

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00127926.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00128406.</p> <p>Complaint IN00127926: Substantiated-Federal and State deficiencies related to the allegations are cited at F312, F441, and F465.</p> <p>Survey Dates: May 1, 2, 3, 6, 7, 8, and 9, 2013</p> <p>Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410</p> <p>Survey Team: Heather Tuttle, R.N. T.C. 5/1-5/3, 5/7-5/9/13 Regina Sanders R.N. Lara Richards, R.N. 5/2-5/3, and 5/7-5/9/13 Cynthia Stramel R.N. 5/2-5/3 and 5/7-5/9/13 Janelyn Kulik R.N. 5/6-5/7/13 Kathleen Vargas, R.N. 5/2/13</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a revisit be scheduled on or after June 8th, 2013.</p>	

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Census Bed Type: SNF/NF: 77 Total: 77</p> <p>Census Payor Source Medicare: 9 Medicaid: 54 Other: 14 Total: 77</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 16, 2013, by Janelyn Kulik, RN.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure resident's and/or their family members were given timely notices of Medicare Non Coverage for 3 of 3 residents reviewed for Liability Notices. (Residents #52, #60, and #63)</p> <p>Findings include:</p> <p>1. On 5/2/13 at 1:45 p.m. the Notices of Medicare Provider Non Coverage records were reviewed.</p> <p>Resident #60's Medicare services were going to end on 4/26/13. The resident's family was mailed the notice on 4/28/13.</p> <p>2. On 5/2/13 at 1:45 p.m. the Notices of Medicare Provider Non Coverage records were reviewed</p> <p>Resident #52's Medicare coverage was going to end on 4/18/13. The resident was given notice on 4/19/13 (one day after the services ended) and refused to sign the paper.</p> <p>3. On 5/2/13 at 1:45 p.m. the Notices of Medicare Provider Non Coverage records were reviewed.</p>	F000156	<p>F156 §483.10(b)(1) -- The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing; What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Resident # 52, # 60 and # 63 did receive their Medicare cut letters with no adverse effects from this alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who currently reside at the facility under Medicare Part A are at risk to be affected by the same alleged deficient practice. The Admissions Coordinador reviewed all of the</p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Resident #63's Medicare coverage was going to end on 4/26/13. The Non Coverage notice was mailed to the resident's family member on 4/27/13 (one day after the services ended).</p> <p>Interview with the Admissions Coordinator at that time, indicated she mails the notices out to the families and writes on the paper that she mailed them. She further indicated she does not send the notices certified so there was no written documentation that she had sent the letter to the resident's family. The Admissions Coordinator was unaware the resident and/or family member was to be given 48 hours notice before the Medicare Coverage ends.</p> <p>3.1-4(a)</p>		<p>residents who were Medicare since January 1 2013 to see if they were affected by this alleged deficient practice. Any other issues that were found were immediately corrected. The Admissions Coordinator was educated on the proper policy and procedure to follow when issuing a Medicare cut letter on May 2 nd 2013. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The Admissions Coordinator will discuss with the team members at the weekly Medicare meeting when a resident will be coming off of Medicare benefits to ensure the letters are mailed out certified timely ongoing. She will log the day and time she mailed out a notice for the residents who have been issued cut letters on the Medicare Cut Letter Log. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The Administrator and/or designee will review the Medicare Cut Letter Log weekly to ensure continued compliance. Any issues identified will be immediately corrected. The audits will be submitted to the QA Committee for review as indicated. An action plan may be developed for identified issues. § Noncompliance with facility</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			procedures will result in education and/or disciplinary action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the Elder Justice Abuse Policy was followed related to ensuring all covered individuals who have contracts with the facility were given notice and/or information on how to report a crime.</p> <p>Findings include:</p> <p>Interview with the Administrator on 5/9/13 at 10:52 a.m., regarding the Elder Justice Act indicated the Corporate Office was supposed to send the information and the policy regarding the Elder Justice Act to all of the contracted services.</p> <p>She indicated she would have to call the cooperate office to get that information.</p> <p>Interview with the Administrator on 5/9/13 at 11:51 a.m., indicated the corporate office cannot provide the information indicating they mailed the information regarding the Elder</p>	F000226	<p>F226</p> <p>The facility must develop and implement written policies and procedures that prohibit Mistreatment, neglect, and abuse of Residents and misappropriation of Resident property.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>No residents have been found to be affected from this</p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Justice Act to all of the contracted services. She further indicated she was aware the contracted agencies needed to be notified, but she was not doing that herself.</p> <p>Review of the undated current Elder Justice Act policy provided by the Administrator indicated "Each employee, agent, contractor, manager, owner, or operator of this facility is individually responsible to report the reasonable suspicion of a crime against a resident. An individual who fails to report is subject to a civil money penalty of up to \$300,000 and exclusion from participation in any Federal health care program."</p> <p>3.1-28(a)</p>		<p>alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who reside at the facility have the Potential to be affected by the alleged Deficient practice.</p> <p>The facility will write a letter explaining the Elder Justice Act and mail it along with a copy of the Elder Justice Act to all its contracted agencies prior to May 31 st , 2013.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>The Human Resource Director and/or designee will continue to mail out the same packet to all its contracted agencies every January to ensure compliance is met.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>The Administrator and/ or designee will review the copies of who they were mailed to, to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			ensure compliance is met ongoing. Any issues identified will be immediately corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure each residents' dignity was maintained related to wearing hospital gowns for 2 of 3 residents reviewed for dignity of the 8 residents who met the criteria for dignity. (Residents #85 and #92)</p> <p>Findings include:</p> <p>1. On 5/2/13 at 12:51 p.m., Resident #85 was observed in her room in bed. The resident was wearing a hospital gown at this time.</p> <p>On 5/3/13 at 8:28 a.m., 11:15 a.m., and 12:29 p.m., the resident was observed in her room in bed. The resident was wearing a hospital gown at these times.</p> <p>On 5/7/13 at 8:40 a.m. and 1:15 p.m., the resident was again observed in her bed wearing a hospital gown.</p> <p>On 5/8/13 at 10:50 a.m., the resident was in her room in bed. She was</p>	F000241	<p>F241 DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident # 85 and # 92 will be dressed in a dignified manor allowing for the resident's and/or families wishes to be honored as to preference of clothing. The residents care plans were updated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who are cognitively impaired who wear hospital gowns are at risk to be affected by this alleged deficient practice. The families of the cognitively impaired residents were called about the residents preferences of clothing while in bed and the care plans were updated accordingly. The</p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>wearing a sweater and pants.</p> <p>The record for Resident #85 was reviewed on 5/3/13 at 12:35 p.m. The resident's diagnoses included, but were not limited to, Huntington's chorea and muscle weakness. There was no care plan related to the resident wearing a hospital gown.</p> <p>Additional record review on 5/8/13 at 2:00 p.m., indicated a plan of care dated 5/8/13 which indicated the following: "After speaking with resident and her sister, it was determined that [resident's name] is appropriate to remain in gowns, as opposed to regular clothes due to her constant movement. Wearing regular clothing would restrict her movement and put her at increased risk for shearing of the skin.</p> <p>Interview with the MDS Coordinator on 5/8/13 at 1:30 p.m., indicated that a dignity care plan was initiated today for wearing a hospital gown in bed. She indicated that she did not understand why the resident was dressed today.</p> <p>2. On 5/01/13 at 12:46 p.m. and 2:47 p.m., Resident #92 was observed laying in bed. The resident was dressed in a hospital gown.</p>		<p>residents who reside in the facility who are not cognitively impaired were spoke with about their clothing preferences while in bed. The residents care plans were updated accordingly. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The DON and/or designee will check 5 residents daily 5 days per week x 1 month then 3 residents daily 3 times per week for 5 months to ensure the resident and/or families wishes are honored. Any issues identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · The DON and/or designee will complete the clothing preference audit tool to ensure compliance is met. · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 5/2/13 at 8 a.m., at 11:04 a.m., and 1:12 p.m. the resident was observed in bed wearing a hospital gown.</p> <p>On 5/3/13 at 7:44 a.m., 11:25 a.m., and 12:44 p.m., the resident was in bed wearing a hospital gown.</p> <p>The Record for Resident #92 was reviewed on 5/3/13 at 7:51 a.m. The resident's diagnoses included, but were not limited to, traumatic brain injury, debility, muscle weakness, pain, and dementia.</p> <p>Review of the current plan of care dated 12/19/12 indicated there was no care plan for dignity related to the resident wearing a hospital gown during the day.</p> <p>Interview with CNA #10 on 5/8/13 at 9:30 a.m., indicated she had taken care of the resident numerous times, and had always known him to wear a hospital gown all day long.</p> <p>Interview with CNA #11 on 5/7/13 at 1:23 p.m. indicated the resident usually wears a hospital gown all day long. She further indicated that was all she had ever seen him dressed in.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Interview with the Assistant Director of Nursing (ADoN) on 5/8/13 at 10:00 a.m., indicated the resident's family prefers the hospital gown, however, this was not care planned.</p> <p>3.1-3(t) .</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written or Physician Orders were followed related to incontinence care and dining for 3 of 3 residents reviewed for activities of daily living of the 11 residents who met the criteria for activities of daily living, for 1 of 4 residents reviewed for accidents of the 5 residents who met the criteria for accidents, for 1 of 3 residents reviewed for Urinary Catheter use of the 19 who met the criteria for Urinary Catheter use and for 1 of 10 residents reviewed for unnecessary medication. (Residents #B, #C, #9, #66, #2, and #92)</p> <p>Findings include:</p> <p>1. On 5/8/13 at 8:39 a.m., Resident #C was observed in her room in bed. At 8:54 a.m., the resident received her breakfast tray. At 9:19 a.m., and 9:28 a.m., the resident's tray was on her bedside table and covered. She had received no assistance with her meal. At 9:31 a.m., CNA #8 was in</p>	F000282	<p>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident # C was fed by the staff and suffered no adverse affects from this alleged deficient practice. Resident # 92 catheter tubing was corrected when it was identified on rounds. No adverse effects were identified or observed. Resident # 66 remains in the facility with stable blood sugars. No adverse effects were identified or observed. Resident # B had been cleaned and changed at the time of the observation and suffered no adverse effects by this alleged deficient practice. Resident # 9 was assessed and has a treatment in place for her finger. Her care plan has been updated to include offering her a cigarette extender while she is outside smoking and encouraging her to keep it on until she is done with</p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the resident's room. She was attempting to feed the resident.</p> <p>The record for Resident #C was reviewed on 5/3/13 at 8:32 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and dementia with behavior disturbance.</p> <p>The plan of care dated 10/6/12 and reviewed 1/24/13, indicated the resident required a mechanically altered diet related to a swallowing problem. The interventions included, but were not limited to, provide feeding assistance for meals.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 5/8/13 at 3:15 p.m., indicated the resident should not have had to wait that long for assistance with her breakfast meal.</p>		<p>her cigarette. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who reside at the facility and are assisted by staff with feeding have the potential to be affected by this alleged deficient practice. On May 8 th , 2013 the residents that required assistance with feeding were observed to ensure they were not affected by this same deficient practice. No other issues were identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure for assisting a resident with feeding.</p> <p>Residents who reside at facility who have indwelling catheters are at risk to be affected by this alleged deficient practice. . On May 8 th , 2013 the residents who had indwelling catheters were checked for proper placement to ensure they were not affected by the same alleged deficient practice. No other issues were identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure on caring for indwelling catheters and placement while in bed.</p> <p>Residents who reside at the facility who have an order for sliding scale insulin have the potential to be affected by this alleged deficient practice. On May 6 th 2013 the residents who</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>have an order for a sliding insulin scale were audited by the DON to ensure they were not affected by the same alleged deficient practice. No other issues were identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedures on proper administration and documentation of sliding insulin coverage.</p> <p>Residents who reside at the facility who are incontinent of urine have the potential to be affected by this alleged deficient practice. On May 7 th , 2013 the residents who are incontinent were checked to ensure they were not affected by the same alleged deficient practice. No other issues were identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure for incontinence care. Residents who reside in the facility who smoke have the potential to be affected by the same deficient practice. On May 7 th , 2013 the other residents who reside at the facility who smoke were assessed for any injuries to ensure they were not affected by the same alleged deficient practice. No other injuries were identified. The Staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities smoking policy and procedure for our residents.</p> <p>What measures will be put into place or what systemic changes you will make to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>ensure that the deficient practice does not recur The Dietary Manager and/or designee will monitor 2 residents daily x 5 days per week then 10 residents weekly x 5 months using <u>the meal observation audit tool</u> to ensure the residents who need assistance with feeding are fed timely. Any issues identified will be immediately corrected. The DON and/or designee will monitor 3 residents 5 days per week with indwelling catheters x 1 month. 5 residents weekly x 5 months using <u>the resident care tracking tool</u> to ensure the indwelling catheters are properly placed. Any issues identified will be immediately corrected. The DON and/or designee will audit 5 residents with coverage 5 x per week x 1 month then 5 residents weekly x 5 months using the <u>daily start up audit tool</u> to ensure the medication is given as ordered and has correct documentation. Any issues identified will be immediately corrected. The DON and/or designee will monitor 3 incontinent residents per day 5 x per week x 1 month then 10 residents weekly x 5 months using <u>the resident care tracking tool</u> to ensure the proper incontinence care is provided. Any issues identified will be immediately corrected. The Activity Director and/or designee will monitor the residents while smoking 1 x daily x 5 days x 1 month then 3 x weekly x 5</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. On 5/3/13 at 11:25 a.m., Resident #92 was observed in bed. At that time, the resident's indwelling foley catheter drainage bag including the tubing was observed on the floor.</p> <p>On 5/3/13 at 12:25 p.m., 12:44 p.m., and 2:05 p.m., the resident was observed in bed. The indwelling foley catheter drainage bag including the tubing was noted on the floor under his bed.</p> <p>The Record for Resident #92 was reviewed on 5/3/13 at 7:51 a.m. The resident's diagnoses included, but were not limited to, sacral wound and dementia.</p>		<p>months using the <u>smoking observation audit tool</u> to ensure the facility smoking policy and procedure is followed for the residents smoking times. Any issues identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Review of Physician Orders on the current May recap dated 2013 indicated the resident had an 18 French indwelling foley catheter.</p> <p>Review of the current care plan dated 3/11/13 indicated the problem of potential for infection related to catheterization. The Nursing approaches were to ensure placement of catheter tubing was below level of the bladder and not to allow the tubing and drainage bag to rest on the floor.</p> <p>Interview with CNA #10 on 5/8/13 at 9:30 a.m., indicated the foley catheter bag was to be placed on the side of the bed below the resident's waist.</p> <p>Interview with the Assistant Director of Nursing ADoN on 5/8/13 at 10:00 a.m., indicated the foley catheter drainage bag and tubing should not have been on the floor.</p> <p>3. Resident #66's record was reviewed 05/07/13 at 8:38 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>A care plan, dated 06/28/12, indicated the resident was a risk for unstable blood sugars. The interventions</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated to administer diabetic medications as ordered.</p> <p>A physician's order, dated 4/20/13, indicated an order for blood sugar checks twice a day at 7 a.m. and 4 p.m., then to administer Novolin regular insulin per sliding scale (amount of insulin given by the result of the blood sugar). The insulin dosages were as follows: Blood sugar 60-150- no insulin Blood sugar 151-200- two units Blood sugar 201-250- four units Blood sugar 251-300- six units Blood sugar 301-350- eight units Blood sugar 351-400 -10 units greater than 400- 12 units and call MD</p> <p>The 04/13 Medication Administration Record (MAR) indicated at 7 a.m. on 04/17/13 the resident's blood sugar was 200 and four units of insulin was given and on 04/26/13 at 7 a.m. the resident's blood sugar was 153 and no insulin was given. The MAR indicated a zero with a line through it.</p> <p>During an interview on 05/06/13 at 8:55 a.m., the Director of Nursing (DoN) indicated the resident should have received two units of insulin at 7 a.m. on 04/17/13 and 04/26/13.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The 04/13 MAR indicated the following blood sugar results and insulin dosages given at 4 p.m.:</p> <p>4/21/13-BS (Blood Sugar) 302-no insulin marked as given</p> <p>4/22/13- BS 322- six units given</p> <p>4/23/13-BS 360- no insulin given</p> <p>4/29/13- BS 286-no insulin marked as given</p> <p>During an interview on 05/06/13 at 8:55 a.m., the DoN indicated at 4 p.m. on 04/21/13, no insulin was given, on 04/22/13 at 4 p.m., the resident should have received eight units of insulin, on 04/23/13 at 4 p.m. no insulin was given, and on 04/29/13 at 4 p.m., there was no insulin marked as given.</p> <p>4. On 5/2/13 at 8:40 a.m. during an interview with Resident #B a strong urine odor was present in the room.</p> <p>On 5/3/13 at 10:10 a.m. the resident was observed in bed watching television. A strong urine odor was present in the room.</p> <p>On 5/7/13 at 8:35 a.m., CNA #8 and a new CNA in training were observed checking for incontinence for Resident #B. The CNA checked the resident's brief due to the urine odor in the room. The resident's brief, cloth pad and gown were all wet. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident was washed with soap and water, a new pad and brief were applied. The resident was repositioned and prepared for breakfast which arrived in her room.</p> <p>Interview with CNA #8 at that time, indicated the resident's gown was also saturated with urine. The CNA then changed her gown.</p> <p>The record for Resident #B was reviewed on 5/3/13 at 10:14 a.m. A care plan dated 10/29/2012 indicated a problem of incontinence of bowel and bladder. The goal was to keep the resident dry and as odor free as possible. The approaches included explaining procedure to resident, observe resident for episodes of incontinence as needed and provide resident with clean pad/brief with each care of incontinence.</p> <p>Interview with CNA #8 on 5/7/13 at 8:32 a.m., indicated the resident was changed before breakfast, and then again before lunch. She indicated she had changed the resident already this morning within the past two hours.</p> <p>5. On 5/2/13 at 11:15 a.m., Resident #9 was observed in the smoking area. At that time, the resident's cigarette</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was burned down to her fingers on her right hand. Upon closer observation she was observed to have open areas on the right middle finger and the right index finger. An unidentified aide supervising in smoking area indicated "those are old burn marks", she also indicated staff were looking for a cigarette holder for the resident.</p> <p>On 5/7/13 at 11:07 a.m., Resident #9 was in the smoking area. There were no Band-Aid on her right index and middle finger. She had smoked the cigarette down until the ash was touching her skin. The resident did not make any indication of pain related to the burns on her fingers.</p> <p>The record for Resident #9 was reviewed on 5/7/13. A document titled "Event Category and Description - Behavior and Mood Events- Unsafe Smoking" dated 5/1/13 indicated the resident had burns on her right middle and index finger. On 5/2/13 there was a Physician's Order for bacitracin ointment to the affected areas on the right hand and to cover with Band-Aid.</p> <p>A care plan dated 9/18/12 indicated a problem of dark yellow stains on right hand fingers related to smoking. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>goal was the skin will remain intact through next review. The approaches included, but were not limited to supervised smoking only, observe for open areas on fingers and notify Physician as needed.</p> <p>A care plan dated 7/14/11 indicated the problem of resident was a cigarette smoker. The goal was the resident will comply with the facilities smoking policy. The approaches included, but were not limited to, supervise smoking in designated smoking area".</p> <p>Interview on 5/7/13 at 11:14 a.m., with the Activities Director, indicated he was aware of the burns on her fingers and had previously reported to nursing staff and that this was an ongoing problem. He indicated the staff were looking for a cigarette holder for the resident.</p> <p>Interview on 5/7/13 at 11:25 a.m., the ADON, indicated the resident had been assessed to smoke in the facility. She also indicated she was aware of the burns on the resident's fingers and agreed preventative measures should have been in place.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure bruises were assessed for 1 of 3 residents reviewed for skin conditions, non-pressure related, for the 6 residents who met the criteria of skin conditions non-pressure related. (Resident #C)</p> <p>Findings include:</p> <p>On 5/2/13 at 10:17 a.m., Resident #C was observed with a reddish/purple bruise to her right forearm.</p> <p>On 5/3/13 at 8:00 a.m., a dark bluish purple bruise was noted to the resident's right forearm.</p> <p>On 5/9/13 at 9:00 a.m., with the Assistant Director of Nursing present, a fading reddish/purple bruise was observed to the resident's right forearm.</p> <p>The record for Resident #C was reviewed on 5/3/13 at 8:32 a.m. The</p>	F000309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WWellbeing Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident # C was immediately assessed by a licensed nurse. The physician and family were notified. No new orders were received. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who currently reside in the facility that are on anticoagulant therapy and have fragile skin are at risk to be affected by this same alleged deficient practice. On May 9 th , 2013 the Skin Nurse and/or</p>	06/08/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>resident's diagnoses included, but were not limited to, anxiety disorder, dementia with behavior disturbance and Alzheimer's disease.</p> <p>The plan of care dated 4/7/12, and reviewed March 2013, indicated the resident was at risk for abnormal bleeding and bruising secondary to daily use of aspirin for anticoagulant therapy and fragile skin.</p> <p>Review of the 4/17/13 readmission assessment, indicated the resident was readmitted to the facility with the following bruises: left facial bruise 1.6 centimeters (cm) x 1.2 cm yellow in color, left arm bruise 4.5 cm x 4 cm red in color, left hand bruise 7 cm x 7.3 cm, purple in color. There was no documentation related to right forearm bruising.</p> <p>A Weekly skin assessment was completed on 4/22/13. Again, there was no documentation related to right forearm bruising.</p> <p>Review of the Nursing progress notes for the dates of 4/17/13 through 5/8/13, indicated there was no documentation related to right arm bruising. Further, no observation nor event form had been completed related to right arm bruising.</p>		<p>designee completed skin checks for the residents who currently reside in our facility who are on anticoagulant therapy to ensure there were no other residents affected by this alleged deficient practice. No other issues were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The nursing staff was re-educated on the facilities policy and procedure for identifying and the documentation requirements of other skin issues such as bruises on 5/14/2013 and 5/15/2013. The skin nurse and/or designee will monitor residents on anticoagulant therapy 5 residents weekly x 1 month then 3residents weekly x 5 months using the <u>resident skin reports</u> to ensure this alleged deficient practice does not reoccur. Any issues identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met.· Noncompliance with facility procedures will result in education and/or disciplinary action on going.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Review of the hospice note completed on 5/6/13 indicated the nurse did a skin check, a lot of old bruises to arms and legs and left hip.</p> <p>Review of the Hospice worksheet completed on 4/29/13, indicated the resident had a bruise on her left arm and lower/upper right arm.</p> <p>The Hospice worksheet completed 5/1/13, indicated the resident had "bruises here and there, too many to mention. Arms and legs."</p> <p>Review of the 5/3/13 Hospice worksheet , indicated the resident had dark bruises to her left and right forearms.</p> <p>Interview with CNA #8, on 5/8/13 at 9:35 a.m., indicated that she was not aware of any recent skin tears, however, the resident does bruise. She indicated that when she does recognize a bruise, that she tells the nurse immediately.</p> <p>Interview with LPN #11 on 5/8/13 at 1:55 p.m., indicated she was aware of the bruises to the right forearm. She indicated they must have documented the wrong arm on the readmission assessment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Interview with the Assistant Director of Nursing on 5/9/13 at 9:00 a.m., indicated there was no documentation in the resident's record related to the bruise to the right forearm. She indicated an event or observation form should have been completed and the resident was going to undergo a head to toe assessment so any skin conditions the resident had could be documented.</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure the necessary care and services were provided related to incontinence care and dining for 3 of 3 residents reviewed for activities of daily living of the 11 residents who met the criteria for activities of daily living. (Residents #B, #C, and #D)</p> <p>Findings include:</p> <p>1. On 5/8/13 at 8:39 a.m., Resident #C was observed in her room in bed. At 8:54 a.m., the resident received her breakfast tray. At 9:19 a.m., and 9:28 a.m., the resident's tray was on her bedside table and covered. She had received no assistance with her meal. At 9:31 a.m., CNA #8 was in the resident's room. She was attempting to feed the resident.</p> <p>The record for Resident #C was reviewed on 5/3/13 at 8:32 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and dementia with behavior</p>	F000312	<p>F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident # C was assisted by staff with her meal and suffered no adverse effects from this alleged deficient practice. Resident # D had been cleaned and changed by the staff and suffered no adverse effects from this alleged deficient practice. Resident # B had been cleaned and changed at the time of the observation and suffered no adverse affects from this alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who reside at the facility and are assisted by staff with feeding have the potential to be affected by this alleged deficient practice.</p>	06/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>disturbance.</p> <p>The plan of care dated 10/6/12 and reviewed 1/24/13, indicated the resident required a mechanically altered diet related to a swallowing problem. The interventions included, but were not limited to, provide feeding assistance for meals.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated 3/16/13, indicated the resident was extensive assistance with eating.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 5/8/13 at 3:15 p.m., indicated the resident should not have had to wait that long for assistance with her breakfast meal.</p>		<p>On May 8 th , 2013 the residents that required assistance with feeding were observed to ensure they were not affected by this same deficient practice. No other issues were identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure for assisting a resident with feeding. Residents who reside at the facility who require assistance with their adl's have the potential to be affected by this alleged deficient practice. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure for answering the residents call lights timely. Residents who reside at the facility who are incontinent of urine have the potential to be affected by this alleged deficient practice. On May 7 th , 2013 the residents who are incontinent were checked to ensure they were not affected by the same alleged deficient practice. No other issues were identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure for incontinence care. Residents who reside at the facility who are incontinent of urine have the potential to be affected by this alleged deficient practice. On May 7 th , 2013 the residents who are incontinent were checked to ensure they were not affected by the same alleged deficient practice. No other issues were</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure for incontinence care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The Dietary Manager and/or designee will monitor 3 residents daily x 5 days per week then 7 residents weekly x 5 months using <u>the meal observation audit tool</u> to ensure the residents who need assistance with feeding are fed timely. Any issues identified will be immediately corrected. The SSD and/or designee will monitor 5 residents who require assistance with their adl's per day 5 days per week x 1 month then 7 residents weekly x 5 months using <u>the call light audit tool</u> to ensure the residents call lights are answered timely. Any issues identified will be immediately corrected. The DON and/or designee will monitor 3 incontinent residents per day 5 x per week x 1 month then 7 residents weekly x 5 months using <u>the resident care tracking tool</u> to ensure the proper incontinence care is provided. Any issues identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. During an interview on 05/01/13 at 1:40 p.m., Resident #D indicated she had been incontinent of urine in her brief. She indicated she had activated the call light twice and the staff came in and turned the call light off and said they needed help to assist her, and they would be back and had not come back yet.</p> <p>The resident then activated her call light again, LPN #2 entered the resident's room, gave the resident her medicine, and turned the call light off. LPN #2 asked the resident why the call light was on, the resident informed LPN #2 she had been incontinent in her brief. LPN #2 then indicated she would get someone to help her and left the room.</p> <p>During an observation on 05/01/13 at 1:51 p.m., staff still had not returned to assist the resident with her incontinency. During an interview at this time, the resident indicated she was unable to stand, and she prefers</p>		<ul style="list-style-type: none"> Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. Noncompliance with facility procedures will result in education and/or disciplinary action on going. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>not to use the bedpan due to comfort, so she urinates in the brief then calls for the staff to come and change her brief.</p> <p>LPN #2 reentered the room at 1:53 p.m. with CNA #3. CNA #3 then left the room to obtain a brief for the resident. CNA #3 returned to the resident's room and the resident's wet brief was changed at 2 p.m. (20 minutes after the call light was activated for the third time). During an interview at the time of the observation, LPN #2 indicated the resident's brief was wet.</p> <p>Resident #D's record was reviewed on 5/3/13 at 8:03 am. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, congestive heart failure, coronary artery disease, and cellulitis of the legs.</p> <p>A Quarterly Minimum Data Set Assessment, dated 3/5/13, indicated the resident's cognition was intact, required extensive assistance with bed mobility and transfers, and was frequently incontinent of urine (seven or more episodes of incontinency).</p> <p>A care plan, dated 3/11/13, indicated the resident was incontinent of bowel</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and bladder at times. The interventions included, respond promptly to resident's elimination request. Keep skin clean and dry.</p> <p>A facility policy, dated 08/08, received as current from the Administrator, titled, "Answering the Call Light", indicated, "...5. If you promised the resident you will return...do so promptly. 6. If assistance is needed when you enter the room, summon help by using the call signal."</p> <p>3. On 5/2/13 at 8:40 a.m. during an interview with Resident #B a strong urine odor was present in the room.</p> <p>On 5/3/13 at 10:10 a.m. the resident was observed in bed watching television. A strong urine odor was present in the room.</p> <p>On 5/7/13 at 8:35 a.m., CNA #8 and a new CNA in training were observed checking for incontinence for Resident #B. The CNA checked the resident's brief due to the urine odor in the room. The resident's brief, cloth pad and gown were all wet. The resident was washed with soap and water, a new pad and brief were applied. The resident was repositioned and prepared for breakfast which arrived in her room.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Interview with CNA #8 at that time, indicated the resident's gown was also saturated with urine. The CNA then changed her gown.</p> <p>The record for Resident #B was reviewed on 5/3/13 at 10:14 a.m. The resident's diagnoses included, but were not limited to, schizophrenia, Alzheimer's dementia, hypertension, diabetes mellitus, CVA (stroke), hemiplegia (partial paralysis), and seizure disorder.</p> <p>The Minimum Data Set (MDS) assessment dated 3/29/2013 indicated the resident was always incontinent of bladder, and not on a toileting program or trial. The resident required extensive assistance for toileting, bed mobility and transfers.</p> <p>A care plan dated 10/29/2012 indicated the problem of incontinence of bowel and bladder. The goal was the resident will be as clean, dry and odor free as possible thru next review. The approaches included, but were not limited to explain procedure to the resident, observe resident for episodes of incontinence as needed and provide the resident with a clean pad and brief with each incontinent episode.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an interview with CNA #8 on 5/7/13 at 8:32 a.m., she indicated the resident was changed before breakfast, and then again before lunch. The CNA indicated she had changed the resident already that morning within past two hours.</p> <p>This Federal Tag relates to Complaint IN00127926</p> <p>3.1-38(a)(3)(C) 3.1-38(a)(3)(D)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure a treatment was obtained when a new open area was observed for 1 of 3 residents reviewed for pressure ulcers of the 34 residents who met the criteria for pressure ulcers. (Resident #99)</p> <p>Findings include:</p> <p>On 5/3/13 at 9:10 a.m., Resident #99 was observed in his room in bed sleeping. The resident had a specialty bed which had a low air loss mattress.</p> <p>The record for Resident #99 was reviewed on 5/3/13 at 9:13 a.m. The resident's diagnoses included, but were not limited to, pancreatic adenocarcinoma, pressure ulcer, and palliative care.</p>	F000314	<p>F314 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable, and a resident having pressure sore receives the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident # 99's nurse observed the open area and immediately assessed, cleansed and dressed the area. She notified the residents' physician. The physician did not return the call until the next day to give a treatment order. No adverse</p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Review of the Nursing progress note dated 3/17/13 at 11:00 p.m., indicated the resident had an open area noted to the back of the hip, which measured 5 centimeters (cm) x 4 cm. The resident's wife was aware. The resident's Physician was called and a message was left.</p> <p>On 3/18/13 at 11:05 p.m., documentation in the Nursing progress note indicated no treatment order had been obtained yet. The open area was cleansed with normal saline and gauze was applied to avoid exposing the area. The resident's physician was called and a message was left. At 11:28 p.m., the resident's physician was called concerning the open area, the Physician indicated to call his office in the morning.</p> <p>On 3/19/13 at 7:42 a.m., documentation of a skin assessment indicated the resident had a Stage 2 open area to his sacrum that measured 5.5 cm x 4.5 cm. No drainage or slough was present. A hydrocolloid dressing was placed to the sacral area and the resident's physician was notified.</p> <p>A Physician's order dated 3/19/13, indicated cleanse sacral wound with</p>		<p>effects were observed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who currently reside at the facility with open areas are at risk to be affected by this alleged deficient practice. On May 8 th , 2013 an audit was completed by the treatment nurse to ensure the residents who currently have pressure sores have a treatment order in place. No new issues were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The licensed nurses were re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure on obtaining treatment orders by the primary care physician or the medical director timely. The DON and/or designee will audit the residents records of 5 residents with pressure sores weekly x 1 month then 3 residents weekly x 5 months using <u>the daily start up audit tool</u> to ensure this alleged deficient practice does not reoccur. Any issues identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>normal saline or wound cleanser. Pat peri wound dry. Apply hydrocolloid every 3 days and prn (as needed) if loose/soiled. Check daily for hydrocolloid placement.</p> <p>Interview with the Director of Nursing on 5/8/13 at 9:43 a.m., indicated staff should have contacted the Medical Director when the resident's primary physician would not return the call. She also indicated a treatment order should have been obtained in a more timely manner.</p> <p>3.1-40(a)(2)</p>		<p>· Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met.· Noncompliance with facility procedures will result in education and/or disciplinary action on going.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure a resident with a foley catheter received the necessary treatment and services to prevent infection related to the placement of the foley catheter for 1 of 3 residents reviewed for Urinary Catheter Use of the 19 residents who met the criteria for Urinary Catheter Use. (Resident #92)</p> <p>Findings include:</p> <p>On 5/3/13 at 11:25 a.m., Resident #92 was observed in bed. At that time, the resident's indwelling foley catheter drainage bag including the tubing was observed on the floor.</p> <p>On 5/3/13 at 12:25 p.m., 12:44 p.m., and 2:05 p.m., the resident was observed in bed. The indwelling foley</p>	F000315	<p>F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the</i></p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>catheter drainage bag including the tubing was noted on the floor under his bed.</p> <p>The Record for Resident #92 was reviewed on 5/3/13 at 7:51 a.m. The resident's diagnoses included, but were not limited to, sacral wound and dementia.</p> <p>Review of Physician Orders on the current May recap dated 2013 indicated the resident had 18 Fr. indwelling foley catheter.</p> <p>Review of the bladder assessment dated 3/11/13 indicated the rationale for the foley catheter was due to the stage four pressure sore.</p> <p>Review of the 3/18/13 quarterly Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented, and he was severely impaired for decision making. The resident was an extensive assist with a two person physical assist for transfers and bed mobility. The resident had a foley catheter and had a history of pressure ulcers in which he currently had a stage four pressure sore.</p> <p>Review of the current care plan dated 3/11/13 indicated the problem of</p>		<p>deficient practice Resident # 92 was admitted to the hospital prior to the facility being notified about this alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> Residents who reside at facility who have indwelling catheters are at risk to be affected by this alleged deficient practice. . . . <p>On May 8 th , 2013 the residents who had indwelling catheters were checked for proper placement to ensure they were not affected by the same alleged deficient practice. No other issues were identified. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure on caring for indwelling catheters and placement while in bed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The DON and/or designee will monitor 3 residents with indwelling catheters 5 days per week x 1 month. 5 residents weekly x 5 months using <u>the resident care tracking audit tool</u> to ensure the indwelling catheters are properly placed. Any issued identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>potential for infection related to catheterization. The Nursing approaches were to ensure placement of catheter tubing was below level of the bladder and not to allow the tubing and drainage bag to rest on the floor.</p> <p>Review of the current 9/05 Emptying Urinary Drainage Bag provided by the Administrator indicated to keep the drainage bag and tubing off the floor at all times to prevent contamination and drainage.</p> <p>Interview with CNA #10 on 5/8/13 at 9:30 a.m., indicated the foley catheter bag was to be placed on the side of bed below the resident's waist.</p> <p>Interview with the Assistant Director of Nursing ADoN on 5/8/13 at 10:00 a.m., indicated the foley catheter drainage bag and tubing should not have been on the floor.</p> <p>3.41(a)(1)</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. Noncompliance with facility procedures will result in education and/or disciplinary action on going. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview the facility failed to provide supervision to prevent an accident related to monitoring a resident while smoking to prevent burns for 1 of 4 residents reviewed for accidents of the 5 residents who met the criteria for accidents (Resident #9).</p> <p>Findings include:</p> <p>On 5/2/13 at 11:15 a.m., Resident #9 was observed in the smoking area. At that time, the resident's cigarette was burned down to her fingers on her right hand. Upon closer observation she was observed to have open areas on the right middle finger and the right index finger. An unidentified aide supervising in smoking area indicated "those are old burn marks", she also indicated staff were looking for a cigarette holder for the resident.</p> <p>On 5/7/13 at 11:07 a.m., Resident #9 was in the smoking area. There were</p>	F000323	<p>F323 FREE OF ACCIDENTS/HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident # 9 was assessed and has a treatment in place for her finger. Her care plan has been updated to include offering her a cigarette extender while she is outside smoking and encouraging her to keep it on until she is done with her cigarette. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</p>	06/08/2013
-----------------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>no Band-Aid on her right index and middle finger. She had smoked the cigarette down until the ash was touching her skin. The resident did not make any indication of pain related to the burns on her fingers.</p> <p>The record for Resident #9 was reviewed on 5/7/13. The Minimum Data Set quarterly assessment dated 2/25/13 indicated the resident's diagnoses included, but were not limited to, Alzheimer's dementia, depression, and pulmonary disease. Her cognitive function was moderately impaired with poor decisions, cues and supervision was needed.</p> <p>A smoking assessment dated 9/11/12 indicated the resident was capable of following the facility safe smoking policy .</p> <p>A document titled "Event Category and Description - Behavior and Mood Events- Unsafe Smoking" dated 5/1/13 indicated the resident had burns on her right middle and index finger. On 5/2/13 there was a Physician's Order for bacitracin ointment to the affected areas on the right hand and to cover with Band-Aid.</p> <p>A care plan dated 9/18/12 indicated a</p>		<p>taken Residents who reside in the facility who smoke have the potential to be affected by the same deficient practice. On May 7 th , 2013 the other residents who reside at the facility who smoke were assessed to ensure they were not affected by the same alleged deficient practice. No other injuries were noted. The Staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities smoking policy and procedure for our residents.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The Activity Director and/or designee will monitor the residents while smoking 1 x daily x 5 days x 1 month then 3 x weekly x 5 months using <u>the smoking observation audit tool</u> to ensure the facility smoking policy and procedure is followed for the residents smoking times. Any areas identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met.· Noncompliance with facility procedures will result 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>problem of dark yellow stains on right hand fingers related to smoking. The goal was the skin will remain intact through next review. The approaches included, but were not limited to supervised smoking only, observe for open areas on fingers and notify Physician as needed.</p> <p>A care plan dated 7/14/11 indicated the problem of resident was a cigarette smoker. The goal was the resident will comply with the facilities smoking policy. The approaches included, but were not limited to, supervise smoking in designated smoking area".</p> <p>Interview on 5/7/13 at 11:14 a.m., with the Activities Director, indicated he was aware of the burns on her fingers and had previously reported to nursing staff and that this was an ongoing problem. He indicated the staff were looking for a cigarette holder for the resident.</p> <p>Interview on 5/7/13 at 11:25 a.m., the ADON, indicated the resident had been assessed to smoke in the facility. She also indicated she was aware of the burns on the resident's fingers and agreed preventative measures should have been in place.</p>		in education and/or disciplinary action on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident maintained acceptable parameters of nutrition related to monitoring a resident with below average Body Mass Index (BMI) and a history of weight loss for 1 of 3 residents reviewed for nutrition of the 5 residents who met the criteria for nutrition. (Resident #52)</p> <p>Findings include:</p> <p>On 5/4/13 at 8:22 a.m., Resident #52 was observed in a wheelchair in the main dining room eating breakfast. The resident was drinking 2% chocolate milk.</p> <p>On 5/8/13 at 8:35 a.m., the resident was up in his wheelchair in the main dining room eating breakfast. The resident was served 2% chocolate milk.</p>	F000325	<p>F325 MAINTAIN NUTRITION STATUS UNLESS AVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident – 1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the residents clinical condition demonstrates that this is not possible; and 2. Receives a therapeutic diet when there is a nutritional problem. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident # 52 was assessed by the dietician on 5/9/2013 and new orders were received for super cereal at breakfast. He will be followed by the NAR committee since he has a low BMI however his weight has been stable. How will you identify other residents having the potential to be affected by the same deficient practice and</p>	06/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 5/8/13 at 12:45 p.m., Resident #52 was observed in his wheelchair in the main dining room eating lunch. He was served meatloaf, bread, potatoes, a vegetable and a dessert. The resident was also drinking 2% chocolate milk. The resident did not receive a magic cup (high calorie ice cream).</p> <p>The Record for Resident #52 was reviewed on 5/8/13 at 11:52 a.m. The resident's diagnoses included, but were not limited to, esophagus ulcer, diverticulosis, depressive disorder, anxiety, alcohol abuse and high blood pressure.</p> <p>Review of the 2/11/13 quarterly Minimum Data Set (MDS) assessment indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. The resident had no oral oral problems and his weight was 99 pounds. He was also receiving a therapeutic diet.</p> <p>Review of Physician Orders on the current May 2013 recap indicated the resident was to receive a regular diet with whole milk at all meals and a magic cup at lunch and dinner. He was also to receive a house</p>		<p>what corrective action will be taken Residents who currently reside at the facility who are below average BMI and have a history of weight loss are at risk to be affected by this alleged deficient practice. The weight histories of the residents who currently reside in the facility on 5/9/2013 were reviewed to ensure this same alleged practice did not reoccur. No other issues were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The Dietary Manager and/or designee will audit 5 residents per day 5 days per week x 1 month then 10 residents per week x 5 months during meals using <u>the meal observation audit tool</u> to ensure this same alleged deficient practice does not reoccur. Any areas identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>supplement 90 cubic centimeters (cc) three times a day.</p> <p>Review of the resident's weight were as follows:</p> <p>10/2/12-98 pounds 11/8/12-97 pounds 12/13/12-102 pounds 1/1/13-102 pounds 2/7/13-99 pounds 3/20/13-96 pounds 3/26/13-93 pounds 4/1/13-89 pounds 4/6/13-94 pounds 5/9/13-96 pounds</p> <p>The resident had a 8.5% weight loss from 1/1/13 to 4/6/13.</p> <p>Review of the Registered Dietitian (RD) progress note dated 12/20/12, indicated the resident received whole milk at meals and 90 cc of the house supplement three times a day. The resident presents with a 5.2% weight loss. However, no recommendations were made at that time.</p> <p>Review of the RD progress note dated 3/21/13, indicated the resident has had a 3.2% weight loss over past month, however, weight loss was anticipated related to his hospital stay. The resident has a low BMI of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>14.55. He receives 90 cc house supplement three times a day. We will continue to follow weekly weights.</p> <p>The next and last RD progress note was dated 4/4/13, which indicated the resident's last weight was 89.2 pounds. The resident presents with 6.7% weight loss over past month. and 12.5% weight loss over past three months. His oral intake varies per food consumption record. Recommend to add back magic cup for lunch and dinner.</p> <p>A note by the Dietary Food Manager on 5/4/13 indicated the resident was not eating well due to dentures missing on the bottom, however, he opted for soft texture foods. His weight has decreased over past six months.</p> <p>Interview with the Restorative Nurse on 5/8/13 at 3:15 p.m., indicated the resident was not currently being weighed weekly. The last documented weight was on 4/6/13. At that time, another weight was requested for the resident.</p> <p>Review of the current and undated Nutrition at Risk (NAR) policy on 5/8/13 provided by Restorative Nurse indicated residents who have had a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>weight loss or with a low BMI should be reviewed in NAR.</p> <p>Interview with the Restorative Nurse on 5/9/13 at 8:35 a.m., indicated she had just took over the NAR committee. She indicated the resident had not been seen in NAR or had even been a part of the meetings for the entire month of March, April or May 2013. She indicated the resident was not weighed weekly and verified the last weight in the chart was on 4/6/13. The Restorative Nurse indicated he should have been seen in NAR and monitored more closely when he was at the weight of 89 pounds. She indicated that he does receive chocolate milk per his choice and she did know that he was suppose to receive whole milk in which he does not like. She further indicated he was suppose to get a magic cup for lunch and dinner and did not yesterday.</p> <p>3.1-46(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to prepare, and store food under sanitary conditions, related to, handling food without gloves, delivering room trays without deserts covered, sanitizer levels incorrect in the three compartment sink, used for washing pots, pans, and cooking utensils, and in the bucket used to sanitize the dining room tables, for 1 of 1 kitchen, 1 of 2 dining rooms, and 1 of 2 units. This had the potential to effect 75 of 77 residents in the facility who received food from the kitchen. (Kitchen, Main Dining Room, and Second Floor Unit)</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal on 05/01/13 at 12:11 p.m., CNA #1, CNA #6, and CNA #3 delivered trays to rooms 218-1, 218-2, 206-2, 212-1, 213-1, 215-1, and 220-1 from the tray cart, located at the door of the second floor dining room. The</p>	F000371	<p>F371FOOD PROCEDURE, STORE/PREPARE/SERVE - SANITARY The facility must – 1. Produce food from sources approved or considered satisfactory by Federal, State or local authorities; and 2. Store, prepare, distribute and serve food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Residents in rooms 218-1, 218-2, 206-2, 212-1, 213-1, 215-1, 220-1, 205-2, 206-1, 214-1, 217-1, 219-1, 220-2, 221-1, 223-3, 224-2 and 228-1 had their meals delivered by the staff with no adverse effects from this alleged deficient practice. The three compartment sink was emptied, cleaned and refilled using the correct amount of chemicals and all the dishes were rewashed immediately by the dietary staff. The residents had no adverse effects from this alleged deficient practice. The dining room table clothes were removed and rewashed prior to replacing them and all the tables were re-cleaned prior to any</p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>desert on the trays were left uncovered.</p> <p>During an observation on 05/01/13 at 12:45 p.m., the second tray cart arrived on the unit. CNA #1, CNA #6, CNA #3, and CNA #7 were delivering trays to rooms 205-2, 206-1, 214-2, 217-1, 219-1, 220-2, 221-1, 223-3, 224-2, and 228-1, from the cart, located at the door of the second floor dining room. The desert on the trays were left uncovered.</p> <p>During an observation on 05/3/13 at 12:55 p.m., CNA #1 was delivering lunch trays to resident rooms, down the hallway with the deserts uncovered. The RN Nurse Consultant was also observed delivering a lunch tray to a resident's room, down the hallway. The desert on the tray was uncovered.</p> <p>During an interview at the time of the observation, the RN Nurse Consultant indicated she was unsure if the desert should be covered.</p> <p>During an interview on 5/7/13 at 7:55 a.m., the DM (Dietary Manager) indicated everything on the tray should have been covered when delivering the meal tray to a resident's room.</p>		<p>resident contact. The residents had no adverse effects from this alleged deficient practice. Resident # 11 suffered no adverse effects from this alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who currently reside at the facility who do not eat in the main dining room are at risk to be affected by this alleged deficient practice. Residents who currently reside at the facility who eat the meals have the potential to be affected by this same alleged deficient practice. On May 3rd, 2013 the dietary staff was re-educated on the proper policy and procedure for the delivery of the meal service, the proper policy and procedure for washing the dishes and cookware. Residents who eat in the dining rooms have the potential to be affected by this same alleged deficient practice. On May 2 nd , 2013 the housekeeping staff was re-educated on the proper way to clean and sanitize the dining room tables. Residents who eat in the dining rooms have the potential to be affected by this same alleged deficient practice. On May 14 th and 15 th 2013, all staff were re-educated on the proper handling of residents food. The Restorative Nurse was immediately re-educated on the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. During an observation of the kitchen with the DM on 05/02/13 at 1:15 p.m., the following was observed:</p> <p>A) The three compartment sink sanitizer, was checked for chemical levels by the DM. No sanitizer chemical registered on the test strip. The sanitizer section of the sink contained bowls and pans.</p> <p>During an interview at the time of the interview, Dietary Aide #8, indicated she had checked the chemical level in the morning, but had not rechecked the chemical levels after lunch. She indicated she should check the chemical levels with every wash.</p> <p>A facility policy, dated 2009, titled, "Manual Washing of Dishes and Cookware", received from the DM as current, indicated, "...C. Sink Three...Add the appropriate amount of sanitizer to the water according to the manufacturer's guidelines...Chlorine solution: 100 PPM (parts per million)...Test the water in the sink using the manufacturer's suggested test strips to ensure appropriate concentration as noted above..."</p>		<p>proper handling of resident food on 5/8/2013. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The Dietary Manager and/or designee will observe one meal service per day 5 days per week x 1 month then 3 days per week x 5 months during meals using <u>the meal observation audit tool</u> to ensure this same alleged deficient practice does not reoccur. Any issues identified will be immediately corrected. The Dietary Manager and/or designee will audit the sanitation log for the three compartment sink 2 x weekly ongoing to ensure ongoing compliance. Any issues identified will be immediately corrected. The housekeeping supervisor will monitor the cleaning of the dining room 3 x per week x 1 month then 1 x per week ongoing using the <u>environmental observation audit tool</u> to ensure this same alleged deficient practice does not reoccur. Any issues identified will be immediately corrected. The Dietary Manager and/or designee will observe one meal service per day 5 days per week x 1 month then 3 days per week x 5 months during meals using <u>the meal observation audit tool</u> to ensure this same alleged deficient practice does not reoccur.</p> <p>How the corrective action(s) will be monitored to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>B) The tables in main dining room were being cleaned by Housekeeper #9. The chemical level of the water in the sanitizer bucket was checked by the DM. No chemical registered in the cleaning bucket.</p> <p>Housekeeper #9 indicated he sometimes used the disinfectant in a spray can to clean the tables. He stated he sprays the disinfectant in the water then washes the table off with the water. He indicated there was no bleach in the bucket of water.</p> <p>A facility policy, dated 2008, titled, "Cleaning Instructions: Dining Room Table Tops, Bases, and Chairs", received as current from the DM, indicated, "...Clean tables, including edges with a detergent solution. B. Follow by wiping down with a sanitizing solution..."</p> <p>3. Observation on 5/8/13 at 8:47 a.m. in the first floor dining room, the Restorative Nurse was observed holding Resident #11's biscuit with her bare hands and spreading eggs onto it. The resident was then observed eating the biscuit.</p> <p>During an interview on 5/8/13 at 8:50 a.m. with Restorative Nurse, she indicated they were supposed to wear gloves when touching resident's</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met. · Noncompliance with facility procedures will result in education and/or disciplinary action on going.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>food.</p> <p>3.1-21(i)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS	06/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>ensure bed pans, urinals, and linens were stored properly as well as cleaning formed feces off of the shower room floor. The facility also failed to ensure the glucometer was cleansed after use for 1 of 1 glucometers observed. This had the potential to affect the 8 residents who received glucometers on the first floor. (Resident #E, The first and second floors)</p> <p>Findings include:</p> <p>1. On 5/3/13 at 12:42 p.m., CNA #9 was observed getting linen from the linen cart located next to Room 127. A washcloth fell on the floor. The washcloth was picked up by the CNA and placed back in the clean linen cart.</p> <p>Interview with the Assistant Director of Nursing on 5/9/13 at 10:00 a.m., indicated the washcloth should have been placed in the dirty laundry.</p>		<p>The facility must established and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A. Infection Control Program The facility must establish an Infection Control Program under which it 1. Investigates, controls, and prevents infections in the facility. 2. Decides what procedures, such as isolation, should be applied to an individual resident, and 3. Maintains a record of incidents and corrective actions related to infections. B. Preventing Spread of Infection 1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infections, the facility must isolate the resident. 2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. 3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. C. Linens Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. <i>What corrective action(s) will be accomplished</i></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>for those residents found to have been affected by the deficient practice CNA# was immediately re-educated the proper way of handling linen on May 3 rd , 2013. LPN # 10 was immediately re-educated on the proper cleaning of the glucometers after each use on 5/6/2013. The shower room stall was immediately cleaned by the staff on 5/8/2013 when we were informed of the issue. The urinals in rooms 201, 123, and 222 were immediately discarded. New ones were issued, labeled with the residents names and covered prior to placing in the residents rooms. The wash basins in rooms 204, 227, were immediately discarded. New one were issued, labeled with the residents name and covered prior to replacing them in the residents rooms. The bed pans in rooms 217, 218, 220, 227 were immediately discarded. New ones were issued, labeled with the residents name and covered prior to replacing them in the residents rooms. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents residing currently in our facility who use our linen have the potential of being affected by this alleged deficient practice. Residents who currently reside in the facility who</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p><i>require glucometer checks have the potential to be affected by this same alleged deficient practice. Residents who currently reside in our facility who use the shower room have the potential to be affected by this same alleged deficient practice. Residents who currently reside in the facility who use urinals, wash basins or bed pans have the potential to be affected by this same alleged deficient practice. The Nursing staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure on the proper handling of linen, cleaning the reusable equipment, cleaning of the shower rooms after resident use and proper storage of urinals, bedpans and wash basins. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The Housekeeping Supervisor and/or designee will monitor 5 days per week x 1 month. 3 days per week x 5 months using <u>the environmental observation log</u> to ensure the linen is properly handled by staff. Any issued identified will be immediately corrected. The DON and/or designee will monitor 3 residents daily requiring blood sugar checks 5 days per week x 1 month. 5 residents weekly x 5 months using <u>the resident care tracking audit tool</u> to ensure the</i></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	2. During an observation on 05/06/13 at 4:02 p.m., LPN #10 prepared to administer a glucometer check (blood sugar) to Resident #E. LPN #10 indicated the glucometer		<i>indwelling catheters are properly placed. Any issued identified will be immediately corrected. The Housekeeping Supervisor and/or designee will monitor 5 days per week x 1 month. 3 days per week x 5 months using <u>the environmental observation log</u> to ensure the shower rooms are clean after resident use. Any issued identified will be immediately corrected. The Housekeeping Supervisor and/or designee will monitor 5 days per week x 1 month. 3 days per week x 5 months using <u>the environmental observation log</u> to ensure the urinals, bed pans and wash basins are clean and appropriately stored. Any issued identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met.· Noncompliance with facility procedures will result in education and/or disciplinary action on going. ·</i>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was cleaned before and after it is used. LPN #10 then wiped the glucometer with a, "Sani-Cloth" (germicidal wipe) for 10 seconds, then set the glucometer on a paper towel to dry.</p> <p>LPN #10 then completed the resident's glucometer test, then wiped the glucometer with a new, "Sani-Cloth" for five seconds, then placed the glucometer in a basket on the medication cart.</p> <p>LPN #10 indicated she did not clean the glucometer for two minutes.</p> <p>The, "Sani-Cloth" packet, indicated, "...TO DISINFECT AND DEODORIZE:...Treated surface must remain visible wet for a full two (2) minutes..."</p> <p>A facility policy, dated 08/08, titled, "Obtaining a Fingerstick Glucose Level", received from the Administrator as current, indicated, "...Clean reusable equipment according to the manufacturer's instructions..."</p> <p>The manufacturer's instructions, provided by the Administrator on 05/07/13 at 8:30 a.m., indicated, "...The following Germicidal products</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>are also acceptable disinfectants for use on meters: Super Sani-Cloth Germicidal Wipe...To use these products, remove a wipe from the container and follow product label instructions to disinfect meter..."</p> <p>3. On 5/8/13 at 8:00 a.m. and at 9:30 a.m., a small amount of formed feces was observed in the shower stall in the first floor shower room.</p> <p>On 5/8/13 at 1:00 p.m. during the Environmental Tour with the Housekeeping Supervisor and Maintenance Manager, a small amount of formed feces was observed in the shower stall in the first floor shower room. The Housekeeping Supervisor was informed the feces had been observed there since 8:00 a.m.</p> <p>4. On 5/8/13 at 1:00 p.m., during the Environmental tour the following was observed on the first and second floors.</p> <p>a. In Room 201 an uncovered urine container was on the bathroom sink.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Two residents resided in this room.</p> <p>b. In Room 204 an uncovered wash basin was on the back of the toilet. Two residents resided in this room.</p> <p>c. In room 217 an uncovered bedpan was on back of the toilet. The toilet seat had a brown substance on it. Two residents resided in this room.</p> <p>d. In Room 218 there was an uncovered bedpan on back of the toilet, a plastic bedpan on floor of bathroom. Two residents resided in this room.</p> <p>e. In Room 220, an uncovered bedpan was on the back of the toilet. There were two residents that resided in this room.</p> <p>f. In Room 227 a bedpan and a basin was uncovered on the floor in the closet. An emesis basin and an urine container were uncovered on back of toilet. There were two residents who resided in this room.</p> <p>g. In Room 123 there was a an uncovered urine container with urine in it on the back of the toilet. Two residents resided in this room.</p> <p>h. In Room 222 there was an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>uncovered urine container in the bathroom. Two residents resided in this room.</p> <p>Interview on 5/8/13 at 3:30 p.m. with the Administrator, indicated the facility did not have a policy regarding storage of bedpans and urine containers. She indicated she knew bedpans should be covered when not in use.</p> <p>This Federal Tag relates to Complaint IN00127926</p> <p>3.1-18(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000465 SS=F	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty floors in 1 of 1 kitchen, which has the potential to affect 75 of 77 residents who receive meals from the kitchen, marred walls, loose trim on resident room doors, missing call light cord, spillage on the tube feeding pole and walls, loose door protectors, and loose laminate on tables for 2 of 2 units (First Floor and Second Floor). This had the potential to effect 77 of 77 residents who reside in the facility.</p> <p>Findings include:</p> <p>1. During an observation on 05/01/13 at 8:22 a.m., with the Dietary Manager (DM), there was grime and debris' on the floor behind the convection oven and on the floor in the dry storage area. The DM acknowledged the floor was dirty.</p> <p>During an observation on 05/02/13 at 1:15 p.m. with the DM, the following was observed:</p>	F000465	<p>F465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIROMENT The facility must provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice . The floor in the kitchen behind the convection oven and dish washing area were immediately cleaned upon observation. The storage room has be refinished the floor in the dry storage area on May 29 th , 2013. Rooms 101, 102, 103, 104, 114, 115, 201, 204, 212, 213, 216, 218, 220, and 222 have all been repaired and/or cleaned. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> Residents residing currently in our facility have the potential of being affected by this alleged deficient practice. The staff was re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure on reporting any issues identified in resident rooms</p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The floor in the dishwashing area had dark brown/black accumulation in the grout of the floor. The DM indicated the grout was supposed to be white.</p> <p>The floor under toaster table was dirty and the tiles were stained.</p>		<p><i>by using the maintenance request slips. The department heads were re-educated on what to look for in the resident rooms when they are doing their guardian angel rounds and the process of reporting any environmental issues using the maintenance request slips on May 31 st ,2013</i></p> <p><i>The housekeeping staff was re-educated on the proper way to clean a residents room and how to follow the deep cleaning and bed cleaning schedules on May 31 st , 2013. The maintenance department was re-educated on the process of the maintenance slips and the log on May 31 st , 2103. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The Maintenance Director and/or designee will log all requests daily and assign them out to the maintenance department to ensure this same alleged deficient practice does not reoccur. The Administrator and/or designee will review the maintenance requests log weekly and spot check items ongoing to ensure this same alleged deficient practice does not reoccur. The Housekeeping Supervisor and/or designee will monitor 5 rooms per day per week x 1 month. 3 rooms per day per week x 5 months using <u>the environmental observation log</u> to</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. During the Environmental tour on 5/8/13 at 1:00 p.m. with the housekeeping supervisor and Maintenance Manager, the following was observed on the first floor:</p> <p>a. In Room 101 there were multiple areas of rust and chipped paint on the heat register next to the left side of the bed. Two residents resided in this room.</p> <p>b. In Room 102 the baseboard was pulling away from the wall in the bathroom, floor tile was missing behind the door, the pull cord for the emergency call light was missing and the floors were dirty. Two residents resided in this room.</p> <p>c. In Room 103 and 104 shared</p>		<p><i>ensure the resident rooms are clean and in good repair. Any issued identified will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</i></p> <p>· Data will be submitted monthly to the QA Committee for review and follow up. Actions plans will be developed for thresholds that are not met.· Noncompliance with facility procedures will result in education and/or disciplinary action on going. ·</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>bathroom, the grab bar was missing from one side of the toilet. The floor mat had multiple tears. There were four residents who resided in these two rooms.</p> <p>d. In Room 114 the door frame was pulling away from the wall. There was one resident in this room.</p> <p>e. In Room 115 the floor mat next to the bed had multiple tears. The heat register cover was bent. The closet door paint was chipped and marred. Walls next to the bed were chipped and marred.</p> <p>2. During the Environmental tour on 5/8/13 at 1:30 p.m. with the Housekeeping Supervisor and Maintenance Manager, the following was observed on the second floor:</p> <p>a. In Room 201 the plaster wall next to bed was buckling. Two residents resided in this room.</p> <p>b. In Room 204 the plaster was coming off the wall behind bathroom sink and scrapes on outside of door. There was one resident who resided in this room.</p> <p>c. In Room 212 the bathroom door sticks and was difficult to open. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013	
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>walls of the door were marred. Two residents resided in this room.</p> <p>d. In Room 213 the caulking around the bathroom sink was cracked. The door protector on the room door was loose. One resident resided in this room.</p> <p>e. In Room 216, the bedside table laminate was scraped and trim was loose with sharp edges. The bathroom door was marred. Two residents resided in this room.</p> <p>f. In Room 218 the baseboard in corner behind bed was cracked. The room door did not stay shut. The walls and bathroom door were marred. The floor was dirty behind the bed. There were two residents who resided in this room.</p> <p>g. In Room 220 the bathroom caulking around the sink was cracked. There was one resident in this room.</p> <p>h. In Room 222 the heater cover was off and there was trash debris in the heater vent. There was one resident in this room.</p> <p>Interview with the Housekeeping Supervisor and Maintenance Manager at that time, indicated all of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the above were in need of cleaning and/or repair.</p> <p>This Federal Tag relates to Complaint IN00127926.</p> <p>3.1-19(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance related to Activities of Daily Living and providing incontinence care through the quality assurance protocol.</p> <p>Findings include:</p> <p>Interview with the Administrator on 5/9/12 at 11:00 a.m., indicated the facility's Quality Assurance Committee meets every month and</p>	F000520	<p>F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS <i>a facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility and at least three other members of the facility staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and</i></p>	06/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2013
NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>consists of herself, the Director of Nursing, and department heads as well as the Medical Director. The Administrator indicated at the time, Activities of Daily Living including providing timely incontinence care had not been addressed or identified as being a problem in Quality Assurance . She indicated there had been no action plan or system put into place to identify the problem of providing timely incontinence care to residents.</p> <p>Further interview with the Administrator indicated when a family member makes a complaint regarding incontinence care or strong urine odors, they would then go and find the CNA responsible and inservice that person. She indicated there was no plan put into place to follow up, however, they recently hired a 3-11 house supervisor to watch over things like that. She further indicated there was no written documentation or audit tool in place to ensure the nurses and the supervisor were monitoring staff to ensure incontinence care was being done timely.</p> <p>3.1-52(b)2</p>		<p>assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were identified that have been affected by this alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents residing currently in our facility who are incontinent of bladder and require assistance by the staff have the potential of being affected by this alleged deficient practice. On May 9 th , 2013 the DON and/ or designee checked the incontinent residents who currently reside in our facility to ensure they have not been affected by this same deficient practice. No other issues were identified. The</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>Nursing staff and the evening House Supervisor were re-educated on 5/14/2013 and 5/15/2013 on the facilities policy and procedure for incontinence care and checking to ensure our residents who are incontinent are kept clean and dry. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The House Supervisor and/or designee will monitor 10 incontinent residents 5 days per week x 1 month the 8 incontinent residents 3 days per week x 5 months using <u>the incontinent resident audit tool</u> to ensure the same alleged deficient practice does not reoccur. Any issued identified will be immediately corrected. The QA committee will follow the outlined QA calander which includes a variety of high risk areas that may require more routine follow up though the QA committee on an ongoing basis. Any other areas identified will be addressed monthly through the QA process. The Administrator and/or designee inserviced the department managers on the new QA calander that will be follow ongoing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Data will be submitted monthly to the QA</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Committee for review and follow up. Actions plans will be developed for thresholds that are not met. Noncompliance with facility procedures will result in education and/or disciplinary action on going.	