PRINTED: 07/13/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED  B. WING 06/11/202				
		155653	B. WI	NG		06/11/	2021
NAME OF P	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
		AND DELIABILITATION OF UTED			ICCOOK AVE		
LAKE CC	OUNTY NURSING /	AND REHABILITATION CENTER		EAST	CHICAGO, IN 46312		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
1 0000							
Bldg. 00							
	This visit was for a	Recertification and State	F 00	000	1.Please reference the		
	Licensure Survey.				enclosed		
					2567 as "plan of correction"		
	Survey dates: June	e 7, 8, 9, 10, and 11, 2021			For the complaint and Annual		
	Eggility number 0	00108			survey that was conducted at Lake County		
	Facility number: 0 Provider number:				Nursing and Rehabilitation		
	AIM number: 1002				Center. I will submit signature		
					sheets of the in-servicing,		
	Census Bed Type: SNF/NF: 60				content of in-service and		
					audit tools.		
	Total: 60				Preparation and / or		
					execution of this plan of		
	Census Payor Type Medicare: 10	<b>:</b> :			correction does not constitute		
	Medicaid: 48				admission or agreement by the provider of the truth facts		
	Other: 2				alleged or conclusion set forth		
	Total: 60				in the statement of		
					deficiencies. This plan of		
	These deficiencies	reflect State Findings cited in			correction is prepared and /		
	accordance with 41	0 IAC 16.2-3.1.			or executed solely because it		
		1 . 1			is required by the provision of		
	Quality review con	npleted on 6/15/21.			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.		
					The Plan of Correction		
					submitted on June 28th, 2021		
					serves as our allegation of compliance. The provider		
					respectfully request a desk		
					review on or after June 28th,		
					2021. Should you		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	ROVIDER OR SUPPLIER DUNTY NURSING A	ND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CODE MCCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 0580 SS=D Bldg. 00	etc.) §483.10(g)(14) No (i) A facility must in resident; consult we physician; and not her authority, the results in injury and requiring physician (B) A significant of physical, mental, of is, a deterioration in psychosocial status conditions or clinic (C) A need to alter (that is, a need to form of treatment of	diffication of Changes. Interpretation of Change		have any questions or concer regarding our Plan of Correction , please do hesitate to Contact me. Sherri Shelby RN, HFA Please accept the following a the facility's plan of correction does not constitute an admission guilt or liability by the facility and is submitted only in response to the regulatory requirement.	n't as on. of

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Event ID:

OR6L11

Facility ID: 000108

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/11/2021	
LAKE C	PROVIDER OR SUPPLIED	AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CODE MCCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	resident from the §483.15(c)(1)(ii). (ii) When making paragraph (g)(14) facility must ensure information specification available and prophysician. (iii) The facility must resident and the rany, when there is (A) A change in reassignment as specified in paragraph (b) A change in resection. (iv) The facility must resident and the rany, when there is (A) A change in resection frederal or State is specified in paragraph section. (iv) The facility must represent the address phone number of representative(s). §483.10(g)(15) Admission to a confacility that is a configuration, included in §483.5 admission agreent configuration, included that comprise the and must specify room changes be under §483.15(c)	(i) of this section, the re that all pertinent fied in §483.15(c)(2) is vided upon request to the last also promptly notify the esident representative, if shoom or roommate ecified in §483.10(e)(6); or esident rights under aw or regulations as raph (e)(10) of this last record and periodically as (mailing and email) and the resident has provided in the periodical part (as a proposite distinct part (as a proposite distinct part (as a proposite distinct part, the policies that apply to tween its different locations (9).	F.0500		07/25/2021
	facility failed to no resident's change in medication refusal	view and interview, the tify the physician of a condition related to for 1 of 1 residents reviewed hange. (Resident 28)	F 0580	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies.	e

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155653	B. W	NG		06/11/2	2021
				CTREET	ADDRESS SITE STATE SID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
		AND DELIABILITATION OF UTED			CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	15	DATE
	Finding includes:				The plan of correction is		
					prepared and submitted becau	ıse	
	The record for Resi	dent 28 was reviewed on			of requirement under state and		
	6/10/21 at 10:10 a.r	n. Diagnoses included, but			federal law. Please accept this		
		malignant neoplasm of the			plan of correction as our credit		
		nsion, ataxia (loss of control			allegation of compliance. Plea		
	of body movements	s), depression, anxiety,			find enclosed this plan of		
	· ·	viors, and psychotic disorder			_ ·		
	with delusions.				correction for this survey.		
					E 590 Notify of Changes in		
	The Annual Minim	um Data Set (MDS)			F 580 Notify of Changes in Condition		
	assessment, dated 5	7/6/21, indicated the resident			It is the facility policy to ensure	,	
	was severely cognitively impaired for decision				that each resident's drug regin		
	making, required supervision with bed mobility,				is free from unnecessary drug		
	had no swallowing disorders, no dental concerns,				Corrective actions which will		
	and experienced a v	weight loss not prescribed by a			accomplished for those	De	
	weight-loss regime.				residents found to have beer	,	
					affected by the deficient	•	
	Physician's Orders,	dated 5/3/21, indicated the			practice:		
	resident was to rece	eive Memantine (a medication			·R28's attending physician w	ıas l	
	used to treat demen	tia) 10 mg (milligrams) twice			notified of resident's refusal o		
	daily at 7:00 a.m. as	nd 1:00 p.m.			memantine medication. No ne		
					orders nor changes in dose	**	
	The May 2021 Med	lication Administration			ordered.		
	Record (MAR), ind	icated the resident received			·R28 remained at his baselir	ne	
	his medication on the	he following days:			of functioning and no adverse		
					side effects noted.		
	- 5/7 at 7:00 a.m.				Side circus fieted.		
	- 5/10 at 7:00 a.m.				How the facility will ident	ifv	
	- 5/11 at 7:00 a.m.				other residents having the	,	
	- 5/12 at 1:00 p.m.				potential to be affected by the		
	- 5/13 at 7:00 a.m.				same deficient practice.		
	- 5/15 at 7:00 a.m.				·All residents have the pote	<sub>ntial</sub>	
	- 5/17 - 5/20 at 7:00	a.m. and 5/19 at 1:00 p.m.			to be affected by the same		
	- 5/23 at 1:00 p.m.				deficient practice.		
	- 5/27 and 5/28 at 1	:00 p.m. and 5/28 - 5/30 at					
	7:00 a.m.				1.The measures the facility \	<sub>will</sub> [	
					take or systems the facility will		
	The resident refuse	d his medication on the other			alter to ensure that the probler		
	days of the month.				will be corrected and will not		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	/2021
		<u> </u>		CTDEET /	ADDDESS CITY STATE 7D CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	JUNIY NUKSING /	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
					recur.		
		R, indicated the resident			·An audit tool will be develo	ped	
	received his medica	ation on the following days:			to ensure all medications are		
					administered and signed off in	า	
	- 6/1 at 7:00 a.m.				EMAR. At least five random		
	- 6/2 at 1:00 p.m.				residents will be selected per		
	- 6/3 at 7:00 a.m.				audit. This will be completed		
	- 6/5 at 1:00 p.m.				times a week for 4 weeks. T	hen	
	- 6/7 at 7:00 a.m.				twice weekly for a total of		
	The resident refused his medication on the other				6 months. any issues will be		
					addressed immediately.		
	days of the month.				Inservice will be provided o	n	
					the following topic:		
		mentation to indicate the			·Signing EMAR after		
	physician was notif	fied of the resident's refusals.			administration of all meds.		
		D' (CM '			·Notification of resident's	1 - <b>£</b>	
		Director of Nursing on			attending physician for refusa	ΙΟΤ	
	_	n., indicated the physician			medications.		
		otified of the medication			1 Quality Assumes Bloom	-	
	refusals.				1.Quality Assurance Plans t		
	2.1.5(a)(2)				monitor facility performance to make sure that corrections ar		
	3.1-5(a)(2)				achieved and are permanent.		
					·All plan of correction audit		
					be reported by the Director of		
					Nursing and or ADON to the		
					Quality Assurance Committee	e and	
					reviewed by the Committee p		
					Month for two (2) Months and		
					recommendations given in ord		
					to assist in ensuring that the		
					facility stay in compliance and	l if	
					concerns are identified the Qu		
					Assurance Committee will add	-	
					additional Months until		
					Compliance is sustained.		
					1 Detec where some still a set	tion	
					1.Dates when corrective act		
					will be completed: June 25, 2	<u>UZ I</u>	
			1				I

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CONSTRUCTION       (X3) DATE S         A. BUILDING       00       COMPLE         B. WING       06/11/2			ETED		
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Asses §483.20(g) Accuration The assessment is resident's status. Based on record resident's accurately complete weight loss for 1 of reviewed. (Resident Finding includes:  The record for Resident Finding includes:  The record for Resident House of the second for Resident House of the second for the	ssments acy of Assessments. must accurately reflect the view and interview, the sure the Minimum Data Set sive assessment was ed related to a significant (20 MDS assessments at 41)  dent 41 was reviewed on . Diagnoses included, but hypertension, schizophrenia, sorder, anxiety, and type 2  ident weighed 217 pounds. ident weighed 187 pounds, 3.8 % weight loss in 6  mum Data Set (MDS) (713/21, indicated the resident paired for daily decision supervision for eating.	F 06		Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credicallegation of compliance. Please find enclosed this plan of correction for this survey.  F 641 Accuracy of Assessment Corrective actions which will accomplished for those residents found to have been affected by the deficient practice:	e on use d s ble se ents	06/25/2021
	indicated the reside	ing/Nutritional Status, nt had a significant weight st month or 10% in the last 6			R41 MDS assessment 5/10/2′ has been modified. Audit was completed of sectio for all MDS completed for may june.	n K	
	at 2:15 p.m., indica inaccurately. The M as having a signific	MDS Coordinator on 6/11/21 ted the MDS was coded MDS should have been coded ant weight loss rather than a ution would be submitted.			1.How the facility will identify other residents having the	/	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	3.1-3(i)			potential to be affected by the same deficient practice.  ·All residents have the pote to be affected by the same deficient practice.	
				1.The measures the facility take or systems the facility will alter to ensure that the proble will be corrected and will not recur.	I
				·An audit tool will be develo to ensure that Section K is completed accurately At least random residents will be select per audit. This will be complete weekly for 4 weeks. Then 2 residents weekly for 5 months	3 cted ed
				Any deficiencies will be corrected immediately.	
				·The MDS coordinator was serviced on accuracy of completing section K.	in
				1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.  All plan of correction audit to be reported by the Director of Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee pomonth for four Months and recommendations given in ore to assist in ensuring that the facility stay in compliance and concerns are identified the Quality Assurance Plans to assist in ensuring that the	will and er der

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				Assurance Committee will add additional Months until Compliance is sustained.  1.Dates when corrective act	
				will be completed: June 25, 20	
F 0657 SS=E Bldg. 00	§483.21(b)(2) A comust be- (i) Developed with of the comprehense (ii) Prepared by an that includes but is (A) The attending (B) A registered not the resident. (C) A nurse aide was resident. (D) A member of for staff. (E) To the extent participation of the resident's represe must be included record if the participation of their resident represent procession of the resident's care plate (F) Other appropriate in disciplines as deneeds or as reques (iii) Reviewed and interdisciplinary terincluding both the quarterly review a	and Revision rehensive Care Plans comprehensive care plan  in 7 days after completion sive assessment. In interdisciplinary team, Is not limited to physician. It is with responsibility for  with responsibility for the  food and nutrition services  cracticable, the Is resident and the Intative(s). An explanation In a resident's medical Inipation of the resident and Interdisciplinary team, Is not limited to physician.  It is a resident and the Intative (s) and the Intative (s) and the Intative (s) and the Intative is determined Interdisciplinary team, Is not limited to physician.  It is not limited t			
		view and interview, the	F 0657	Submission of this plan of	06/25/2021

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Facility ID: 000108

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLE	ETED
		155653	B. WI	NG		06/11/2	2021
			Ь,	STDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
1 41/5 00	NUNTY AUTOONO A	ND DELIABILITATION CENTED			CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'- I	DATE
	facility failed to pro	vide documentation of care			correction does not constitute		
	conferences held wi	th the resident and facility			admission or agreement by th	e l	
	staff for 4 of 4 resid	ents reviewed for care			provider of the truth of facts		
	planning decisions.	(Residents 12, 47, 45, and			alleged or correction set forth on		
	25)				the statement of deficiencies.		
	•				The plan of correction is		
	Findings include:				prepared and submitted becau	150	
	Č						
	1. Interview with R	esident 12 on 6/7/21 at 2:17			of requirement under state and		
	p.m., indicated she had not been invited to her				federal law. Please accept this		
care conference meetings.					plan of correction as our credi	I	
					allegation of compliance. Plea	se	
	The record for Resident 12 was reviewed on				find enclosed this plan of		
6/9/21 at 3:52 p.m. Diagnoses included, but				correction for this survey.			
	were not limited to,	schizophrenia, dementia					
	with behavioral dist	urbance, major depressive			F 657 Care Plan Timing and		
	disorder, hypertensi	on, and anxiety.			Revision		
	The Quarterly Minis	mum Data Set (MDS)			Corrective actions which will	be	
	assessment, dated 4	/21/21, indicated the resident			accomplished for those		
	was alert and orient	ed for daily decision making			residents found to have beer	ן י	
	and she needed supe	ervision with one person			affected by the deficient		
	physical assistance	for dressing, eating, and			practice:		
	bathing.				·R12 has been notified of he		
					care conference schedule and	I	
		mentation within the last 6			letter of invitation was sent ou	ו וט	
	months of the reside	ent being invited to her care			R12's responsible party	_	
	conference.				R47 has been notified of he		
					care conference schedule and letter of invitation was sent ou	I	
		7/21 at 1:59 p.m. with the				ו וט	
		nd the Social Service			R47's responsible party R45 has been notified of he		
		there had been no formal care			care conference schedule and		
		resident in the last 6 months.			letter of invitation was sent ou	I	
	They were unsure on who was supposed to send				R45's responsible party	0	
		orm the family and/or the			R45's responsible party R25 has been notified of he	ar	
	resident when the care conference was to be				care conference schedule and	-	
		g an interview with Resident			letter of invitation was sent ou		
		20 a.m., she indicated she did				ו וט	
	not know anything a	about a care conference			R25's responsible party		
	meeting.						

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OR6L11 Facility ID: 000108

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
LAKE CO	NINTY NILIDONIC /	AND REHABILITATION CENTER			ICCOOK AVE CHICAGO, IN 46312		
LAKE CC	JUNIT NURSING A	AND REHABILITATION CENTER		EAST	CHICAGO, IN 40312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					How the facility will iden	tify	
		dent 47 was reviewed on			other residents having the		
	_	Diagnoses included, but			potential to be affected by the		
		, COPD (chronic obstructive			same deficient practice.		
		, chronic kidney disease,			·All residents have the poter	ntial	
		neumatoid arthritis, and			to be affected by the same		
	history of pneumon	na.			deficient practice.		
	The Quarterly Mini	mum Data Set (MDS)			1.The measures the facility	will	
	assessment, dated 5	5/18/21, indicated the resident			take or systems the facility wil	I	
	was alert and orient	ted. She needed limited			alter to ensure that the proble	m	
	assistance with 1 pe	erson physical assist with bed			will be corrected and will not		
	mobility, transfers, dressing and toilet use.				recur.		
					·An audit tool will be develo	ped	
	There was no docum	mentation the resident had a			to ensure that care conference	es	
	care conference in	the last 6 months.			are being scheduled and the		
					resident and a care plan invita	ation	
		9/21 at 1:59 p.m. with the			letter is being sent out to the		
		and the Social Service			resident's responsible party. A		
		there had been no formal care			least 3 random residents will l		
		e resident in the last 6 months.			selected per audit. This will be	9	
		on who was supposed to send			completed weekly for 4		
		form the family and/or the			weeks. Then 2 residents wee	-	
		are conference was to be			for 5 months, Any deficiencie		
	scheduled.				will be corrected immediately.		
	3. During an interv	riew with Resident 45 on			·The Care plan coordinator	and	
	_	., he indicated he did not			interdisciplinary team were in		
		conference meeting with			serviced on the resumption of	:	
	staff.	_			scheduling resident care		
					conferences and to ensure that	at	
	The record for Resi	dent 45 was reviewed on			the resident is aware of the		
	6/9/21 at 11:45 a.m	. Diagnoses included, but			scheduled conference and a	care	
	were not limited to, left side rib fractures, high				plan invitation letter is being s	ent	
	blood pressure, type 2 diabetes, COPD (chronic				out to their responsible party.		
	obstructive pulmon	ary disease), anxiety, tremors,			1.Quality Assurance Plans t	0	
	contracture right an	d left knee, diabetic			monitor facility performance to	)	
	neuropathy, abnorn	nal gait, and acute respiratory			make sure that corrections are	е	
	failure.				achieved and are permanent.		
					All plan of correction audit will	be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	2021
				CTREET	DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
		****			CCOOK AVE		
LAKE CC	DUNIY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTION (EACH CORRECTION CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION CORRECTION CORR	<sub>TC</sub>	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	15	DATE
	The Quarterly Mini	imum Data Set (MDS)			reported by the Director of		
		5/17/21, indicated the resident			Nursing and or ADON to the		
		ted. The resident needed			Quality Assurance Committee	and	
	supervision with se	t up only for personal hygiene			reviewed by the Committee pe		
	-	and the activity of bathing did not occur in the			Month for four Months and		
	assessment reference period. In the last 7 days,				recommendations given in ord	er	
	the resident received the medication of insulin 6				to assist in ensuring that the		
	times and received oxygen while a resident.				facility stay in compliance and	if	
	times and received only gen white a resident				concerns are identified the Qu		
	There was no documentation the resident had a				Assurance Committee will add	,	
	care conference in the last 6 months.				additional Months until		
					Compliance is sustained		
	An interview on 6/9/21 at 1:59 p.m. with the				•		
	MDS Coordinator and the Social Service						
		there had been no formal care					
	· ·	e resident in the last 6 months.					
		on who was supposed to send					
		form the family and/or the					
		are conference was to be					
		view with Resident 25 on					
	6/7/21 at 2:44 p.m	, indicated she had not had a					
	_	te in approximately 2 years.					
	•						
	The record for Resi	ident 25 was reviewed on					
	6/11/21 at 2:31 p.m	Diagnoses included, but					
	_	, heart failure, hemiplegia					
		, major depression, anxiety,					
	and diabetes.						
	The Annual Minim	um Data Set (MDS)					
	assessment, dated 5	5/5/21, indicated the resident					
	was alert and orient						
	There was no docur	mentation to indicate she was					
	invited to, and/or at	ttended, a care conference in					
	2020 or 2021.						
	Interview with the	Social Worker on 6/10/21 at					
	4:10 p.m., indicated	the facility had not yet					
	resumed care confe	rences since the pandemic in					
			ı				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	COM	E SURVEY PLETED 1/2021	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CO. ICCOOK AVE CHICAGO, IN 46312	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1) Activities Daily Liv §483.24(a) Based assessment of a ruthe resident's need must provide their services to ensure activities of daily lic circumstances of the condition demonst was unavoidable, ensuring that:  §483.24(a)(1) A reappropriate treatm maintain or improviout the activities of those specified in section  §483.24(b) Activities The facility must proceed accordance with proceeding activities §483.24(b)(1) Hyggrooming, and orativities §483.24(b)(2) Motambulation, include §483.24(b)(3) Elim §483.24(b)(3) Elim	ing (ADLs)/Mntn Abilities on the comprehensive esident and consistent with ds and choices, the facility necessary care and that a resident's abilities in ving do not diminish unless the individual's clinical trate that such diminution This includes the facility  esident is given the nent and services to ye his or her ability to carry f daily living, including paragraph (b) of this  es of daily living. provide care and services in paragraph (a) for the of daily living: piene -bathing, dressing, al care, bility-transfer and ling walking,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE:			(X3) DATE SURV	'EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	)
		155653	B. WI	NG		06/11/202 <sup>-</sup>	1 I
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CO	DUNTY NURSING A	AND REHABILITATION CENTER		EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CON	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	§483.24(b)(5) Cor	mmunication, including					
	(i) Speech,						
	(ii) Language,						
	(iii) Other functional communication systems.						
	Based on observation, record review and		F 06	576	Submission of this plan of	06	/25/2021
		ty failed to ensure residents			correction does not constitute		
	who needed assista	nce with ADLs (activities of			admission or agreement by th	e	
	daily living) were p	rovided assistance related to			provider of the truth of facts		
	bathing and nail car	re for 2 of 11 residents			alleged or correction set forth	on	
	reviewed for ADLs	. (Residents 12 and 41)			the statement of deficiencies.		
	Findings include:				The plan of correction is		
					prepared and submitted becau	150	
					of requirement under state and		
	1. Interview with Resident 12 on 6/7/21 at 2:47				federal law. Please accept this		
	p.m., indicated ther	e were times when she only			-		
	received one showe	er a week and the rest of the			plan of correction as our credi		
	time, she had to wa	sh up on her own.			allegation of compliance. Plea	se	
					find enclosed this plan of		
	The record for Resi	dent 12 was reviewed on			correction for this survey.		
	6/9/21 at 3:52 p.m.	Diagnoses included, but					
	were not limited to,	schizophrenia, dementia			F 676 Activities of Daily Livir	-	
	with behavioral dis	turbance, major depressive			It is the facility policy to ensure		
	disorder, hypertens	ion, and anxiety.		that each resident's drug re			
					is free from unnecessary drug		
	The Quarterly Mini	mum Data Set (MDS)			Corrective actions which wil	be	
	assessment, dated 4	/21/21, indicated the resident			accomplished for those		
		ed for daily decision making			residents found to have been		
	_	ervision with one person			affected by the deficient		
	physical assistance	for dressing, eating, and			practice:		
	bathing.				·R12 is scheduled to receive		
					shower 2x/week with staff		
		lan, dated 6/2/21, indicated			assistance.		
		risk for a self-care deficit in			R41 is scheduled to receive		
		eeding, and transfers related			shower 2x/week with staff		
		on (dementia), lack of			assistance.		
	·	ulty walking, and COPD			4		
	(chronic obstructive pulmonary disease) with				1. How the facility will ident	шу	
	shortness of breath.	Interventions included, but			other residents having the		
	were not limited to,	provide assistance with			potential to be affected by the		
	ADLs as needed.				same deficient practice.		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155653	B. WING		06/11/2021
			- CERTIFIE	TARRES CITY OF THE CORE	
NAME OF I	PROVIDER OR SUPPLIEF	<b>t</b>		T ADDRESS, CITY, STATE, ZIP CODE	
	N. INIT. ( N. I.			MCCOOK AVE	
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER	EASI	CHICAGO, IN 46312	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				·All residents have the pote	ential
	The resident was so	heduled to receive a shower		to be affected by the same	
	on the day shift on	Tuesday and Friday.		deficient practice.	
	There was no docur	mentation in the bathing task		1.The measures the facility	will
	to determine if the	resident received a complete		take or systems the facility w	ill
	bed bath or a shower for May and June 2021.			alter to ensure that the proble	em
				will be corrected and will not	
	The documentation	in the bathing task, indicated		recur.	
	the resident needed	supervision/set up help with		·An audit tool will be develo	pped
	physical help in the part of bathing on 5/17, 5/18,			to ensure that each resident	s
	5/20, and 6/8/21.			being scheduled to receive	
				shower or bed bath (as	
	There was no docur	mentation indicating the		appropriate) and ensure that	
	resident received a	shower or complete bed bath		such care services are prope	erly
	at least two times a	week.		documented on the resident's	3
				medical records. At least 5	
	Interview with the l	Director of Nursing on		random residents will be sele	ected
	6/10/21 at 4:05 p.m	., indicated there was no		per audit 2 x weekly. This wil	l be
		e resident received a shower		completed for 4 weeks. The	
	_	eath at least 2 times a week		random residents per week	
	for 5/2021 and 6/20	21.		total of 6 months. social ser	
				will do a random interview wi	
		47 p.m. and 2:40 p.m.,		resident and 1 responsible pa	-
		served in his room lying on		weekly for 4 weeks to ensure	that
	_	hair was greasy in appearance		services are being provided.	
	and his fingernails	were long.		The Nursing staff were in	
				serviced on ensuring that res	
		a.m. and 2:00 p.m., the		receives shower or bed bath	(as
	_	observed in his room lying on		appropriate) as scheduled.	
	_	hair remained greasy in		1.Quality Assurance Plans	
	appearance and his	fingernails were long.		monitor facility performance	
				make sure that corrections a	
		dent 41 was reviewed on		achieved and are permanent	
		. Diagnoses included, but		·All plan of correction audit	
	·	hypertension, schizophrenia,		be reported by the Director o	Ī
	-	sorder, anxiety, and type 2		Nursing and or ADON to the	
	diabetes.			Quality Assurance Committee	
		D		reviewed by the Committee p	er
	I The Quarterly Mini	mum Data Set (MDS)	1	Month for four Months and	ĺ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155653	B. WI	NG		06/11/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			CCOOK AVE		
LAKE CO	OUNTY NURSING A	AND REHABILITATION CENTER			CHICAGO, IN 46312		
			1	l			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		/13/21, indicated the resident			recommendations given in ord	er	
	was cognitively impaired for daily decision				to assist in ensuring that the		
	_	led supervision with one		facility stay in compliance and			
		istance for personal hygiene.			concerns are identified the Quality		
		dependent in bathing with one			Assurance Committee will add	on	
	person physical assi	istance.			additional Months until		
	TI C DI 1 15/15/01 1 1 1 1 1				Compliance is sustained.		
	· ·	d 5/17/21, indicated the			Dates when corrective action	WIII	
		for an ADL self-care			be completed: June 25, 2021		
		related to weakness related breathing difficulty					
		chronic obstructive					
		. Interventions included, but					
		check nail length and trim					
		ay and as necessary and the					
		inimum to maximum					
	assistance for bathin						
	assistance for batting	ng/snowering.					
	The revised Care Pl	an, dated 6/8/21, indicated					
		reference to shower once a					
	_	Interventions included, but					
	· ·	resident will be offered a					
		d shower days. If resident					
		l assist and supervise washing					
	up.	1 8					
	_						
	The resident was sc	heduled to receive a shower					
	on the day shift on	Tuesday and Friday.					
	There was no docur	nentation in the bathing task					
		resident received a shower					
	for May and June 2	021.					
		in the bathing task, indicated					
		supervision/set up help with					
		part of bathing on 5/8, 5/20,					
	and 6/8/21.						
		nentation indicating the					
	resident received a	shower or complete bed bath					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155653	B. WI	NG		06/11/	2021
		AND REHABILITATION CENTER		5025 M	NDDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
	*				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
F 0677 SS=E Bldg. 00	as well as nail care.  Interview with the I 6/10/21 at 4:05 p.m. documentation if the or a complete bed be week for 5/2021 and the resident's finger trimmed as needed.  3.1-38(a)(2)(A)  483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene;  Based on observation interview, the facility residents received at (activities of daily licare and nail care for ADLs. (Resident and 211)  Findings include:  1. Interview with Ram., indicated he disbecause of issues with the record for Residents and 1 interview with Ram., indicated he disbecause of issues with the record for Residents and 210 p.m. were not limited to, pulmonary disease), kidney disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to, pulmonary disease, conglictions at 200 p.m. were not limited to 200 p.m. were not limi	on, record review and ty failed to ensure dependent ssistance with ADLs iving) related to bathing, hair or 8 of 11 residents reviewed ts 10, 37, 47, 51, 45, 25, 43, tesident 10 on 6/7/21 at 10:58 idn't always get his showers ith the shower room.  dent 10 was reviewed on Diagnoses included, but COPD (chronic obstructive type 2 diabetes with chronic gestive heart failure,	F 06	TAG	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credit allegation of compliance. Please find enclosed this plan of correction for this survey.  F 677 ADL for Dependent Residents  Corrective actions which will accomplished for those	e on use d s ble se	DATE  06/25/2021
	kidney disease, congestive heart failure, obstructive sleep apnea, and morbid obesity.					be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 B. WING 06/11/2021 155653 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE LAKE COUNTY NURSING AND REHABILITATION CENTER EAST CHICAGO, IN 46312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ The Annual Minimum Data Set (MDS) residents found to have been assessment, dated 3/19/21, indicated the resident affected by the deficient was cognitively intact for daily decision making. practice: ·R10 is scheduled to receive He required extensive assistance with one person shower 2x/week with staff physical assistance for bathing. assistance. ·R37 is scheduled to receive The revised Care Plan, dated 6/7/21, indicated the resident was at risk for a self-care deficit in shower 2x/week with staff bathing, dressing, feeding, and transfers related assistance. ·R47 is scheduled to receive to pain in his left foot/ankle, difficulty walking, and COPD with shortness of breath. shower 2x/week with staff Interventions included, but were not limited to. assistance provide assistance with ADLs as needed. ·R51's nails were trimmed, and nail hygiene is maintained. ·R45 is scheduled to receive The resident was scheduled for showers on the day shift on Monday and Thursday. shower 2x/week with staff assistance. ·R25 is scheduled to receive There was no documentation in the bathing task to determine if the resident received a complete bed bath 2x/week with staff bed bath or a shower for May and June 2021. assistance. ·R43 is scheduled to receive The documentation in the bathing task, indicated bed bath 2x/week with staff assistance the resident needed assistance in the part of bathing on 5/17, 5/18, 5/20, and 6/8/21. ·R211 is scheduled to receive bed bath 2x/week with staff Interview with the Director of Nursing on assistance. 6/10/21 at 4:05 p.m., indicated there was no documentation if the resident received a shower How the facility will identify other residents having the or a complete bed bath at least 2 times a week for 5/2021 and 6/2021. potential to be affected by the same deficient practice. 2. On 6/7/21 at 10:32 a.m., 12:40 p.m., and 2:30 ·All residents have the potential p.m., Resident 37 was observed with a dark to be affected by the same substance underneath her fingernails. deficient practice. The record for Resident 37 was reviewed on The measures the facility will 6/9/21 at 1:19 p.m. Diagnoses included, but take or systems the facility will were not limited to, stroke, dementia without alter to ensure that the problem will be corrected and will not behavior disturbance, dysphagia (difficulty swallowing), adult failure to thrive, recur.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	/2021
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
LAKECO		AND DELIABILITATION CENTED			ICCOOK AVE		
LAKE CC	JUNIT NURSING F	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY		DATE
	_	iplegia (muscle weakness),			·An audit tool will be develo		
	and psychotic disor	der with hallucinations.			to ensure that each resident is	3	
					being scheduled to receive		
		mum Data Set (MDS)			shower or bed bath (as		
	assessment, dated 5/12/21, indicated the resident				appropriate) 2x/week and suc	h	
	was cognitively impaired for daily decision				care services are properly		
	making and was totally dependent on staff for				documented on the resident's		
	personal hygiene and bathing.				medical records. At least 5		
					random residents will be selec		
	The Care Plan, dated 5/17/21, indicated the				per audit. This will be complet	ed 2	
	resident had an activities of daily living (ADL)				times a week for four weeks.		
	self-care performance deficit related to stroke				Then 2 times per week for a t		
	with hemiplegia, contractures to right hip, wrist,				of 6 months. Any deficiencies		
	·	of coordination. Interventions			be corrected immediately. soc	iai	
		not limited to, the resident			services will do a random		
	_	assistance with bathing and			interview with 1 resident and		
	_	ck nail length and trim and			responsible party weekly for 4 weeks to ensure services are	•	
	clean on bath day a	nd as necessary.			being provided.		
	The regident was se	cheduled to receive a shower			·The Nursing staff were in		
		Tuesday and Friday.			serviced on ensuring that resi	dent	
	on the day shift on	ruesday and rriday.			receives shower or bed bath (		
	The hathing task sh	eet indicated the resident was			appropriate) as scheduled.	as	
	_	n staff for bathing on 5/5,			1.Quality Assurance Plans t	0	
	5/11, 5/17, 5/18, 5/2				monitor facility performance to		
		not indicate what type of			make sure that corrections are		
	bathing was perform				achieved and are permanent.	_	
					·All plan of correction audit v	will	
	Interview with the l	Director of Nursing on			be reported by the Director of		
		., indicated there was no			Nursing and or ADON to the		
	_	e resident received a shower			Quality Assurance Committee	and	
	or a complete bed b	oath at least 2 times a week			reviewed by the Committee pe		
	_	221. 3. Interview with	1		Month for four Months and		
	Resident 47 on 6/7/	21 at 10:22 a.m., indicated			recommendations given in ord	der	
		ong with the shower down			to assist in ensuring that the		
	_	was too cold so I have not had	1		facility stay in compliance and	if	
	a shower in a while."				concerns are identified the Qu		
					Assurance Committee will add	d on	
	The record for Resi	dent 47 was reviewed on	1		additional Months until		
	6/9/21 at 3:40 p.m. Diagnoses included, but				Compliance is sustained.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/11/2021	
	ROVIDER OR SUPPLIER DUNTY NURSING A	AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CODE MCCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to, COPD (chronic obstructive pulmonary disease), chronic kidney disease, atrial fibrillation, rheumatoid arthritis, and history of pneumonia.			1.Dates when corrective act will be completed: <u>June 25, 20</u>	
	assessment, dated 5 was alert and orient assistance with 1 pe mobility, transfers,	mum Data Set (MDS) /18/21, indicated the resident ed. She needed limited erson physical assist with bed dressing and toilet use. The did not occur during the ee period.			
	resident had an AD deficit related to act impaired balance. bathing/showers we dry sensitive skin, a	L self-care performance tivity intolerance, fatigue, and The approaches for the to avoid scrubbing and pat and provide a sponge bath shower could not be tolerated.			
	The resident was so Tuesday and Friday	heduled for a shower on vevenings.			
	to determine if the 1	mentation in the bathing task resident received a complete or for May and June 2021.			
	the resident needed	in the bathing task, indicated 1 person assist with physical athing on 5/5, 5/24, 5/27, and			
		mentation indicating the shower or complete bed bath week.			
	6/10/21 at 10:00 a.r	Director of Nursing on n., indicated there was no e resident received a shower			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING 'ING	00	COMPL	
		155653	D. W	- ING		06/11/	2021
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EAST C	HICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		oath at least 2 times a week					
	for 5/2021 and 6/20	021.					
	observed sitting in were long and dirty	8 a.m., Resident 51 was a wheelchair. Her fingernails r. There was food all over her					
	shirt and pants.						
	On 6/7/21 at 11:30	a.m., and 12:30 p.m., the					
		yed in her wheelchair with					
	long dirty fingernai	ls and still wearing the same					
stained shirt and pants.							
		.m., and 1:48 p.m., the ved sitting in her wheelchair.					
	Tier inigernans wer	c unity.					
	On 6/9/21 at 9:10 a	.m., the resident was					
		her wheelchair. Her					
	fingernails were dir	ty.					
		ident 51 was reviewed on					
		. Diagnoses included, but , COPD (chronic obstructive					
		, high blood pressure, muscle					
		fective disorder, anxiety, and					
	dementia with beha						
		of the Significant Change					
		(MDS) assessment, dated					
		e resident was not alert and d limited assistance with 1					
		ist with bed mobility. The					
		dependent on staff with 1					
		ist for dressing, eating, and					
	personal hygiene.	<i>C, C,</i>					
	The Core Di 1	od 5/4/21 indicated the					
		ed 5/4/21, indicated the L self-care performance					
		tivity intolerance, confusion,					
	deficit related to ac	avity intolerance, confusion,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R.		5025 M	CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER			HICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		approaches were to check nail					
	~	clean on bath day and as					
	necessary. Provide a sponge bath when a full bath or shower could not be tolerated.						
	The resident was sc	heduled for a shower on					
	Tuesday and Friday evenings.						
		in the bathing task indicated					
		1 person assist with physical					
		athing on 5/6, 5/7, 5/8, 5/17,					
		6/7/21. There was no					
	indication if the resident received a shower or a bed bath. There was no documentation if nail						
	care had been provi	ded.					
	Interview with the I	Director of Nursing on					
		n., indicated there was no					
		e resident had a shower or a					
		n May or June 2021. The					
	1 -	e to be cleaned during					
	showers or baths an	_					
		11 P. 11 . 45					
	_	ew with Resident 45 on					
		., indicated he preferred a					
		ed it at least 2 times a week,					
		ad not been washed in very					
	long time and his he	zau nelieu.					
	The record for Resi	dent 45 was reviewed on					
		. Diagnoses included, but					
		left side rib fractures, high					
		e 2 diabetes, COPD (chronic					
		ary disease), anxiety, tremors,					
	_	d left knee, diabetic					
		nal gait, and acute respiratory					
	failure.	· ·					
		mum Data Set (MDS)					
	assessment, dated 5	/17/21, indicated the resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	supervision with se and the activity of b assessment reference	-			
	The Care Plan, dated 5/17/21, indicated the resident had an ADL self-care performance deficit related to contractures of the left and right knees, tremors, and lack of coordination.  The resident was scheduled for a shower on Monday and Thursday evenings.  The documentation in the bathing task for the last 30 days indicated there was no documentation if the resident received a complete bed bath or had a shampoo. The resident received physical help with assist with part of the bathing activity on 5/24, 6/3, 6/7, and 6/9/21.				
		mentation indicating the shower or complete bed bath week.			
	6/10/21 at 10:00 a.r documentation if the complete bed bath is resident's hair was to baths. 6. Intervit 6/7/21 at 2:44 p.m., personal physical as	Director of Nursing on m., indicated there was no e resident had a shower or n May or June 2021. The to be washed during showers ew with Resident 25 on indicated she required a 2 ssist with her care. When CNA scheduled, she did not bed bath.			
	6/11/21 at 2:31 p.m were not limited to,	esident was reviewed on . Diagnoses included, but heart failure, hemiplegia, nxiety, and diabetes.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		A. BUILDING 00  B. WING			COMPLETED 06/11/2021		
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		5025 M	DDRESS, CITY, STATE, ZIP CODE CCOOK AVE HICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	The Annual Minimulassessment, dated 5/2 was alert and oriented help with part of bath 1 person physical as hygiene.  A Care Plan, dated 5/2 ADL self-care performered interventions included provide sponge bath could not be tolerated. There was no document resident received a conformal of the folial provide sponge bath could not be tolerated. There was no document with the folial provide sponge bath could not be tolerated. There was no document with the folial provide sponge bath could not be tolerated. There was no document with the folial provide sponge bath could not be tolerated. There was no document with the folial provide sponge bath could not be tolerated. There was no document with the folial provide sponge with the folial prov	m Data Set (MDS) (5/21, indicated the resident ed. She required physical ching activities and extensive sistance with personal (5/3/21, indicated she had an armance deficit. The ed, but were not limited to, when a full bath or shower ed. (a) (a) (b) (c) (c) (d) (d) (d) (e) (e) (e) (f) (f) (f) (f) (f) (f) (f) (f) (f) (f		TAG	DEFICIENCY)		DATE
	occur during the ass						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE ( A. BUILDING B. WING	00	COME	E SURVEY PLETED 1/2021	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	5025	CADDRESS, CITY, STATE, ZIP COD MCCOOK AVE CHICAGO, IN 46312	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	-	2021 bathing documentation ed a full bed bath on 5/19/21.				
	6/10/21 at 4:05 p.m implementing a syst	Director of Nursing on ., indicated she was tem to ensure staff properly as and/or complete bed baths.				
	a.m., indicated "I ha	esident 211 on 6/8/21 at 9:52 ate it here, I have not had a bed here until today and that is the here."				
	6/8/21 at 4:11 p.m. 5/28/21. Diagnoses	esident was reviewed on She was admitted on included, but were not ack of coordination, diabetes, eumonia, and acute				
		luation Assessment, dated e resident was alert and				
		nentation to indicate the shower and/or a complete bed ssion.				
	6/10/21 at 4:05 p.m implementing a syst	Director of Nursing on ., indicated she was tem to ensure staff properly as and/or complete bed baths.				
	3.1-38(a)(3)(B) 3.1-38(a)(3)(E)					
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of Quality of care is a	f care a fundamental principle that				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	/2021
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
		AND DELIADII ITATION CENTED			ICCOOK AVE		
LAKE CC	DUNIY NURSING F	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ment and care provided to					
	facility residents. I						
	1	ssessment of a resident, the					
	facility must ensure that residents receive						
		e in accordance with					
	1 '	dards of practice, the					
	comprehensive person-centered care plan, and the residents' choices.  Based on observation, record review and interview, the facility failed to ensure areas of						
			F 00	584	Submission of this plan of		06/25/2021
					correction does not constitute		
	_	sed and monitored and			admission or agreement by th	е	
	treatments were completed as ordered for 3 of 3				provider of the truth of facts		
	residents reviewed for skin conditions				alleged or correction set forth	on	
	(non-pressure related). (Residents 10, 51, and				the statement of deficiencies.		
	29)				The plan of correction is		
	F: 1: 1 1				prepared and submitted becau	use	
	Findings include:				of requirement under state and		
	1 0 6/0/21 + 10	55 12.00			federal law. Please accept this	s	
		55 a.m. and 2:00 p.m.,			plan of correction as our credi	ble	
		served with an area of purple left antecubital area.			allegation of compliance. Plea	se	
	discoloration to his	ien antecubitai area.			find enclosed this plan of		
	On 6/0/21 at 0:00 a	.m., the discoloration			correction for this survey.		
		ident's left antecubital area.			,		
	Temamed to the resi	ident's left afficeubital area.			F 684 Quality of Care		
	The record for Resi	dent 10 was reviewed on					
		Diagnoses included, but			Corrective actions which wil	l be	
	_	, COPD (chronic obstructive			accomplished for those		
		, type 2 diabetes with chronic			residents found to have been	n	
		gestive heart failure,			affected by the deficient		
	1	onea, and morbid obesity.			practice:		
		,			·R10's discoloration on the I	eft	
	The Annual Minim	um Data Set (MDS)			antecubital area is now resolv		
		1/19/21, indicated the resident			R10 remains within his baselir		
		act for daily decision making.			functioning. No signs of distre	ss	
		ive assistance with one person			noted.		
	physical assistance for bathing and supervision				·R51 is currently not at the		
	for bed mobility and				facility.		
					·R29's discoloration on the t	-	
	The weekly skin as	sessment, dated 6/8/21,			of his right and left hands have	е	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155653 B. WING 06/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE LAKE COUNTY NURSING AND REHABILITATION CENTER EAST CHICAGO, IN 46312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ DEFICIENCY) indicated the resident had no current skin issues. been assessed, monitored and are being documented on the medical records. R29 remains A Physician's Order, dated 6/3/21, indicated the within his baseline of functioning. resident was to receive Aspirin 81 milligrams No signs of distress noted. (mg) daily. Interview with the Director of Nursing (DON) on How the facility will identify other residents having the 6/10/21 at 4:05 p.m., indicated she would review the resident's record. potential to be affected by the same deficient practice. Nurses' Notes, dated 6/11/21 at 2:55 p.m., ·All residents have the potential indicated the resident had a bruise to his left arm. to be affected by the same The physician was notified and orders were deficient practice. received to monitor the bruise until it was 1.The measures the facility will resolved. take or systems the facility will Interview with the DON on 6/11/21 at 3:30 p.m., alter to ensure that the problem will be corrected and will not indicated the bruise should have been assessed and monitored until it was healed.2. On 6/7/21 at recur 9:49 a.m., 11:30 a.m., and 12:30 p.m., Resident An audit tool will be developed 51 was observed sitting in her wheelchair to ensure that any alteration in wearing shorts. There was a bandage observed on skin condition are being her lower left leg that was dated 6/5/21. assessed, monitored, and properly documented. At least two The record for Resident 51 was reviewed on random residents will be selected 6/9/21 at 10:47 a.m. Diagnoses included, but per audit. This will be completed 3 were not limited to, COPD (chronic obstructive times a week for 4 weeks. Then pulmonary disease), high blood pressure, muscle 2 times per week for 5 months. weakness, schizoaffective disorder, anxiety, and Any deficiencies will be corrected dementia with behavioral disorder. immediately. ·Nurses were in serviced on The Modification of the Significant Change proper skin assessment, Minimum Data Set (MDS) assessment, dated monitoring of alterations in skin, 5/6/21, indicated the resident was not alert and and proper documentation of oriented and needed limited assistance with 1 findings and treatment on the medical records. person physical assist with bed mobility. The resident was totally dependent on staff with 1 Quality Assurance Plans to person physical assist for dressing, eating, and personal hygiene. The resident had 1 fall with no monitor facility performance to make sure that corrections are injury since the last assessment.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		(X2) MUL' A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL 06/11/	ETED	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	į	5025 MC	DDRESS, CITY, STATE, ZIP CODE CCOOK AVE HICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The Care Plan, date resident had actual on the left shin relat (a collection of block vessel).  Physician's Orders, "Left shin: Cleanse pack with wet to moders the design of the left shin: Cleanse apply collagen and the Wound Physician's Orders, "Left shin: Cleanse apply collagen and the Wound Physician indicated the left shin by 1 cm, by 0. granulation tissue in apply a foam border days.  Physician's Orders, shin: Cleanse with indressing. Every day Wednesday, and Fr. A skin assessment, left shin had an ope the Treatment Adn dated 5/2021, indicashin had not been sit two times a day on the day shift.	d 5/25/21, indicated the impairment of skin integrity ted to an evacuated hematoma od outside of the blood  dated 5/21/21, indicated with normal saline, dry, then poist gauze and cover with dry y."  dated 5/29/21, indicated with normal saline, dry, then foam dressing daily."  an note, dated 6/4/21, in measured 0.6 centimeters 4 cm. There was 100% oted. The treatment was to rethree times a week for 23  dated 6/8/21, indicated "Left normal saline, and apply foam y shift every Monday, iday."  dated 6/8/21, indicated the			achieved and are permanent.  All plan of correction audit was be reported by the Director of Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee per Month for four Months and recommendations given in ord to assist in ensuring that the facility stay in compliance and concerns are identified the Quantum Assurance Committee will add additional Months until Compliance is sustained.  Dates when corrective action will be completed: June 2021  1.	and er er if ality on	
	treatment of collage	en and a foam dressing was completed 6/1-6/7/21.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		ì í	JILDING	<u>00</u>	COMPL 06/11/	ETED	
	ROVIDER OR SUPPLIER DUNTY NURSING A	ND REHABILITATION CENTER		5025 M	DDRESS, CITY, STATE, ZIP CODE CCOOK AVE HICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	(ADON) on 6/9/21 at treatment was to be Physician.  3. On 6/8/21 at 11:0 observed in bed. He discoloration on the hands.  On 6/9/21 at 4:08 p. the areas of discolor the time indicated he hands in his wheeled. The record for the re 6/9/21 at 1:07 p.m. were not limited to, heart failure, hyperto. The Admission Min assessment, dated 5/2 was alert and oriented person physical assist transfers.  The Weekly Skin O 6/9/21, indicated no the purple areas of dright and left hands.  Interview and obser Director of Nursing indicated the resider on the top of his hard document the areas.  Interview with the	esident was reviewed on Diagnoses included, but lack of physical exercise, ension, diabetes, and sepsis.  Joinum Data Set (MDS)  Joinum D					
	6/11/21 at 3:10 p.m. discoloration should	, indicated areas of I have been assessed,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	<u> </u>			COMPLETED	
		155653	B. WING 06/11/2021				2021
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER			5025 M	DDRESS, CITY, STATE, ZIP CODE CCOOK AVE HICAGO, IN 46312			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	documented, and mo	onitored until healed.					
	3.1-37(a)						
F 0686	483.25(b)(1)(i)(ii)						
SS=D	Treatment/Svcs to	Prevent/Heal Pressure					
Bldg. 00	Ulcer						
	§483.25(b) Skin In						
	§483.25(b)(1) Pres						
		prehensive assessment of					
		ility must ensure that-					
	• •	ives care, consistent with lards of practice, to prevent					
	•	nd does not develop					
	•	nless the individual's clinical					
	-	trates that they were					
	unavoidable; and	•					
	(ii) A resident with	pressure ulcers receives					
		ent and services, consistent					
	•	standards of practice, to					
		prevent infection and					
	prevent new ulcers	· -					
		on, record review, and	F 06	86	Submission of this plan of		06/25/2021
		ty failed to ensure a resident r received the necessary			correction does not constitute		
	•	ces to promote healing			admission or agreement by the	9	
		reatments were completed as			provider of the truth of facts	20	
		e Wound Physician for 1 of 1			alleged or correction set forth of the statement of deficiencies.	וזכ	
	residents reviewed f				The plan of correction is		
	(Resident 15)	-			prepared and submitted becau	150	
					of requirement under state and		
	Finding includes:				federal law. Please accept this		
					plan of correction as our credit		
		a.m., Resident 15 was			allegation of compliance. Pleas		
		bed. At that time, both of her			find enclosed this plan of		
		directly on the mattress, they			correction for this survey.		
	was dated 6/4/21.	The left outer foot bandage					
	was uaieu 0/4/21.				F686 Treatment/Prevent/Heal		
	On 6/7/21 at 10:30 a	a.m., CNA 3 was preparing to			Pressure Ulcer		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		155653	B. W	ING		06/11/2	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
1 41/5 00	NUNTY AUTOONO A	ND DELIABILITATION CENTED			CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	provide morning car	re for the resident. At that					
		resident over to her left side.			Corrective actions which will	l be	
	· ·	andage noted on the resident's			accomplished for those		
	_	te. There were no other			residents found to have beer	ո	
		he resident's buttocks,			affected by the deficient		
	-	or hip areas. There were no			practice:		
		the resident's foot. There was			·R15 receives wound treatm	ent	
	-	on the resident's left lateral			and wound care daily as order		
	-	dated 6/4/21. The resident			·R15's wounds are being		
		on her left heel and left outer			assessed by the wound care N	<sub>MD</sub> I	
	-	eas were open to air and			weekly.		
		tissue (dead or devitalized			·R15's wounds remain stable	e	
	skin tissue).	Control (and of an invitation			with no signs of infection.		
	skiii tissae).				war ne eigne er imeeaen.		
	On 6/7/21 at 3·17 n	.m., CNA 1 was asked to			How the facility will identify oth	ner	
	-	's sock to her left foot. The	residents having the potential to				
		lateral outer foot was still			be affected by the same	.	
	dated 6/4/21.	interial outer 1000 was still			deficient practice.		
	dated of 1/21.				·All residents with pressure		
	On 6/8/21 at 2:46 n	.m., the Assistant Director of			ulcers have the potential to be		
	-	ras preparing to change the			affected by the same deficient		
	- '	on her open areas. The			practice.	'	
	_	ed in bed with both heels			praduce.		
		e mattress without elevation.			1.The measures the facility \	will	
		e (a topical antiseptic) to both			take or systems the facility will		
		els and left them open to air.			alter to ensure that the probler		
	-	oserved with a large amount of			will be corrected and will not		
		bandage to the left lateral			recur.		
		dated 6/4/21. The bandage			·An audit tool will be develor	ned	
		here was a moderate amount of			to ensure that residents with s		
		n the gauze sponge. The area			alteration receives wound care		
		otic tissue and yellow slough			ordered. At least 3 random	- 30	
	_	The pressure ulcer was			residents will be selected per		
		l saline and a collagen			audit. This will be completed 3		
		on the open area followed by			times a week for 4 weeks. The		
		nere was no bandage observed			times weekly for 5 months. An		
	_	left foot near her big toe.			deficiencies will be corrected	У	
		necrotic and pink tissue with			immediately.		
	_	-					
	-	The pressure sore was cleaned			·Nursing staff has been		
	with normal saline a	and a collagen bandage and			in-serviced on the wound		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER DUNTY NURSING <i>F</i>	ND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
IAU	foam dressing was on the right hip was with slough noted. of drainage noted or cleansed the open a placed a collagen be and covered it with no other bandages rafter a skin assessmareas observed on horse to be a contracture of the contractures to the raconvulsions, and a secondary of the contracture of the convulsions, and a secondary of the contracture of the convulsions, and a secondary of the contracture of the convulsions of	placed over it. The bandage removed. The area was pink There was a moderate amount in the old bandage. She rea with normal saline and andage on top of the wound a foam dressing. There were noted on the resident's body. The neutron of the removed on the resident's body. The neutron of the wound a foam dressing of the word on the resident's body. The neutron of the removed on Diagnoses included, but Alzheimer's disease, high mentia, muscle weakness, right and left knees, stroke.  The resident had memory problems and was or decision making. She was in staff with 2 person physical lity, transfers, toilet use and the was a limited assist with 1 leating. The resident had one er.	IAG	prevention policy, on skin and wound assessments, timely administration of treatments a ordered, and proper documentation of wound care services provided.  1. Quality Assurance Plans to monitor facility performance to make sure that corrections and achieved and are permanent.  All plan of correction audit to be reported by the Director of Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee reviewed by the Committee pomonth for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and concerns are identified the Quality Assurance Committee will additional Months until Compliance is sustained.  Dates when corrective action will be completed: June 2021  1.	is soo o o o o o o o o o o o o o o o o o

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	COM	E SURVEY PLETED 1/2021	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	5025	ET ADDRESS, CITY, STATE, ZIP CO MCCOOK AVE T CHICAGO, IN 46312	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  eness.	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated a score of resident was a high	ssment, dated 6/2/21, 11 which indicated the risk for pressure sores. dated 5/4/21, indicated right				
	then apply hydrocol week. Right and let and leave open to ai					
	follows: - cleanse the right h collagen and foam of - cleanse the left lat apply collagen and - cleanse the left dis	dated 5/29/21, were as ip with normal saline, apply dressing daily until healed. eral foot with normal saline foam dressing daily. tal medial foot with normal apply collagen and foam				
	indicated the follow - unstageable pressu measured 4.3 centin thick adherent black betadine once daily air.	neters (cm) by 3.6 cm, 100% a necrotic tissue. Apply for 9 days and leave open to				
	measured 2.5 cm by adherent devitalized collagen sheet and a daily and cover with - Unstageable deep medial foot: measu skin. Discontinue oprep once daily Shear wound to rig	tissue injury to left distal red 3.5 cm by 1 cm intact ollagen sheet and apply skin				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		(X2) MULTIPLE C A. BUILDING B. WING	00		LETED /2021	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP COD MCCOOK AVE CHICAGO, IN 46312	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	50% of granulation	alized necrotic tissue and tissue. Discontinue collagen osorb oil emulsion daily and essing.				
	for the resident after	treatment orders put in place r the above visit and rom the Wound Physician.				
	upper buttocks: clea then apply iodosorb Left distal medial fo	dated 6/9/21, indicated Right anse with normal saline, dry, and cover with dry dressing. Soot: cleanse with normal n prep and leave open to air.				
	6/2021, indicated al signed out as being 6/7/21, including th observed with an ur	ninistration Record (TAR) for l of the treatments were completed on 6/5, 6/6, and e right hip (upper buttocks) adated dressing and left lateral had been observed dated & 6/8/21.				
	indicated the banda Physician's Orders a	ADON on 6/8/21 at 3:20 p.m., ges were to be changed as per and there was no hydrocolloid tock during the wound pleted.				
	6/10/21 at 10:00 a.m were to be changed	Director of Nursing on  n., indicated the treatments as ordered by the Physician. the same open area as the right				
F 0000	3.1-40(a)(2)					
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervisi	ion/Devices				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLE			ETED	
		155653	B. WING 06/11/2021				/2021
				STREET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹					
LAKE COUNTY NURSING AND REHABILITATION CENTER				ICCOOK AVE			
LAKE CC	JUNIT NURSING F	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	§483.25(d) Accide	ents.					
	The facility must e	ensure that -					
	§483.25(d)(1) The	e resident environment					
	remains as free o	f accident hazards as is					
	possible; and						
	§483.25(d)(2)Eac	h resident receives					
	adequate supervi	sion and assistance devices					
	to prevent accider	nts.					
		view and interview, the	F 00	589	Submission of this plan of		06/25/2021
	facility failed to ensure residents were free from				correction does not constitute		
		ensuring proper footwear			admission or agreement by the	e	
		esident with a history of falls			provider of the truth of facts		
		reviewed for accidents.			alleged or correction set forth	on	
	(Resident 51)				the statement of deficiencies.		
					The plan of correction is		
	Finding includes:				prepared and submitted becau	use	
					of requirement under state and		
		.m.,11:30 a.m., and 12:30			federal law. Please accept this		
	1 ~	vas observed sitting in a			plan of correction as our credi		
	_	g plain white ankle socks to			allegation of compliance. Plea		
	both feet. There we	ere no non skid soles noted.			find enclosed this plan of		
	0 (10/04 ) 0 00				correction for this survey.		
		.m., the resident was					
	_	her wheelchair wearing plain			F689 Free of accident		
		feet. There were no non skid			hazards/supervision		
		0 a.m., the resident was					
		bed with a mattress beside the			Corrective actions which will	l be	
	black socks to both	she was wearing the same			accomplished for those		
	black socks to both	reet.			residents found to have been	า	
	On 6/9/21 at 0.10 a	.m., the resident was			affected by the deficient		
		her wheelchair in the hall			practice:		
	_	elchair. She was wearing a			·R51 is currently not in the		
	^ ^ ~	ocks to both feet. There were			facility.		
	no non skid soles n						
	no non said soies ir				How the facility will identify oth	ner	
	On 6/9/21 at 10:45	a.m., the resident was			residents having the potential	to	
		or mattress beside the bed.			be affected by the same		
		loud and holding on to the			deficient practice.		
	I or , out	and the same and the same	1		1		I

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AND PLAN OF CORRECTION  DENTIFICATION NUMBER: 155653  NAME OF PROVIDER OR SUPPLER  LAKE COUNTY NURSING AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 112021  DENTIFICATION OCENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OF 102 MARKET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312  DENTIFICATION OCENTER  A BUILDING OCENTER OCENTER  A BUILDING OCENTER OCE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER  LAKE COUNTY NURSING AND REHABILITATION CENTER  SOME MCCOOK AVE EAST CHICAGO. IN 48312  DESTRETE ADDRESS, CITY, STATE, JIP CODE SOME MCCOOK AVE EAST CHICAGO. IN 48312  ID PRIEFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Side of the bed. She was wearing the same knee high sweeks. The LTR existing Director of Nursing (ADON) was notified immediately the resident had rolled out of her bed.  On 69/21 at 203 p.m., the resident was observed on the floor mattress beside her bed. She was dressed in a hospital gown wearing plain knee high sweeks. There were no most fission for the resident.  The record for Resident 51 was reviewed on 69/21 at 1047 a.m. Diagnoses included, but were not limited to. COPD (chronic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoaffective disorder, anxiety, and dementia with behavioral disorder.  The Modification of the Significant Change Minimum Data Sct (MDS) assessment, dated 3/6/21, indicated the resident was notally dependent on saft with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not altern and oriented and needed limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not altern and oriented and needed limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not altern and oriented and needed limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not altern and oriented and needed limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not altern and oriented and needed limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not altern and oriented and needed limited assistance with 1 person physical assist for fall state of the resident was not altern and oriented and				ì í				
STREET ADDRESS, CITY, STATE, ZIP CODE.  SOLON AVE  EAST CHICAGO. IN 46312  D  RREFIX TAG SIGNIA AND STATEMENT OF DEFICIENCIES  Side of the bed. She was wearing the same knee high socks to both feet. The Assistant Director of Nursing (ADON) was notified immediately the resident had rolled out of her bed.  On 6/9/21 at 12/30 p.m., the resident was observed on the floor matress beside her bed. She was dressed in a hospital gown wearing plain kace high socks. There were no non skids on them. The ADON was right outside the door preparing medication for the resident.  The record for Resident 51 was reviewed on 6/9/21 at 10/47 a.m. Diagnoses included, but were not limited to, CODP (chronic obstructive pulmonary disease), high blood pressure, musele weakness, schizoralicive disorder, anxiety, and dementia with behavioral disorder.  The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was totally dependent on staff with 1 person physical assist for dressing, eating, and personal hygiene. The resident was to alread oriented and needed limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident was to alread personal hygiene. The resident was to alread and personal hygiene. The resident was to alread to the resident was a trisk for falls due to incontinence, imparted cognition, and psychotropic medication use. The resident part of last with the domobility. The resident was to the bed and did move/crawl around on the mat and floor.  A fall risk assessment, dated 2/4/21, indicated the resident had a score of 21 indicating a high nisk.	AND PLAN	OF CORRECTION		<u> </u>				
LAKE COUNTY NURSING AND REHABILITATION CENTER  IXA ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SIDENTIFY OF LAKE IDENTIFYING INFORMATION)  side of the bed. She was wearing the same knee high socks to both feet. The Assistant Director of Nursing (ADON) was notified immediately the resident had rolled out of her bed.  On 6:9/21 at 2:03 p.m., the resident was observed on the floor mattress beside her bed. She was dressed in a hospital gown wearing plain knee high socks. There were no non skids on them. The ADON was right outside the door preparing medication for the resident.  The record for Resident 51 was reviewed on 6:9/21 at 10:47 a.m. Diagnoses included, but were not limited to, COPID (chronic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoffective disorder, anxiety, and dementia with behavioral disorder.  The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5:6/21, indicated the resident was not alcet and oriented and needed limited assistance with 1 person physical assist with bed mobility. The resident may not alcet and oriented and needed limited assistance with 1 person physical assist with bed mobility. The resident was to a fall and personal hygiene. The resident had a limit with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not alcet and oriented and medded limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident was not alcet and oriented and needed limited assistance with 1 person physical assist with bed mobility. The resident was tall bed to incomtinence, impaired eagmition, and psychotropic medication use. The resident had life with no injury since the last assessment.  A fall risk assessment, dated 24/21, indicated the resident was not alcet and oriented and dimove/cmwl around on the mat and floor.  A fall risk assessment, dated 24/21, indicated the resident was not alcet and oriented and dimove/cmwl around on the mat and floor.			155653	в. W			06/11/	2021
SOZÉ MICCOOK AVE	NAME OF P	ROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   TAG	TWINE OF T	NO VIDER OR SOLVEIL			5025 M	CCOOK AVE		
REFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  side of the bed. She was wearing the same knee high socks to both feet. The Assistant Director of Nursing (ADON) was notified immediately the resident had rolled out of her bed.  On 6/9/21 at 2:03 p.m., the resident was observed on the floor mattress beside her bed. She was dressed in a hospital gown wearing plain knee high socks. There were no non skids on them. The ADON was right outside the door preparing medication for the resident.  The record for Resident 51 was reviewed on 6/9/21 at 10:47 a.m. Diagnoses included, but were not limited to, COPP (chronic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoaffective disorder, anxiety, and dementia with behavioral disorder.  The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was at risk for falls due to incontinence, impaired cognition, and psychotropic medication use. The resident preferred to lay on a mat next to the bed and did move/crawl around on the mat and floor.  A fall risk assessment, dated 2/4/21, indicated the resident had a score of 21 indicating a high risk.	LAKE CC	OUNTY NURSING	AND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312		
side of the bed. She was wearing the same knee high socks to both feet. The Assistant Director of Nursing (ADON) was notified immediately the resident had rolled out of her bed.  On 6/9/21 at 2:03 p.m., the resident was observed on the floor mattress beside her bed. She was dressed in a hospital gown wearing plain knee high socks. There were no non skids on them. The ADON was right outside the door preparing medication for the resident.  The record for Resident 51 was reviewed on 6/9/21 at 10-47 a.m. Diagnoses included, but were not limited to, COPD (chromic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoaffective disorder, anxiety, and dementia with behavioral disorder.  The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was totally dependent on staff with 1 person physical assist for dressing, eating, and personal hygiene. The resident and personal hygiene. The resident and personal hygiene. The resident preferred to lay on a mat next to the bed and did move/crawl around on the mat and floor.  A fall risk assessment, dated 2/4/21, indicated the resident may a dround on the mat and floor.  A fall risk assessment, dated 2/4/21, indicated the resident had a score of 21 indicating a high risk.		SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
All residents have the potential to be affected by the same high socks to both fect. The Assistant Director of Nursing (ADON) was notified immediately the resident had rolled out of her bed.  On 6/9/21 at 2:03 p.m., the resident was observed on the floor mattress beside her bed.  She was dressed in a hospital gown wearing plain knee high sooks. There were no moskids on them. The ADON was right outside the door preparing medication for the resident.  The record for Resident 51 was reviewed on 6/9/21 at 10:47 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoffective disorder, anxiety, and dementia with behavioral disorder.  The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was not alert and oriented and needed limited assistance with 1 person physical assist for dressing, eating, and personal hygiene. The resident had a sessessment.  The Care Plan, revised 5/24/21, indicated the resident was a rot store to the bed and did move/crawl around on the mat and floor.  A fall risk assessment, dated 2/4/21, indicated the resident had a score of 21 indicating a high risk.	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
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facility stay in compliance and if concerns are identified the Quality the resident had a score of 21 indicating a high risk.  facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until		to the bed and did 1	move/crawl around on the mat			recommendations given in ord	der	
A fall risk assessment, dated 2/4/21, indicated the resident had a score of 21 indicating a high risk.  concerns are identified the Quality  Assurance Committee will add on additional Months until		and floor.				_		
the resident had a score of 21 indicating a high risk.  Assurance Committee will add on additional Months until						1		
risk. additional Months until							•	
		the resident had a s	core of 21 indicating a high				d on	
Compliance is sustained.		risk.						
						Compliance is sustained.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	indicated the reside	d 4/14/21 at 9:30 a.m., at was observed sitting on the ed and the wall. The resident d to get up.		Dates when corrective action be completed: <u>June 25, 2021</u> 1.	
	indicated the reside	d 6/9/21 at 1:15 p.m., nt was observed lying on her at for her mother and wanting the bed.			
		d 6/9/21 at 2:17 p.m., nt was observed rolling out of e mat.			
	6/10/21 at 10:00 a.r. should have been w feet while in bed an	Director of Nursing on in., indicated the resident earing non skid socks on both d up in the wheelchair. If also be wearing shoes.			
	indicated the resided by the day shift. Shoot have many pairs mostly plain socks	A 2 on 6/10/21 at 3:15 p.m., nt was dressed every morning are indicated the resident did s of non skid socks, she had with no non skid soles. She e resident more pairs of non			
	3.1-45(a)(2)				
F 0692 SS=E Bldg. 00	§483.25(g) Assisto (Includes naso-ga tubes, both percut gastrostomy and p jejunostomy, and	n Status Maintenance ed nutrition and hydration. stric and gastrostomy raneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the re that a resident-			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMPL	
ANDILAN	or connection	155653	B. WI		00	06/11/	
LAKE CO	NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			5025 M EAST C	ADDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312  PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	usual body weight range and electro resident's clinical this is not possible indicate otherwise §483.25(g)(2) Is of intake to maintain health; §483.25(g)(3) Is of when there is a numbealth care provided diet.  Based on record reversed facility failed to ensucceptable parameter related to meal conscompleted, supplemed documented, and the notified of supplemed were nutritionally a reviewed for nutritionally a reviewed for nutritionally a reviewed for nutritionally and the supplemed were nutritionally a reviewed for nutritionally and the supplemed were nutritionally a reviewed for nutritionally a reviewed for nutritionally and the supplemed were nutritionally a reviewed for nutritionally a reviewed for nutritionally a reviewed in her roomes identification was feeding pureed meat and pureceive ice cream was feeding in bed eating.	ritional status, such as a cor desirable body weight lyte balance, unless the condition demonstrates that a cor resident preferences of the condition demonstrates that a cor resident preferences of the condition demonstrates that a cor resident preferences of the corresponding to t	F 06	592	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credict allegation of compliance. Please find enclosed this plan of correction for this survey.  F692 Nutrition/Hydration State Maintenance  Corrective actions which will accomplished for those residents found to have been affected by the deficient practice:	on use d s ble se	06/25/2021

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W		<u> </u>	06/11/	
		.55555			<u> </u>	30, 11,	
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The record for Resi	ident 37 was reviewed on			·R37 was evaluated by the		
	6/9/21 at 1:19 p.m.	Diagnoses included, but			dietitian. Recommendations		
	were not limited to,	, stroke, dementia without			relayed to MD and carried out	t.	
	behavior disturbance	ce, dysphagia (difficulty			·R37 remains at his baselin	e of	
	swallowing), adult	failure to thrive,			functioning. No distress noted	l <b>.</b>	
	schizophrenia, hem	iplegia (muscle weakness),					
	and psychotic disor	der with hallucinations.			How the facility will identify ot	her	
					residents having the potential	to	
	The Quarterly Mini	imum Data Set (MDS)			be affected by the same		
	assessment, dated 5	5/12/21, indicated the resident			deficient practice.		
	was cognitively imp	paired for daily decision			·All residents have the pote	ntial	
	making and needed	supervision with eating. She			to be affected by the same		
	received a mechani	cally altered, therapeutic diet			deficient practice.		
	and had sustained a	significant weight loss of 5%					
	in one month or 10	% in 6 months.			1.The measures the facility	will	
					take or systems the facility will	II	
	The Care Plan, date	ed 5/17/21, indicated the			alter to ensure that the proble	m	
	resident had a poter	ntial nutritional problem. The			will be corrected and will not		
	resident received a	mechanically altered diet and			recur.		
	had variable intake.	. She was underweight as			·An audit tool will be develo	ped	
	evidenced by a bod	y mass index (BMI) below			to ensure that residents with		
	normal range of 18	.5-24.9 related to energy			nutritional risk are properly		
	intake less than ene	ergy expenditure. The resident			assessed and nutritional intak	æ	
	also had a history v	veight loss. Interventions			including supplement is being		
	included, but were	not limited to, provide, serve			monitored and recorded. At le	ast	
	diet as ordered and	monitor intake and record			three random residents will be	<b>e</b>	
	every meal.				selected per audit. This will be	9	
					completed 5 times a week for	4	
	On 11/9/20, the res	ident weighed 75 pounds. On			weeks. Then 3 times for 5		
	5/13/21, the residen	nt weighed 66 pounds, a 12%			months. Any deficiencies will	be	
	weight loss in 6 mc	onths.			corrected immediately.		
					Nursing staff has been		
	A Physician's Orde	r, dated 4/24/21, indicated the			in-serviced on timely MD and		
	resident was to receive a frozen nutritional treat				dietitian notification of residen	ıt's	
	two times a day and	d Ensure Plus 237 milliliters			refusal to ordered supplemen	ts	
	(ml) three times a day.				and proper documentations o	f	
	(iii) three times a day.				meal consumptions.		
	A Physician's Orde	r, dated 5/25/21, indicated the			1.Quality Assurance Plans t	:0	
		eive a pureed diet with double			monitor facility performance to		
		er cereal at breakfast and ice			make sure that corrections are		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	NG		06/11/	′2021
					-		
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	OUNTY NURSING A	AND REHABILITATION CENTER		EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWINED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	cream at lunch.				achieved and are permanent.		
					All plan of correction audit v	vill	
	The May 2021 Medication Administration				be reported by the Director of		
	-	licated the Ensure was not			Nursing and or ADON to the		
	· · ·	administered midday on 5/7,			Quality Assurance Committee	and	
	5/11, 5/14, 5/19, and 5/23/21. The evening Ensure was not signed out on 5/10 and 5/17/21.				reviewed by the Committee pe		
					Month for four Months and		
					recommendations given in ord	ler	
	The May 2021 Foo	d Consumption log, indicated			to assist in ensuring that the		
	•	umented on the dates as			facility stay in compliance and	if	
	follows:				concerns are identified the Qu	ality	
	Breakfast: 5/28, 5/2	29, 5/30, and 5/31/21			Assurance Committee will add	lon	
	Lunch: 5/28, 5/29,	5/30, and 5/31/21			additional Months until		
	Dinner: 5/12, 5/15,	, 5/16, 5/17, 5/21, 5/24,			Compliance is sustained.		
	5/25, 5/26, 5/27, an	d 5/28-5/31/21					
					Dates when corrective ac	tion	
	The June 2021 Foo	d Consumption log, indicated			will be completed: June 25, 20	<u>)21</u>	
	meals were not doc	umented on the dates as			1.		
	follows:						
	Dinner: 6/1, 6/7, ar	nd 6/8/21					
	Interview with the l	Director of Nursing on					
	6/10/21 at 4:05 p.m	., indicated the resident					
	should have receive	ed her supplements as ordered					
	and her food consu	mption should have been					
	documented.						
	2. On 6/7/21 at 12:	47 p.m., Resident 41 was					
	observed in his room	m lying on top of his bed.					
	The resident's lunch	n tray was placed on his over					
		ner side of his room. At 2:40					
		remained on the over bed					
	table and the resident had not eaten anything.						
	The record for Resident 41 was reviewed on						
	6/9/21 at 10:41 a.m. Diagnoses included, but						
	were not limited to, hypertension, schizophrenia,						
		sorder, anxiety, and type 2					
	diabetes.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155653	B. WI	NG		06/11/	/2021
				CED FEET	A PARTICLE CONT. CT. TE. TIP CORE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	OUNTY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	On 11/9/20, the resi	ident weighed 217 pounds.					
	On 5/10/21, the resi	ident weighed 187 pounds,					
	which indicated a 1	3.8 % weight loss in 6					
	months.						
	The Quarterly Mini	mum Data Set (MDS)					
	assessment, dated 5	3/13/21, indicated the resident					
		paired for daily decision					
	making and needed	supervision for eating.					
		ed 5/10/21, indicated the					
		tional problem or a potential					
	nutritional problem	<del>-</del>					
	_	liagnosis of tonsil cancer and					
	· ·	structive pulmonary disease)					
	-	of weight loss. Interventions					
		not limited to, provide, serve					
		onitor intake and record every					
	meal.						
	EI 14 0004 E						
	<u>-</u>	d Consumption log, indicated					
		umented on the dates as					
	follows:	20. 5/20 1.5/21/21					
		29, 5/30, and 5/31/21					
	Lunch: 5/28, 5/29,						
		, 5/16, 5/17, 5/21, 5/24,					
	5/25, 5/26, 5/27, an	d 3/28-3/31/21					
	The June 2021 Fee	d Consumption log, indicated					
		umented on the dates as					
	follows:	uniented on the dates as					
	Breakfast: 6/1/21						
	Lunch: 6/1/21						
	Dinner: 6/1, 6/4, 6/	/6 6/7 and 6/8/21					
	Diffici. 0/1, 0/4, 0/	0, 0, 1, and 0, 0, 21					
	Interview with the Director of Nursing on						
	Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the resident's						
	_	should have been documented					
	for each meal.	mode have been documented					
	101 cuch mean.						
			1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	/2021
				CEREE	ADDRESS STAY STATE THE SORE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	DUNIY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3. The record for R	Resident 44 was reviewed on					
	6/8/21 at 2:10 p.m.	Diagnoses included, but					
	were not limited to,	stroke, hemiplegia (muscle					
	weakness), major d	epressive disorder, dementia					
	with behavior distu	rbance, anxiety, dysphagia					
	(difficulty swallowing	ing), and type 2 diabetes.					
		mum Data Set (MDS)					
	· ·	5/14/21, indicated the resident					
		paired for daily decision					
	-	eded supervision with eating					
	and received a mech	hanically altered diet.					
		1.7(0.1/0.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.					
		ed 5/24/21, indicated the					
		tional problem or potential					
	nutritional problem						
	-	d diet due to the diagnosis of					
	dysphagia and histo						
		ded, but were not limited to,					
	-	as ordered. Monitor intake					
	and record every m	eal.					
	On 11/0/20 4h	: 1411-2041-					
		ident weighed 204 pounds.					
		ident weighed 159 pounds, a					
	22% weight loss in	the past 6 months.					
	The May 2021 Food	d Consumption log, indicated					
		umented on the dates as					
	follows:	unicited on the dates as					
		29, 5/30, and 5/31/21					
	Lunch: 5/28, 5/29,						
		, 5/16, 5/17, 5/21, 5/24,					
	5/25, 5/26, and 5/28						
	5.25, 5.20, and 5/20						
	The June 2021 Food	d Consumption log, indicated					
		umented on the dates as					
	follows:						
	Breakfast: 6/1/21						
	Lunch: 6/1/21						
	Dinner: 6/1 and 6/7	7/21					
			1	J	l		ī

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	NSTRUCTION  00	(X3) DATE :	ETED	
		155653	B. Wl	NG		06/11/	2021
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		5025 M	ADDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	6/10/21 at 4:05 p.m food consumption s for each meal.4. Or Resident 15 was obinside her room. At Director of Nursing tray and was going received a cup of appureed sausage and  The record for Reside/8/21 at 1:53 p.m. not limited to, Alzh pressure, dementia, contractures to the reconvulsions, and a s  The Quarterly Minitassessment, dated 4 was not alert and or short and long term severely impaired for totally dependent or assist for bed mobil bathing. The resident person physical assist 149 pounds with no received a therapeut diet. The resident had nutritic mechanically altereneeds, and history of approaches were to ordered. Monitor in	dent 15 was reviewed on Diagnoses included, but were eimer's disease, high blood muscle weakness, right and left knees, stroke.  mum Data Set (MDS) /28/21, indicated the resident iented. The resident had memory problems and was or decision making. She was a staff with 2 person physical ity, transfers, toilet use and at was a limited assist with 1 ist for eating. She weighed current weight loss. She tic and mechanically altered and 1 stage 1 pressure ulcer.  d 5/24/21, indicated the onal problems due to a d diet, increased nutritional					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		155653	B. W	ING		06/11/	/2021
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULTER			5025 M	CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE	DATE
	and 149 pounds on	5/13/21 which was a 23.98%					
	weight loss in 6 mo	onths. The weight loss was					
	_	ndicating a significant weight					
	_	obtained on 6/8/21 and					
	indicated the reside	ent still weighed 149 pounds.					
	The last documents	ed Registered Dietitian (RD)					
		indicated the resident					
		liet with house shakes at					
		weight on 5/13/21 was 149					
		y Mass Index of 25.7.					
		,					
	The meal consumpt	tion logs in the last 30 days					
	indicated breakfast	was not documented on 5/8,					
	5/9, 5/12, 5/21, 5/2	3, 5/27-5/31, and 6/4/21.					
	Lunch was not doc	umented on 5/7, 5/8, 5/9,					
		31, and 6/4/21. Dinner was					
		5/6, 5/7, 5/10, 5/11, 5/12,					
		19, 5/24, 5/28-5/31, 6/1, and					
	6/4-6/7/21.						
	Interview with the	Director of Nursing on					
		m., indicated there were many					
		consumption log for all three					
		d for Resident 28 was					
	reviewed on 6/10/2	1 at 10:10 a.m. Diagnoses					
	included, but were	not limited to, malignant					
	1 -	ophagus, hypertension, ataxia					
	(loss of control of b	-					
		, dementia with behaviors, and					
	psychotic disorder	with delusions.					
	The Annual Missing	um Data Sat (MDS)					
		um Data Set (MDS) 5/6/21, indicated the resident					
		tively impaired for decision					
		apervision with bed mobility,					
		disorders, no dental concerns,					
	_	weight loss not prescribed by a					
	weight-loss regime						
	l see to see to game.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155653		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	COMI	E SURVEY PLETED 1/2021			
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	Protein liquid suppl 7:00 a.m. and 1:00 J	dated 5/12/21, indicated ement (Ensure) twice a day at o.m., to promote weight.						
	potential for nutritic interventions includ	ed, but were not limited to, (RD) to evaluate and make						
	-							
	The June 2021 MA	(22, and 5/28-5/31/21) R, indicated the resident on the following dates:						
	- 6/1, 6/3-6/4, 6/6, a There was no docur was notified of the	nentation to indicate the RD						
	6/10/21 at 4:05 p.m	Director of Nursing on ., indicated the RD should of the resident's refusals.						
	3.1-46(a)(1)							
F 0695 SS=E Bldg. 00	,,,	eostomy Care and atory care, including and tracheal suctioning.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155653 B. WING 06/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE LAKE COUNTY NURSING AND REHABILITATION CENTER EAST CHICAGO, IN 46312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and F 0695 Submission of this plan of 06/25/2021 interview, the facility failed to provide proper correction does not constitute respiratory care and services related to oxygen at admission or agreement by the the correct flow rate and connected to the provider of the truth of facts concentrator, having orders for oxygen, alleged or correction set forth on monitoring of humidification bottles, and the statement of deficiencies. changing and dating the oxygen tubing for 4 of 4 The plan of correction is residents reviewed for oxygen. (Residents 10, prepared and submitted because 47, 45, and 211) of requirement under state and federal law. Please accept this Findings include: plan of correction as our credible allegation of compliance. Please 1. On 6/7/21 at 11:03 a.m. and 12:37 p.m., the find enclosed this plan of oxygen tubing for Resident 10 was dated correction for this survey. 5/17/21. The humidification bottle, dated 4/26/21, was not connected to the oxygen concentrator and was on the floor. The resident Respiratory/Tracheostomy was wearing oxygen by the way of a nasal cannula Care and Suctioning and his oxygen concentrator was set at 4 liters per minute. Corrective actions which will be accomplished for those On 6/8/21 at 10:37 a.m., 2:00 p.m., and 2:58 residents found to have been p.m., the resident's oxygen tubing was dated affected by the deficient 5/17/21 and the oxygen concentrator was set at 4 practice: liters. ·R10's oxygen set-up and settings are corrected and is now On 6/9/21 at 9:00 a.m., 11:55 a.m., and 1:05 set per md order, O2 tubing is p.m., the resident's oxygen tubing was dated dated per policy, R10's O2 5/17/21 and the oxygen concentrator was set at 4 saturation remains within baseline. liters. No signs of distress noted. ·R47's oxygen set-up and On 6/10/21 at 9:00 a.m., the resident's oxygen

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. WI	NG		06/11/	2021
				CEDELET	ADDRESS COMMUNICATE STREET, ST		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	tubing was dated 5/17/21 and the oxygen				settings are corrected and is n	ow	
	concentrator was set at 4 liters.				set per md order, O2 tubing is		
					dated per policy, R47's O2		
	The record for Resident 10 was reviewed on 6/9/21 at 3:00 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive				saturation remains within base	line.	
					No signs of distress noted.		
					·R45's oxygen set-up and		
	pulmonary disease), type 2 diabetes with chronic				settings are corrected and is n	ow	
		gestive heart failure,			set per md order, O2 tubing is		
	obstructive sleep ap	onea, and morbid obesity.			dated per policy, R45's O2		
		•			saturation remains within base	line.	
	The Annual Minim	um Data Set (MDS)			No signs of distress noted.		
	assessment, dated 3	/19/21, indicated the resident			·R211's oxygen set-up and		
	was cognitively inta	act for daily decision making			settings are corrected and is n	ow	
	and he required the	use of oxygen during the			set per md order, O2 tubing is		
	assessment reference	e period.			dated per policy, R211's O2		
					saturation remains within base	line.	
	The Care Plan, date	ed 5/26/21, indicated the			No signs of distress noted.		
	resident was at risk	for impaired gas exchange					
	secondary to chroni	c respiratory failure,			How the facility will identify oth	er	
	obstructive sleep ap	nea requiring bipap use, and			residents having the potential	to	
	COPD. The resider	nt experienced positional			be affected by the same		
	shortness of breath	as well as shortness of breath			deficient practice.		
	while lying flat and	with activity secondary to			·All residents who are receiv	ing	
	COPD. Interventio	ns included, but were not			Oxygen therapy have the pote	ntial	
	limited to, oxygen a	as ordered.			to be affected by the same		
					deficient practice.		
	A Physician's Order	r, dated 4/29/21, indicated					
		nnula oxygen at 3 liters per			The measures the facility will t		
	_	orn) for shortness of breath or			or systems the facility will alter		
	oxygen saturation le	ess than 92%. The resident's			ensure that the problem will be	)	
		vas to be checked every shift.			corrected and will not recur.		
		and mask or cannula were to			∙An audit tool will be develop		
	_	ed. When changed, the tubing			to ensure that resident's oxyge		
	and/or mask were to be dated.				therapy is administered correc	-	
					per doctor's order and ensure		
	The May and June 2				the O2 tubing's and humidifier	s	
	Administration Records (MAR's), indicated the				are checked and dated		
		ibing had not been signed out			appropriately per policy. At lea	st	
	_	prn oxygen had not been			five random residents will be		
	signed out as being	applied.			selected per audit. This will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. WI	NG		06/11/	2021
				CTD FFT A	ADDRESS OF A TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	DUNIY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1.2	DATE
					completed 3 times a week for	4	
	Interview with the l	Director of Nursing (DON) on			weeks. Then 2 times weekly	for	
	6/10/21 at 4:05 p.m., indicated the resident had				3 months. Any deficiencies wil	l be	
	been hospitalized to	wice in May and his tubing			corrected immediately.		
	should have been cl	hanged each time he returned.			·Nursing staff has been		
	The DON also indicated a clarification order needed to be obtained related to the correct flow rate and if the oxygen should be used continuously.				in-serviced on proper oxygen		
					set-up: O2 rate, correct		
					concentrator set-up, checking	the	
					functionality of humidification		
					bottles, proper dating of oxyge		
		12 a.m., Resident 47 was			tubing and proper documentat		
	observed laying in	bed. She was wearing oxygen			of respiratory services provide	d	
	per nasal cannula a	nd it was connected to the			on the resident's medical reco	rd.	
	portable tank which	was set at 2 liters per minute.			Quality Assurance Plans to		
	The humidification	bottle on the concentrator			monitor facility performance to	)	
	was empty. There	were 2 bottles on top of the			make sure that corrections are	,	
		ated 5/17 and the other dated			achieved and are permanent.		
		ent indicated she had not been			·All plan of correction audit v	vill	
		in the room due to the			be reported by the Director of		
		g out of the humidification			Nursing and or ADON to the		
	bottles. There was i	no date on her oxygen tubing.			Quality Assurance Committee		
					reviewed by the Committee pe	er	
	-	.m. and 6/9/21 at 9:00 a.m.,			Month for 5 Months and		
		served wearing oxygen at 2			recommendations given in ord	er	
	liters per minute pe	r nasal cannula.			to assist in ensuring that the		
					facility stay in compliance and		
		dent 47 was reviewed on			concerns are identified the Qu	, I	
		Diagnoses included, but			Assurance Committee will add	on	
	· · · · · · · · · · · · · · · · · · ·	COPD (chronic obstructive			additional Months until		
		, chronic kidney disease,			Compliance is sustained.		
		neumatoid arthritis, and			Dates when corrective action v	:11	
	history of pneumon	11a.				WIII	
	The Open to the M	Impure Data Sat (MDS)			be completed: June 25, 2021		
		mum Data Set (MDS)			1.		
		5/18/21, indicated the resident ted. She needed limited					
	_	erson physical assist with bed					
	mobility, transfers,	dressing and toilet use.					
	A Claus D1 1 1 1	4/20/21 :1:1:1					
	A Care Plan, dated	4/30/21, indicated the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		 JILDING	<u>00</u>	COMPL 06/11/	ETED	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	5025 M	DDRESS, CITY, STATE, ZIP CODE CCOOK AVE HICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		for a complication of COPD.  o wear oxygen as ordered.				
	apply oxygen per na	dated 5/3/21, indicated may usal cannula 2 liters per r shortness of breath or if sess than 90%.				
	for 5/2021, indicated	ministration Record (MAR) d the resident's oxygen ecked every shift and there %.				
		ndicated all of the oxygen ecked were greater than 90%.				
	6/10/21 at 10:00 a.n humidification bottl not dated, nor was the indicated the residen	e was empty on 6/7/21 and he oxygen tubing. She nt will dip below 90% with on if she did not have any on,				
	Resident 45 was obs his bed. At that tim nasal cannula at 4 li humidification bottl	50 a.m. and 2:30 p.m., served sitting on the side of e, he was wearing oxygen per ters per minute. The e on the concentrator was tubing was not dated.				
	6/9/21 at 11:45 a.m. were not limited to,	dent 45 was reviewed on Diagnoses included, but left side rib fractures, COPD pulmonary disease), anxiety, y failure.				
		mum Data Set (MDS) /17/21, indicated the resident				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		JILDING	<u>00</u>	COMPL 06/11/	ETED	
	PROVIDER OR SUPPLIER DUNTY NURSING A	ND REHABILITATION CENTER	5025 M	DDRESS, CITY, STATE, ZIP CODE CCOOK AVE HICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		ed. The resident needed up only for personal hygiene while a resident.				
	resident was at risk related to respirator	d 5/17/21, indicated the for impaired gas exchange y failure and COPD. The vide oxygen as ordered.				
		dated 5/3/21, indicated nnula at 4 liters continuously.				
	-	dated 4/29/21, indicated to ng and mask or cannula ing and mask.				
	6/10/21 at 10:00 a.n humidification bottl be changed weekly On 6/8/21 at 9:52 a. observed in bed. Ho	Director of Nursing on and, indicated the es and oxygen tubing were to and dated when changed. 4. m., Resident 211 was er oxygen concentrator was minute and her oxygen tubing				
	observed in bed. He	a.m., the resident was er oxygen concentrator as per minute and her tubing				
	6/8/21 at 4:11 p.m. 5/28/21. Diagnoses	esident was reviewed on She was admitted on included, but were not ack of coordination, diabetes, eumonia, and acute				
	risk for impaired ga	5/1/21, indicated she was at sexchange. The ed, but were not limited to,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155653	B. WING 06/11/2021			2021	
			<u> </u>	CED DEE	DDDEGG CHTW CTATE THE CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	NINTY AUTOONIO A	ND DELIABILITATION OF NITED			CCOOK AVE		
LAKE COUNTY NURSING AND REHABILITATION CENTER			EASIC	CHICAGO, IN 46312			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	administer oxygen a	as prescribed or per standing					
	order.						
	The June 2021 Phys	sician's Order Summary					
	(POS) indicated the	resident was to receive					
	oxygen at 4 liters.						
	Interview with the I	Director of Nursing on					
		., indicated the resident's					
	oxygen rate should	have been set as ordered and					
	her oxygen tubing s	hould have been dated.					
	3.1-47(a)(6)						
	400 0 = ( 1) (=)						
F 0730	483.35(d)(7)	D : 401 /					
SS=D	Nurse Aide Peforn	n Review-12 nr/yr					
Bldg. 00	In-Service						
		gular in-service education.					
	•	omplete a performance					
	-	rse aide at least once					
	_	and must provide regular on based on the outcome					
		In-service training must					
		quirements of §483.95(g).					
		riew and interview, the	E 07	20	Cubmission of this plan of		06/25/2021
		sure performance reviews for	F 07	30	Submission of this plan of correction does not constitute		06/25/2021
	_	re completed at least once					
	-	r 3 of 3 records reviewed for			admission or agreement by the	<sup>‡</sup>	
	annual performance				provider of the truth of facts		
	amiaar perrormance	Teviews.			alleged or correction set forth	on	
	Finding includes:				the statement of deficiencies.		
					The plan of correction is		
	The Employee Files	s were reviewed on 6/11/21 at			prepared and submitted becau		
		ving was not completed:			of requirement under state and		
	,				federal law. Please accept this		
	1. CNA 4, hired on	12/26/13, no annual			plan of correction as our credit		
	performance review				allegation of compliance. Plea	se	
	2. CNA 5, hired on				find enclosed this plan of		
	performance review				correction for this survey.		
	_	10/12/12, no annual					
	· · · · · · · · · · · · · · · · · · ·		1				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			CCOOK AVE		
	NUNTY NUIDONIO /	AND DELIABILITATION CENTED			CHICAGO, IN 46312		
LAKE COUNTY NURSING AND REHABILITATION CENTER		AND REHABILITATION CENTER		EASIC	HICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	performance review	7.			F 730 Nurse Aide Perform		
					Review-12 hr/yr In-service		
	Interview with the I	Healthcare Manager on			It is the policy of the facility to		
	6/11/21 at 1:32 p.m	., indicated the above CNAs			complete a performance revie	w of	
	did not have annual	performance reviews.			every nurse aide at least once	;	
					every 12 months, and must		
	3.1-14(h)				provide regular in-service		
					education based on the outco	me	
					of these reviews.		
					Corrective actions which will	l be	
					accomplished for those		
					residents found to have beer	1	
					affected by the deficient		
					practice:		
					No resident was affected by	/	
					this deficient practice.		
					How the facility will identify oth	ner	
					residents having the potential		
					be affected by the same defici		
					practice.	Ont	
					No residents have the poter	ntial	
					to be affected as no resident v		
					affected by this deficient		
					practice. However, facility		
					recognizes that annual		
					performance evaluation contri	bute	
					to increase job satisfaction and	d	
					high customer service		
					satisfaction.		
					The measures the facility will t		
					or systems the facility will alter		
					ensure that the problem will be	Э	
					corrected and will not recur.		
					1.		
					·A tool will be developed to a		
					Certified Nursing Aides with no		
					annual performance review. T	his	
					will be completed by Human		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/11/2021		
	PROVIDER OR SUPPLIER DUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
			Resource Department and discuss schedule of reviews we Director of Nursing.  Nursing aides: C.N.A 4, C.N.5, and C.N.A 6 will be evaluate by completion date of June 25 2021.  A 1:1 in-service will be provided to Human Resource Director and Director of Nursing by the Facility Administrator to ensure that annual performance reviews are scheduled and conducted annually.  Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.  All plan of correction audit we be reported by the Administration to the Quality Assurance  Committee and reviewed by the Committee per Month for 5 Months and recommendations given in ord to assist in ensuring that the facility stay in compliance and concerns are identified the Quality Assurance Committee will additional Months untill  Compliance is sustained.	A.A ed , ag g ce vill cor ae if ality on		
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETED			
		155653	B. W	ING		06/11/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CCOOK AVE		
LAKE CO	OUNTY NURSING A	AND REHABILITATION CENTER			CHICAGO, IN 46312		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG				TAG	DEFICIENCE		DATE
		rug regimen must be free ⁄ drugs. An unnecessary					
	drug is any drug v	-					
	urug is ariy urug v	viieli useu-					
	8483 45(d)(1) In e	excessive dose (including					
	duplicate drug the	· -					
	auphoute urug tric						
	§483.45(d)(2) For	excessive duration; or					
		• •					
	§483.45(d)(3) Wit	hout adequate monitoring;					
	or						
		hout adequate indications					
	for its use; or						
		he presence of adverse					
	•	nich indicate the dose					
	snould be reduced	d or discontinued; or					
	\$492.45(d)(6).4p	y combinations of the					
		paragraphs (d)(1) through					
	(5) of this section.						
	` '	view and interview, the	F 0'	757	Submission of this plan of		06/25/2021
		sure insulin was given as	1 0	131	correction does not constitute		00/23/2021
	-	sugars were monitored, as			admission or agreement by the	<b>_</b>	
		s not being held per blood			provider of the truth of facts		
		s for 2 of 5 residents			alleged or correction set forth	on	
		essary medications.			the statement of deficiencies.	Oi i	
	(Residents 4 and 45				The plan of correction is		
					prepared and submitted becau	ISA	
	Findings include:				of requirement under state and		
					federal law. Please accept this		
		Resident 4 on 6/8/21 at 9:41			plan of correction as our credi		
		lid not receive his insulin on a			allegation of compliance. Plea		
	consistent basis.				find enclosed this plan of		
					correction for this survey.		
		ident 4 was reviewed on			derived.		
	_	Diagnoses included, but			F 757 Drug Regimen is Free		
		type 2 diabetes with			from Unnecessary Drugs		
	nyperglycemia (hig	th blood sugar), peripheral					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
		i '	î î		î î		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155653	B. WING		06/11/2021		
NAME OF P	ROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
	IDDR OR OUT LIE		5025 M	CCOOK AVE			
LAKE CC	OUNTY NURSING	AND REHABILITATION CENTER	EAST CHICAGO, IN 46312				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		d cellulite of the left lower		It is the facility policy to ensure	<b>I</b>		
	limb.			that each resident's drug regir	<b>I</b>		
				is free from unnecessary drug			
		imum Data Set (MDS)		Corrective actions which wil	l be		
	· ·	4/8/21, indicated the resident		accomplished for those			
		n injections 7 times within the		residents found to have been	n		
	assessment referen	ce period.		affected by the deficient			
				practice:			
		ed 5/25/21, indicated the		·R4's Insulin order was			
		for complications related to		reviewed and verified with MD			
	diabetes. Intervent	ions included, but were not		R4 received scheduled Insulir	n and		
	limited to, administer medications as prescribed			was monitored for any			
	and evaluate blood glucose level per ordered			hypo/hyperglycemia.			
	frequency.			·R4's Midodrine order was			
				reviewed. Blood pressure			
	A Physician's Orde	er, dated 4/26/21, indicated the		n of			
	resident was to rece	eive Flatus insulin 33 units at		Midodrine.			
	bedtime and Homo	ology insulin 24 units with					
	meals.			How the facility will identify oth	ner		
				residents having the potential	to		
	A Physician's Orde	er, dated 5/1/21, indicated the		be affected by the same defici	ient		
	resident's blood sug	gar was to be monitored		practice.			
	before meals and the	ne physician was to be notified		·All residents receiving med	s		
	if the blood sugar v	was below 60 or above 400.		may have the potential to be			
	-			affected by the same deficient	t		
	The Medication Ad	dministration Record (MAR),		practice.			
	dated 5/2021, indic	cated there was no		The measures the facility will	take		
	documentation of t	he resident's Homology		or systems the facility will alte	r to		
		ion on 5/8 at 8:00 a.m. and		ensure that the problem will be			
	12:00 p.m., 5/10 at	6:00 p.m., 5/14 at 12:00		corrected and will not recur.			
	p.m., 5/17 at 6:00 p	o.m., 5/19 at 12:00 p.m., and		·An audit tool will be develo	ped		
		m. The resident's Flatus		to ensure that Insulin are			
	insulin was not sign	ned out as being given on 5/10		administered and signed off ir	1		
	and 5/17/21 at 8:00			EMAR. At least five random			
				residents will be selected per			
	The 5/2021 MAR a	also indicated the resident's		audit. This will be completed 3	3		
	blood sugar was no	ot checked on 5/5 at 7:30 a.m.		times a week for 4 weeks. Th			
	_	0 at 5:30 p.m., 5/14 at 11:30		times a week for 5 months.			
		o.m., and 5/19/21 at 11:30					
	a m	,		·An audit tool will be develor	ned		

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Event ID:

OR6L11

Facility ID: 000108

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155653 B. WING 06/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE LAKE COUNTY NURSING AND REHABILITATION CENTER EAST CHICAGO, IN 46312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) to ensure that all medications are The 6/2021 MAR, indicated the resident's administered and signed off in the EMAR. At least 5 random Homology was not signed out as being given on residents will be selected per 6/4/21 at 12:00 p.m. audit. this will be completed 3 a week for 2 weeks then 2x a week Interview with the Director of Nursing on for 6 months. 6/10/21 at 4:05 p.m., indicated the resident's insulin should have been signed out as ordered as well as the blood glucose monitoring completed ·Inservice will be provided on and documented. 2. The record for Resident 45 the following topic: was reviewed on 6/9/21 at 11:45 a.m. Diagnoses ·Signing EMAR after included, but were not limited to, high blood administration of Insulin and blood sugar monitoring pressure, type 2 diabetes, COPD (chronic ·Obtaining blood pressure obstructive pulmonary disease), anxiety, diabetic reading prior to administration of neuropathy, and acute respiratory failure. Midodrine. The Quarterly Minimum Data Set (MDS) ·all medications with Parameters are monitored and assessment, dated 5/17/21, indicated the resident documented. notification of was alert and oriented. The resident needed supervision with set up only for personal hygiene attending physician if results are and the activity of bathing did not occur in the outside the parapmeters. assessment reference period. In the last 7 days the resident received the medication of insulin 6 Quality Assurance Plans to times and received oxygen while a resident. monitor facility performance to make sure that corrections are achieved and are permanent. The Care Plan, dated 5/17/21, indicated the resident had Diabetes Mellitus and was at risk for ·All plan of correction audit will adverse effects of hypo/hyperglycemia (low and be reported by the Director of Nursing and or ADON to the high blood sugar). The approaches were to provide diabetes medication as ordered by doctor Quality Assurance Committee and and monitor/document for side effects and reviewed by the Committee per effectiveness. Month for four Months and recommendations given in order to assist in ensuring that the A Care Plan, dated 5/17/21, indicated the resident had hypertension and was at risk for facility stay in compliance and if complications. The approaches were to give concerns are identified the Quality antihypertensive medications as ordered. Assurance Committee will add on Monitor for side effects such as orthostatic additional Months until hypotension (low blood pressure) and increased Compliance is sustained. heart rate.

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PRINTED: 07/13/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155653		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	glucose monitoring Insulin Solution 100 subcutaneous two ti Midodrine (a medic pressure) HCl Table tablet by mouth two Hold for blood pressure) The Medication Addated 5/2021 indica not signed out as be dose on 5/5, 5/6, 5/5/28/21 and for the 5/31/21.  There was no docur 6/2021 MAR or in tresident's blood pretimes a day at 9:00 medication Midodri Interview with the I 6/10/21 at 10:00 a.r. blood pressure was administration of th Insulin was to be signed.	dated 5/3/21, indicated blood two times a day. Novolog 0 units/ml, inject 8 units mes a day for diabetes. Pation to treat low blood et 2.5 milligrams (mg) 1 to times a day for hypotension. Sure greater than 120/80.  ministration Record (MAR), ted the Novolog Insulin was being administered for the a.m. 11, 5/14, 5/16, 5/23, and p.m. dose on 5/17 and  mentation on the 5/2021 and the vital sign section of the ssure being monitored two a.m. and 4:00 p.m. before the time was administered.  Director of Nursing on m., indicated the resident's to be taken before the e Midodrine. The Novolog gned out as being ered by the physician.		Dates when corrective action be completed: June 25, 2021  1.	
F 0758 SS=D Bldg. 00	Use §483.45(e) Psychology §483.45(c)(3) A point of the standard of the stand	Psychotropic Meds/PRN			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155653	B. WI	ING		06/11/	/2021
NAME OF I	PROVIDER OR SUPPLIER	<b>.</b>	•		ADDRESS, CITY, STATE, ZIP CODE	•	
IAKECC	NINTY NI IRSING	AND REHABILITATION CENTER			CCOOK AVE CHICAGO, IN 46312		
			1	<u> </u>			(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG  CROSS-REFERENCED TO THE APP  TAG  DEFICIENCY)		RIATE DATE	
	the following cate						
	(i) Anti-psychotic;						
	(ii) Anti-depressar						
	(iii) Anti-anxiety; a	ınd					
	(iv) Hypnotic						
	Based on a comp	rehensive assessment of a					
	· ·	ty must ensure that					
	\$400 45(-\\4\ B	sidente volta le t ·					
		sidents who have not used s are not given these drugs					
	1	ation is necessary to treat a					
		as diagnosed and					
	documented in the	_					
	§483.45(e)(2) Res						
		s receive gradual dose					
		ehavioral interventions, ontraindicated, in an effort					
	to discontinue the						
		•					
		sidents do not receive					
	1	s pursuant to a PRN order					
		ation is necessary to treat a					
	diagnosed specific						
	documented in the	e clinical record; and					
	§483.45(e)(4) PR	N orders for psychotropic					
	drugs are limited	to 14 days. Except as					
	provided in §483.4	45(e)(5), if the attending					
	1 ' '	cribing practitioner believes					
		te for the PRN order to be					
	1	14 days, he or she should					
		tionale in the resident's					
	the PRN order.	d indicate the duration for					
	uie i Nivoluel.						
	§483.45(e)(5) PR	N orders for anti-psychotic					
		to 14 days and cannot be					
	renewed unless th	ne attending physician or					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00			ETED	
		155653	B. W	NG		06/11/2021		
				CED FEE	ADDRESS OF A STATE OF CODE		-	
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE			
					CCOOK AVE			
LAKE COUNTY NURSING AND REHABILITATION CENTER			EAST CHICAGO, IN 46312					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROWING BY AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	16	DATE	
	prescribing practit	ioner evaluates the						
resident for the appropriateness of that								
	medication.							
	Based on record rev	view and interview, the	F 0'	758	Submission of this plan of		06/25/2021	
	facility failed to dis	continue and/or provide a			correction does not constitute			
	rationale for continu	ued use of an as needed (prn)			admission or agreement by the	е		
	psychotropic medic	eation for 1 of 5 residents			provider of the truth of facts	-		
	reviewed for unnec	essary medications.			alleged or correction set forth	on		
	(Resident 43)				the statement of deficiencies.			
					The plan of correction is			
	Finding includes:				prepared and submitted becau	ISE		
					of requirement under state and			
	The record for Resident 43 was reviewed on				federal law. Please accept this			
	6/8/21 at 1:53 p.m. Diagnoses included, but				plan of correction as our credi			
		injured cervical spine,			allegation of compliance. Plea			
	· ·	structive pulmonary disease),			find enclosed this plan of	3 <del>C</del>		
		tes, colostomy, anxiety,		correction for this survey.				
	paraplegia, insomni	a, and pressure ulcers.			Correction for this survey.			
					F 758 Free from Unnecessar	v		
		mum Data Set (MDS)			Use of Psychotropic Meds/Pl	_		
		7/14/21, indicated the resident			Use	NI V		
		ted and required total 1 person			It is the facility policy to ensure	2		
		with bed mobility, transfers,			that residents are not gives	•		
	~ .	nal hygiene. She received			psychotropic drugs unless the			
		medications, antidepressant			medication is necessary to trea			
		otics, and opioids during the			specific condition as diagnose			
	past 7 day look bac	k period.			and documented in the clinical			
	A Disserial and Confer	4-4-4-2/5/21 :4:4-4			record.			
	-	r, dated 2/5/21, indicated iety medication) 0.5 mg			Corrective actions which will	be		
	(milligrams) as need	· ·			accomplished for those			
	(minigranis) as need	ucu for steep.			residents found to have beer	1		
	The Pharmacy Reco	ommendation, dated			affected by the deficient			
		ted "please consider Xanax			practice:			
	· ·	sychotropic medication in use			·R 43's Xanax 0.5 mg order	was		
		choices were to discontinue,			reviewed. Pharmacy			
		no change (with indication for			recommendation to either			
	use and duration).	to things (with majoriton for			discontinue or add a stop date	or		
	ase and adiamon).				no change was relayed to MD.			
	There was no docur	mentation to indicate the			MD order was obtained.			
	1		1		I			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  06/11/2021
	PROVIDER OR SUPPLIEF	AND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	consider the as need past 14 days.  Interview with the left 6/10/21 a 4:05 p.m. should have been needs to be a should have b	ded of the recommendation to ded medication in use for the Director of Nursing on an indicated the physician of the physician of the days without on for its use.		1.How the facility will identify other residents having the potential to be affected by the same deficient practice.  All residents with order for psychotropic drugs with no stream to date past 14 days will have the potential to be affected by this deficient practice.  1.The measures the facility wing alter to ensure that the proble will be corrected and will not recur.  An audit tool will be develon to ensure that all PRN psychotropic drugs past 14 day with pharmacy recommendating discontinue, put a stop date of change order will be relayed to MD for order. After the audit, facility will review new PRN psychotropic drug orders This be completed 3 times a week weeks. Then 2 times a week weeks. Then 2 times a week for 5 months.  Inservice will be provided of the following topic:  PRN Psychotropic Drug orders should have stop date 14 days from start date.  Pharmacy recommendations should be relayed to MD.  1.Quality Assurance Plans to monitor facility performance to	PRN opp ne s will ll m  ped ays on to r o

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CONSTRUCTION   (X3) DATE SURVEY     A. BUILDING   00   COMPLETED     B. WING   06/11/2021			
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				make sure that corrections are achieved and are permanent. All plan of correction audit was the reported by the Director of Nursing and or ADON to the Quality Assurance Committee reviewed by the Committee permembers and recommendations given in order to assist in ensuring that the facility stay in compliance and concerns are identified the Quantum Assurance Committee will additional Months until Compliance is sustained.	vill  and er  ler  if ality
F 0759 SS=D Bldg. 00	§483.45(f) Medica The facility must e				
	5 percent or great Based on observation interview, the facilist medication error rate residents observed of Three errors were of opportunities for error rate of 12%. ( Finding includes:  During medication	er; on, record review, and ty failed to ensure a e of less than 5% for 1 of 6 during medication pass. bserved during 25 ror during medication s resulted in a medication Resident 45)  pass on 6/8/21 at 3:57 p.m.,	F 0759	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credicallegation of compliance. Pleas	on use d s ble
	medication for Resi held inhaler of Prov 108 (90 Base) micro	ed preparing and pouring dent 45. She removed a hand entil HFA Aerosol Solution ograms (mcg), administer 2 prn (as needed) for wheezing.		find enclosed this plan of correction for this survey.  F 759 Free of Medication Erro	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. WING 06/11/2021				/2021
					-	00/11/	
NAME OF F	ROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	OUNTY NURSING A	AND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	CROSS-REFERENCED TO THE APPROPRI		ΓE	DATE	
IAG				IAG			DATE
		nother hand held inhaler of			It is the facility policy to ensure		
		shale 1 puff daily. After			that medication error rates are	not	
		supplies she entered the			5 percent or greater.		
		ne handed the Proventil			Corrective actions which will	be	
		ent and instructed him to take			accomplished for those		
	_	nt placed the inhaler in his			residents found to have beer	l	
	_	down on the dispenser and			affected by the deficient		
	_	ne immediately pushed down			practice:		
	_	he second puff. He did not			·R 45 was assessed for any		
	_	ffs nor was he instructed by			possible side effects of the		
	the QMA to wait 1 to 2 minutes in between puffs.				medication error committed by		
	The QMA immediately handed him the inhaler of				QMA1. R46 is in stable condit	ion	
	Arnuity. The resident placed it in his mouth and				with no signs and symptoms o	f	
	pressed down and is	nhaled 1 puff. He did not wait			possible ill effects from medica	ation	
	any time in between the 2 different inhalers nor				error.		
	was he instructed to	wait in between the inhalers.					
					How the facility will identify oth	er	
	Interview with the	QMA at that time, indicated			residents having the potential to		
		ut the wait time in between		be affected by the same deficient			
		nhaler or between 2 different			practice.		
	inhalers.				· All residents who receives o	ral	
					inhalers have the potential to b	e	
	The record for Resi	dent 45 was reviewed on			affected by the same deficient		
	6/10/21 at 9:15 a.m				practice.		
					'		
	Physician's Orders.	dated 5/3/21, indicated			The measures the facility will t	ake	
		osol Powder Breath Activated			or systems the facility will alter		
		ne Furoate), 1 inhalation			ensure that the problem will be		
	- ·	ay. Symbicort Aerosol			corrected and will not recur.		
	-	lations orally two times a			·QMA 1 was provided with 1	·1	
	_	A Aerosol Solution 108 (90			education and competency on		
		inhale orally every 6 hours as			proper administration of oral		
	needed (prn) for wh				inhalation drugs.		
	needed (pin) for wi	iccznig			Inservice will be provided or	,	
	The Medication Ad	ministration Decord (MAD)			· •		
		ministration Record (MAR),			the following topic:		
		ated the Arnuity was			Proper Administration of		
		morning pass, the Symbicort			Oral Inhalers to include wait tir		
		morning and evening pass, and			in between puffs and another	orai	
	Proventil was only	prn.			inhaler.		
					·DON and or nurse		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		A. BUILDING B. WING	00	COMPLETED 06/11/2021
	PROVIDER OR SUPPLIER DUNTY NURSING AND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The current 10/25/14 "Oral Inhalation Administration" policy, provided by the Director of Nursing (DON) on 6/10/21 at 12:29 p.m., indicated if another puff of the same or different medication was required, wait at least 1 to 2 minutes between.  Interview with the DON at that time, indicated the QMA should have waited in between puffs and she was aware she had administered the wrong inhaler.  3.1-48(c)(1)		manager/pharmacy nurse consultant will observe two rainurses or more twice a week of four weeks on how to properly administer oral inhalers. Then nurse ongoing weekly for a tot 6 months.  Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.  All plan of correction observation audit will be report by the Director of Nursing and ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuthat the facility stay in compliand if concerns are identified to Quality Assurance Committee add on additional Months until Compliance is sustained.  Dates when corrective action to be completed: June 25, 2021	ted or ce ne suring noce the will
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/11/2021		
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER			5025 M	NDDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	§483.45(h)(1) In a Federal laws, the and biologicals in under proper tempermit only authoraccess to the key §483.45(h)(2) The separately locked compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the frackage drug districts the quantity storedose can be read Based on observation topical medications observations. (Res Finding includes:  On 6/9/21 at 4:08 probservation and intropical medications stand. Moisture based (an antihistamine to and itching), and Dranti-inflammatory tractinic keratoses). Tesident, indicated itching and shoulded.  The record for the ref 6/9/21 at 1:07 p.m.	e facility must provide premanently affixed storage of controlled drugs Il of the Comprehensive ention and Control Act of rugs subject to abuse, acility uses single unit ribution systems in which d is minimal and a missing ribution systems in w	F 070	61	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credicallegation of compliance. Please find enclosed this plan of correction for this survey.  F 761 Label/Store Drugs and Biologicals It is the facility policy to ensure that drugs and biologicals use must be labeled in accordance.	on use d s ble se	06/25/2021

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Facility ID: 000108

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SUR	VEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPLETE	D	
		155653	B. W	NG		06/11/202	21
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	·	5025 M	ADDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312		
(X4) ID	STIMMARYS	TATEMENT OF DEFICIENCIES	I	ID		1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		OMPLETION
TAG	ì ·	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	DATE
		tension, diabetes, and sepsis.			with currently accepted		2.112
	assessment, dated 5 was alert and orient person physical ass transfers.  There were no Physuse of the above medical at 4:10 p.m the resident had the	nimum Data Set (MDS)  1/7/21, indicated the resident 1/21, indicated the resident 1/21, indicated extensive 1 1/21 istance with bed mobility and 1/21 istance with bed mobility and 1/21 istance with bed mobility and 1/22 istance with bed mobility and 1/23 istance with bed mobility and 1/24 istance with bed wi			professional principles, and include the appropriate access and cautionary instructions, ar the expiration date when applicable.  Corrective actions which will accomplished for those residents found to have been affected by the deficient practice:  R 29's three topical medications (moisture barrier, Dipenhydramine/Zinc topical cream, and Diclofenac) obseron his nightstand were remove and stored properly with his	be  ved	
					permission. R29 was in good and not in any form of distress.  How the facility will identify oth residents having the potential be affected by the same deficipractice.  All residents who receives medications in the facility may have the potential to be affected by the same deficient practice.  The measures the facility will after ensure that the problem will be corrected and will not recur.  Facility will inspect all resident rooms for medications left at bedside/nightstand, remand store properly in medications/carts as appropriate.  Inservice will be provided on the following topic:	ed ake to e sove,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	PROVIDER OR SUPPLIER DUNTY NURSING AND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			Proper Medication Storage-no medications will be at bedside/nightstand/resident rooms DON or nurse manager will conduct random observation of random rooms for any medications left at resident room/bedside/nightstand. This be completed 3 times a week weeks then weekly for 5 month	of 2 will for 4
			1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction observati audit will be reported by the Director of Nursing and or ADO to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuthat the facility stay in complia and if concerns	on ON De Jiring
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.			
	§483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER			5025 M	ADDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	requested, assist (i) In making appo	intments; and or transportation to and			
	refer residents wit for dental services occur within 3 day documentation of resident could still while awaiting der	st promptly, within 3 days, h lost or damaged dentures s. If a referral does not s, the facility must provide what they did to ensure the eat and drink adequately ntal services and the instances that led to the			
	those circumstand damage of dentur- responsibility and for the loss or dan determined in acc	may not charge a resident			
	eligible and wish t reimbursement of	st assist residents who are o participate to apply for dental services as an expense under the State			
	facility failed to pro for a resident with o	view and interview, the ovide routine dental services complaints related to his teeth reviewed for dental services.	F 0791	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies.	

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CTATEMEN	T OF DEFICIENCIES	V1) DD OVIDED (CLIDDLIED /CLIA	(V2) M	III TIDI E CO	MICTRICTION	(V2) DATE	CLIDVEV
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ſ ,		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		155653	B. WING 06/11/202			/2021	
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF P	ROVIDER OR SUPPLIE	R					
	ALINITA ALI IDONA	AND DELIABILITATION OF ITE			CCOOK AVE		
LAKE CC	OUNTY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	Finding includes:				The plan of correction is		
	Tillding includes.						
	The record for Dec	ident 28 was reviewed on			prepared and submitted becau		
					of requirement under state and		
		m. Diagnoses included, but			federal law. Please accept this		
		, malignant neoplasm of the			plan of correction as our credi		
		ension, ataxia (loss of control			allegation of compliance. Plea	se	
	-	s), depression, anxiety,			find enclosed this plan of		
		aviors, and psychotic disorder			correction for this survey.		
	with delusions.				j		
					F 791 Routine Emergency		
		num Data Set (MDS)			Dental Services		
	·	5/6/21, indicated the resident			It is the facility policy to assist		
		tively impaired for decision		residents in obtaining r			
		upervision with bed mobility,		24-hour emergency			
	had no swallowing	disorders, no dental concerns,		Corrective actions which will b			
	and experienced a	weight loss not prescribed by a			accomplished for those		
	weight-loss regime				residents found to have been	1	
	_					•	
	A Nutrition/Dietary	y Note, dated 5/12/21 at 3:08			affected by the deficient		
	-	resident's family member was			practice:		
	_	ould be seen by a dentist, he			·R 28 was assessed for oral		
		ated to his teeth causing him			care and pain. Pain was		
	_	er indicated she would notify	managed. Dental appoint			t was	
		schedule a dental evaluation.	scheduled by the facility for				
					6/29/21.		
	Interview with the	Social Worker and the					
		21 at 3:50 p.m., indicated they			1.How the facility will identify	/	
		f the concern from the			other residents having the		
		ember related to scheduling a			potential to be affected by the		
	dental evaluation.	ember related to seneduling a			same deficient practice.		
	dentai evaluatioil.				·All residents with teeth have		
	2.1.24(a)(1)				potential to be affected by the		
	3.1-24(a)(1)				same deficient practice.		
					1.The measures the facility v	will	
					take or systems the facility wil	I	
					alter to ensure that the proble		
					will be corrected and will not		
					recur.		
					·Facility monitoring will inclu	de	
					completion of routine requeste		
	1		1		p 10011110 10400010		I

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	OF CORRECTION	IDENTIFICATION NUMBER:  155653	A. BUILDING  B. WING	00	COMPLETED 06/11/2021
	PROVIDER OR SUPPLIED	R AND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				dental care and will identify residents who have dental car needs. Appropriate nursing assessments and pain management will be performe MD and Family/POA will be notified, Dental services/appointment will be scheduled. DOB or designee do at least 5 random residents audit 2X weekly. this will be completed for 4 weeks then 2 random residents per week for months.  Inservice will be provided of the following topic:  Proper notification to so worker/nurse for any dental consult needed due to teeth p Scheduling of dental appointn timely to address resident's to discomfort.  Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.  All plan of correction observation audit will be report by the Director of Nursing and ADON to the Quality Assurance Committee and reviewed by the Committee and reviewed by the Committee per Month for 5 Months and recommendations given in order to assist in ensithat the facility stay in compliance in additional Months until Compliance is sustained.	d.  will sper  r 6  n  ocial  ain. nent eeth  ce  ted I or ce ne suring ince the will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SU         A. BUILDING       00       COMPLE*         B. WING       06/11/2			ETED		
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Ap Temp §483.60(d) Food a Each resident rece provides- §483.60(d)(1) Foo that conserve nutr appearance; §483.60(d)(2) Foo palatable, attractiv appetizing temper Based on observation failed to ensure food an appetizing temper reviewed for food. 47) Finding includes: On 6/8/21 at 9:36 a. food did not taste go On 6/7/21 at 10:53 a	pear, Palatable/Prefer and drink eives and the facility d prepared by methods itive value, flavor, and d and drink that is re, and at a safe and	F 08		Dates when corrective action was be completed: June 25, 2021  - 1.  Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth of the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credit allegation of compliance. Please allegation of compliance. Please	e on use d	06/25/2021
	Interview with Resi p.m., indicated the emorning.	dent 12 on 6/7/21 at 2:20 eggs were cold in the dent 45 on 6/7/21 at 11:47			find enclosed this plan of correction for this survey.  F 804 Nutritive Value/Appear Palatable/Prefer Temp It is the policy of the facility to	;	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155653	B. WING 06/11/2021			2021	
		l .		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			CCOOK AVE		
IAKECC	NINTY NI IRSING /	AND REHABILITATION CENTER			CHICAGO, IN 46312		
					// 110/100, 11 <b>1 1</b> 0012		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	a.m., indicated the f	food was horrible and cold.			ensure that each resident		
					receives and the facility provid		
		a.m., Resident 45 indicated			food prepared by methods tha		
	the food was alway	s cold.			conserve nutritive value, flavo		
					appearance. Food and drink a		
		a.m., a test tray was obtained.			palatable, attractive, and at a	sate	
		s were 101.4 degrees			and appetizing temperature,		
		cinnamon raisin toast was			Corrective actions which will	be	
	soggy in appearance	e.			accomplished for those		
	Internal of D	31			residents found to have beer	1	
		ident 4 on 6/10/21 at 9:06			affected by the deficient		
		cinnamon toast was just warm			practice:		
		and the eggs were luke warm.		R4 was satisfied with taste and			
	He indicated breakt	fast wasn't very good.			temperature of food served du	iring	
	I4	31			next meal and at breakfast.  ·R 10 was satisfied with tast	•	
		ident 10 on 6/10/21 at 9:10					
		eggs weren't that warm but he nd the bread was barely warm.			and temperature of food serve during next meal.	:u	
	ate them anyway an	id the bread was barely warm.			·R12 was satisfied with		
	When informed abo	out the eggs being cold on			temperature of eggs served du	ırina	
		Cook had no comment.			breakfast.	ailig	
	0/10/21, the Dictary	Cook had no comment.			·R45 was satisfied with taste	,	
	Interview with the I	Director of Nursing on	and temperature of food served				
		., indicated the eggs should			during next meal.	·u	
	have been warmer.	., marcated the eggs should			daring next mean		
	nave occii warmer.				How the facility will identify oth	ner	
	3.1-21(a)(2)				residents having the potential		
	()( <del>-</del> )				be affected by the same defici		
					practice.		
					·All residents who receive fo	od	
				and nutrition in the facility will			
				have the potential to be affected	ed of		
					the same deficient practice.		
					'		
					The measures the facility will t	ake	
					or systems the facility will alter		
			ensure that the problem will be				
					corrected and will not recur.		
					1.		
					·An observation tool will be		
			I				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/11/2021
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	5025 N	ADDRESS, CITY, STATE, ZIP CODE ICCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				developed to test appearance food temperature and palatab during mealtimes. This observation will be conducted the Administrator on five differences weekly for two weeks.	by
				·A 1:1 in-service will be provided to Dietary Manager on nutritive value/appearance, palatability and preferred temperature of food	
				·In-service will be provided to dietary and nursing staff who prepares and serve meal tray ensure that food temperature maintained when it is served a food is presentable and palata when served.	s to is and
				Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.  Administrator w conduct observation on five different meals to check on food temperature, palatability, and appearance. observation will be conducted by the Administrator on five different	e ill This
				meals weekly for 4 weeks. Th  meals weekly for 3 months.  All plan of correction observation tool will be report	en 3

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		A. BUILDING 00  B. WING			(X3) DATE SURVEY COMPLETED 06/11/2021	
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER		502	EET ADDRESS, CITY, STATE, ZIP CO 25 MCCOOK AVE ST CHICAGO, IN 46312	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE	(X5) COMPLETION DATE
F 0812 SS=F Bldg. 00	§483.60(i) Food sa The facility must - §483.60(i)(1) - Pro approved or consi- federal, state or lo (i) This may includ directly from local applicable State a regulations. (ii) This provision of facilities from using gardens, subject to	e food items obtained producers, subject to nd local laws or  does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling  does not preclude issuming foods not		by the Administrator to the Assurance Committee as reviewed by the Committee and the Committee of the Commit	nd tee per in order the e and if he Quality ill add on	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155653 B. WING 06/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5025 MCCOOK AVE LAKE COUNTY NURSING AND REHABILITATION CENTER EAST CHICAGO, IN 46312 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  $\mathsf{TAG}$ TAG DATE DEFICIENCY) §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility F 0812 06/25/2021 Submission of this plan of failed to ensure food was stored, prepared, and correction does not constitute served under sanitary conditions related to an admission or agreement by the accumulation of ice build-up in the reach in provider of the truth of facts cooler, an accumulation of calcium build-up in alleged or correction set forth on the ice machine, debris in the utensil holder, the statement of deficiencies. crumbs and dried substances in the hot plate The plan of correction is holder, debris on the floors of the walk-in prepared and submitted because refrigerator and freezer, and prepoured cereal of requirement under state and bowls with no date, and two 2 tier carts with federal law. Please accept this rusted wheels and dried food substances. This plan of correction as our credible had the potential to affect all 60 residents who allegation of compliance. Please received food from the kitchen. (The Main find enclosed this plan of Kitchen) correction for this survey. Finding includes: F 812 Food procurement Store/prepare/Serve-Sanitary During the Initial Tour of the kitchen with the It is the policy of the facility to Dietary Food Manager (DFM) on 6/7/21 at 9:09 procure food from sources a.m., the following was observed: approved or considered satisfactory by federal, state or a. The reach in cooler had an accumulation of local authorities. ice build-up. Corrective actions which will be accomplished for those b. There was an accumulation of calcium build-up residents found to have been in the ice machine. affected by the deficient practice: c. The was debris in the utensil holder. ·No resident was affected by this deficient practice. d. There were crumbs and dried substances in the hot plate holder. 1. How the facility will identify other residents having the e. There was debris on the floors of the walk-in potential to be affected by the refrigerator and freezer. same deficient practice. This had the potential to affect d. There were 6 bowls of prepoured cereal all 60 residents who receive food stored in the dry food storage area with no date.

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	ING		06/11/	/2021
				OTT DEF	ADDRESS SITU STATE TO SOFT		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	OUNTY NURSING A	AND REHABILITATION CENTER		EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWDENG N. I.V. OF CONNECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
					from the kitchen.		
	e. There were two.	2 tier carts with rusted					
	wheels and dried fo				1.The measures the facility	will	
					take or systems the facility wil		
Interview at the time with the DFM, indicated the				alter to ensure that the proble			
	above was in need				will be corrected and will not		
	uss (c ), us in insta	or cremming.			recur.		
	3.1-21(i)(3)				1		
	2.1 21(1)(3)				·The reach in cooler was		
					defrosted and cleaned.		
					·The calcium build-up in the	ice	
					machine was removed and ice		
					machine cleaned.	•	
					·The debris from the utensil		
					holder was removed and uten	cil	
					holder cleaned.	SII	
					·The crumbs and dried		
					substances in the hot plate ho	ldor	
					<u> </u>		
					were removed and hot plate h cleaned.	oluei	
					Debris on the floors of the		
					walk-in refrigerator and freeze	r	
					wark-in reinigerator and fleeze		
					·The cereal content in a boy		
					identified was discarded and	VI	
						tod	
					replaced with one that was da  The two-tier carts with ruste		
					wheels and dried food substa		
					wheels and dried lood substail were cleaned.	1003	
					·In-services were provided t	0	
					dietary staff, including dietary	U	
					manager on food safety		
					requirements that include procurement of food from		
					· ·		
					approved sources, proper	on	
					storage, preparation, distributi	un,	
					and sanitation of kitchen.		
					·Dietary consultant and or		
					Administrator will conduct		
			1		observation of the kitchen to c	over	Ì

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		00	COMPLETED 06/11/2021
	PROVIDER OR SUPPLIER DUNTY NURSING AND REHABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE CCOOK AVE 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 APPROPRIA DEFICIENCY)	
			sanitation and proper storage food at least three times week for 4 weeks. Then 2 times wee for 5 months.	ily
			1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.  All plan of correction observation tool will be reported by the Administrator and or Dietary Consultant to the Qual Assurance Committee and reviewed by the Committee performed by the Committee perf	ed lity er der if lality d on
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection			

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Event ID:

OR6L11

Facility ID: 000108

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653		A. BUILD B. WING		STRUCTION  00	(X3) DATE S COMPL 06/11/	ETED	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	5	025 MC	DDRESS, CITY, STATE, ZIP CODE COOK AVE HICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	prevention and co	ntrol program (IPCP) that minimum, the following					
	identifying, reportice controlling infection diseases for all revisitors, and other services under a cobased upon the faconducted accord following accepted:  §483.80(a)(2) Write and procedures for include, but are not identify possible or infections before the persons in the facondiction of the	ing to §483.70(e) and d national standards;  tten standards, policies, or the program, which must of limited to: reveillance designed to ommunicable diseases or hey can spread to other illity; whom possible incidents of sease or infections should transmission-based followed to prevent spread or isolation should be used uding but not limited to: duration of the isolation, the infectious agent or limited to that the isolation should be the possible for the resident					
ı		contact will transmit the					

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Event ID:

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Facility ID: 000108

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155653	B. WI	NG		06/11/	2021
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			CCOOK AVE		
IVECC	NINTY NI IDRING	AND REHABILITATION CENTER			CHICAGO, IN 46312		
		AND REHABILITATION CENTER		LAST	### ##################################		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	disease; and						
(vi)The hand hygiene procedures to be							
	followed by staff involved in direct resident						
	contact.						
	C400 00/-)/4) A -						
		ystem for recording					
		d under the facility's IPCP					
		e actions taken by the					
	facility.						
	§483.80(e) Linens						
	. ,	andle, store, process, and					
		-					
transport linens so as to prevent the spread of infection.							
	or inicotion.						
	§483.80(f) Annua	l review.					
	- ''	nduct an annual review of					
	I -	ate their program, as					
	necessary.						
	Based on observation	on, record review, and	F 08	80	Submission of this plan of		06/25/2021
	interview, the facili	ty failed to ensure infection			correction does not constitute		
	control guidelines v	were in place and			admission or agreement by the	е	
	implemented, inclu	ding those to prevent and/or			provider of the truth of facts		
		, related to hand hygiene not			alleged or correction set forth	on	
	completed after dire	ect resident contact and glove			the statement of deficiencies.		
		ng the appropriate personal			The plan of correction is		
	1 ^ ^	nt (PPE) while doing			prepared and submitted becau	ıse	
	_	and for completing an aerosol			of requirement under state and		
	_	t, and not monitoring for			federal law. Please accept this		
	I -	nd symptoms while in			plan of correction as our credit		
		precautions for 1 of 2			allegation of compliance. Plea		
	_	observations, 3 of 6			find enclosed this plan of	- *	
		servations, and 1 of 2			correction for this survey.		
		ission based precautions.					
	(LPN 1, Residents	45, 4, and 211)			F880 Infection Control		
	Findings include:						
	i mamga merude.				Corrective actions which will	be	
	1. On 6/7/21 at 11:	23 a.m., LPN 1 was asked by			accomplished for those		
		perform a rapid COVID-19			residents found to have beer	1	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		155653	B. W	ING		06/11/2	2021
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROVIDERIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	VIE.	DATE
	test on him. The L	PN donned a pair of clean			affected by the deficient		
	gloves without perf	forming hand hygiene. She			practice:		
opened the swab and placed it in the employee's				·There was no noted spread	t l		
nose and then placed it in a Binax Now rapid test				infection and communicable			
	card and laid it on t	the nurses' station counter.			diseases.		
	The LPN was not w	vearing a N95 face mask or					
	face shield when sh	ne obtained the specimen. She			How the facility will identify otl	her	
	did not clean the co	ounter top of the nurses'			residents having the potential	to	
	station before placi	ng the specimen on the	1		be affected by the same		
	_	had obtained the sample, with			deficient practice.		
	her gloved hands sl	ne picked up her pen and wrote			·All residents have the poter	ntial	
	on the Binax card a	and then placed the box of test			to be affected by the same		
	kits back under the	shelf with the same gloved			deficient practice.		
	hands she had used	to test with. She removed the					
	gloves and left the	station. She returned minutes			The measures the facility will	take	
	later and with her u	ingloved hands she picked up			or systems the facility will alte	r to	
	the Binax card with	the swab and specimen in			ensure that the problem will b	e	
	place and walked d	own the hallway.			corrected and will not recur.		
					·An audit tool will be develo	ped	
	Interview with the	Director of Nursing on			to ensure that proper infection	1	
	6/10/21 at 2:00 p.m	n., indicated the nurse should			control observation is in place	to	
	have worn the corre	ect PPE while doing			control and prevent spread of		
	COVID-19 testing.	She should not have placed			infection. At least 2 staff mem	bers	
	the Binax card on to	op of the nurses' station or			will be selected per audit. Thi	s will	
	carried it out of the	station without gloves on.			be completed 3 times a week	for 4	
					weeks. Then 2 times for 5		
	2. During medicati	ion pass on 6/8/21 at 3:57			months. Any deficiencies will	be	
	p.m., QMA 1 was o	observed preparing medication			corrected immediately.		
	for Resident 45. A	t that time, she indicated she			·Nursing staff has been		
	needed to check the	e resident's blood sugar with			in-serviced on the infection		
	the glucometer. Sh	e removed the glucometer			control policy including but no	t	
	from the medication	n cart, a lancet, and the bottle			limited to:		
	of strips and entered	d the resident's room. She			1.Hand hygiene before a	nd	
		al medications first and then,			after donning and doffing of		
	without performing	s hand hygiene, she wiped the			gloves.		
	resident's finger wit	th an alcohol wipe. She did			2.Wearing of appropriate	•	
	not donn a pair of c	clean gloves to either hand.			personal protective equipmen	t	
	She pricked his fing	ger and obtained the blood on			(PPE) when administering aeı	rosol	
	the strip that was al	ready inserted in the			generating procedures, when		
		e. After the reading was			rendering care of residents the	at I	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		155653	B. W	NG	<u></u>	06/11/2	2021
		100000		_		00/11/2	2021
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	OUNTY NURSING A	AND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	obtained, she picke	d up her supplies and walked			are on TBP (transmission bas		
		ne threw the used lancet into			precautions) and when perforr	ming	
		d placed the machine on top of			covid testing.		
		. She started to open the			3.Observance of proper		
		l was immediately stopped and			infection control while perform	ing	
	_	and hygiene before she			blood glucose check		
	proceeded.				Quality Assurance Plans to		
					monitor facility performance to		
	,	A 1 at that time, indicated she			make sure that corrections are	)	
		to wear gloves when			achieved and are permanent.		
		meter. She was also aware			·All plan of correction audit v	VIII	
		e placed in the sharps			be reported by the Director of		
	container.				Nursing and or ADON to the		
	0 (0/01 11.15				Quality Assurance Committee		
		o.m., the resident was seated	reviewed by the Committee per				
		h his room. At that time, he	Month for four Months and				
		ng a hand held nebulizer and			recommendations given in ord	ier	
		wall next to his bed. The room			to assist in ensuring that the	:£	
	-	there was no staff observed in			facility stay in compliance and		
	his room.				concerns are identified the Qu Assurance Committee will add	,	
	T4	Ai-t-ut Diut-u - CNIiu-			additional Months until	i Oii	
		Assistant Director of Nursing					
	_	m., indicated she did not face mask, an isolation gown			Compliance is sustained.		
	· ·	set the resident up for the			Dates when corrective action v	A/ill	
	· ·	and when she disconnected			be completed: June 25, 2021	VVIII	
		nent. She wore a surgical face			be completed. <u>Julie 25, 2021</u>		
	mask in his room.	ient. She wore a surgical face					
	mask in ms 100m.						
	The record for the I	Resident 45 was reviewed on			Directed Plan of Correction		
		. The resident was fully			F880		
		first COVID-19 dose on					
	1/6/21 and the seco						
	An Indiana Departr	ment of Health (IDOH)			Please accept the following as	the	
	document, dated 6/1/21 and titled, "Long-term				facility's credible allegation of		
	Care Facilities Guidelines in Response to				compliance. This plan of		
	COVID-19 Vaccina	ation," indicated, " Staff			correction does not constitute	any	
	providing direct car	re within six feet of the			admission of guilt or liability by	/ the	
	resident while AGP	P [Aerosol Generating			facility and is submitted only o	n	
			1		Ī		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. W	B. WING 06/11/2021			/2021
				_	•	00/ 1.1/	
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	OUNTY NURSING A	AND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ogress should wear full PPE			response to the regulatory		
		sk and eye protection for all			requirements.		
	types of scenarios				requirements.		
	types of section in						
	3. On 6/8/21 at 4:13 p.m., LPN 2 was observed						
		4's blood sugar by the way of			1.Staff received education fr	om	
	_	lonned a pair of clean gloves			Assurance with links to pertine		
	-	ed the resident's finger with an			CDC guidance on Covid 19. T		
	_	ricked the finger with the			following links included:	110	
		his blood. He discarded the			Clean Hands -		
		can and did not perform hand			https://youtu.be/xmYMUly7qiE		
	_	epared an insulin injection for			https://youtu.be/xiffTivioly/qie	<u>.</u>	
		-			Lagana		
		nned a pair of clean gloves to			Lessons -	4	
		noved the vial from the			https://youtu.be/YYTATw9yav4	<u>4</u>	
		e drew up 24 units of insulin					
	and administered it	to the resident.	2.The Infection Preventionist,				
			Director of Nursing in conjunction				
		V 2 at that time, indicated he			with the Medical Director and		
		giene was to be performed			senior leadership completed		
	after glove removal				policies related to the develop	ment	
					and implementation of the		
	_	on pass on 6/10/21 at 8:38			following:		
		erved preparing medication			·Develop and implement		
		After pouring all of her			procedures to allow visitors int		
		tered the resident's room with			the facility as per CDC & ISDH	ł	
		meter, and the blood pressure			guidelines.		
		donned a pair of clean gloves			·At the door symptom che		
		out performing hand hygiene.			symptom check for all essentia		
	She checked the res	sident's blood sugar and then			employees, vendors and other	s	
		ed hands, she placed the blood			before entering the facility		
	pressure cuff on the	e resident's arm. She then			·Develop and implemente	ed	
	administered the mo	edications to the resident.			procedures for screening of all		
	The RN left the roo	m to get a pair of scissors to			staff at the beginning of their s	hift,	
	cut off an arm brace	elet from the hospital on the			mid shift and end of their shift		
	resident's arm. She	removed her gloves and did			fever, respiratory symptoms. T	his	
	not perform hand h	ygiene. She came back into			includes actively measuring ar	nd	
	the room and donne	ed another pair of clean	recording staff temperatures and				
		out performing hand hygiene,			assessment of shortness of		
		and off and checked the			breath, new or changed cough	١,	
	resident's blood pre	ssure and pulse.			and sore throat.		
		•	1		l e e e e e e e e e e e e e e e e e e e		Ī

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155653	B. WI	NG		06/11/	/2021
				CTREET	ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
L ALCE 0.0	NINTY NUIDONIO	AND DELIABILITATION OF NEED			CCOOK AVE		
LAKE CC	DUNIY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					·Remind residents to		
	Interview with RN 1 on 6/10/21 at 2:10 p.m.,				practice social distancing and		
	indicated she was a	ware she was supposed to			perform frequent hand hygien	e.	
perform hand hygiene after glove removal.				·Educate and assist the			
					resident to utilize an appropria	ate	
	The current 12/31/2	20 "Hand Hygiene" policy,			mask to reduce droplet spread	d.	
	provided by the Dir	rector of Nursing on 6/10/21			·Coordinate with medical		
	at 12:30 p.m., indic	ated use alcohol based hand			provider to obtain necessary		
	sanitizer or wash ha	ands with soap and water after			testing to identify cause of		
	touching a patient a	and immediately after glove			symptoms.		
	removal.						
	5. The record for Resident 211 was reviewed on						
	_	She was admitted on					
	5/28/21. Diagnoses	s included, but were not			1.Root Cause Analysis:		
		ack of coordination, diabetes,					
	obesity, bacteria pn	eumonia, and acute					
	respiratory failure.						
					Problem statement		
		duation Assessment, dated			Staff failed to perform hand		
		e resident was alert and			hygiene before entering and a		
	oriented.				exiting rooms and proper don	ning	
					and doffing of PPE		
	1 -	dated 5/28/21, indicated					
	_	isolation related to new			Why?		
		sion, end date 6/8/21, and			Lack of staff training.		
		oring (+/-) Loss of smell,			Why?		
		OB, Cough, Decreased			Lack of supervised return		
		:: += Symptoms present (add			observations		
	note) - = Symptoms	s absent, every shift."			Why?		
	TI I 2021 T				Staff trying to rush through		
		atment Administration Record			assignments		
		o COVID-19 monitoring on			Why?		
	the following dates:				Accessibility of hand sanitizer		
	Days: 6/1 and 6/5/2	.1			dispensers		
	Evenings: 6/7/21	./21			Root Cause(s)	and	
	Nights: 6/1, 6/3-6/6	V/∠1			Staff education on proper h	ariu	
	Intomious with the	Director of Nursing ar			hygiene		
		Director of Nursing on			Making hand sanitizer more accessible	7	
	_	., indicated the resident					
	snouid nave been as	ssessed and monitored for	1		3. Staff education of proper		I

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	<u>00</u>	COMPL	ETED
		155653	B. W	ING		06/11/	2021
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  CCOOK AVE		
LAKE CC	OUNTY NURSING A	ND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	COVID-19 sympton	ns every shift as ordered.			donning and doffing of PPE		
	3.1-18(b)				To validate root causes, ask the following: If you removed this cause, would this event or problem have been prevented	root	
					1.Implemented system changes:  Increase routine in-servicing staff on Infection control prevention basics including but not limited to hand hygiene, migloves, gown, utilizing proper lifor transmission based precautions.	t ask,	
					·Increase routine return demonstration for hand hygier and proper PPE use	e	
					Develop and implement infection signs and symptom tracking tool to monitor all residents and staff for communicable, respiratory infections. All nursing leaders be educated on how to use the tool.  Staff involved were educated (with return demonstration) for hand washi and ABHS and have an understanding on when to per HH, that handwashing with so and water will be performed w	ing form	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY  COMPLETED
ANDILAN	OI CORRECTION	155653	B. WING	00	06/11/2021
		100000		ADDRESS SITV STATE ZID SODE	00/11/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE  CCOOK AVE	
LAKE CC	OUNTY NURSING A	ND REHABILITATION CENTER		CHICAGO, IN 46312	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		
				hands are visibly soiled or the of ABHS as appropriate.	use
				·All staff will receive	
				education on using PPE relate	ed to
				droplet precautions. Education	
				include demonstration and	
				knowledge check testing.	
				1 Monitoring: Monitoring of	
				1.Monitoring: Monitoring of approaches to ensure infectio	ns
				are controlled will include:	
				·The Facility will ensure	
				adequate supplies of PPE are	
				readily available to all staff	
				·The Infection Preventior	
				and/or the Director of Nursing	,
				each day and more often as necessary, will review infectio	n
				prevention tracking and trendi	
				Any unexpected increases in	1.9.
				infection will result in	
				communication with the Medic	cal
				Director, Public Health	
				Department and the state surv	•
				agency in order to obtain furth	
				assistance to control infection Such monitoring will continue	
				the facility has been infection	
			1	for at least four weeks.	. [
				·The Infection Preventior	nist,
				Director of Nursing and other	
				nursing leadership will conduc	et
				Daily rounds throughout the	
				facility to ensure staff are	
				exercising appropriate use of	PPE
				and to ensure infection contro	I
			1	procedures are followed for 6	
				weeks.	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155653			A. BUILDING  B. WING	00	COMPLETED 06/11/2021
	ROVIDER OR SUPPLIER DUNTY NURSING AND RE	HABILITATION CENTER	5025 M	ADDRESS, CITY, STATE, ZIP CODE CCOOK AVE CHICAGO, IN 46312	
(X4) ID PREFIX TAG	SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDEI	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				The facility conducted Rewith the help of the Infection Preventionist.  1.The facility through QAPI program will review, update, a make changes to the DPOC a needed for substantial complia for no less than 6 months.	nd s
				Completion date:	
				1.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Environ §483.90(i) Other Environr The facility must provide a sanitary, and comfortable residents, staff and the published on observation and in failed to ensure the residents clean and in good repair relations.	nental Conditions a safe, functional, environment for ablic. atterview, the facility s' environment was atted to rust, missing	F 0921	Submission of this plan of correction does not constitute admission or agreement by the	06/25/2021
	base boards, chipped paint, a doors, dried food spillage or walls, and loose heat registe (The First and Second floors Findings include:  During the Environmental T Housekeeping and Maintena	n walls, holes in rs for 2 of 2 units.		provider of the truth of facts alleged or correction set forth the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credit allegation of compliance. Plea	on use d s ble

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Event ID:

OR6L11

Facility ID: 000108

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		155653	B. W	NG		06/11/2021
		100000				00/11/2021
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TVIVIL OF I	KO VIDEK OK SCI I EIEI			5025 M	CCOOK AVE	
LAKE CO	DUNTY NURSING A	AND REHABILITATION CENTER		EAST C	CHICAGO, IN 46312	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	6/11/21 at 11:29 a.r	n., the following was			find enclosed this plan of	
	observed:				correction for this survey.	
	1. The First floor:				F 921	
	The This Hoof.				Safe/Functional/sanitary/Co	mfo
	a The wall next to	bed 1 in Room 103 was			rtable Environment	
		accumulation of dried food			It is the policy of the facility to	
		behind the head of the bed for			provide a safe, functional,	
		d food spillage. The bathroom			sanitary, and comfortable	
		re also marred. Two residents			environment for resident's, sta	ff
					and the public.	
resided in the room and 3 residents shared the bathroom.				Corrective actions which will	l ha	
bathroom.					be	
	1. The lease of the	-1			accomplished for those	
		closet doors in Room 104 had			residents found to have beer	)
		int. The bathroom walls and			affected by the deficient	
		rred. One person resided in			practice:	
	the room and 3 resi	dents shared the bathroom.			·No resident was affected by	/
					this deficient practice.	
		e heat register in Room 107				
	1	ed away from the wall. One			How the facility will identify oth	
	resident resided in t	the room.			residents having the potential	
					be affected by the same defici	ent
		in the bathroom of Room 108			practice.	
		from the wall near the toilet.			·All residents residing in the	
	Two residents share	ed the bathroom.			facility have the potential to be	;
					affected by the deficient practi	ce.
		nk in Room 109 was pulling				
	away from the wall	. The sink was being propped				
	up with two pieces	of wood There were rust			The measures the facility will t	ake
	stains on the wall u	nderneath the bathroom sink.			or systems the facility will alter	· to
	One resident used to	he bathroom.			ensure that the problem will b	е
					corrected and will not recur.	
	f. The door frame i	in Room 116 was marred			1.	
	along with the wall	s. One resident resided in the			·The wall next to bed 1 in Ro	oom
	room.				103 that was marred and had	
					accumulation of dried food	
	g. The walls in Ro	om 119 were scratched and			spillage was cleaned.	
		oom door was also hard to			·The base of the closet door	s in
		resided in this room and used			Room 104 had areas of chippe	
	the bathroom.				paint. Area was fixed and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	COMPLETED	
		155653	<u> </u>		06/11/2021		
				_		00,11,	202 .
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE COUNTY NURSING AND REHABILITATION CENTER				EAST C	CHICAGO, IN 46312		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					repainted.		
	h. The walls in Roo	om 121 were marred as well			·The bathroom walls and do		
	as the bathroom do	or and door frames. Two			in Room 104 was marred. Th	е	
	residents resided in	the room and 2 residents			walls and doors were repaired	i.	
	used the bathroom.				·The cover for the heat regis	ster	
					in Room 107 was loose and p	ulled	
	i. There was a large	e hole behind the door in			away from the wall. Cover wa	as	
	Room 123. Two re	sidents lived in this room.			tightened and appropriate rep	air	
					was done.		
	j. The walls in Roo	om 125 were marred as well as			·The base board in the		
	the closet door and door frame. One resident resided in this room.				bathroom of Room 108 was		
					peeling away from the wall ne	ar	
					the toilet. This has been		
	2. The Second floo	r:			inspected and repaired.		
					The door frame in Room 11	16	
	a. There were secti	ons of missing base board in			was marred along with malls.	This	
		om 204. Three residents			has been repaired.		
	shared the bathroon	n.			Two walls in Room 119 we	re	
					scratched and marred. This w	as	
	b. The base board l	heat register cover was			repaired.		
	hanging off in Roor	n 209. Two residents resided			·The bathroom door that wa	S	
	in this room.				hard to open in Rm 119 was		
					repaired.		
	c. There were areas	s of peeling paint and missing			∙The walls in Room 121 wer	·e	
	base boards in Room	m 226. One resident resided			marred as well as the bathroo	m	
	in the room.				door and door frames. This wa	as	
					repaired.		
	Interview with the I	Housekeeping Supervisor at			·There was a large hole beh	ind	
	the time, indicated a	all of the above areas were in			the door in Room 123. This w	/as	
	need of cleaning an	d/or repair.			inspected and repaired.		
					The walls in Room 125 wer	·e	
	3.1-19(f)				marred as well as the closet d	loor	
					or door frame. This was		
					inspected and repaired.		
					The base board heat regist	er	
					cover was hanging off in Roor		
					208. This was inspected and		
					fixed.		
					·The areas of peeling paint	and	
					missing base boards in Room		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/11/2021			
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				was fixed and base boards replaced.  1:1 Inservice was provided Housekeeping/Maintenance Director on addressing and managing environmental conditions that should be safe functional, sanitary, and comfortable for residents, stat and public. Inservice will inclusystem for staff to report time any environmental/maintenancissues that need repair.  Inservice will be provided to staff to ensure timely reporting any repair/maintenance/environmentsues to housekeeping direct and or Administrator.  Administrator will facilitate system to report areas in the facility that need repair and w in-service staff on how and with to report maintenance and environmental issues.  Administrator will ensure all areas identified during survey were fixed and repaired and w conduct environmental rounds twice weekly for four weeks weekly for four weekly for 5 months.	e,  If,  de  ly  ce  p all  g of  ental  tor			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> COMPLETE			ETED		
155653		B. WING 06/11/2021			2021		
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CCOOK AVE		
LAKECO	NINTV NILIDOINIC A	ND REHABILITATION CENTER			CHICAGO, IN 46312		
LAKE CO	OUNTY NURSING A	IND REHABILITATION CENTER		EAST	CHICAGO, IN 40312		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Housekeeping/Maintenance		
					Director to the Quality Assurar	nce	
					Committee and reviewed by th	ie	
					Committee per Month for four		
					Months and recommendations	i	
					given in order to assist in ensu	ıring	
					that the facility stay in complia		
					and if concerns are identified t	he	
					Quality Assurance Committee		
					add on additional Months until		
					Compliance is sustained.		
					Dates when corrective action v	will	
					be completed: June 25, 2021	•	
					1.		
F 0925	483.90(i)(4)						
SS=F		e Pest Control Program					
Bldg. 00	_ ,,,,	tain an effective pest					
		that the facility is free of					
	pests and rodents.						
		on and interview, the facility	F 09	925	Submission of this plan of		06/25/2021
		n effective pest control			correction does not constitute		
		he facility was free from			admission or agreement by the	9	
	-	lated to live ants and roaches			provider of the truth of facts		
		had the potential to affect 60			alleged or correction set forth	on	
		who resided in the facility			the statement of deficiencies.		
		om the kitchen. (The Main			The plan of correction is		
	Kitchen)				prepared and submitted becau	ıse	
	Ti., 4i., . : 1 1				of requirement under state and	d	
	Finding includes:				federal law. Please accept this	;	
	During the Initial To	our of the Kitchen on 6/7/21			plan of correction as our credi	ble	
	•	bur of the Kitchen on 6/7/21  be Dietary Food Manager			allegation of compliance. Plea	se	
	(DFM), the following	-			find enclosed this plan of		
	(DITMI), the following	ig was ouserved.			correction for this survey.		
	There were ? live ro	paches crawling on the floor			,		
		re were also small ants			F 925 Maintains Effective Pe	st	
		or. They were not near any			Control Program		
	crawing on the 1100	1. They were not hear any	1		_		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		155653	B. WING			06/11/2021	
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE COUNTY NURSING AND REHABILITATION CENTER				EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	NDOLUDENIA N. LIV OF CONDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	food, clean dishes,	or food prep equipment.			It is the policy of the facility to		
	,	1 1 1 1			maintain an effective pest cont	trol	
	Interview at the tim	e with the DFM, indicated the			program so that the facility is fi		
		y been sprayed for pests last			of pests and rodents.		
	week.	,			Corrective actions which will	be	
					accomplished for those		
	Interview with the	Administrator on 6/9/21 at			residents found to have been	1	
		I when the roaches and ants			affected by the deficient	-	
	* :	June 1st, the pest control			practice:		
		d out to spray. This was the			·No resident was affected by	,	
		ctivity had been observed.			this deficient practice.		
	, ,	t previously in December			and demonstrations		
		ve maintenance with no bugs			1.How the facility will identify	,	
	-	trol company came back out			other residents having the		
	•	June 8th and sprayed again.			potential to be affected by the		
		so being deep cleaned on the			same deficient practice.		
		pase boards were being			·All residents residing in the		
	_	t helping in the past.			facility have the potential to be		
	Temoved due to that	t helping in the past.			affected by the deficient practic		
	Interview with the I	Dietary Cook on 6/11/21 at			anected by the delicient practi	ce.	
		ed when pest control sprays,					
		into an open area to die.			1.The measures the facility v	vill	
	the pests come out	into an open area to die.			take or systems the facility will		
	3.1-19(f)(4)				alter to ensure that the proble		
	J.1-17(1)(4)				will be corrected and will not	111	
					recur.		
					·Kitchen was cleaned. Pest		
					Control was called for inspection	on	
					and elimination of the infestation		
					·1:1 Inservice will be provide		
					Dietary Manager and	ע נט	
					Housekeeping/Maintenance		
					Director on managing kitchen sanitation.		
						all	
					Inservice will be provided to		
					staff to maintain cleanliness of	ıne	
					environment and reporting	<u>.</u>	
					immediately any observation o	)1	
					pest infestation.		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		155653	B. WING		06/11/2021	
			STR	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		25 MCCOOK AVE		
LAKECO	DUNTY NURSING	AND REHABILITATION CENTER		ST CHICAGO, IN 46312		
	ı					
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE APPROPR	ATE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAC		DATE	
				·An observation tool will be		
				developed to check the kitch		
				any pests. This observation		
				be conducted twice weekly four weeks and issues identified		
				will be addressed immediate		
				Then weekly for 5 months.	у.	
				Quality Assurance Plans to		
				monitor facility performance	o	
				make sure that corrections a		
				achieved and are permanent		
				·All plan of correction		
				observation tool will be repor	ted	
				by the Administrator , Dietary	,	
				Manager and		
				Housekeeping/Maintenance		
				Director to the Quality Assura	ance	
				Committee and reviewed by		
				Committee per Month for fou		
				Months and recommendation		
				given in order to assist in ens	_	
				that the facility stay in compli		
				and if concerns are identified		
				Quality Assurance Committe add on additional Months un		
				Compliance is sustained.	.11	
				Compliance is sustained.		
				Dates when corrective action	will	
				be completed: June 25, 2021		
F 9999						
Bldg. 00						
	3.1-14 PERSONN	EL	F 9999	Submission of this plan of	06/25/2021	
				correction does not constitute	•	
		an organized ongoing inservice		admission or agreement by t	he	
		ning program planned in		provider of the truth of facts		
	_	sonnel. This training shall		alleged or correction set forth	on	
		limited to, the following:		the statement of deficiencies		
	(1) Residents' right	ts.		The plan of correction is		

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	K MEDICARE & MEDIC		<b>I</b>		OMB NO. 0938-0391	
		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		155653	B. WING		06/11/2021	
NAME OF I		2	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	X.	5025 N	MCCOOK AVE		
LAKE CO	DUNTY NURSING A	AND REHABILITATION CENTER	EAST	CHICAGO, IN 46312		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	T	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
		lized populations served.		prepared and submitted becau		
		vely impaired residents.		of requirement under state and		
		3 1		federal law. Please accept this		
	(u) In addition to th	ne required inservice hours in		plan of correction as our credit		
	1 1	who have regular contact		1.		
		have a minimum of six (6)		allegation of compliance. Pleas	Se	
		specific training within six (6)		find enclosed this plan of		
		nployment, or within thirty		correction for this survey.		
	(30) days for person	nnel assigned to the		F 9999 1.1-14 PERSONNEL		
	Alzheimer's and de	mentia special care unit, and		It is the facility policy to conduc	ct	
	three (3) hours annu	ually thereafter to meet the		an organized ongoing in-service		
	needs or preference	es, or both, of cognitively		education and training program		
	impaired residents	and to gain understanding of		planned in advance for all	11	
	the current standard	ds of care for residents with		personnel. This training shall		
	dementia.			include nut not limited to, the		
				following:		
	This rule was not m	net as evidenced by:		1.Resident's Rights		
		·		1.Needs of specialized		
	Based on record rev	view and interview, the		populations served		
		sure annual resident rights,		2.Care of cognitively impaire		
	-	dementia training was		residents	·u	
	completed for 5 of	_		Corrective actions which will	ha	
	_	Dietary Cook 2, CNA 7,			be	
		d the Social Service Designee)		accomplished for those residents found to have been		
		,		affected by the deficient	1	
	Finding includes:					
				practice:  ·No resident was affected by	,	
	The employee recor	rds were reviewed on 6/11/21		-		
		dicated the following:		this deficient practice.		
	_	hired on 8/11/16, had no		How the facility will identify att	nor	
	· ·	cating she had received her		How the facility will identify oth		
		nts and abuse inservices. The		residents having the potential to		
		eceived 3 hours of annual		be affected by the same deficient	eni	
	dementia training.	-		practice.		
	g.			·All residents who receives o		
	- Dietary Cook 2 w	who was hired on 1/22/19, had		and services from staff require		
		ndicating she had received her		complete training in the facility		
	annual resident righ	_		may have the potential to be		
	amidai resident figi	no mon vico.		affected by the deficient practic	ce.	

- CNA 7, who was hired on 4/28/17, had no

The measures the facility will take

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D.			(X3) DATE	3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
155653		B. WING 06/11/2021			2021		
				CTREET	ADDRESS OF A STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					CCOOK AVE		
LAKE CC	DUNTY NURSING A	AND REHABILITATION CENTER		EASIC	CHICAGO, IN 46312		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES			ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
	documentation indi	cating she had received her			or systems the facility will alter	r to	
		ts and abuse inservices.			ensure that the problem will be		
					corrected and will not recur.		
	- Housekeeper 1, w	ho was hired on 12/31/19,			·1:1 in-service was provided	to	
		on indicating he had received			HR and Administrator of the		
		rights and abuse inservices.			training required annually.		
	The Housekeeper h	ad also not received 3 hours			·Facility Administrator will we	ork	
	of annual dementia				with Human Resource Directo		
					and Director of Nursing to		
	- The Social Service	e Designee, who was hired on			implement a training program	to	
	2/28/17, had no doc	rumentation indicating he had			cover required training and		
	received his annual	resident rights inservice.			in-services for staff. This will		
					include a training process for i	new	
	Interview with the	Administrator on 6/11/21 at			hire and other staff annually.	The	
	4:00 p.m., indicated	she thought the above			new hire training will be		
	training had been co	ompleted on "Relias" but they			incorporated on the onboardin	g	
	couldn't access the	system since they changed			and new hire orientation sched	dule	
	corporations.				and annual training will be par	t of	
					the Facility's Annual Skills Fai	r for	
					Staff. Dementia Management		
					Training will be offered at leas		
					twice a year in the facility and	the	
					operator will review available		
					online learning programs that	may	
					be utilized by staff for online		
					learning and education.		
					Facility provided the require	ed	
					training for the sampled staff		
					during the health inspection		
					survey:		
					·LPN1-Completed Reside	ents	
					rights and abuse in-services.		
					Dementia training has been		
					scheduled.		
					·Dietary Cook 2-complete		
					annual residents rights in-serv		
					·C.N.A 7 completed annu	ıaı	
					resident rights and abuse		
					in-services		
					·Housekeeper 1 complete	ed	

PRINTED: 07/13/2021 FORM APPROVED OMB NO. 0938-0391

CROSS-REFERENCED TO THE APPROPRIATE	
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  5025 MCCOOK AVE EAST CHICAGO, IN 46312  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  annual resident rights and abuse in-services. Annual Dementia	14
NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY  annual resident rights and abuse in-services. Annual Dementia	41
Social Service Designee completed his annual resident rights in-service  Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.  All plan of correction will be reported by the Administrator and HR to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained.  Dates when corrective action will be completed: June 25, 2021	(X5) OMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OR6L11

Facility ID: 000108

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