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 09/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING & 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
F0000	This visit was for the Investigation of Complaints IN00110622, IN00115667, IN00116116, and IN00116717. Complaint IN00110622-Substantiated. Fedral/state deficiencies related to the allegations are cited at F279 and F514. Complaint IN00115667-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00116116-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00116717-Substantiated. No deficiencies related to the allegation are cited. Unrelated deficiency cited. Survey team: Janet Adams RN Survey dates: September 20, 21, & 24, 2012 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census bed type:	F0000	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 October 23, 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.

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	SNF/NF: 81 Total: 81 Census payor type: Medicare: 8 Medicaid: 55 Other: 18 Total: 81 Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 9/25/12 Cathy Emswiller RN			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview the facility failed to ensure the resident's plan of care for aggressive behaviors included individualized interventions for staff to implement when the resident displayed aggressive behaviors for 1 of 1 residents reviewed for behavior care plans in the sample of 10. (Resident #E) Findings include: The record for Resident #E was reviewed on 9/20/12 at 9:20 a.m. The resident's diagnoses included, chronic pulmonary	F0279	**F279 Comprehensive Care Plans** It is the practice of this provider to develop, review and revise the resident's comprehensive plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident #E's care plans were updated on 9/24/2012 **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 residing in the	10/12/2012

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	disease, anxiety, agitation, and insomnia. The resident was sent to the hospital on 9/13/12 and was re admitted to the facility on 9/17/12. The resident's current care plans were reviewed. A care plan initiated on 5/24/12 indicated the resident had a history of verbal aggression, threatening others, and throwing objects. The care plan was last updated with a goal date of 12/31/12. There were two approaches listed on the care plan. The approaches were for the resident to be counseled and educated on appropriate behavior when needed by staff and for staff to praise the resident for appropriate behavior. Both of the above approaches were initiated on 5/24/12. There were no approaches or interventions for staff to follow when the resident displayed physically aggressive behaviors listed on the care plan. When interviewed on 9/24/12 at 9:15 a.m., the Social Worker indicated the resident had a history of becoming aggressive, hitting doors, attempting to open the doors. The Social Worker indicated the resident's behaviors usually occurred when she wanted to smoke a cigarette, talk to her daughter, or be taken outside. The Social Worker indicated at one time a staff member made a sign with an arrow pointing to the Nurses' Station		facility with aggressive behaviors have the potential to be affected by the alleged deficient practice. · The Interdisciplinary Team has been re-educated by the Director of Clinical Services on individualized care plan completion on 9/24/2012. · **The behavior occurrence forms completed from September 1, 2012 through October 11 th , 2012 have been reviewed by the social service director and/or designee for accuracy and updated as indicated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Interdisciplinary Team reviews the 24 Hour Report Sheet and new Physician orders Monday-Friday excluding holidays. · Residents comprehensive care plans will be developed upon admission and reviewed at least quarterly by the IDT and updated as needed. · The care plan will be completed as indicated based on the issues identified with the completion of the comprehensive MDS/CAA process. · The IDT Team s responsible to ensure resident's plan of care is an accurate reflection of residents needs. **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**·	

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	that indicated smoking this way. The Social Worker indicated and specific interventions for addressing the resident's aggressive behaviors should have been included in the resident's care plan. The Social Worker also indicated the resident had aggressive physical behaviors earlier in the month and was sent out to the hospital due to aggressive behaviors. The Social Worker indicated the resident's plan of care was not updated related to the above. This federal tag relates to Complaint IN00110622. 3.1-35(b)(2)		The MDS Coordinator and/or designee will use the Care Plan QA tool to audit 3 residents with behaviors weekly x 4,then monthly thereafter. · Data will be submitted to the QA Committee monthly for review. An action plan may be developed for identified issues.	

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F0323 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 observation, record review, and interview the facility failed to ensure bed alarms were in place and call lights were in reach for 1 of 2 residents in the sample of 10 with bed alarms. (Resident #E) Findings include: During orientation tour on 9/20/12 at 4:25 a.m., Resident #E was observed in bed. There was an alarm box on top of short dresser next to the resident's bed. There were no cords attached to the box. The end of an alarm cord was observed on the floor under the head of bed. The resident's call light cord was on the floor and the end push button on the end of the cord was under the resident's bed and out of her reach. LPN #2 was present during the tour and exited the room without attaching the alarm or removing the call light from the floor. On 9/20/12 at 4:40 a.m., the resident remained in bed. The resident was awake. The alarm box remained on top of the	F0323	**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's alarm and call light was corrected and this did not re-occur the remainder of the survey. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · · One other resident was identified with a bed alarm. An audit was completed on 9/20/2012 and resident was not	10/12/2012

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	dresser with no cords attached to it. The resident's call light remained on the floor and out of the resident's reach. LPN #2 was present in the room. The resident asked for water and the LPN gave the resident a cup of water and exited the room without attaching the alarm or removing the call light from the floor. On 9/20/12 at 6:15 a.m. and 6:50 a.m., the resident was observed in bed. The alarm box remained on top of the dresser next to the resident's bed. There were no cords attached to the alarm box. There were no staff members present in the resident's room at the above times. On 9/20/12 at 7:10 a.m., the resident was in bed. There were no staff members in the residents room. The alarm box remained on top of the dresser next to the resident's bed. There were no cords attached to the alarm box. The resident started to attempt to sit up at the side of the bed. CNA #1 was asked to enter the resident's room. CNA #1 entered the resident's room and asked the resident to lay down in the bed. The CNA assisted the resident to lay back down and then the CNA exited the room without attaching the alarm cord or removing the call light from the floor. LPN #1 entered the resident's room when the CNA exited.		identified as being deficient. · The DON completed an In service for nursing staff on Fall Prevention Interventions on 10/2/2012 and 10/3/2012. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The DON and/or designee will monitor resident care by making rounds on their units to ensure fall interventions are in place. Concerns are addressed with the nursing staff, as needed. Rounds are completed each shift by the charge nurse, by department heads Monday - Friday to monitor resident fall interventions. Concerns will be addressed with the nursing staff utilizing an in service and/or disciplinary action on an ongoing basis. · The Director of Nursing Services and/or designee is responsible to monitor for facility compliance. · Charge nurses/nursing assistants are responsible to ensure residents receive the necessary fall prevention measures that they require. **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 will complete the "Fall Management" QA tool weekly x 4, then monthly thereafter. · Data will be submitted monthly to the QA Committee for review and	

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	The record for Resident #E was reviewed on 9/20/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, cardiac pacemaker, ischemic heart disease, chronic airway obstruction, anxiety, and insomnia. Review of the active Physician orders indicated there was an order for the resident to have a bed alarm to the bed and the alarm was to be checked every shift. The start date of the order was 9/17/12. A Fall Risk assessment was completed on 9/17/12. The assessment indicated the resident had one or two falls in the last 3 months. The resident's total score on the assessment was (18) which indicated the resident was at high risk for falls. A care plan initiated on 11/22/2011 indicated the resident was at risk for falls due to a history of falls. The care plan was last updated with a goal date of 9/27/12. Care plan interventions/approaches included for the resident to have a bed alarm to the bed and for staff to encourage the resident to use the call light. When interviewed on 9/20/12 at 6:55 a.m., LPN #1 indicated the resident was to have a bed alarm and the cord should have been attached to the alarm box. 3.1-45(a)(2)		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. · Nursing staff were in serviced on Falls Management and fall prevention measures by the DON on 10/2/2012 and 10/3/2012	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review, and interview the facility to ensure clinical records were accurate and complete related to documentation of skin conditions and the completion of behavior occurrence forms for 1 of 1 residents in the sample of 10 reviewed for accurate and complete clinical records. (Resident #E) Findings include: During orientation tour on 9/20/12 at 4:25 a.m., Resident #E was observed in bed with geri gloves (coverings over the arms and part of the hands to protect the skin) in place on both arms. A part of the clear transparent dressing was observed at the opening of the geri gloves between the thumb and index finger on the resident's	F0514	**F514** **RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident # E's Skin Integrity assessment was updated during the survey. · The	10/12/2012

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	right hand. The record for Resident #E was reviewed on 9/20/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, cardiac pacemaker, ischemic heart disease, chronic airway obstruction, anxiety, and insomnia. The resident was admitted to the hospital on 9/13/12 and was re admitted to the facility on 9/17/12. A Nursing Progress Note completed on 8/26/12 at 5:45 p.m. indicated the resident was noted to have a skin tear to the left forearm and the area was cleansed and covered with a bandage and the Physician was notified. There was no documentation in the Progress Notes dated 8/26/12 through 8/31/12 to indicated if the skin tear had healed. A treatment sheet indicating the area was treated with a dressing was not available. Bath and Skin Report Sheets" were reviewed for 8/12 and 9/12. The sheet indicated a skin tear was noted on the 8/28/12 entry. The 8/30/12 sheet indicated the resident's skin was intact. There was no documentation in the clinical record to indicate when the skin tear had healed. Review of the 9/17/12 Admission-Full Clinical/Body Observation form indicated		Nursing staff was re-educated by the DON on 10/2/201 and 10/3/2012 on completion of the Skin Integrity Assessments, Measurements and Assessments on Other Skin Problems, completion of the Behavior Occurrence Forms and documentation. **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 residing in the facility with aggressive behaviors have the potential to be affected by the alleged deficient practice. · The behavior occurrence forms completed from September 1, 2012 through October 11 th , 2012 have been reviewed by the social service director and/or designee for accuracy and updated as indicated.· An audit was completed with residents admitted on 9/15/2012 through 9/24/2012 with skin tears re-assessed by the DON and/or designee to ensure the assessments were accurate and complete. No other residents were identified as being affected by the alleged by the deficient practice. · The Social Service Director and/or designee reviewed the care plans of all the resident's with behavior occurrence forms completed from 9/1/2012 through 10/11/2012 to ensure a behavior care plan was in place with appropriate interventions. **What measures**	

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	the resident was admitted from an acute care hospital. The Progress Notes section on this form indicated the resident returned from the hospital at 6:30 p.m. The form did not indicate the resident had skin tears. The form was revised by staff on 9/23/12 at 9:26 a.m. and indicated the resident had skin tears to the right inferior forearm, right lateral hand, left inferior forearm, left medial forearm, and right superior forearm upon admission. Skin Integrity Conditions entries with observation dates of 9/18/12 were completed by the Wound Nurse. The entries indicated the resident had skin tears to the right lateral hand, left medial forearm, right inferior forearm, and left inferior forearm. The "Measurement, Assessments of Pressure Ulcers, Wounds, and Other Skin Problems" policy was received form the Administrator on 9/20/12 at 11:30 a.m. There was no date on the policy. The policy indicated the nurse was responsible to measure and describe any skin conditions in the clinical record upon first observation of any skin conditions. A "Behavior and Mood Events-Aggressive/Combative Behavior" form was initiated on 9/13/12 for an event that occurred on 9/13/12 at 6:40 p.m. The		**will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The DON and/or designee will audit 100% of new and re admission charts to ensure compliance. **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 will audit 50% of the resident records of residents with skin conditions weekly x 4 weeks, then monthly thereafter. · SSD and/or designee will audit 100% of the Behavior Occurrence Forms to ensure accurate completion on going. · 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. An all staff in service was conducted on 10/10/12 and 10/11/2012 by the HFA and the SSD to re-educate staff on the correct procedure for completing a behavior occurrence form. Noncompliance with facility procedures will result in education and/or disciplinary action on going.	

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	form was completed by RN#1. The form indicated Resident #E grabbed another resident who was using the telephone and was trying to get the phone away from the other resident. The form also indicated the resident had been verbally abusive much of the afternoon. The resident's family and the resident's Physician were notified. The facility conducted interviews with other staff members related to the resident's behaviors on 9/13/12. One staff interview related to the resident's behavior on 9/13/12 indicated the resident went to smoke at 6:00 p.m. and was then trying to leave and the resident has a pot in her hand and RN#1 had convinced her to take the pot out of her hands. A second interview related the resident's behaviors indicated the resident was trying to leave and was almost breaking the window with a pot. A third interview indicated the resident had to be redirected several times. Another staff interview indicated the resident was cussing and trying to hit whoever was in front of her. Review of the Behavior Occurrence forms indicated there was only one form completed on the 3:00 p.m. - 11:00 p.m. shift on 9/13/12. This form was completed by Nursing. There time on form was listed as "3-11 shift" This form indicated the resident was calling out,			

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	spitting, screaming, throwing objects, refusing medications, and scratching others. There were no separate forms to indicate the time all of the above behaviors occurred. There were no Nursing Progress notes for the above behaviors. When interviewed on 9/21/12 at 10:00 a.m., the Wound Nurse indicated the resident was admitted with the skin tears and she completed the above forms on 9/18/12. When interviewed on 9/21/21 at 10:00 a.m., the DON (Director of Nursing) indicated the admitting Nurse indicated the resident was admitted with the skin tears on 9/17/12. The DON indicated clear dressings were in place. The DON indicated the skin tears should have been documented upon admission. When interviewed on 9/24/12 at 1:15 p.m., the DON indicated skin tears are documented on the Bath and Skin Report sheets. The DON indicated the above report sheets indicated on 8/30/12 the resident's skin was intact and there was no other documentation of when the skin tear healed in the resident's clinical record. When interviewed on 9/24/12 at 9:15			

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 09/24/2012
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	a.m., the Social Worker indicated Behavior Occurrence forms were to be filled out for each resident behavior and she reviews these forms each day she is working. This federal tag relates to Complaint IN00110622. 3.1-50(a)(1) 3.1-50(a)(2)			