

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 02/05/2015
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NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F000000	<p>This visit was for the Investigation of Complaint IN00161025 and IN00161697.</p> <p>Complaint IN00161025- Substantiated. Federal/State deficiency related to the allegation is cited at F250.</p> <p>Complaint IN00161697- Substantiated. Federal/State deficiency related to the allegations is cited at F425.</p> <p>Survey dates: February 4 & 5, 2015</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Survey team: Janet Adams, RN-TC Heather Tuttle, RN</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 12 Medicaid: 40 Other: 11 Total: 63</p>	F000000	<p>February 16, 2015</p> <p>Kim Rhoades, Director of Long Term Care Indiana State Department of Public Health 2 North Meridian St. Sec 4-B Indianapolis, In 46204-3006</p> <p>Dear Ms.Rhoades:</p> <p>Please reference the enclosed 2567L as "Plan of Correction" for the February 5, 2015 Complaint (IN00161025 and IN00161697) survey that was conducted at Lake County Nursing and Rehabilitation Center.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 6, 2015 by Jodi Meyer, RN</p>		<p>I will submit signature sheets of the in-servicing, content of in-service and audit tools February 16, 2015. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community.</p> <p>The Plan of Correction submitted on February 16, 2015 serves as our allegation of compliance. The provider respectfully request a Desk review on or after February 27, 2015. Should you have any question or concerns regarding the Plan of Corrections, please contact me.</p> <p>Respectfully,</p>	

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure medically related social services were provided for the residents to maintain the highest practicable physical and psycho-social well being related to the discharge of a resident to a potentially unsafe environment for 1 of 3 residents reviewed for discharge planning in the sample of 7. (Resident #C)</p> <p>Findings include:</p> <p>The closed record for Resident #C was reviewed on 2/5/15 at 10:21 a.m. The resident was admitted from the hospital on 11/26/14. The resident's diagnoses included, but were not limited to, anxiety disorder, schizophrenia, depressive disorder, diabetes mellitus, high blood pressure, and asthma. The resident was discharged home on 12/5/14.</p>	F000250	<p>Neysa Holman Stewart, HFA</p> <p>F250</p> <p>PLAN OF CORRECTION</p> <p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>1. The corrective action taken for the resident found to have been affected by the deficient practice: Resident # C no longer resides in the facility.</p>	02/27/2015

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	<p>The 12/2014 Physician orders were reviewed. An order was written on 12/5/14 for the resident to be discharged home with Home Health and all medications.</p> <p>Review of the 12/5/14 Discharge Plan of Care note indicated the resident was discharged home by car with Home Health Referrals. The note indicated the resident was discharged at 5:30 p.m.</p> <p>The 12/2014 Progress Notes were reviewed. A Social Service Progress Note was completed on 12/4/14 at 11:07 a.m. The entry indicated Social Service spoke with the resident related to discharge planning. The resident indicated she would be returning to her daughter's home and she would notify Social Service after speaking with her Daughter related to discharge transportation, date, and time. The next entry in the Progress Notes was made on 12/5/14 at 11:08 a.m. The entry was also made by Social Service and indicated the resident stated her Daughter was picking her up at 5:30 p.m. The entry also indicated Social Service confirmed the Physician's discharge with Nursing staff and then attempted to call the resident's Daughter to confirm the discharge plans. The next entry in the Progress Notes was made on 12/5/14 at 8:03 p.m. That entry</p>		<p>2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents discharged home since 12/01/14 received well-being checks from Social Service Director starting 2/12/15 to ensure home services are effective.</p> <p>3. The measures put into place and a systemic change made to ensure the deficient practice not reoccurs: Admission Director, Social Service Director and Nurse Liaison were in-serviced on 2/06/15 by the Administrator regarding discharge planning and changes made on the Inquiry form and Clinical Evaluation form. Inquiry Assessment form and Clinical Evaluation form has been modified to include the question is "APS involved".</p> <p>4. To ensure the deficient practice does not reoccur, the</p>	

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	<p>was completed by Nursing. The entry indicated the resident's Daughter was in the facility to take her Mother home, medications given and explained, and no questions were asked by the resident or the family.</p> <p>The resident's hospital records were reviewed. The resident was admitted to the hospital on 11/7/14 and discharged to the facility on 11/26/14. The 11/7/14 Emergency Department records indicated the resident was transported to the hospital by EMS (Emergency Services) transport. The resident was confused and presented with complaints of nausea and vomiting, fatigue, chest pain, shortness of breath, and diarrhea. The resident also had fecal and urinary incontinence. The EMS reported the resident had been non compliant with insulin administration and had not been taking her medications as prescribed since her last hospitalization in October. The Emergency Department notes also indicated the EMS staff found the resident laying on the couch at her Daughters' house soiled with urine and stool. The resident present having generalized weakness, diarrhea, nausea and vomiting. The resident was noted to be soaked with urine and incontinent of stool and laying on a urine soaked couch at home. The home was noted to be filled with cigarette smoke and the</p>		<p>monitoring system established is to:</p> <p>Administrator / Designee will monitor <u>100%</u> inquires for <u>4</u> weeks. Then <u>50%</u> inquires for <u>4</u> <u>weeks</u> and <u>25%</u> inquires for <u>8</u> <u>weeks</u>. The audits will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated.</p> <p>5. Completion date systemic changes will be completed: 2 /27/2015</p>	

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	<p>resident had not taken her medications in five days.</p> <p>The Emergency Department Physician's physical examination noted the resident was thin, frail, and the odor of urine was present. Further Emergency Department notes indicated the resident had an adult diaper on which was soaked with urine along with her clothes. Her Blood Sugar level was 502 when taken by the EMS transport workers. The Emergency Department notes also indicated APS (Adult Protective Services were to be contacted by Case Management.</p> <p>The hospital Physician's History and Physical notes were reviewed. The notes indicated the resident presented to the Emergency Department via EMS and her blood sugar obtained while in route to the hospital was elevated at 502. The resident was confused and was admitted to the Intensive Care Unit. Adult Protective Services were to be on the case because of the resident's home conditions on arrival.</p> <p>The Emergency Department final diagnoses were dehydration, hyponatremia (low serum sodium level), diabetic ketoacidosis, and urinary tract infection. The Emergency Department laboratory test results indicated the</p>			

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	<p>following results were noted: Glucose level:6 97 (70-99 normal range) Sodium level: 119 (135-145 normal range) Potassium level: 5.2 (3.1-5.2 normal range) WBC: 20.49 (4.5-11.0 normal range)</p> <p>When interviewed on 2/5/14 at 2:33 p.m., the facility Administrator indicated she had not been aware of the above Emergency Room records indicating the resident was admitted from her Daughter's home in the above noted condition. The Administrator indicated the hospital usually would have notified the facility if there was APS involvement and she had not been informed prior to reading the above Emergency Room notes today. The facility Administrator indicated the above information was in the resident's admission packet records and should have been noted before the resident was discharged home with her Daughter.</p> <p>This Federal tag relates to Complaint IN00161025.</p> <p>3.1-34(a)(5)</p>				

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F000425 SS=D	<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. Based on observation, record review, and interview, the facility failed to ensure pharmaceutical services for receiving and dispensing medications were provided related to obtaining medications in a timely manner for 1 of 3 residents reviewed for medication administration in the sample of 7. (Resident #E)</p> <p>Findings include:</p> <p>On 2/4/15 at 6:55 p.m., Resident #E was observed sitting in a wheel chair in the hallway near the second floor Dining</p>	F000425	<p>F425 PLAN OF CORRECTION Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. 1. The corrective action taken for the resident found to have been affected by the deficient practice: A medication audit was completed on 12/22/14 and 2/5/15 for Resident #E, all other medication were available. On 12/22/14 Zaroxolyn was delivered</p>	02/27/2015

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	<p>Room. The resident's bilateral lower extremities appeared swollen.</p> <p>The record for Resident #E was reviewed on 2/5/15 at 8:42 a.m. The resident's diagnoses included, but were not limited to, pneumonia, congestive heart failure, high blood pressure, cough, and cellulitis.</p> <p>Review of the 12/17/14 Physician Progress Note indicated the resident complained her legs were swelling. The Progress Note also indicated the resident had poor pedal pulses and congestive heart failure.</p> <p>The 12/2014 Nursing Progress Notes were reviewed. An entry made on 12/18/14 at 2:12 a.m. indicated the resident's Lasix (a diuretic medication) had been increased. An entry made on 12/18/14 at 8:14 p.m. indicated the swelling in the resident's bilateral lower extremities remained.</p> <p>The 12/2014 Medication Administration Record was reviewed. There were Physician orders for the resident to receive Zaroxlyn (a diuretic medication) 5 milligrams once a day at 9:00 a.m. for a diagnosis of congestive heart failure. The Zaroxlyn was circled as not given on 12/18/14 thru 12/22/14. An entry was made on the back page of the Medication</p>		<p>and has been available since 12/22/14. No other concerns were identified. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: All residents on Zaroxolyn are at risk for this alleged deficient practice. An audit of all residents' on Zaroxolyn was completed on 12/22/14 and no other residents were affected by this alleged deficient practice. A house audit of all resident's meds has been completed and issues were promptly addressed / meds reordered to ensure all are available. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccurs: Nurses were re-educated on 12/22/14 and will be re-educated on 2/18/15 regarding medication availability and reordering processing. DON/Designee will compare "Refill Report" (that is available through pharmacy) to delivery report to ensure that meds are reordered and available for distribution to residents as per MD orders. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: DON / Designee will monitor all resident's meds for availability <u>5 times</u> a week for 4 weeks, <u>3 times</u> a week for 4 weeks, <u>2 days</u> per week for 2 months. The audits</p>				

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	<p>Administration Record on 12/18/14 at 10:00 a.m. This entry indicated the Zaroxlyn was not available. There were no further entries related the medication not being given 12/19/14 through 12/22/14.</p> <p>A Pharmacy fax sheet dated 12/22/14 was reviewed. The sheet indicated Pharmacy reported the metolazone (Zaroxlyn) 5 milligrams order order could not be filled as the most recent previous delivery of (15) pills was sent out on 12/12/14.</p> <p>A Proof of Delivery Pharmacy form was reviewed. The form indicated one package of Zaroxlyn 5 milligram tablets was ordered on 12/22/14 and delivered on 12/22/14 at 7:30 p.m.</p> <p>When interviewed on 2/5/15 at 12:05 p.m., the facility Administrator indicated Resident #E approached on a Monday and stated one of her pills was missing on Sunday when the Nurses' her medications were given. The Administrator indicated she then spoke with the Director of Nursing and the Assistant Director of Nursing to follow up with the concern about the resident missing pills.</p> <p>When interviewed on 2/5/15 at 12:10 p.m., the Director of Nursing indicated</p>		<p>will be discussed during our monthly QA meeting. QA committee will determine if continued auditing is necessary once 100% compliance threshold is achieved for two consecutive months. This plan to be amended when indicated. 5. Completion date systemic changes will be completed: 2/27/2015</p>	

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	<p>she first knew of the Zaroxlyn not being given on 12/22/14. The Director of Nursing indicated the Pharmacy note that (15) pills had been most recently delivered on 12/12/14 and the re-order was too soon</p> <p>When interviewed again on 2/5/15 at 12:40 p.m., the Director of Nursing indicated the missing doses of the Zaroxlyn had not been found in the Medication Cart. The Director of Nursing indicated the Pharmacy needed a verification signature to ensure the facility would cover the cost of the new pills which would be sent. The Director of Nursing indicated this should have been initiated when the Nurse first noted no Zaroxlyn was in the Medication Cart.</p> <p>This Federal tag relates to Complaint IN00161697.</p> <p>3.1-25(a)</p>						