

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
--------------------	--	---------------	---	----------------------

F0000	<p>This visit was for the Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00103446.</p> <p>This survey was done in conjunction with the Investigation of Complaint IN00105332</p> <p>Complaint IN00103446: Substantiated-Federal and State deficiencies related to the allegations are cited at F253, F282, F312, F309, and F322</p> <p>Survey Dates: March 5, 6, 7, 8, 9, & 12, 2012</p> <p>Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Janet Adams, R.N. Kathleen Vargas, R.N.</p> <p>Census Bed Type: 67 SNF/NF 67 Total</p> <p>Census Payor Source</p>	F0000	<p>March 28th 2012, 155653100267410000108, Indiana State Department of Health 2 north Meridian Street IN. 46204 Re; Survey event ID OIR511. To Whom it may concern; On March 12th 2012 the ISDH licensure survey IN00103446 was conducted at Lake County Nursing and Rehab by the Division of Long Term Care, Indiana State Department of Health to determine if the facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The facility recieved 23 F-tag violations. The facility is submitting this plan of correction which does not constitute admission of agreement by the provider of the truth of the faccts alleged or conclusions set forth in the statement of deficieincies. The plan of correction is prepared and/or executed soley related to the provisions of federal and state laws that require it. This letter shall serve as the allegation of compliance effective April 6th 2012. Thank you for your cooperation. Respectfully, Katy Robertson Administrator</p>	
-------	--	-------	--	--

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.

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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
	<p>8 Medicare 46 Medicaid 13 other 67 Total</p> <p>Stage Two Sample: 34</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 16, 2012 by Bev Faulkner, RN</p>			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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
	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to provide oral and written information to residents and/or family members about applying for Medicaid benefits for 1 resident of the 4 residents reviewed for Admission/Transfer/Discharge status. (Resident #H)</p> <p>Findings include:</p> <p>The closed record for Resident #H was reviewed on 3/12/12 at 9:00 a.m. The resident was admitted to the facility on 2/14/12 from an acute care hospital. The resident was discharged from the facility on 3/5/12. The resident's diagnoses included, but were not limited to, pain, anxiety, congestive heart failure, high blood</p>	F0156	<p>Lake County Nursing and Rehab F156 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RH and family were provided oral and written information regarding applying for Medicaid benefits How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents admission acknowledgement for Medicare and Medicaid benefit letters were reviewed by Administrator or</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>pressure, and esophageal reflux.</p> <p>The "Resident Admission Agreement Acknowledgement Sheet" was reviewed. The sheet was to be signed by the resident or legal representative to verify acknowledgment of receipt of the Admission information and contracts. The resident's legal representative signed the sheet on 3/5/12.</p> <p>When interviewed on 3/12/12 at 10:05 a.m., the Social Service Director indicated the resident and his wife requested the resident be discharged on 3/5/12. The Social Service Director indicated the resident's payor status was Medicaid pending and on 3/5/12 she attempted to make arrangements for Home Health and Physical Therapy for the resident.</p> <p>When interviewed on 3/12/12 at 1:15 p.m., the Admissions Director indicated the resident was admitted to the facility on 2/14/12 from the hospital. The Admissions Director indicated a member of the Marketing Department completed an admission inquiry of the resident on 2/10/12. The inquiry indicated the resident's payor status was to be Medicaid pending and the facility would need to start</p>		<p>designee with no other residents observed to be affected by the alleged deficient practice. All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur?</p> <p>The admission coordinator has been in-serviced regarding the timely completion of the following;</p> <p>a) provide oral and written information to residents and/or family members about applying for Medicaid benefits What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?</p> <p>The Admission Coordinator or designee will log new residents who are admitted to the facility to ensure that the facility provides oral and written information to residents and/or family members about applying for Medicaid benefits by reviewing the Admission Acknowledgment letter noting resident and/or family receipt. The results will be reviewed by the Administrator or designee weekly. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if compliance is determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>the process. The Admissions Director indicated the facility did not start the process until 3/5/12 when the resident and his wife requested to meet with her prior to his discharge home.</p> <p>When interviewed on 3/12/12 at 1:40 p.m., the Administrator indicated the resident/and or his family should have been given information on Medicaid and the facility should have initiated the Medicaid application prior to 3/5/12.</p> <p>When interviewed on 3/11/12 at 6:00 p.m., the resident's family member indicated they were not given the Admission paperwork with the information for applying for Medicaid to sign until 3/5/12.</p> <p>3.1-4(f)(1)</p>		meeting. Monitoring will be ongoing.	

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0157 SS=D	<p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the resident's physician and interested family member were notified of a change in status related</p>	F0157	Lake County Nursing and Rehab F157 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability	04/06/2012	

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>to a significant weight loss, for 1 of 3 residents reviewed for nutrition of the 8 who met the criteria for nutrition. (Resident #G)</p> <p>Findings include:</p> <p>The record for Resident #G was reviewed on 3/8/12 at 9:45 a.m. The resident had diagnoses that included, but were not limited to, anemia, dysphagia (difficulty swallowing), and adult failure to thrive.</p> <p>The Significant Change Minimum Data Set (MDS), completed on 2/13/12, indicated the resident's height was 73 inches and his weight was 124 pounds. It also indicated the resident had a significant weight loss and had a feeding tube in place.</p> <p>The resident's weights recorded on the restorative weight sheet were as follows:</p> <p>11/21/11 134 pounds 11/28/11 134.5 pounds 12/5/11 134 pounds 1/11/12 134 pounds 1/18/11 131.5 pounds 1/25/12 131.5 pounds 2/8/12 125 pounds reweigh 123.5 pounds 2/15/12 125 pounds</p>		<p>by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RG's family and physician were notified of the weight loss How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents significant weight loss are at risk for the alleged deficient practice Those residents noted in March 2012 with significant weight loss were reviewed for family and physician notifications to ensure completion. What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Nursing staff have been in-serviced regarding the following; a) ensuring the resident's physician and interested family member are notified of a change in status related to a significant weight loss. What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit weights weekly to ensure that residents physician and interested family member are notified for those residents who</p>				

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>There was a progress note, dated 2/8/12, written by the Registered Dietitian that indicated, "Tube feeding review: Resident receiving Pulmocare 240 ml (milliliters) 6 x/day with 150 ml water flush after each bolus feeding; 30 ml water flush before/after medications. Tolerating well per nursing. No residuals. No intolerances noted . . . No pressure areas noted. Weight history, 2/6/12 125 lbs, 2/7/12 123.5 lbs, 1/19/12 131.5 lbs per NAR (Nutrition at Risk), 2/1/12 132.4 lbs (per NAR) Significant weight loss of 6.7% in 1 week, down 9.8% in 3 months, 137 lbs 11/8/11. Resident underweight . . ."</p> <p>The policy titled "Weight Assessment and Intervention," revised August 2008, was provided by the Administrator on 3/9/12. She indicated the policy was current. The policy indicated, "Resident's Physician, Nursing Supervisor and resident's family/responsible party should be notified of any significant weight loss or gain."</p> <p>The progress notes, dated 2/6/12 through 3/7/12, were reviewed. There was no evidence the Physician and the resident's family were notified of the resident's weight loss.</p>		<p>have a significant weight loss. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Interview with the MDS Coordinator on 3/8/12 at 2:12 p.m., indicated the Physician and the resident's family were not notified of the resident's weight loss.</p> <p>3.1-5(a)(2)</p>			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure each resident's complaint and/or grievance was documented and followed through related to missing barber scissors and money for 2 of 3 residents reviewed for personal property of the 6 residents who met the criteria for personal property. (Residents #E and #74)</p> <p>Findings include:</p> <p>1. During an interview with Resident #E on 3/06/2012 at 10:13 a.m., the resident indicated the first day he was admitted to the facility his professional barber scissors were stolen or came up missing. He further indicated that he had reported it to staff, to a "lady" whose office was across the hall. The resident also indicated the item was still missing and he has not heard anything yet.</p> <p>The record for Resident #E was reviewed on 3/7/12 at 2:00 p.m. The resident was admitted to the facility on 2/23/12 from the hospital. Review</p>	F0166	<p>Lake County Nursing and Rehab F166 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RE has been discharged. R74 complaint was documented and followed through related to the missing money How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All resident greivances/complaints have been reviewed by the Administrator or designee to ensure that concerns were documented and followed through with a summary upon completion. No other residents were noted to be affected by the alleged deficient practice.All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to</p>	04/06/2012	

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>of Nursing Progress Notes, dated 2/23/12, indicated the resident was alert and oriented to person, place, and time.</p> <p>Interview with the Director of Nursing (DoN) on 3/8/12 at 10:05 a.m., indicated her office was across the hall from Resident #E and she was the person he had told in regards to the scissors. She further indicated she had reviewed the resident's entire complaint/grievance during the morning meeting with the other department heads that day; however, she could not remember what day the resident had told her. She indicated she had thought the resident told her this about the second or third day he had been there.</p> <p>Interview with the Director of Housekeeping on 3/8/12 at 10:07 a.m., indicated she did not remember any conversation or grievance regarding a missing pair of barber scissors from the DoN during a morning meeting. She indicated she was unaware the resident was missing any personal items.</p> <p>Interview with the Social Service Director at 10:35 a.m., on 3/8/12 indicated she was informed the resident had a complaint that he was</p>		<p>ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring each residents complaint and/or grievance is documented on a concern/grievance form and followed through b) providing a summary of the report to the resident upon completion of the investigation What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The Administrator or designee will audit resident/family complaint and/or grievances weekly to ensure they are completed on the appropriate form, followed through and a summary was provided to the resident. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>missing something but she was unclear on what it was. She further indicated she did remember the DoN reporting it in the morning meeting the resident was missing something but the DoN's information was not specific. The Social Service Director indicated after the information was brought to her attention she went to the resident and asked him if everything was okay and how he was doing. She indicated she did not ask the resident what he was missing or if he had any complaints.</p> <p>Review of the complaint/grievances for February/March 2012 indicated there was no complaint or grievance form filled out regarding the resident's missing barber scissors.</p> <p>Further interview with the Social Service Director at that time, indicated she did not follow the facility's policy regarding complaint and grievance and did not complete a form regarding the missing personal property She indicated no staff member followed through with the resident's concern.</p> <p>2. Interview with Resident #74 on 03/05/12 at 1:48 p.m., indicated that he had money missing in October of 2011. He indicated \$60 was missing. He also indicated it was reported to</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>the Administrator and it was never replaced.</p> <p>Interview with the current Administrator on 3/9/12 at 9:11 a.m., indicated there were no written grievances related to missing money for the resident. She indicated she was not the Administrator in October. She also indicated the current Social Service Director was aware of the allegation that \$60 was being held in a safe by the facility for the resident and then the money was reported missing.</p> <p>Interview with the Social Service Director, on 3/9/12 at 9:42 a.m., indicated that she was aware of the resident's allegation of missing money. She indicated the resident stated he gave \$60 to the previous Administrator to put in a safe. The safe was in the Administrator's office. The Administrator left the facility and was working elsewhere. When the resident requested the money, the new Administrator indicated the \$60 was not there. No grievance form was completed at that time. She indicated that she informed the resident that it was better for him to use the facility trust fund and that way when money was removed or placed in the fund, he would get a receipt. She indicated</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>a grievance form should have been completed for the resident's concern of missing money.</p> <p>Review of the current 12/04 Filing a Grievance/Complaint policy provided by the Administrator on 3/8/12, indicated "Staff members are encouraged to assist residents in filing a grievance and/or complaint when the resident believes that his/her rights have been violated. Should a staff member overhear or be the recipient of a complaint voiced by a resident, a resident's representative (sponsor), or another interested family member of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other resident, etc., the staff member is encouraged to assist the resident, or person acting in the resident's behalf, to file a written complaint with the facility. Staff members will inform the resident or the person acting in the resident's behalf that he or she may file a grievance or complaint with the administrator or other government agencies as noted on the resident's bulletin board, without fear of threat or any other form of reprisal. Upon receipt of a written grievance and/or complaint, designated individual will investigate the allegations and submit</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>a written report of such findings to the administrator within five working days of receiving the grievance and/or complaint. Such report will be made orally by the administrator, or his or her designee, within five working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the resident."</p> <p>3.1-7(a)(2)</p>			

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
F0170 SS=C	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>Based on interview, the facility failed to ensure mail was delivered to the facility on Saturday. This had the potential to affect the 67 residents residing in the facility.</p> <p>Findings include:</p> <p>Interview with the Resident Council President on 3/12/12 at 10:15 a.m., indicated that mail was not delivered to the facility on Saturday.</p> <p>Interview with the Activity Director on 3/12/12 at 10:30 a.m., indicated that mail was not delivered to the facility on Saturdays.</p> <p>Interview with the Administrator on 3/12/12 at 11:57 a.m., indicated that she talked with the receptionist and sometimes the mail gets delivered on Saturday and sometimes it doesn't. The Administrator indicated that she called the post office and the post office indicated there should be no reason why the facility isn't receiving mail on Saturday.</p> <p>3.1-3(s)(1)</p>	F0170	<p>Lake County Nursing and Rehab F170 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? The Corporate Vice President of Nursing met with the mail carrier who stated she does deliver mail to Lake County Nursing and Rehab every Saturday. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? The Administrator or designee has reviewed and mail has been delivered on Saturdays. There have been no other concerns related to mail not being delivered on Saturdays by any residents. All residents are at risk for the alleged deficient practice. What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur?</p>	04/06/2012			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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
			<p>Receptionist's have been in-serviced regarding the following; a) ensuring that mail is delivered on Saturdays b) notifying the Administrator in the event that mail is not delivered on Saturdays What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The Administrator or designee will audit on Saturdays to ensure that mail was delivered. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>	

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure the residents were treated with dignity related to staff standing while feeding for 1 of 1 residents in the stage 2 sample of 34, observed during 2 of 2 dining observations. (Resident #J)</p> <p>Findings include:</p> <p>On 3/6/12 at 8:43 a.m., CNA #6 was observed standing and feeding Resident #J his breakfast. The resident was lying in bed. There was a standard chair in the room.</p> <p>On 3/7/12 at 8:49 a.m., CNA #6 was observed standing and feeding Resident #J his breakfast, the resident was lying in the bed.</p> <p>Interview with CNA #4 on 3/9/12 at 2:09 p.m., indicated that when feeding a resident, staff were to sit at eye level and they were not to stand.</p> <p>Interview with LPN #3 on 3/9/12 at 2:19 p.m., indicated staff were to be</p>	F0241	<p>Lake County Nursing and Rehab F241 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RJ has been fed with dignity as evidenced by staff sitting during while feeding RJ How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents that are dependent for feeding at risk for the alleged deficient practice The C.N.A. #6 that was observed standing during the feeding was provided 1:1 inservice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur?</p> <p>Nursing staff have been in-serviced regarding the following; a) ensuring residents</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	sitting in a chair when feeding a resident. 3.1-3(t)		are treated with dignity related to staff sitting while feeding residents who require assistance What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times per week rotating meal times to ensure staff does not stand during feeding of any resident. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.		

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure activity services were provided for a dependent resident related to having the television on while the resident was in her room for 1 of 3 residents of the 8 who met the criteria for activities. (Resident #F)</p> <p>Findings include:</p> <p>On 3/5/12 at 12:00 p.m. and 3:00 p.m., Resident #F was observed in her room in bed during this three hour span. The resident's eyes were closed and the resident's television was turned off. There was no radio in the resident's room. Review of the current March 2012 Activity Calendar indicated Bible Study with music was the activity going on in the second floor dining room.</p> <p>On 3/6/12 at 8:30 a.m. and 10:30 a.m., the resident was observed in her room in bed. Again, her television was turned off.</p>	F0248	<p>Lake County Nursing and Rehab F248 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RF has a radio and tv in her room that are utilized by staff and is escorted to and from activities which provide sensory stimulation. RF also receives 1:1 in the event she is unable to attend group activities due to her medical condition How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents who are dependent requiring activity services were audited by the activity director to ensure activity services were provided, including the use of television and/or radio while in their room with no other residents</p>	04/06/2012	

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>On 3/7/12 at 8:39 a.m., 10:40 a.m., and 12:43 p.m., the resident was observed in her room sleeping at all of those times. The residents television was turned off and she had no radio in her room. At 2:55 p.m., the resident was observed in her room in bed. The resident's eyes were open at this time. The resident's television was not turned on, there was no sensory stimulation for the resident at that time.</p> <p>On 3/8/12 at 8:25 a.m., the resident was observed in her in room in bed. The resident's eyes were open. Her eyes were open at this time and her television was not turned on. At 10:00 a.m. and 12:35 p.m., the resident remained in her room in her bed with the television turned off.</p> <p>On 3/12/12 at 8:30 a.m. and 9:50 a.m., the resident was observed in her room in bed. The resident's television was not turned on.</p> <p>The record for Resident #F was reviewed on 3/8/12 at 9:00 a.m. The resident's diagnoses included, but were not limited to, aphasia and cerebral vascular accident (stroke).</p> <p>The Significant Change Minimum</p>		<p>noted to be affected by the alleged deficient practice All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring activity services are provided for a dependent resident b) ensuring activity services are provided including the use of radio or television while resident is in bed What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The Administrator or designee will audit three times weekly to ensure residents who are dependent are provided activity services. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if compliance is determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Data Set (MDS) Assessment completed on 12/8/11, indicated the resident's cognitive skills for daily decision making were severely impaired.</p> <p>The interview for daily and activity preferences was not conducted due to the resident rarely/never understood and her family was not available.</p> <p>The plan of care, dated 12/8/11, indicated the resident had minimum response to sensory stimulation. The interventions indicated the resident was to be provided a variety of sensory items to get response, provide escort to and from activities and provide sensory stimulation in a calm environment.</p> <p>The Music therapy assessment and plan of care completed by Hospice staff on 12/27/11, indicated to add the possibility of playing music on a compact disc player in the resident's room for comfort measures.</p> <p>The Activity Progress Note, dated 2/24/12 at 1:33 p.m., indicated the resident participated in sensory club and at times will show response to sensory stimulation provided. Resident's family often visits.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Resident sits quietly during activities.</p> <p>Further review of Activity Progress Notes indicated there was no current Activity Assessment for the resident to indicate her past or current preferences.</p> <p>Review of the 1:1 Activity Response Form for the month of February and March 2012, indicated the resident received 1:1 visits three times a week for sensory stimulation.</p> <p>Interview with Activity Aide #2 on 3/12/12 at 9:00 a.m., indicated the resident received 1:1 visits. She also indicated the resident should be up in her recliner and brought to the lounge area for activities.</p> <p>Interview with the Activity Director on 3/12/12 at 9:45 a.m., indicated the resident received one to one activities several times a week. She also indicated the resident was to be brought out of her room for activities. She also indicated the resident's television was to be turned on when the resident was in her room and all staff were responsible for ensuring it was turned on.</p> <p>3.1-33(a)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
F0253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure the resident's environment was clean and free from urine odors, and in good repair related to dusty wood blinds, marred and gouged resident room walls, and dirty and broken floor registers for 12 of 20 rooms observed and for 2 of 2 dining rooms on 2 of 2 floors. (The first and second floors)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/05/2012 at 3:19 p.m., the bathroom for Room 115 had a strong urine odor. On 3/06/2012 at 9:53 a.m., there was a strong urine odor in the bathroom for Room 117 and there was dried bowel movement on the raised toilet seat. On 3/05/2012 at 2:40 p.m., there was a musty odor in the bathroom for Room 118. On 3/05/2012 at 11:04 a.m., there was urine odor in the bathroom for Room 102. 	F0253	<p>Lake County Nursing and Rehab F253 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Room 102,115, 116, 118and 117 were deep cleaned and there is no strong urine, musty smell or soiled toilet seat noted. Room 116 gouges and holes in wall have been fixed. Room 126 register vent along the floor by the window have been fixed. Room 121's privacy curtains were replaced Room 201's closet door was replaced, the curtain was correctly hung on the curtain rod and the metal heating unit behind the head of bed was repaired Room 202's drape was attached to the curtain rod Room 220's caulking around the bathroom sink was replaced Room 216's closet door were placed back on track and the heat register cover has been fixed The 2 dusty/dirty</p>	04/06/2012			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>5. On 3/06/2012 at 10:00 a.m., there was a strong urine odor in the bathroom for Room 116. Further observation of the resident's room indicated there were two 12 inch strips of gouged areas located behind the bed where there were holes in the resident walls. There was a round six inch gouged area by the bed where the straight chair was located.</p> <p>Interview with Resident #M on 3/05/2012 at 3:15 p.m., indicated "Sometimes you do smell bad odors in this facility and it is mostly urine odor." The resident indicated at the time the smell mainly comes from the first floor.</p> <p>Interview with the Housekeeping Supervisor on 3/12/12 at 10:20 a.m., during the Environmental Tour, indicated most of the urine smells were caused from the CNAs placing the soiled incontinence briefs into the trash cans in the resident rooms and leaving them in the trash cans instead of taking them out and placing them into the soiled utility room.</p> <p>6. On 3/06/2012 at 7:45 a.m., in Room 126 the register vent along the floor by the window side near the head of the bed was torn away from</p>		<p>ceiling vents in the shower room have been cleaned The ceiling light located in the shower stall has been fixed The beauty shop walls with black mars have been fixed and the hair in the sink bowl and on the chair have been cleaned. The bed pan with urine in room 118 was removed. The 6 stained ceiling tiles in the 2 nd floor dining room and 6 sets of dusty window blinds have been corrected The heat register along the wall in the main dining room and outside in main entrance were cleaned. The walls behind the bed in room 214 were repairedThe stained chair in the beauty shop was cleaned and the facility is looking into a replacement chair at this time</p> <p>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents are at risk for the alleged deficient practice</p> <p>What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) Keeping the facility free of urine odors b) Notifying maintenance when rooms are need of repair c) Notifying housekeeping d) Cleaning the beauty shop e) Removing bed pans after use f) Ensuring soiled briefs are disposed of properly</p> <p>What quality assurance plans</p>		

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>the wall.</p> <p>7. On 3/05/2012 at 2:21 p.m., in Room 121 there were several stains on the privacy curtain between the beds. The stains were dark brown and gray in color.</p> <p>8. On 3/06/2012 at 8:49 a.m., in Room 201 the wall above the closet doors had a four inch gouged area. The window curtain was hanging down and not completely on the curtain rod and the metal heating unit behind the head of the bed was bent and in need of repair.</p> <p>9. On 3/06/2012 at 9:53 a.m., in Room 202 the material from the drapes was not all attached to the curtain rod.</p> <p>10. On 3/06/2012 at 9:39 a.m., in Room 220 the caulking around bathroom sink was discolored and pulling away from sink and wall.</p> <p>11. On 3/05/2012 at 2:35 p.m., in Room 216 both closet doors were observed off of the track. The cover over the heat register was also observed to be coming off.</p> <p>12. On 3/05/2012 at 2:51 p.m., in Room 214 there were gouged marks</p>		<p>will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The Administrator or designee will audit rooms three times weekly to ensure that the facility is free of urine odors, heat registers and bedside curtains are clean. Drapes are hung properly and closet doors are on their tracks. As well as over housekeeping, dusting and marred walls. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>behind the bed.</p> <p>13. During the Environmental on 3/12/12 at 9:25 a.m., the following was observed on the first floor:</p> <p>A. There were two dusty and dirty ceiling vents in the shower room. The ceiling light located in the shower stall was rusty.</p> <p>B. The Beauty shop walls were marred and with black marks on all four walls. There were hair clippings observed on the chair by the sink bowl. The green chair was observed with a six inch discoloration identified by the housekeeping supervisor as hair dye.</p> <p>C There was a bedpan filled with urine observed on top of bed 1 in Room 118. There was no resident in the room at that time and there was a soiled brief in garbage can. The room had a strong urine smell.</p> <p>14. During the Environmental Tour on 3/12/12 at 9:55 a.m., the following was observed on the second floor:</p> <p>A. There were six stained ceiling tiles observed in second floor dining room. There were also six sets of woods blinds observed on the window panes</p>			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>that had a moderate amount of dust on them.</p> <p>15. On 3/12/12 at 10:10 a.m., the heat register along the wall in the main dining room approximately 40 feet long had a large amount of dried food/beverage spillage and was rusty and full of dust. Continued observation just outside of the Main Dining Room indicated two eight foot sections of the heat register located by the main entrance windows were noted to be dirty and rusty.</p> <p>Interview with the Maintenance Supervisor and The Housekeeping Supervisor on 3/12/12 at 10:25 a.m., indicated all the above was in need of cleaning and/or repair.</p> <p>This Federal Tag relates to Complaint IN00103446</p> <p>3.1-19(f)</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessment was completed related to range of motion for 1 of 3 residents of the 17 who met the criteria for range of motion and for coding tube feedings for 1 of 3 residents of the 5 who met the criteria</p>	F0278	<p>Lake County Nursing and Rehab F278 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>for tube feedings. (Residents #D and #K)</p> <p>Findings include:</p> <p>1. On 3/7/12 at 8:40 a.m., Resident #K was observed in the hallway. The resident had contractures to his left and right hands.</p> <p>The record for Resident #K was reviewed on 3/8/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis and muscle weakness.</p> <p>The Admission MDS Assessment, dated 2/24/12, indicated the resident had no impairment of his upper extremities, which included shoulder, elbow, wrist, and hand, in relation to functional limitation in range of motion.</p> <p>The resident's Joint Mobility Assessment, dated 2/20/12, indicated the resident had moderate to severe limitation in his left and right hands and fingers.</p> <p>Interview with the Restorative Nurse on 3/12/12 at 9:00 a.m., indicated the resident's MDS was coded inaccurately related to the resident's range of motion status.</p>		<p>residents found to have been affected by the alleged deficient practice? RK MDS assessment has been modified to reflect the contractures to his left and right hand RB MDS assessment has been modified to reflect the feeding tube and amount of fluids How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with contractures and gtubes whos MDS was completed during February and March 2012 were reviewed and no residents were identified of the alleged deficient practiceAll residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) to ensure that the MDS assessment is completed accurately b) to ensure that the MDS assessment is completed accufately with the emphasis on tube feeding and range of motion What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three residents MDS per week related to those with gtubes and contractures to ensure an</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>2. The closed clinical record for Resident #B was reviewed on 3/7/12 at 9:18 a.m. The resident was admitted to the facility on 1/20/12 from the hospital. The resident was admitted with a percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>Review of the Admission MDS (Minimum Data Set) assessment, dated 1/27/12, indicated under the nutrition section the resident had no swallowing disorders, no oral problems and was receiving a therapeutic diet. The resident's feeding tube and the amount of fluids he was receiving was not checked or coded on the MDS assessment.</p> <p>Interview with MDS Coordinator on 3/10/12 at 2:45 p.m., indicated the MDS was inaccurately coded and she should have coded the feeding tube as well as the amount of fluids he was</p>		<p>accurate MDS assessment was completed accurately. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>	

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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
	receiving through the peg tube. 3.1-31(d)			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>Based on record review and interview, the facility failed to initiate a plan of care related to activities of daily living (ADL's) for 1 of 3 residents of the 10 who met the criteria for activities of daily living. The facility also failed to initiate a plan of care related to bruising for 1 of 3 residents of the 5 who met the criteria for non-pressure area skin conditions. (Residents #D and #K)</p> <p>Findings include:</p> <p>1. The record for Resident #K was</p>	F0279	<p>Lake County Nursing and Rehab F279 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RK care plan has been completed to reflect the ADL's that identified CAA RD care plan has been completed to</p>	04/06/2012	

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>reviewed on 3/8/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis, muscle weakness, below the knee amputation, and lack of coordination.</p> <p>The Admission Minimum Data Set (MDS) Assessment, dated 2/24/12, indicated the resident had a limited range of motion in his lower extremities.</p> <p>Review of the CAA's Summary completed with the Admission MDS indicated activities of daily living had triggered and the area was to be addressed on the care plan.</p> <p>Review of the resident's current plan of care indicated that he did not have a current plan related to ADL's.</p> <p>Interview with the Restorative Nurse on 3/12/12 at 8:50 a.m., indicated the ADL care plan had not been initiated as identified on the CAA's.</p>		<p>reflect the anticoagulation therapy and history of bruising How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with bruising and who are on anticoagulation therapy and those with contractures have been reviewed by the DON or designee with no further deficiencies noted. All residents who CAA's triggered for ADL's were reviewed by the DON or designee to ensure that a plan of care was in place with no deficiencies noted. All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) to initiate a plan of care related to those identified on the CAA b) to initiate a plan of care related to ADL's c) to initiate a plan of care related to anticoagulation therapy and bruising What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit 3 care plans per week to ensure care plans have been completed with the emphasis on those care plans related to ADL and coagulation therapy. A summary of the</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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
	<p>2. The record for Resident #D was reviewed on 3/8/12 at 8:35 a.m. The resident was admitted to the facility on 12/3/11 from the hospital. The resident's diagnoses included, but were not limited to anemia, congestive heart failure, pressure ulcers, edema, muscle weakness, and malnutrition.</p> <p>Review of the nursing admission assessment, dated 12/3/11, indicated multiple discolorations-dark purple/red to bilateral arms, with abrasions and scabbed areas to right lower leg left leg.</p> <p>Review of the readmission full body assessment, dated 3/2/12, indicated bruises scattered on left and right side of arms.</p> <p>Review of Physician Orders, dated 3/2/12, indicated the resident was receiving Plavix (a medication used to</p>		<p>findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>	

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>thin blood) 75 milligrams (mg) daily as well as Aspirin 325 mg one tablet daily.</p> <p>Review of the current plan of care, dated 12/11-3/12, indicated there was no plan of care in place for the resident regarding his history of bruises or non pressure areas and/or the prevention of bruising.</p> <p>Review nurses notes, dated 3/2/12, indicated the resident had scattered ecchymotic areas to left and right arms.</p> <p>Interview with Minimum Data Set (MDS) Coordinator on 3/9/12 at 1:44 p.m., indicated she only writes a care plan for a resident being at risk for bruising if that resident was on an anticoagulant medication such as Coumadin. She further indicated she has never considered writing a care plan for a resident with a history of bruising, skin tears, or fragile skin when they had not been on anticoagulant therapy.</p> <p>3.1-35(a)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure physician's orders and/or the plan of care were followed as written related to:</p> <ul style="list-style-type: none"> a body pillow not in place for 1 of 3 residents of the 6 who met the criteria for accidents; a resident not being provided activity services for 1 of 3 residents of the 8 who met the criteria for activities; not being provided assistance with meals and/or getting out of bed for 1 of 3 residents of the 10 who met the criteria for activities of daily living; supplements not provided with meals for 1 of 3 residents of the 8 who met the criteria for nutrition; a pressure ulcer dressing not on as ordered for 1 of 3 residents of the 17 who met the criteria for pressure ulcers; lack of monitoring of skin conditions for 1 of 3 residents of the 5 who met the criteria for non-pressure skin conditions, and monitoring tube feeding sites for 1 of 3 residents of the 5 who met the criteria for tube feedings. (Residents 	F0282	<p>Lake County Nursing and Rehab F282 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RB has been discharged RF has a radio and tv in her room that are utilized by staff and is escorted to and from activities which provide sensory stimulation. RF also has been up to her gerichair as her medical condition allows C.N.A. #6 was inserviced regarding proper sitting while feeding. RD treatment orders were clarified as necessary and dressing was applied RC received oral antibiotic Keflex and Benadryl. The physician also assessed RC on 3/21/2012 with noted improvement RL has been discharged RG body pillow remains in use and the facility has purchased spare pillow during cleaning times How will the</p>	04/06/2012

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>#B, #C, #D, #F, #G, and #L)</p> <p>Findings include:</p> <p>1. On 3/5/12 at 12:00 p.m. and 3:00 p.m., Resident #F was observed in her room in bed. The resident's eyes were closed and the resident's television was turned off. There was no radio in the resident's room. There was a geri-chair recliner located at the foot of the resident's bed.</p> <p>On 3/6/12 at 8:30 a.m. and 10:30 a.m., the resident was observed in her room in bed. Again, her television was turned off.</p> <p>On 3/7/12 at 8:39 a.m., 10:40 a.m., 12:43 p.m., and 2:55 p.m., the resident was observed in her in room in bed. The resident's television was turned off. A geri-chair recliner was observed at the foot of the resident's bed.</p> <p>On 3/8/12 at 8:25 a.m., the resident was in her room in bed. The resident's television was not turned on. At 8:34 a.m., CNA #2 entered the resident's room with her breakfast tray. The CNA placed the tray on the resident's overbed table and walked out of the room. At 8:43 a.m., the</p>		<p>facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with treatment orders, body pillows, peg tubes, scratches and supplements orders were reviewed along with hands on and visual review through rounds by the DON or designee were performed with no other residents identified as being affected. During the survey all other residents that remained in their room for prolonged period of time were checked that activities and sensory stimulation was provided with no other residents identified. All residents with treatment orders, body pillows, peg tubes, scratches and supplements are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) following physicians orders and the plan of care b) providing assistance with meals to those residents who require assistance c) fall prevention interventions are in place such as a body pillow d) residents are to be up out of bed as their medical condition allows e) supplements are provided with meals such as supercereal f) pressure ulcer dressings are in place as ordered g) staff monitor and document skin conditions</p>	

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>resident's tray was covered and on her overbed table. No staff were in the resident's room at this time. At 8:47 a.m., CNA #2 went into the resident's room and removed her tray. He indicated the resident didn't want to eat, and that she doesn't eat much. The CNA then proceeded back into the resident's room and uncovered the resident's breakfast tray and attempted to feed the resident. The geri-recliner was positioned at the foot of the resident's bed. At 10:00 a.m. and 12:35 p.m., the resident remained in her room in bed. The television remained off and the geri-chair remained at the foot of the resident's bed.</p> <p>On 3/12/12 at 8:30 a.m. and 9:50 a.m., the resident was observed in her room in bed. Again, the television was turned off and the geri-chair recliner was located at the foot of the bed.</p> <p>The record for Resident #F was reviewed on 3/8/12 at 9:00 a.m. The resident's diagnoses included, but were not limited to, aphasia and cerebral vascular accident (stroke).</p> <p>The plan of care' dated 12/20/11' indicated the resident had impaired mobility and cognition, and required</p>		<p>that are non-pressure related h) staff monitor and document tube feeding sites i) provide activity services such as radio and television stimulation What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times per week to ensure physicians orders and plan of care were followed with the emphasis on tube feeding, assistance with meals ie.supercereal provided (rotating meals), fall preventions interventions in place, residents up out of bed, pressure ulcer dressings are in place, skin conditions monitoring and that staff provide activity services such as radio and television stimulation. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>staff assist with all transfers. The interventions indicated the resident was to be assisted with transfers and locomotion on and off the unit.</p> <p>The plan of care, dated 9/2/11 and reviewed on 12/20/11, indicated the resident required the use of a recliner chair to aid in positioning when out of bed due to limitations in the upper and lower extremities and the resident's inability to properly position self when in wheelchair. The interventions indicated the resident was to be assisted into the recliner chair as the primary mode of locomotion when out of bed.</p> <p>The plan of care, dated 12/8/11, indicated the resident had minimum response to sensory stimulation. The interventions indicated a variety of sensory items were to be provided to get a response, provide escort to and from activities and provide sensory stimulation in a calm environment.</p> <p>Interview with CNA #2 on 3/9/12 at 8:45 a.m., indicated he was not aware this was the first time the resident was out of bed all week.</p> <p>Interview with LPN #2 on 3/9/12 at 8:45 a.m., indicated that this was the first time the resident had been out of</p>			

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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			
	<p>bed all week.</p> <p>Interview with Activity Aide #2 on 3/12/12 at 9:00 a.m., indicated the resident should be up in her recliner and brought to the lounge area for activities.</p> <p>Interview with the Activity Director on 3/12/12 at 9:45 a.m., indicated the resident was to be brought out of her room for activities and her television should have been turned on.</p> <p>2. On 3/12/12 at 4:45 a.m., Resident #D was observed in his room in bed. The resident was positioned on his left side. The resident's buttock area was exposed. The resident had no dressing to the pressure sore to his sacrum. At this time, LPN #1 cleansed the resident's pressure area with wound cleanser, placed a gauze pad over the wound and then covered the area with a protective dressing. The resident was observed with a reddened area to his right trochanter, there was no dressing to the area at this time. LPN #1 indicated the area was old and did not require a dressing.</p> <p>The record for Resident #D was reviewed on 3/12/12 at 9:10 a.m. A physician's order, dated 3/7/12,</p>						

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>indicated the resident's coccyx wound was to be cleansed daily with normal saline or wound cleanser, pat dry. Apply santyl ointment to wound bed and cover with dry dressing daily.</p> <p>A physician's order, dated 3/9/12, indicated the resident's right trochanter was to be cleansed with normal saline or wound cleanser and apply silvadene. The area was to be covered with a dry dressing daily.</p> <p>The plan of care, dated 12/3/11, indicated the resident had an alteration in his skin integrity as evidenced by having a pressure ulcer. The interventions indicated the areas were to be treated per the physician's order.</p> <p>Interview with the Treatment Nurse on 3/12/12 at 8:45 a.m., indicated, that she had not been informed the resident had removed his dressing during the midnight shift. She indicated she would ensure the correct dressing was applied.</p> <p>3. The closed record for Resident #B was reviewed on 3/7/12 at 9:18 a.m. The resident was admitted to facility on 1/20/12 from the hospital with a PEG tube.</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Review of Physician Orders, dated 2/1/12, indicated apply normal saline to PEG tube site, pat dry and apply dry dressing daily.</p> <p>Review of the Treatment Administration Record (TAR), dated 1/20-2/20/12, indicated the order for the PEG tube site to be cleansed everyday with normal saline and cover with dry dressing was not transcribed onto the TAR. There was no evidence this had been done everyday as ordered by the Physician.</p> <p>Review of Nursing Progress Notes for 2/1-2/4/12 indicated there was no evidence the PEG tube had a dressing on it.</p> <p>Interview with LPN #5 on 3/9/12 at 3:13 p.m., indicated at the time of the resident's discharge from the facility there was no dressing around the PEG tube site.</p> <p>4. On 3/05/2012 at 11:08 a.m., Resident #C was observed with red areas of scratches to the right ankle area as well as left ankle.</p> <p>On 3/7/12 at 8:20 a.m., the resident was observed with red scratch marks noted at the bottom of both of her</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>legs.</p> <p>On 3/7/12 at 3:03 p.m., the resident was observed sitting in her wheelchair in her room. LPN #6 was observed at the time assessing the resident's bilateral lower extremities. The right lower extremity was swollen with pitting edema noted as well as dry skin noted. There were multiple scabbed areas noted throughout her foot and lower leg with scratch marks. The left lower extremity was also noted to be red with dry skin and had multiple scabbed areas throughout as well as scratch marks. At that time, the resident was asked if she scratched her legs and she indicated yes she does every night, she indicated her legs itched all the time.</p> <p>The record for Resident #C was reviewed on 3/7/12 at 8:46 a.m. The resident's diagnoses included but were not limited to, anemia, allergic dermatitis, peripheral vascular disease and cellulitis to left foot.</p> <p>Review of the current plan of care, dated 6/12/11 and updated on 1/19/12, indicated the resident has allergic dermatitis. The nursing approaches were to encourage the resident not to scratch and to notify nurse if itching develops or increases.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Review of the current plan of care, dated 6/12/11 and updated on 1/19/12, indicated the resident was at risk for skin breakdown related to peripheral vascular disease, and scratching skin causing it to bleed at times. The nursing approaches were to do skin checks daily with a.m., care and full body checks to be done twice weekly on shower days.</p> <p>Review of Nursing Progress Notes, dated 3/1/12 at 1:10 p.m., indicated the resident's right leg was pink with scabbed areas.</p> <p>Review of Nursing Progress Notes, dated 3/1/12 at 8:36 p.m., indicated the resident's left lower leg had multiple scabbed areas from resident previously scratching and the right lower extremity had multiple open areas that were now starting to scab over.</p> <p>Review of Nurses Notes, dated 3/6/12 2:14 a.m., indicated the resident's bilateral lower extremities were pink in color and cool to touch with multiple scabbed areas.</p> <p>Review of the Bath and Skin Report Sheet, dated 3/1 and 3/7/12, indicated the resident's skin was</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>intact with no redness, rashes or excoriation. The skin check was completed by the shower aide and the LPN.</p> <p>Interview with LPN #6 who completed both assessments on the shower sheets indicated he had thought that only new areas were to be identified on the sheets.</p> <p>Interview with the Director of Nursing on 3/9/12 at 8:12 a.m., indicated the bath and skin sheets should be completed with the resident's current skin conditions including rashes, excoriation, skin tears and bruising .</p> <p>5. On 3/7/12 at 8:13 a.m., Resident #L was observed sitting at a table in the Main Dining Room. The resident was served his breakfast tray of a hard boiled egg, biscuits, and a bowl of raisin bran cold cereal. He did not receive any Supercereal (a fortified hot cereal) with his meal tray. Supercereal was not offered to the resident during the meal service.</p> <p>On 3/8/12 at 7:56 a.m., the resident was observed sitting in a wheel chair at a table in the Main Dining Room. The resident was served his breakfast tray at 8:02 a.m. There were two hard boiled eggs, toast, sausage, and a bowl of a raisin bran cold cereal.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>There was no Supercereal served to the resident. The tray card that was served with the meal tray indicated the resident was to receive Supercereal at breakfast. The resident left the Main Dining Room at 8:20 a.m. and had not received or been offered any Supercereal.</p> <p>On 3/12/12 at 8:18 a.m., the resident was sitting in a wheel chair in the Main Dining Room. The resident was served his breakfast tray at this time. The resident received two hard boiled eggs, toast, and a bowl of raisin bran cold cereal. The resident was not served or offered any Supercereal during the meal. The tray card served with the meal tray indicated the resident was to receive Supercereal at breakfast.</p> <p>The record of Resident #L was reviewed on 3/7/12 at 2:32 p.m. The resident's diagnoses included, but were not limited to, convulsions, dysphagia (difficulty swallowing), depressive disorder, anemia, and anxiety disorder. The current Physician orders indicated the resident was to receive a Regular diet with Supercereal at breakfast. The order was initially written on 11/29/11.</p> <p>When interviewed on 3/12/12 at 1:08</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>p.m., the Director of Nursing indicated the resident should have received the Supercereal as ordered by the Physician.</p> <p>6. Resident #G was observed on 3/7/12 at 8:14 a.m., in bed. The resident was awake. There was no body pillow in the resident's bed.</p> <p>The resident was observed in bed on 3/7/12 at 10:24 a.m., the resident was close to the edge of the bed. Interview with the MDS Coordinator at that time, indicated that she was getting help to reposition the resident in the bed. There was no body pillow in the bed.</p> <p>Continued observations of the resident in the bed on 3/7/12 at 12:41 p.m. and 2:55 p.m., indicated there was no body pillow in the bed.</p> <p>Observation of the resident in bed on 3/8/12 at 8:16 a.m., indicated there was no body pillow in the bed.</p> <p>The resident was observed in bed on 3/8/12 at 1:14 p.m. There was no body pillow in the bed. Interview with the MDS Coordinator at that time, indicated there was no body pillow in the bed.</p> <p>The record for Resident #G was</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>reviewed on 3/8/12 at 9:45 a.m. The resident had diagnoses that included, but were not limited to, convulsions, hemiplegia, and dementia.</p> <p>There was a care plan, dated 11/2/11, that indicated the resident was at risk for falls due to diagnosis of hemiplegia, CVA (cerebral vascular accident-stroke), and that the resident at times would state that he purposely put himself on the floor. The interventions to reduce the risk of falls included:</p> <ul style="list-style-type: none"> -body pillow when in bed (initiated 3/5/12) -assist out of bed during p.m. shift -assist out of bed daily -resident to use bariatric bed -bed bolsters to bed to assist in positioning (initiated 1/18/12) -keep bed in lowest position -keep bed arranged so nightstand is not directly next to bed -floor mat at bedside <p>Interview with CNA #4 on 3/9/12 at 2:15 p.m., indicated each resident had a care card in the room that indicated any special needs, such as fall devices, how much assistance was needed to transfer, and continence. Review of the care card for Resident #G indicated the resident was a fall risk and staff were to use a</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>body pillow, get him up in the p.m., use bed bolsters and keep the bed in the lowest position</p> <p>Interview with The MDS Coordinator on 3/8/12 at 1:24 p.m., indicated the Director of Nursing had indicated the resident's body pillow was soiled and had been sent to laundry. She indicated there were no other body pillows to be used while the soiled one was being cleaned. She indicated the resident should have a body pillow to prevent falls from the bed. She indicated the resident's care plan had interventions for a body pillow to be used to prevent falls, she indicated the care plan was not followed.</p> <p>This Federal tag relates to Complaint #IN00103446.</p> <p>3.1-35(g)(2)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with non pressure ulcers related to bruises, skin tears, rashes, and scratch marks were assessed and the areas were monitored to prevent further skin issues from arising for 3 of 3 residents reviewed for skin condition non pressure related of the 5 who met the criteria for skin condition non pressure related. The facility also failed to ensure residents were monitored for bowel management related to adverse side effects/consequences from taking narcotic medication for 1 of 11 residents reviewed for unnecessary medications(Resident's #C, #D, #E, and #H)</p> <p>Findings include:</p> <p>1. On 3/05/2012 at 11:08 a.m., Resident #C was observed with red areas of scratches to the right ankle</p>	F0309	<p>Lake County Nursing and Rehab F309 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RC was treated with Keflex antibiotic and Benadryl. On 3/22/2012 the physician assessed and documented improvement RE has been discharged home RD was assessed during the survey and will be assessed per policy RH has been discharged home without complication How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? No other residents were identified with scratches through review of medical records and hands on observationAll current</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>area as well as left ankle.</p> <p>On 3/7/12 at 8:20 a.m., the resident was observed with red scratch marks noted at the bottom of both of her legs.</p> <p>On 3/7/12 at 3:03 p.m., the resident was observed sitting in her wheelchair in her room. LPN #6 was observed at the time assessing the resident's bilateral lower extremities. The right lower extremity was swollen with pitting edema noted as well as dry skin noted. There were multiple scabbed areas noted throughout her foot and lower leg with scratch marks. The left lower extremity was also noted to be red with dry skin and had multiple scabbed areas throughout as well as scratch marks. At that time, the resident was asked if she scratched her legs and she indicated yes she does every night, she indicated her legs itched all the time.</p> <p>Interview with LPN #6 on 3/7/12 at 3:08 p.m., indicated the resident did not have anything ordered for her complaints of scratching or itching. The LPN indicated there was a topical cream ordered, but nothing in place such as a medication to prevent the resident from scratching her legs all the time.</p>		<p>residents with bruises were identified during the surveyAll residents with bruises, scratches, non-pressure ulcers and utilize narcotics are at risk for the alleged deficient practice All residents that take narcotics on routine schedule have been reviewed for consitaption with no residents identifiedWhat measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensure residents with non-pressure ulcers related to bruises, skin tears, rashes and scratches are assessed and monitored to prevent further skin concerns from arising. b) ensure residents are monitored for bowel management related to adverse side effects/consequences related to side effects of taking narcotics What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times weekly to ensure that residents with non-pressure ulcers such as bruises, skin tears, rashes and scratches have been identified, assessed and documented in the medical record. The DON or designee will further audit bowel patterns three times per week for residents receiving Opidod's that</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>The record for Resident #C was reviewed on 3/7/12 at 8:46 a.m. The resident's diagnoses included but were not limited to, anemia, allergic dermatitis, peripheral vascular disease and cellulitis to left foot.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 1/19/12, indicated the resident was alert and oriented and was able to understand as well as be understood. The resident had no pressure ulcers, but had applications of ointments/medications to her skin other than to feet.</p> <p>Review of the current plan of care 6/12/11 and updated on 1/19/12 indicated the resident has allergic dermatitis. The nursing approaches were to encourage the resident not to scratch and to notify nurse if itching develops or increases.</p> <p>Review of the current plan of care, dated 6/12/11 and updated on 1/19/12, indicated the resident was at risk for skin breakdown related to peripheral vascular disease, and scratching skin causing it to bleed at times. The nursing approaches were to do skin checks daily with a.m., care and full body checks to be done twice</p>		<p>may cause. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>	

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>weekly on shower days.</p> <p>Review of Physician Orders, dated 3/17/10 and on the current 3/12 recap, indicated a treatment for her bilateral lower extremities, to apply ammonium lactate 12% at bedtime. Another Physician Order, dated 2/20/12, indicated triamcinolone acetonide ointment 0.1% small amount topical bid to bilateral lower extremities.</p> <p>Nursing progress notes, dated 1/13/12 at 8:23 a.m., indicated this writer observed resident to have red areas to bilateral lower extremities, resident states that she scratched her legs due to itching. The resident's Physician was called and received a new order for triple antibiotic ointment times five days.</p> <p>Nurses notes on 1/18/12 at 8:51 a.m., indicated there was no evidence of any assessment or documentation regarding the resident scratches or her itching. The next documented entry in Nursing Notes was on 1/25/12 and there was no assessment or documentation regarding the resident's scratches or itching.</p> <p>Nurses Notes, dated 2/17/12 3:28</p>						

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>p.m., indicated the writer observed swelling to top of the left foot that was pitting edema and noted the foot to be red and tender to touch. The Physician was notified and new orders for keflex (an antibiotic) for cellulitis was obtained.</p> <p>Nurses Notes, dated 2/28/12 at 5:20 a.m., indicated left lower extremity has multiple scabbed areas with no drainage observed, the right lower extremity has multiple deep open areas to the ankle and extending up to the middle of the leg with no drainage. The resident states that they do itch. Will communicate to oncoming nurse.</p> <p>Nurses Notes at 12:22 p.m., on 2/28/12 indicated received a new order from Physician to extend the antibiotic for five more days.</p> <p>Further review of Physician Orders at that time indicated there was nothing ordered for the resident's complaints of itching or scratching her legs.</p> <p>Nursing Progress Notes, dated 2/29/12 at 2:11 a.m., indicated bilateral lower extremities remain pink/red in color and warm to touch with multiple open areas noted to right lower extremity due to resident</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>scratching.</p> <p>Review of Nursing Progress Notes, dated 3/1/12 at 1:10 p.m., indicated the resident's right leg was pink with scabbed areas.</p> <p>Review of Nursing Progress Notes, dated 3/1/12 at 8:36 p.m., indicated the resident's left lower leg had multiple scabbed areas from resident previously scratching and the right lower extremity had multiple open areas that were now starting to scab over.</p> <p>Review of Nurses Notes, dated 3/6/12 2:14 a.m., indicated the resident's bilateral lower extremities were pink in color and cool to touch with multiple scabbed areas.</p> <p>Review of the Bath and Skin report sheet for 1/12 indicated skin check/assessments were completed on 1/6, 1/12, 1/20 and 1/27 and all were checked skin was intact. There were no areas of redness/rash, or excoriation noted.</p> <p>Review of the Bath and Skin Report Sheet, dated 3/1 and 3/7/12, indicated the resident's skin was intact with no redness, rashes or excoriation. The skin check was</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>completed by the shower aide and the LPN. Interview with LPN #6 who completed both assessments on the shower sheets indicated he had thought that only new areas were to be identified on the sheets.</p> <p>Interview with CNA #7 on 3/8/12 at 6:34 a.m., indicated the resident constantly scratches her legs, she indicated they put Vaseline on her legs to try and soothe them. She further indicated the resident complains to them they itch and they report that information to the nurse. She further indicated at the time she has been employed at the facility since September and her legs have been like that.</p> <p>Interview with the Director of Nursing on 3/9/12 at 8:12 a.m., indicated the bath and skin sheets should be completed with the resident's current skin conditions including rashes, excoriation, skin tears and bruising. Further interview with the Director of Nursing at the time, indicated she was not able to find the resident's bath sheets for the month of February 2012.</p> <p>2. On 3/5/2012 at 12:42 p.m., Resident #E was observed with two bruises on right forearm.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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
	<p>On 3/6/12 at 10:13 a.m., during a an interview with the resident there were two bruises observed to his right forearm. The bruises were red/blue in color.</p> <p>3/6/12 at 3:30 p.m., The resident was observed up in a wheelchair by the nurses station. At that time, the resident had two bruises to his right forearm which were red/blue in color.</p> <p>The record for Resident #E was reviewed on 3/7/12 at 2:00 p.m. The resident was admitted to facility on 2/23/12 from the hospital. Review of Nursing Progress Notes, dated 2/23/12, indicated the resident was alert and oriented to person, place, and time.</p> <p>Review of an admission nursing assessment, dated 2/23/12, indicated the resident was admitted with no bruises to his skin.</p> <p>Review of Nursing Progress Notes, dated 2/23/12 at 7:30 p.m., resident has fractured ribs due to fall in hospital. No visible bruising noted upon assessment.</p> <p>Continued review of Nursing Progress Notes, dated 2/23/12 through 3/6/12,</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>indicated there was no documentation the resident had two bruises on his right forearm.</p> <p>Review of the March 2012 skin/bath sheet indicated the resident received a shower (no date available) and his skin was intact with no bruising.</p> <p>Review of the Medication Administration Record (MAR) dated 2/23/12 indicated the resident was receiving Aspirin 325 mg 1 tab daily, and Plavix 75 milligrams daily.</p> <p>Interview with the Director of Nursing on 3/8/12 10:01 a.m., indicated she did notice the areas to his right forearms during the last couple of days in which they were red/purple in color. She further indicated that she would expect the nursing staff to assess and document in nurses notes the size and location of the bruises when they were first observed. Further interview with the Director of Nursing indicated there was no evidence of any assessment of the resident's bruising and/or red/purple discoloration to his right forearm in the resident's chart.</p> <p>3. On 3/6/2012 at 10:07 a.m., Resident #D was observed with areas of red discoloration to the left arm and</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>forearm, with bruising to the top of the right hand.</p> <p>On 3/7/12 at 8:34 a.m., the resident was observed in bed. There were bruises noted to his right arm and forearm they were yellow and red in color.</p> <p>On 3/8/12 at 6:25 a.m., the resident was observed in the shower room. The resident was observed multiple bruises red, purple and yellow in color to both of his arms.</p> <p>On 3/8/12 at 10:00 a.m., the resident was observed in bed. The resident was observed with a purple red bruised area to top of right hand, and bruises to both of the resident's forearms.</p> <p>On 3/9/12 8:39 a.m., the resident was observed in bed wearing a hospital gown. There were bruises to the top of his right hand and multiple bruising to both of his arms.</p> <p>On 3/9/12 at 1:33 p.m., LPN #4 performed a skin assessment for the resident. At that time the resident was observed in bed, he had a large bruise on the top of his right hand that was red and purple in color and multiple bruises red and blue in color</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>to both forearms and upper arms. The LPN indicated at the time that she could not tell if the resident had new bruises, or if they were old. The LPN indicated she was unaware of what the facility's policy and procedure was for monitoring, assessing and documenting bruised areas.</p> <p>The record for Resident #D was reviewed on 3/8/12 at 8:35 a.m. The resident was admitted to facility on 12/3/11 and readmitted to the facility on 3/2/12 after a hospitalization. The resident's diagnoses included, but were not limited to anemia, pressure ulcers, edema, muscle weakness, chronic airway obstruction, malnutrition, high blood pressure, and coronary artery occlusion.</p> <p>Review of Admission MDS assessment 12/10/11 indicated the resident needed extensive assistance with transfers, bed mobility, dressing and bathing. The resident had range of motion limitations to both his upper and lower extremities and was admitted with pressure ulcers.</p> <p>Review of the current care plans, dated 12/22/11, indicated there was no care plan for the resident's bruising or fragile skin.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Review of the nursing admission assessment, dated 12/3/11, indicated multiple discolorations-dark purple/red to bilateral arms, with abrasions and scabbed areas to right lower leg left leg.</p> <p>Review of the readmission full body assessment, dated 3/2/12, indicated bruises scattered on left and right side of arms. Nurses Notes, dated 3/2/12, indicated there were scattered ecchymotic areas to the left and right arms. Further review of Nurses Notes, dated 3/2/12, indicated the areas were not measured.</p> <p>Review of Physician Orders, dated 3/2/12, indicated the resident was receiving Plavix (a medication used to thin blood) 75 milligrams (mg) daily as well as Aspirin 325 mg one tablet daily.</p> <p>Review of Nurses Notes, dated 2/21/12, indicated the resident had a fall and sustained skin tears to his left elbow and right arm. The resident's Physician was notified and treatments orders were obtained for those skin tears.</p> <p>Further review of Nursing Progress</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Notes, dated 3/2-3/8/12, indicated there was assessment or monitoring of the bruises the resident was readmitted to the facility with on 3/2/12.</p> <p>Review of Bath and Skin Report sheet for the month of 3/12 indicated the resident received a shower on 3/6 and 3/8/12 and there was no documentation of skin tears or bruising noted on the sheets. The bath sheets were signed by the shower CNA and by a LPN that the resident's skin had been assessed for bruising and skin tears.</p> <p>Interview with the Director of Nursing on 3/9/12 at 10:33 a.m., indicated his bruises documented nor were they followed through or assessed. She further indicated at the time if staff were to observe a bruise or skin tear they were to follow up with measurements and assessments.</p> <p>Interview with LPN #3 on 3/9/12 at 1:37 p.m., indicated bruises were to measured at the time of admission with the description of each bruise and documented on the nursing admission sheet.</p> <p>4. The closed record for Resident #H</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>was reviewed on 3/12/12 at 9:00 a.m. The resident was admitted to the facility on 2/14/12. The resident's diagnoses included, but were not limited to, pain, anxiety, congestive heart failure, high blood pressure, and esophageal reflux.</p> <p>There were Physician orders for the resident to receive Hydrocodone/acetaminophen (an opioid agonist medication for pain) 5 mg (milligrams)/325 mg two tablets every 6 hours as needed, Oxycontin(an opioid agonist medication for pain) 20 mg ER (extended release) every 12 hours, Celebrex (a nonsteroidal anti inflammatory medication) 100 mg twice a day, and Tramadol (an opioid agonist medication for pain) 50 mg three times a day.</p> <p>The 2/2012 Medication Administration Record indicated the resident received 19 doses of the as needed Hydrocodone/acetaminophen between 2/14/12 and 2/22/12.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated constipation was listed as an adverse reaction to the above four medications.</p> <p>The 2/2012 Vital Signs report for</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>recording bowel movements indicated the first entry was made on 2/16/12. The following were the only entries made from 2/16/12 through 2/23/12.</p> <p>2/16/12 at 1:26 a.m.- "none" 2/16/12 at 7:34 a.m.- "none" 2/17/12 at 2:45 a.m.- "none" 2/18/12 at 1:37 a.m.- "none" 2/19/12 at 3:50 a.m.- "none" 2/20/12 at 1:22 a.m.- "none" 2/21/12 at 1:49 a.m.- "unavailable/not taken" 2/21/12 at 10:12 p.m.- "none" 2/22/12 at 8:12 p.m.- "none"</p> <p>When interviewed on 3/12/12 at 10:00 a.m., the Restorative Nurse indicated staff are to record the residents bowel movement every shift on the vital signs record to indicate if the resident had a bowel movement every shift.</p> <p>This Federal Tag relates to Complaint IN00103446</p> <p>3.1-37(a)</p>			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 3 residents of the 10 who met the criteria for activities of daily living were given assistance with eating and transferring out of bed. (Resident #F)</p> <p>Findings include:</p> <p>On 3/5/12 at 12:00 p.m. and 3:00 p.m., Resident #F was observed in her room in bed. There was a geri-chair recliner located at the foot of the resident's bed.</p> <p>On 3/6/12 at 8:30 a.m. and 10:30 a.m., the resident was observed in her room in bed.</p> <p>On 3/7/12 at 8:39 a.m., 10:40 a.m., 12:43 p.m., and 2:55 p.m., the resident was observed in her in room in bed. A geri-chair recliner was observed at the foot of the resident's bed.</p> <p>On 3/8/12 at 8:25 a.m., the resident was in her room in bed. At 8:34 a.m.,</p>	F0312	<p>Lake County Nursing and Rehab F312 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RF is assisted out of bed in her geri chair and assisted with her activities of daily living. RF is assisted with meals and encouragement is also provided</p> <p>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents who are dependent for activities of daily living were reviewed by the DON or designee through rounds and review of medical record with no other resident identified as being affected. All residents that are dependent on staff are at risk for the alleged deficient practice</p> <p>What measures will the facility take systems the facility will</p>	04/06/2012	

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>CNA #2 entered the resident's room with her breakfast tray. The CNA placed the tray on the resident's overbed table and walked out of the room. At 8:43 a.m., the resident's tray was covered and on her overbed table. No staff were in the resident's room at this time. At 8:47 a.m., CNA #2 went into the resident's room and removed her tray. He indicated the resident didn't want to eat, and that she doesn't eat much. The CNA then proceeded back into the resident's room and uncovered the resident's breakfast tray and attempted to feed the resident. The geri-recliner was positioned at the foot of the residents bed. At 10:00 a.m. and 12:35 p.m., the resident remained in her room in bed. The geri-chair remained at the foot of the resident's bed.</p> <p>On 3/12/12 at 8:30 a.m. and 9:50 a.m., the resident was observed in her room in bed. Again, the geri-chair recliner was located at the foot of the bed.</p> <p>The record for Resident #F was reviewed on 3/8/12 at 9:00 a.m. The resident's diagnoses included, but were not limited to, aphasia and cerebral vascular accident (stroke).</p> <p>The Quarterly Minimum Data Set</p>		<p>alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring that residents are provided assistance with activities of daily living b) ensuring that residents are provided assistance with ADL such as eating and transferring out of bed What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times weekly to ensure that residents are provided assistance with activity of daily living including those who need assistance with eating and transferring out of bed through rounds and observations. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>(MDS) Assessment, dated 2/24/12, indicated the resident required extensive assistance with eating and extensive assistance with transfers with two plus person assist.</p> <p>The plan of care, dated 12/20/11, indicated the resident had impaired mobility and cognition, and required staff assist with all transfers. The interventions indicated the resident was to be assisted with transfers and locomotion on and off the unit.</p> <p>The plan of care, dated 9/2/11 and reviewed on 12/20/11, indicated the resident required the use of a recliner chair to aid in positioning when out of bed due to limitations in the upper and lower extremities and the resident's inability to properly position self when in wheelchair. The interventions indicated the resident was to be assisted into the recliner chair as the primary mode of locomotion when out of bed.</p> <p>The plan of care, dated 9/2/11 and reviewed on 12/20/11, indicated the resident required a mechanically altered diet related to the current diagnosis of dysphagia. The interventions indicated encouragement of oral intake of food and fluids was to be provided.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Interview with LPN #2 on 3/9/12 at 8:45 a.m., indicated that this was the first time the resident had been out of bed all week. Continued interview at this time, indicated the CNA should have attempted to feed the resident as well prior to removing the tray out of the resident's room the first time.</p> <p>This federal tag relates to Complaint IN00103446.</p> <p>3.1-38(a)(3)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure treatments were applied to pressure sores as ordered for 1 of 3 residents of the 17 who met the criteria for pressure sores. (Resident #D)</p> <p>Findings include:</p> <p>On 3/12/12 at 4:45 a.m., Resident #D was observed in his room in bed. The resident was positioned on his left side. The resident's buttock area was exposed. The resident had no dressing to the pressure sore to his sacrum. At this time, LPN #1 was informed the resident's dressing was off. The LPN entered the room and cleansed the resident's pressure area with wound cleanser, placed a gauze pad over the wound and then covered the area with a protective dressing. The resident was observed with a</p>	F0314	<p>Lake County Nursing and Rehab F314-1 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RD dressing to the sacral area was changed by the nurse upon notification that dressing came off RD wound care orders were reviewed with the wound clinic and treatment applied as ordered.</p> <p>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents receiving wound care orders were reviewed through hands on observation by the DON and/or designee noting</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>reddened area to his right trochanter, there was no dressing to the area at this time. LPN #1 indicated the area was old and did not require a dressing. The LPN indicated the last time she saw the resident's dressing on was around 12:00 and 1:00 a.m.</p> <p>Interview with CNA #1 on 3/12/12 at 5:30 a.m., indicated the resident had a history of removing his dressing. CNA #1 indicated that he found the resident's dressing on the floor. He could not remember the last time he saw the resident's dressing in place.</p> <p>The record for Resident #D was reviewed on 3/12/12 at 9:10 a.m. A physician's order, dated 3/7/12, indicated the resident's coccyx wound was to be cleansed daily with normal saline or wound cleanser, pat dry. Apply santyl ointment to wound bed and cover with dry dressing daily.</p> <p>A physician's order, dated 3/9/12, indicated the resident's right trochanter was to be cleansed with normal saline or wound cleanser and apply silvadene. The area was to be covered with a dry dressing daily.</p> <p>The Admission Minimum Data Set (MDS) Assessment, dated 12/10/11, indicated the resident was at risk for</p>		<p>all dressings were in place as ordered All residents receiving wound care orders are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring that treatments are applied to pressure sore as ordered b) notifying the nurse in the event a dressing comes off, is soiled and must be replaced What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times weekly alternating shifts to ensure that treatments to pressure sore areas are in place as ordered and that in the event a dressing comes off or is soiled staff notify the nurse to replace the dressing, A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>pressure ulcers and had one or more unhealed pressure ulcers at a Stage 1 or higher. The area was identified as unstageable area and was present on admission. The area measured 4.3 centimeters (cm) x 3.7 cm.</p> <p>The plan of care, dated 12/3/11, indicated the resident had an alteration in his skin integrity as evidenced by having a pressure ulcer. The interventions indicated the areas were to be treated per the physician's order.</p> <p>The Skin Integrity Sheet, dated 3/9/12, indicated the area to the right trochanter was a Stage 2 and measured 3 cm x 1 cm x 0.1 cm. No sheets were provided for the coccyx area.</p> <p>Interview with the Treatment Nurse on 3/12/12 at 8:45 a.m., indicated, that she had not been informed the resident had removed his dressing during the midnight shift. She indicated she would ensure the correct dressing was applied.</p> <p>3.1-40(a)(2)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure interventions were provided to prevent urinary tract infections, related to catheter tubing on the floor for 1 of 3 residents reviewed for urinary catheters of the 4 who met the criteria for urinary catheters. (Resident #56)</p> <p>Findings include:</p> <p>Resident #56 was observed on 3/6/12 at 8:33 a.m. The resident was seated in his wheelchair. He was in the second floor dining room. The resident's urinary catheter tubing was lying on the floor of the dining room.</p> <p>On 3/7/12 at 12:45 p.m., the resident was observed in his wheelchair. A staff member was observed propelling the resident out of the</p>	F0315	<p>Lake County Nursing and Rehab F315 POC Please accept the following as the facility plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? R56 foley catheter tubing was lifted off the floor How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with foley catheters were reviewed by the DON and/or designee through hands on review and observations with no other residents identified as being affectedAll residents with foley catheters are at risk for the</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>second floor dining room. The resident's urinary catheter tubing was dragging on the floor.</p> <p>The record for Resident #56 was reviewed on 3/7/12 at 9:44 a.m. The resident had diagnoses that included, but were not limited to, spina bifida, suprapubic catheter (a surgical opening in the abdomen for the placement of a tube to drain urine) and neurogenic bladder.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, completed on 1/5/12, indicated the resident had an indwelling catheter.</p> <p>Interview on 3/12/12 at 8:55 a.m., with CNA #4 indicated the catheter tubing of the resident was to placed in the privacy bag and the tubing should not be on the floor. She indicated the tubing on the floor increases the risk for urinary tract infections.</p> <p>Interview with the Director of Nursing on 3/12/12 at 10:15 a.m., indicated the catheter tubing for all residents should not be on the floor.</p> <p>3.1-41(a)(2)</p>		<p>alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring interventions are provided to prevent urinary tract infections such as keeping tubing of the urinary catheter off of the floor What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times per week to ensure that those residents receiving foley catheters are provided care to prevent urinary tract infections with the emphasis on the tubing of the foley catheter bag touching the floor. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on record review and interview, the facility failed to ensure treatment and services for a percutaneous endoscopic gastrostomy (PEG) tube site were rendered as ordered by the physician for an ostomy that had redness for 1 of 3 residents reviewed for tube feeding in the stage two sample of 34. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 3/7/12 at 9:18 a.m. The resident was admitted to facility on 1/20/12 from hospital with a PEG tube.</p> <p>Review of the Admission MDS (Minimum Data Set) assessment, dated 1/27/12, indicated the resident was able to be understood and could understand. The resident needed extensive assistance with his bed</p>	F0322	<p>Lake County Nursing and Rehab F322POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RB has been discharged How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with peg tubes were assessed by their nurse with no other resident noted to be affected by the alleged deficient practiceAll residents with peg tubes orders were reviewed to ensure they were transcribed to the treatment administration record with no deficiencies noted. What measures will the facility take</p>	04/06/2012			

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>mobility and toilet use with two person assist. The resident also needed extensive assistance with dressing, personal hygiene and eating with only a one person physical assist. The resident had range of motion impairment to both sides for upper and lower extremities</p> <p>Review of Physician Orders, dated 1/20/12, indicated PEG tube water flush 100 cubic centimeters (cc) every shift and a regular diet with no concentrated sweets and may have thin liquids. Further review of Physician Orders, dated 1/28/12, indicated PEG tube site care daily.</p> <p>Review of an "Observation/Concern" form made by the resident's family member, dated 1/31/12, indicated a concern that the resident's PEG tube site was red. The facility's follow up was that nursing staff were educated on resident's needs and the family was notified and pleased with the follow up dated 2/2/12.</p> <p>Review of Nursing Progress Notes, dated 1/31, 2/2, 2/3, and 2/4/12, indicated there was no assessment of the resident's PEG tube site or redness noted.</p> <p>Review of Physician Orders, dated</p>		<p>systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring treatment and services for a PEG tube site are rendered as ordered by the physician b) ensuring that PEG tube care orders are transcribed to the TAR</p> <p>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times per week to ensure that those residents receiving PEG tubes receive the treatment and services as ordered by the physician, including transcribing orders to the TAR. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>2/1/12, indicated apply normal saline to PEG tube site, pat dry and apply dry dressing daily.</p> <p>Review of the Treatment Administration Record (TAR), dated 1/20-2/20/12, indicated the order for the PEG tube site to be cleansed everyday with normal saline and cover with dry dressing was not transcribed onto the TAR. There was no evidence this had been done everyday as ordered by the Physician.</p> <p>Further review of the clinical record indicated there no was bath or skin report sheet for the month of 1/12 or 2/12 completed for the resident to assess or monitor for any new skin conditions by the ostomy site.</p> <p>Interview with Assistant Director of Nursing (ADON) on 3/9/12 at 12:49 p.m., indicated she was the Director of Nursing (DON) at the time the resident was here and when the family had made the concern regarding the PEG tube being red. She further indicated there was no assessment or any evidence of documentation of the resident's peg tube at the time of the family's concern or after.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Review of Nursing Progress Notes, dated 2/4/12, indicated the resident's family were taking the resident out of the facility per ambulance in which they had arranged themselves to the hospital. The resident left the facility against medical advise on 2/4/12 at 2:30 p.m.</p> <p>Review of the Emergency Room Nursing Progress Notes, dated 2/4/12 at 3:20 p.m., indicated the resident's PEG tube had purulent drainage around the g-tube site. Further documentation from the emergency notes indicated at 9:10 p.m., there was still a scant amount of purulent drainage observed coming from the g-tube site.</p> <p>Interview with LPN #5 on 3/9/12 at 3:13 p.m., indicated she was the nurse on duty the day the resident's brother and sister were present in the room and decided to take the resident to the hospital and discharge from the facility. The LPN indicated at the time of discharge the resident's PEG tube was observed tied in a knot and there was no dressing around the site. The LPN indicated she had assessed the resident's PEG tube site earlier in her shift and there was no dressing over his site at that time either.</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>Interview with the DoN on 3/12/12 at 11:00 a.m., indicated the physician's order had not been transcribed onto the 2/12 TAR and does not know if the treatment had been completed or not for the PEG tube site.</p> <p>This Federal Tag relates to Complaint IN00103446</p> <p>3.1-44(a)(2)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0323 SS=D	<p>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.</p> <p>Based on observation, record review and interview, the facility failed to ensure safety devices were provided to prevent falls related to a body pillow not in use for 1 of 3 residents reviewed for accidents of the 6 residents who met the criteria for accidents. (Resident #G)</p> <p>Findings include:</p> <p>Resident #G was observed on 3/7/12 at 8:14 a.m. in bed, the resident was awake. There was no body pillow in the residents bed.</p> <p>The resident was observed in bed on 3/7/12 at 10:24 a.m., the resident was close to the edge of the bed. Interview with the MDS Coordinator at that time, indicated that she was getting help to reposition the resident in the bed. There was no body pillow in the bed.</p> <p>Continued observations of the resident in the bed on 3/7/12 at 12:41 p.m. and 2:55 p.m., indicated there</p>	F0323	<p>Lake County Nursing and Rehab F323POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RG's body pillow remains in use and the facility has purchased spare pillows will be utilized during cleaning times How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with safety devices including body pillows were audited by the DON or designee through hands on observation and review of medical records with no residents identified as being affectedAll residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>was no body pillow in the bed.</p> <p>Observation of the resident in bed on 3/8/12 at 8:16 a.m., indicated there was no body pillow in the bed.</p> <p>The resident was observed in bed on 3/8/12 at 1:14 p.m. There was no body pillow in the bed. Interview with the MDS Coordinator at that time, indicated there was no body pillow in the bed.</p> <p>The record for Resident #G was reviewed on 3/8/12 at 9:45 a.m. The resident had diagnoses that included, but were not limited to, convulsions, hemiplegia, and dementia.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, completed on 2/13/12, indicated the resident required extensive assistance of 2 staff members for transfers and that his upper extremities and lower extremities had limited range of motion on both sides.</p> <p>There was a care plan, dated 11/2/11, that indicated the resident was at risk for falls due to diagnosis of hemiplegia, CVA (cerebral vascular accident-stroke), and that the resident at times would state that he purposely put himself on the floor. The</p>		<p>corrected and will not recur?</p> <p>Staff have been in-serviced regarding the following; a) ensuring safety devices are provided to prevent falls related to a body pillow What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit 5 residents three times per week to ensure that safety devices are in place to prevent falls. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>interventions to reduce the risk of falls included:</p> <ul style="list-style-type: none"> -body pillow when in bed (initiated 3/5/12) -assist out of bed during p.m. shift -assist out of bed daily -resident to use bariatric bed -bed bolsters to bed to assist in positioning (initiated 1/18/12) -keep bed in lowest position -keep bed arranged so nightstand is not directly next to bed -floor mat at bedside <p>There was a fall risk assessment completed on 1/23/12. The resident's fall risk was 17. A score of 10 or higher represents high risk for falls.</p> <p>Review of the fall observation reports indicated the resident had a history of falls. The resident was found on the floor next to his bed on 2/6/12, 1/31/12, 1/18/12, and 1/16/12.</p> <p>Interview with CNA #4 on 3/9/12 at 2:15 p.m., indicated each resident had a care card in the room that indicated any special needs, such as fall devices, how much assistance was needed to transfer, and continence. Review of the care card for Resident #G indicated the resident was a fall risk and staff were to use a body pillow, get him up in the p.m.,</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>use bed bolsters and keep the bed in the lowest position</p> <p>Interview with The MDS Coordinator on 3/8/12 at 1:24 p.m., indicated the Director of Nursing had indicated the resident's body pillow was soiled and had been sent to laundry. She indicated there were no other body pillows to use while the soiled one was being cleaned. She indicated the resident should have a body pillow to prevent falls from the bed.</p> <p>3.1-45(a)(2)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 11 residents who were reviewed for unnecessary drugs received interventions prior to receiving as needed anti-anxiety medications. (Residents #G)</p> <p>Findings include:</p>	F0329	<p>Lake County Nursing and Rehab F329 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RG remains in the facility and staff are</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
			<p>attempting non-pharmaceutical interventions prior to medication</p> <p>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents that receive PRN psychotropic medications were reviewed by the DON and/or designee with no other residents identified as being affected. All residents on PRN psychotropic medications are at risk for the alleged deficient practice. What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? staff have been inserviced on the following; a) ensuring non-pharmaceutical interventions are attempted and documented prior to the utilization of prn medications such as antianxiety medications b) ensuring that staff document on the psychoactive med given form the non-pharmaceutical interventions that were attempted</p> <p>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times weekly to ensure that staff attempted and documented non-pharmaceutical interventions prior a administering a prn anti anxiety medication other than pain management. A summary of</p>		

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>1. The record for Resident #G was reviewed on 3/8/12 at 9:45 a.m. The resident had diagnoses that included, but were not limited to, anxiety state, insomnia, and dementia.</p> <p>Review of the resident's current physician's orders indicated the resident had a physician order, dated 1/6/12, for lorazepam (an anti-anxiety medication) 1 mg (milligram) every 6 hours prn (as needed) for anxiety.</p> <p>The form titled "Individual Resident Control Medication Record Sheet" indicated the resident received lorazepam on the following days:</p> <p>2/9/12 at 7 p.m. 2/6/12 at 9 a.m. 1/26/12 at 4 p.m. 1/26/12 at 9 a.m. 1/23/12 at 9 am.</p> <p>The medication flow sheet, dated</p>		<p>the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>				

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>2/1/12 through 2/29/12, indicated the resident received lorazepam on 2/2/12, 2/3/12 and 2/17/12.</p> <p>The resident's progress notes were reviewed. There was no evidence in the record that non-pharmaceutical interventions were attempted prior to the administration of the lorazepam and there was no documentation of the resident's behavior that indicated the reason for the medication to be administered on 2/17/12, 2/9/12, 2/6/12, 2/3/12, 2/2/12, 1/26/12 and 1/23/12.</p> <p>Interview with the MDS Coordinator on 3/12/12 at 8:47 a.m., indicated that before a PRN anti-anxiety medication was given, interventions were to be tried and documented on the form titled, "Psychoactive Med Given." Continued interview with the MDS Coordinator indicated there was no evidence that interventions were attempted prior to the administration of lorazepam in the months of January and February 2012.</p> <p>A blank copy of the form titled "Psychoactive Med Given" was reviewed. The form was provided by LPN #2. The form indicated the resident's behavior was to be documented with the interventions</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>attempted, sample interventions were, "removed for environmental stimulation, attempted different staff to intervene, ambulated or exercised, given snack." The resident's responses to the interventions were to be documented. The form then indicated, "If all appropriate attempts were made and unsuccessful, document the drug given and the results."</p> <p>Interview with the Medical Records Manager on 3/12/12 at 10:00 a.m., indicated there were no "Psychoactive Med Given" sheets available for review for January and February, 2012 for Resident #G.</p> <p>The policy titled "PRN orders" revised on August 2008, was provided by the Administrator on 3/12/12 at 9:00 a.m. She indicated the policy was current. The policy indicated "PRN orders or related documentation shall specify the circumstances under which the medication shall be offered or given, in as much detail as is needed to give the medication properly."</p> <p>3.1-48(a)(4)</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, record review and interview, the facility failed to ensure expired medications were disposed timely related to 2 of 2 opened vials of Aplisol (a medication used for tuberculin testing). This had the potential to affect residents on 2 of 2 units requiring annual or admission tuberculin testing. (First and Second Floor)</p> <p>Findings include:</p> <p>On 3/7/12 at 1:45 p.m., the medication room on the first floor was observed. There were 2 vials of</p>	F0425	<p>Lake County Nursing and Rehab F425 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Both vials of Aplisol were disposed of immediately How will the facility identify other residents having the potential to be affected by</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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	
	<p>opened Aplisol noted in the refrigerator of the medication room. There was a label on one vial that indicated it was opened on 1/30/12. The other vial of Aplisol in the refrigerator indicated it was opened on 1/3/12.</p> <p>Interview with the Director of Nursing (DON) at that time, indicated the vials had date opened labels on them that indicated the vials were opened more than 30 days ago. The Pharmacy label indicated the vials were delivered to the facility on 12/16/11.</p> <p>Interview with the DON on 3/7/12 at 1:52 p.m., indicated the Aplisol was used for residents residing on both the first and second floor who were in need of annual or admission tuberculin testing. She indicated the Aplisol expired 30 days after it was opened. She indicated the vials were expired and should have been discarded.</p> <p>The policy titled "Storage and Expiration Dating of Drugs, Biological, Syringes and Needles, dated January 2009, was provide by the Administrator on 3/9/12. She indicated the policy was current. The policy indicated that the facility should ensure that drugs and biologicals</p>		<p>the same alleged deficient practice? All medication rooms and medication carts were reviewed by the DON with no other expired medications noted. The pharmacy also came to the facility and reviewed for expired medications with no expired medications noted. All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring expired medications were disposed of timely after expiration. What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit twice weekly to ensure that expired medications were disposed of timely. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>that: (1) have an expired date on them (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier. Once any drug or biological is opened, the facility should follow manufacturer/ supplier guidelines with respect to expiration dates for opened medications.</p> <p>The manufacturer's recommendations for Aplisol, manufactured and distributed by JHP Pharmaceuticals, LLC and dated January 2008, was provided by the Nurse consultant on 3/9/12. The manufacturer's recommendation, indicated the storage for the Aplisol: "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."</p> <p>3.1-25(o)</p>			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure pharmacy recommendations were carried out in a timely manner for 6 of 10 residents who were reviewed for unnecessary medications. (Residents #F, #K, #27, #56, #74 and #101)</p> <p>Findings include:</p> <p>1. The record for Resident #101 was reviewed on 3/7/12 at 9:00 a.m. The resident's diagnoses included, but was not limited to, anemia.</p> <p>Review of the Pharmacy Recommendation sheet, dated 2/22/12, indicated the resident was receiving Aranesp (a medication to treat anemia) but no follow-up lab monitoring orders were noted. Recommendations were made to obtain laboratory orders.</p> <p>The physician was contacted on</p>	F0428	<p>Lake County Nursing and Rehab F428 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RF, RK, R27, R56, R74 and R101 pharmacy recommendations have been carried out with orders noted How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All pharmacy recommendations were reviewed with no other residents were affected by the alleged deficient practice. (they have been carried out)All residents that have pharmacy recommendations are at risk for the alleged deficient practice What measures will the</p>	04/06/2012	

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>3/8/12 at 6:45 p.m. and orders were received.</p> <p>2. The record for Resident #K was reviewed on 3/8/12 at 1:00 p.m. The resident's diagnoses included, but were not limited to, acute pain and depressive disorder.</p> <p>Review of the Pharmacy Recommendation sheet, dated 2/22/12, indicated the pharmacist recommended for the resident's anti-depressant to be discontinued and/or find alternative treatment.</p> <p>The Physician was notified of the recommendations on 3/8/12.</p> <p>3. The record for Resident #F was reviewed on 3/8/12 at 9:00 a.m. The resident's diagnoses included, but was not limited to, constipation.</p> <p>Review of the Pharmacy Recommendation sheet, dated 12/14/11, indicated the pharmacist recommended for the resident's Docusate Sodium 100 milligrams (mg) twice a day to be changed to 200 mg daily.</p> <p>The resident's physician was contacted on 3/8/12 related to the pharmacy recommendation. The</p>		<p>facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring pharmacy recommendations are carried out in a timely manner b) in the event a physician does not respond to the recommendation the DON will notify the Medical Director for further assistance What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times weekly to ensure that pharmacy recommendations have been carried out in a timely manner. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
	<p>physician accepted the recommendation at this time.</p> <p>4. The record for Resident #27 was reviewed on 3/8/12 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, stroke, high blood pressure, and heart failure.</p> <p>The 1/2012 Pharmacy Consultation Reports were reviewed. A report was made by the Pharmacist on 1/25/12. The report indicated the Pharmacist recommended to consider initiating a Simvastatin (a medication to lower cholesterol levels). The rationale for the recommendation indicated the American Diabetes Association of Clinical Practice suggests considering statin (category of medications to lower cholesterol levels) for diabetic individuals with cardiovascular disease.</p> <p>The 1/25/12 Pharmacy Consultation Report was signed as accepted by the resident's Physician on 3/8/12 at 5:39 p.m. An entry made in the Nursing Progress Notes on 3/8/12 at 5:39 p.m., indicated staff spoke with the resident's Physician and informed him of the above pharmacy recommendations and new orders</p>						

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>were started for the resident to receive Simvastatin 10 mg daily in the evening. There was no documentation in the 1/12, 2/12, or 3/12 Nursing Progress Notes indicating the facility had addressed the above pharmacy recommendation prior to 3/8/12.</p> <p>5. The record for Resident #74 was reviewed on 3/8/12 at 1:50 p.m. The resident had diagnoses that included, but were not limited to, depression, hemiplegia and convulsions.</p> <p>A Consultation Report, dated 2/22/12, completed by the Pharmacist was reviewed. The report indicated, "(Resident's name) has not had an assessment of renal function within the past six months. Recommendation: Please consider monitoring serum creatinine on the next convenient lab day and every 6 months thereafter so that appropriate staging can be assigned from the Glomerular Filtration Rate (GFR) and appropriate dosing adjustments can be made based upon estimated creatinine clearance(CrCl)."</p> <p>The recommendation was not acted upon until 3/9/12, at that time a physician order was obtained for a</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>serum creatinine level every 6 months. Review of the physician's orders indicated a physician order, dated 3/9/12, that indicated, "serum creatinine level to be done on the second Monday of March and September."</p> <p>The nursing progress note, dated 3/9/12 at 7:39 a.m., indicated, "Call to (doctor's name) regarding Pharmacy Recommendation. New order received to obtain serum creatinine levels every 6 months starting 3/12/12.... "</p> <p>Review of the resident's record indicated he had physician's orders for routine labs to be drawn every Monday.</p> <p>Review of the nursing progress notes, dated 2/22/12 through 3/8/12, indicated there was no evidence that the physician was notified of the Pharmacist recommendation.</p> <p>A physician progress note, dated 3/7/12, indicated the physician had visited the resident. There was no documentation by the physician of the Pharmacist's recommendation.</p> <p>6. The record for Resident #56 was reviewed on 3/7/12 at 9:44 a.m. The</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>resident had diagnoses that included, but were not limited to, spina bifida, paraplegia and anemia.</p> <p>The current physician's orders were reviewed. There were orders for Vitamin C 500 mg (milligrams) 1 tablet daily and for donepezil (a medication used to treat Alzheimer's disease) 5 mg daily at HS (hour of sleep).</p> <p>There was a Consultant Report, dated 12/15/11, that was completed by the Pharmacist. The report indicated "(Resident's name) has been on Vitamin C since 7/11, please consider discontinuing vitamin C. Rationale for Recommendation - Long term vitamin C and zinc sulfate therapy not only may cause GI upset, but also has not been shown to prevent pressure ulcer formation. If this therapy is to continue, it is recommended that a) the prescriber document an assessment of the risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential for adverse consequences."</p> <p>The facility did not act upon the</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>recommendation until 3/7/12. At that time there was a note written that indicated the physician wanted the medication continued for the resident's wounds.</p> <p>There was a Consultant Report, dated 1/25/12, that was completed by the Pharmacist. The report indicated "(Resident's Name) has tolerated donepezil 5 mg after at least four weeks of continuous treatment. Recommendation: Please consider increasing donepezil to 10 mg daily in the evening. Rationale for recommendation- The 10 mg daily dose may provide additional benefit in some individuals."</p> <p>The facility did not respond to the recommendation until 3/9/12 at 7:30 a.m. There was a written note, dated 3/9/12, that indicated the physician gave the order to increase the medication to 10 mg as per the recommendation made by the Pharmacist.</p> <p>Interview with LPN #3 on 3/9/12 at 10:40 a.m., indicated after the Pharmacist reviews the residents' medications then he mails his recommendations to the facility. She indicated the recommendations should arrive to the facility within a</p>			

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>week. The recommendations then should be completed within a week. The Director of Nursing or the Assistant Director of Nursing were responsible to ensure the recommendations were carried out timely. She indicated the recommendations for December 2011, January 2012 and February 2012 were not carried out in a timely manner.</p> <p>3.1-25(i)</p>			

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F0441	Lake County Nursing and Rehab F441 POC Please accept	04/06/2012			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>ensure soiled and uncontained linens were disposed of properly as well as handwashing was completed after glove removal for 2 resident rooms and for 1 of 10 residents observed during medication pass. (Rooms 101 and 119) (Resident #96)</p> <p>Findings include</p> <p>1. On 3/8/12 at 6:33 a.m., a pile of soiled bed linens were observed on the floor in Room 101 by bed 1. The soiled bed linens were not in a plastic bag or contained in anyway. The sheets were observed with dried substance on them.</p> <p>On 3/8/12 at 6:33 a.m., there was soiled bed linens in the middle of the room by bed 2 in Room 119. The bed linens were not in a plastic bag nor were they contained in a container. The linens were observed to be dirty.</p> <p>When interviewed at this time, CNA #7 indicated the midnight aide must have left them in the middle of the floor, and indicated they should have been picked up after the resident had gotten out of bed.</p>		<p>the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? The soiled linens were removed The nurse washed her hands How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring soiled and uncontained linens are disposed of properly b) ensuring handwashing has been completed after removal of gloves and resident care What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit (5) staff members three times per week via observations rotating shifts to ensure that staff disposes of soiled linens in a bag and that</p>		

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>2. On 3/8/12 at 11:30 a.m., LPN #6 was observed preparing medications for Resident #96. The LPN prepared several oral medications and also an injection of Heparin (a medication to prevent clots). The LPN entered the resident's room and administered the oral medications to the resident. The LPN then washed her hands and put on a pair of disposable gloves, pulled the residents gown up, and gave the injection of Heparin into the resident's abdomen.</p> <p>The LPN then removed the gloves and placed them in the trash can in the resident's room. LPN #6 walked out of the resident's room without washing her hands or applying any alcohol sanitizer. The LPN walked down the hallway to the Nurses' station.</p> <p>When interviewed on 3/8/12 at 11:45</p>		<p>staff complete handwashing after removal of gloves and resident care. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
	<p>a.m., the LPN indicated Resident #96 was treated for C- difficile toxin (an infection in the stool).</p> <p>When interviewed on 3/8/12 at 12:05 p.m., LPN #6 indicated the facility policy is for staff to wash their hands after the removal of gloves. The LPN also indicated she did not wash her hands after removing her gloves in the resident's room.</p> <p>The facility policy titled "Handwashing/Hand Hygiene" was reviewed on 3/8/12 at 1:10 p.m. There was a revised date of August 2008 on the policy. The facility Administrator provided the policy and identified the policy as current. The policy indicated if hands were not visibly soiled, employee may use an alcohol based hand rub after removing gloves.</p> <p>3.1-18(l) 3.1-19(g)(1)</p>			

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 03/12/2012	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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			
F0463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to ensure a functioning call system was in working condition in a resident bathroom related to the emergency call system in a 1 of 20 resident rooms observed. (Room 214)</p> <p>Findings include:</p> <p>1. On 3/05/2012 at 2:50 p.m., the emergency call light system in the bathroom of Room 214 was not working. At that time, the CNA indicated the emergency call light did not light up outside of the resident's room or light up at the nurse's station.</p> <p>On 3/6/12 8:17 a.m., the emergency call light in bathroom in Room 214 was still not functioning.</p> <p>Observation on 3/12/12 at 10:01 a.m., in Room 214, the Maintenance Supervisor was observed turning on the emergency call light in the bathroom. The call light did not light up outside of the room or at the nurses station. He further indicated</p>	F0463	<p>Lake County Nursing and Rehab F463 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Room 214 call light has been fixed How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? The maintenance director reviewed all call lights within facility with no other concerns noted.All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur?</p> <p>Staff have been in-serviced regarding the following; a) ensuring each resident has a functioning call system in working condition both in their room and bathroom b) notifying</p>	04/06/2012			

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>the call system was not functioning. Further interview with the Maintenance Supervisor at that time, indicated he was not made aware the emergency call light was not working.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>		<p>maintenance with any malfunctioning system is noted What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The Administrator or designee will audit twice weekly to ensure call systems are in working order in resident rooms and bathrooms. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
F0502 SS=D	<p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained as ordered related to complete blood counts for 1 of 10 residents reviewed for unnecessary medications. (Resident #101)</p> <p>Findings include:</p> <p>The record for Resident #101 was reviewed on 3/7/12 at 9:00 a.m. The resident's diagnoses included, but was not limited to, anemia.</p> <p>A Physician's Order, dated 12/15/11, indicated the resident was to have a Complete Blood Count (CBC) weekly on Wednesday.</p> <p>Review of the laboratory results for the months of December 2011, January, February and March 2012, indicated the resident had a CBC drawn on 12/28/11, 1/4/12, 2/29/12 and 3/7/12.</p> <p>Interview with LPN #2 on 3/8/12 at 2:40 p.m., indicated she was unsure</p>	F0502	<p>Lake County Nursing and Rehab F502POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? R101 CBC was completed and the laboratory has been notified to complete CBC weekly How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents lab orders were reviewed with no other residents noted to be affected by the alleged deficient practiceAll residents with lab orders are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) ensuring laboratory tests are obtained as ordered</p>	04/06/2012	

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>as why the labs had not been done. She further indicated the lab requisition had been resubmitted. Continued interview with the LPN indicated the resident's labs were not obtained as ordered.</p> <p>3.1-49(a)</p>		<p>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent? The DON or designee will audit three times weekly to ensure that laboratory tests are completed as ordered. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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
F0520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance of non pressure skin conditions related to lack of assessment and documentation of bruises and scratches through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with Administrator on 3/9/12 at 2:26 p.m., indicated she had been</p>	F0520	<p>Lake County Nursing and Rehab F520 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? The ADON</p>	04/06/2012

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>the Administrator at the facility since 1/31/12. She further indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Director of Nursing, and department heads as well as the Medical Director. She indicated the facility's last meeting was held on 2/20/12 and prior to that was 1/6/12. The Administrator indicated as she reviewed the minutes from the last two meetings and the concern of monitoring and assessing non pressure sores such as scratches and bruising had not been addressed or identified as being a problem. She indicated there had been no action plan or system put into place to identify the problem of non pressure ulcer assessment or monitoring for residents who acquire bruises.</p> <p>Interview with LPN #4 on 3/9/12 at 1:33 p.m., indicated she was unaware of what the non pressure ulcer skin policy and procedure was when a resident acquired a bruise or skin tear or was admitted to the facility with multiple bruising or skin tears. She further indicated she had no idea if the areas were to be measured and where in the resident's chart they were to be documented. She further indicated she just did not know this</p>		<p>has been reassigned to a new position and is receiving the appropriate training The facility has policy and procedure manuals available to staff How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? Staff interviews were conducted by the DON with no concerns noted regarding the policy and procedure for pressure ulcer and skin, where to document and when to measure non-pressure ulcer related to skin conditions such as bruises and scratches or where the policy and procedure manual is located and how to use. The DON has initiated ongoing inservicing for the aboveAll residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur? Staff have been in-serviced regarding the following; a) Policy and Procedure for pressure ulcer and skin b) Where to document and when to measure non-pressure ulcer related skin conditions such as bruises and scratches c) Where the policy and procedure manual is located within the facility d) Identifying areas of non-compliance and presenting those areas as needed to the Quality Assurance Committee What quality assurance plans will be used to</p>		

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 03/12/2012
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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	
	<p>facility's policy regarding non pressure ulcers.</p> <p>Interview with the ADON (who previously was the Director of Nursing) on 3/9/12 at 1:37 p.m., indicated she was only given a couple days of orientation upon hiring at facility. She further indicated she was unsure what the facility's policy was regarding measuring, monitoring and assessing bruises for a resident at the time of admission to the facility. She indicated she had not seen a policy regarding non pressure ulcers.</p> <p>Interview with Director of Nursing on 3/9/12 at 1:40 p.m., indicated she had only been in the position for the last two weeks, but would expect her staff to measure, assess, and monitor the bruises at the time of admission and when they first appear. She indicated she has participated in one quality assurance meeting since she has been the director, and further indicated there was no quality assurance plan in place for the monitoring or assessment of non pressure areas, but now does know that documentation and assessment was a problem at the facility.</p> <p>3.1-52(b)(2)</p>		<p>monitor the facilities performance to ensure corrections are achieved and permanent? The Administrator or designee will audit three times per week to ensure staff is aware of the policy and procedure related to pressure and non-pressure ulcers as well as where to locate the Policy and Procedure manual. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		

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 03/12/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & 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 PERCEDED 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