126780. 3.1-47(a)(4)			

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 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	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
F009999	STATE RULES: Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: Documentation of orientation to the facility and to the specific job skills. This state rules was not met as evidenced by: Based on record review and interview, the facility failed to ensure documentation of job specific orientation was located in the personnel files for 5 of 8 Nursing employees hired since 11/1/12. (LPN's #1, #3, #6, #7 and RN #4) Findings include: The facility Employee Files were reviewed on 4/12/13 at 9:10 a.m. There was no documentation of any Job Specific Orientation for the following employees: LPN #1- hired on 1/29/13 LPN #3- hired on 11/18/12 LPN #6- hired on 1/16/13 LPN #7- hired on 1/11/13 RN #4 - hired on 3/4/13	F009999	**F9999Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: Documentation of orientation to the facility and to the specific job skills. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Skills checklist for trach care and re insertion was completed for the nurses who currently work at the facility on 4/16/13 and 4/23/13. LPN's # 1, # 3, # 6, # 7 and RN # 4 job specific orientations will be completed by the DON prior to 5/9/2013.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Nurses who are currently employed at the facility are at risk to be affected by this alleged deficient practice. The current nurses who work at the facility will have a job specific orientation completed by the DON and/or designee by 5/9/2013 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** The Department managers have been	05/09/2013

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 04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	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
	When interviewed on 4/12/13 at 10:15 a.m., the Human Resource Staff indicated she could locate any documentation of the above staff members completing Job Specific Orientation. This state tag relates to Complaint IN00126780. 3.1-13(q)(7)		in serviced on completing the job specific orientation checklist upon hiring new employees on 4/30/2013. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** The Human Resource Director and/or designee will audit all new hires using the state form 5440 Employee Record audit tool ongoing to ensure continued compliance. Any issues found will be immediately corrected during the review. The audits will be submitted to the QA Committee for review as indicated. An action plan may be developed for identified issues. § Noncompliance with facility procedures will result in education and/or disciplinary action.	