

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2012
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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F0000	<p>This visit was for the Investigation of Complaint IN00105332.</p> <p>This survey was done in conjunction with the Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00103446.</p> <p>Complaint IN00105332: Substantiated-Federal and State deficiencies related to the allegations are cited at F156, F253, F282, F309, F314, and F463</p> <p>Survey Dates: March 5, 6, 7, 8, 9, &amp; 12, 2012</p> <p>Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410</p> <p>Survey Team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Janet Adams, R.N. Kathleen Vargas, R.N.</p> <p>Census Bed Type: 67 SNF/NF 67 Total</p> <p>Census Payor Source</p>	F0000	<p>March 28th 2012, 155653100267410000108, Indiana State Department of Health 2 north Meridian Street IN. 46204 Re; Survey event ID R5ED11. To Whom it may concern; On March 12th 2012 the ISDH complaint survey IN00105332 was conducted at Lake County Nursing and Rehab by the Division of Long Term Care, Indiana State Department of Health to determine if the facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The facility recieved 6 F-tag violations. The facility is submitting this plan of correction which does not constitute admission of agreement by the provider of the truth of the faccts alleged or conclusions set forth in the statement of deficieincies. The plan of correction is prepared and/or executed soley related to the provisions of federal and state laws that require it. This letter shall serve as the allegation of compliance effective April 6th 2012. Thank you for your cooperation. Respectfully, Kathlee n B. Robertson Administrator</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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

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

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

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

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

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	<p>the process. The Admissions Director indicated the facility did not start the process until 3/5/12 when the resident and his wife requested to meet with her prior to his discharge home.</p> <p>When interviewed on 3/12/12 at 1:40 p.m., the Administrator indicated the resident/and or his family should have been given information on Medicaid and the facility should have initiated the Medicaid application prior to 3/5/12.</p> <p>When interviewed on 3/11/12, at 6:00 p.m., the resident's family member indicated they were not given the Admission paperwork with the information for applying for Medicaid to sign until 3/5/12.</p> <p>This federal tag relates to complaint IN00105332.</p> <p>3.1-4(f)(1)</p>		<p>meeting. Monitoring will be ongoing. <b>What date will the corrective action be completed? April 6 th 2012</b></p>		

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

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

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

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

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	<p>that had a moderate amount of dust on them.</p> <p>15. On 3/12/12 at 10:10 a.m., the heat register along the wall in the main dining room approximately 40 feet long had a large amount of dried food/beverage spillage and was rusty and full of dust. Continued observation just outside of the Main Dining Room indicated two eight foot sections of the heat register located by the main entrance windows were noted to be dirty and rusty.</p> <p>Interview with the Maintenance Supervisor and The Housekeeping Supervisor on 3/12/12 at 10:25 a.m., indicated all the above was in need of cleaning and/or repair.</p> <p>This Federal Tag relates to Complaint IN00105332</p> <p>3.1-19(f)</p>			

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

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	<p><b>#B, #C, #D, #F, #G, and #L)</b></p> <p>Findings include:</p> <p>1. On 3/5/12 at 12:00 p.m. and 3:00 p.m., Resident #F was observed in her room in bed. The resident's eyes were closed and the resident's television was turned off. There was no radio in the resident's room. There was a geri-chair recliner located at the foot of the resident's bed.</p> <p>On 3/6/12 at 8:30 a.m. and 10:30 a.m., the resident was observed in her room in bed. Again, her television was turned off.</p> <p>On 3/7/12 at 8:39 a.m., 10:40 a.m., 12:43 p.m., and 2:55 p.m., the resident was observed in her in room in bed. The resident's television was turned off. A geri-chair recliner was observed at the foot of the resident's bed.</p> <p>On 3/8/12 at 8:25 a.m., the resident was in her room in bed. The resident's television was not turned on. At 8:34 a.m., CNA #2 entered the resident's room with her breakfast tray. The CNA placed the tray on the resident's overbed table and walked out of the room. At 8:43 a.m., the resident's tray was covered and on</p>		<p><b>facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with treatment orders, body pillows, peg tubes, scratches and supplements are at risk for the alleged deficient practice <b>What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur?</b></b></p> <p>Staff have been in-serviced regarding the following; a) following physicians orders and the plan of care b) providing assistance with meals to those residents who require assistance c) fall prevention interventions are in place such as a body pillow d) residents are to be up out of bed as their medical condition allows e) supplements are provided with meals such as supercereal f) pressure ulcer dressings are in place as ordered g) staff monitor and document skin conditions that are non-pressure related h) staff monitor and document tube feeding sites i) provide activity services such as radio and television stimulation <b>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?</b> The DON or designee will audit three times per week to ensure physicians orders and plan of care were followed with the emphasis on</p>				

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	<p>her overbed table. No staff were in the resident's room at this time. At 8:47 a.m., CNA #2 went into the resident's room and removed her tray. He indicated the resident didn't want to eat, and that she doesn't eat much. The CNA then proceeded back into the resident's room and uncovered the resident's breakfast tray and attempted to feed the resident. The geri-recliner was positioned at the foot of the resident's bed. At 10:00 a.m. and 12:35 p.m., the resident remained in her room in bed. The television remained off and the geri-chair remained at the foot of the resident's bed.</p> <p>On 3/12/12 at 8:30 a.m. and 9:50 a.m., the resident was observed in her room in bed. Again, the television was turned off and the geri-chair recliner was located at the foot of the bed.</p> <p>The record for Resident #F was reviewed on 3/8/12 at 9:00 a.m. The resident's diagnoses included, but were not limited to, aphasia and cerebral vascular accident (stroke).</p> <p>The plan of care, dated 12/20/11, indicated the resident had impaired mobility and cognition, and required staff assist with all transfers. The</p>		<p>tube feeding, assistance with meals (supercereal provided), fall preventions interventions in place, residents up out of bed, pressure ulcer dressings are in place, skin conditions monitoring and that staff provide activity services such as radio and television stimulation. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>				

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

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

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	<p>was to be cleansed daily with normal saline or wound cleanser, pat dry. Apply santyl ointment to wound bed and cover with dry dressing daily.</p> <p>A physician's order, dated 3/9/12, indicated the resident's right trochanter was to be cleansed with normal saline or wound cleanser and apply silvadene. The area was to be covered with a dry dressing daily.</p> <p>The plan of care, dated 12/3/11, indicated the resident had an alteration in his skin integrity as evidenced by having a pressure ulcer. The interventions indicated the areas were to be treated per the physician's order.</p> <p>Interview with the Treatment Nurse on 3/12/12 at 8:45 a.m., indicated, that she had not been informed the resident had removed his dressing during the midnight shift. She indicated she would ensure the correct dressing was applied.</p> <p>3. The closed record for Resident #B was reviewed on 3/7/12 at 9:18 a.m. The resident was admitted to facility on 1/20/12 from the hospital with a PEG tube.</p> <p>Review of Physician Orders, dated 2/1/12, indicated apply normal saline</p>			

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	<p>to PEG tube site, pat dry and apply dry dressing daily.</p> <p>Review of the Treatment Administration Record (TAR), dated 1/20-2/20/12, indicated the order for the PEG tube site to be cleansed everyday with normal saline and cover with dry dressing was not transcribed onto the TAR. There was no evidence this had been done everyday as ordered by the Physician.</p> <p>Interview with LPN #5 on 3/9/12 at 3:13 p.m., indicated at the time of the resident's discharge from the facility there was no dressing around the PEG tube site.</p> <p>4. On 3/05/2012 at 11:08 a.m., Resident #C was observed with red areas of scratches to the right ankle area as well as left ankle.</p> <p>On 3/7/12 at 8:20 a.m., the resident was observed with red scratch marks noted at the bottom of both of her legs.</p> <p>On 3/7/12 at 3:03 p.m., the resident was observed sitting in her wheelchair in her room. LPN #6 was observed at the time assessing the resident's bilateral lower extremities. The right</p>			

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	<p>lower extremity was swollen with pitting edema noted as well as dry skin noted. There were multiple scabbed areas noted throughout her foot and lower leg with scratch marks. The left lower extremity was also noted to be red with dry skin and had multiple scabbed areas throughout as well as scratch marks. At that time, the resident was asked if she scratched her legs and she indicated yes she does every night. She indicated her legs itched all the time.</p> <p>The record for Resident #C was reviewed on 3/7/12 at 8:46 a.m. The resident's diagnoses included but were not limited to, anemia, allergic dermatitis, peripheral vascular disease and cellulitis to left foot.</p> <p>Review of the current plan of care, dated 6/12/11 and updated on 1/19/12, indicated the resident has allergic dermatitis. The nursing approaches were to encourage the resident not to scratch and to notify nurse if itching develops or increases.</p> <p>Review of the current plan of care, dated 6/12/11 and updated on 1/19/12, indicated the resident was at risk for skin breakdown related to peripheral vascular disease, and scratching skin causing it to bleed at</p>			

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	<p>times. The nursing approaches were to do skin checks daily with a.m., care and full body checks to be done twice weekly on shower days.</p> <p>Review of Nursing Progress Notes, dated 3/1/12 at 1:10 p.m., indicated the resident's right leg was pink with scabbed areas.</p> <p>Review of Nursing Progress Notes, dated 3/1/12 at 8:36 p.m., indicated the resident's left lower leg had multiple scabbed areas from resident previously scratching and the right lower extremity had multiple open areas that were now starting to scab over.</p> <p>Review of Nurses Notes, dated 3/6/12 2:14 a.m., indicated the resident's bilateral lower extremities were pink in color and cool to touch with multiple scabbed areas.</p> <p>Review of the Bath and Skin Report Sheet, dated 3/1 and 3/7/12, indicated the resident's skin was intact with no redness, rashes or excoriation. The skin check was completed by the shower aide and the LPN. Interview with LPN #6 who completed both assessments on the shower sheets indicated he had thought that only new areas were to</p>			

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	<p>be identified on the sheets.</p> <p>Interview with the Director of Nursing on 3/9/12 at 8:12 a.m., indicated the bath and skin sheets should be completed with the resident's current skin conditions including rashes, excoriation, skin tears and bruising .</p> <p>5. On 3/7/12 at 8:13 a.m., Resident #L was observed sitting at a table in the Main Dining Room. The resident was served his breakfast tray of a hard boiled egg, biscuits, and a bowl of raisin bran cold cereal. He did not receive any Supercereal (a fortified hot cereal) with his meal tray. Supercereal was not offered to the resident during the meal service.</p> <p>On 3/8/12 at 7:56 a.m., the resident was observed sitting in a wheel chair at a table in the Main Dining Room. The resident was served his breakfast tray at 8:02 a.m. There were two hard boiled eggs, toast, sausage, and a bowl of a raisin bran cold cereal. There was no Supercereal served to the resident. The tray card that was served with the meal tray indicated the resident was to receive Supercereal at breakfast. The resident left the Main Dining Room at 8:20 a.m. and had not received or been offered any Supercereal.</p>						

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	<p>On 3/12/12 at 8:18 a.m., the resident was sitting in a wheel chair in the Main Dining Room. The resident was served his breakfast tray at this time. The resident received two hard boiled eggs, toast, and a bowl of raisin bran cold cereal. The resident was not served or offered any Supercereal during the meal. The tray card served with the meal tray indicated the resident was to receive Supercereal at breakfast.</p> <p>The record of Resident #L was reviewed on 3/7/12 at 2:32 p.m. The resident's diagnoses included, but were not limited to, convulsions, dysphagia (difficulty swallowing), depressive disorder, anemia, and anxiety disorder. The current Physician orders indicated the resident was to receive a Regular diet with Supercereal at breakfast. The order was initially written on 11/29/11.</p> <p>When interviewed on 3/12/12 at 1:08 p.m., the Director of Nursing indicated the resident should have received the Supercereal as ordered by the Physician.</p> <p>6. Resident #G was observed on 3/7/12 at 8:14 a.m., in bed, the resident was awake. There was no</p>			

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	<p>body pillow in the residents bed.</p> <p>The resident was observed in bed on 3/7/12 at 10:24 a.m., the resident was close to the edge of the bed. Interview with the MDS Coordinator at that time, indicated that she was getting help to reposition the resident in the bed. There was no body pillow in the bed.</p> <p>Continued observations of the resident in the bed on 3/7/12 at 12:41 p.m. and 2:55 p.m., indicated there was no body pillow in the bed.</p> <p>Observation of the resident in bed on 3/8/12 at 8:16 a.m., indicated there was no body pillow in the bed.</p> <p>The resident was observed in bed on 3/8/12 at 1:14 p.m. There was no body pillow in the bed. Interview with the MDS Coordinator at that time, indicated there was no body pillow in the bed.</p> <p>The record for Resident #G was reviewed on 3/8/12 at 9:45 a.m. The resident had diagnoses that included, but were not limited to, convulsions, hemiplegia, and dementia.</p> <p>There was a care plan, dated 11/2/11, that indicated the resident was at risk</p>			

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	<p>for falls due to diagnosis of hemiplegia, CVA (cerebral vascular accident-stroke), and that the resident at times would state that he purposely put himself on the floor. The interventions to reduce the risk of falls included:</p> <ul style="list-style-type: none"> <li>-body pillow when in bed (initiated 3/5/12)</li> <li>-assist out of bed during p.m. shift</li> <li>-assist out of bed daily</li> <li>-resident to use bariatric bed</li> <li>-bed bolsters to bed to assist in positioning (initiated 1/18/12)</li> <li>-keep bed in lowest position</li> <li>-keep bed arranged so nightstand is not directly next to bed</li> <li>-floor mat at bedside</li> </ul> <p>Interview with CNA #4 on 3/9/12 at 2:15 p.m., indicated each resident had a care card in the room that indicated any special needs, such as fall devices, how much assistance was needed to transfer, and continence. Review of the care card for Resident #G, indicated the resident was a fall risk and staff were to use a body pillow, get him up in the p.m., use bed bolsters and keep the bed in the lowest position</p> <p>Interview with The MDS Coordinator on 3/8/12 at 1:24 p.m., indicated the Director of Nursing had indicated the</p>			

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	<p>resident's body pillow was soiled and had been sent to laundry. She indicated there were no other body pillows to be used while the soiled one was being cleaned. She indicated the resident should have a body pillow to prevent falls from the bed. She indicated the resident's care plan had interventions for a body pillow to be used to prevent falls, she indicated the care plan was not followed.</p> <p>This Federal tag relates to Complaint #IN00105332.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident's with non pressure ulcers related to bruises, skin tears, rashes, and scratch marks were assessed and the areas were monitored to prevent further skin issues from arising for 3 of 3 residents reviewed for skin condition non pressure related of the 5 who met the criteria for skin condition non pressure related. The facility also failed to ensure resident's were monitored for bowel management related to adverse side effects/consequences from taking narcotic medication for 1 of 11 resident's reviewed for unnecessary medications(Resident's #C, #D, #E, and #H)</p> <p>Findings include:</p> <p>1. On 3/05/2012 at 11:08 a.m., Resident #C was observed with red areas of scratches to the right ankle</p>	F0309	<p><b>Lake County Nursing and Rehab F309 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? RC was treated with Keflex antibiotic and Benadryl. On 3/22/2012 the physician assessed and documented improvement RE has been discharged home RD was assessed during the survey and will be assessed per policy RH has been discharged home without complication <b>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents with bruises, scratches, non-pressure ulcers and utilize narcotics are at risk for the alleged deficient practice <b>What</b></b></b></p>	04/06/2012

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	<p>area as well as left ankle.</p> <p>On 3/7/12 at 8:20 a.m., the resident was observed with red scratch marks noted at the bottom of both of her legs.</p> <p>On 3/7/12 at 3:03 p.m., the resident was observed sitting in her wheelchair in her room. LPN #6 was observed at the time assessing the resident's bilateral lower extremities. The right lower extremity was swollen with pitting edema noted as well as dry skin noted. There were multiple scabbed areas noted throughout her foot and lower leg with scratch marks. The left lower extremity was also noted to be red with dry skin and had multiple scabbed areas throughout as well as scratch marks. At that time, the resident was asked if she scratched her legs and she indicated yes she does every night, she indicated her legs itched all the time.</p> <p>Interview with LPN #6 on 3/7/12 at 3:08 p.m., indicated the resident did not have anything ordered for her complaints of scratching or itching. The LPN indicated there was a topical cream ordered, but nothing in place such as a medication to prevent the resident from scratching her legs all the time.</p>		<p><b>measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur?</b> Staff have been in-serviced regarding the following; a) ensure residents with non-pressure ulcers related to bruises, skin tears, rashes and scratches are assessed and monitored to prevent further skin concerns from arising. b) ensure residents are monitored for bowel management related to adverse side effects/consequences related to side effects of taking narcotics <b>What quality assurance plans will be used to monitor the facilities performance to ensure corrections are achieved and permanent?</b> The DON or designee will audit three times weekly to ensure that residents with non-pressure ulcers such as bruises, skin tears, rashes and scratches have been identified, assessed and documented in the medical record. The DON or designee will further audit bowel patterns three times per week for residents receiving Opiod's that may cause. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be</p>		

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	<p>The record for Resident #C was reviewed on 3/7/12 at 8:46 a.m. The resident's diagnoses included but were not limited to, anemia, allergic dermatitis, peripheral vascular disease and cellulitis to left foot.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 1/19/12, indicated the resident was alert and oriented and was able to understand as well as be understood. The resident had no pressure ulcers, but had applications of ointments/medications to her skin other than to feet.</p> <p>Review of the current plan of care, dated 6/12/11 and updated on 1/19/12, indicated the resident has allergic dermatitis. The nursing approaches were to encourage the resident not to scratch and to notify nurse if itching develops or increases.</p> <p>Review of the current plan of care, dated 6/12/11 and updated on 1/19/12, indicated the resident was at risk for skin breakdown related to peripheral vascular disease, and scratching skin causing it to bleed at times. The nursing approaches were to do skin checks daily with a.m., care and full body checks to be done twice</p>		ongoing.	

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

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

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

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

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

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

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

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

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

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

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

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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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	<p>recording bowel movements indicated the first entry was made on 2/16/12. The following were the only entries made from 2/16/12 through 2/23/12.</p> <p>2/16/12 at 1:26 a.m.- "none" 2/16/12 at 7:34 a.m.- "none" 2/17/12 at 2:45 a.m.- "none" 2/18/12 at 1:37 a.m.- "none" 2/19/12 at 3:50 a.m.- "none" 2/20/12 at 1:22 a.m.- "none" 2/21/12 at 1:49 a.m.- "unavailable/not taken" 2/21/12 at 10:12 p.m.- "none" 2/22/12 at 8:12 p.m.- "none"</p> <p>When interviewed on 3/12/12 at 10:00 a.m., the Restorative Nurse indicated staff are to record the resident's bowel movement every shift on the vital signs record to indicate if the resident had a bowel movement every shift.</p> <p>This Federal Tag relates to Complaint IN00105332</p> <p>3.1-37(a)</p>			

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

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

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	<p>pressure ulcers and had one or more unhealed pressure ulcers at a Stage 1 or higher. The area was identified as unstageable area and was present on admission. The area measured 4.3 centimeters (cm) x 3.7 cm.</p> <p>The plan of care, dated 12/3/11, indicated the resident had an alteration in his skin integrity as evidenced by having a pressure ulcer. The interventions indicated the areas were to be treated per the physician's order.</p> <p>The Skin Integrity Sheet, dated 3/9/12, indicated the area to the right trochanter was a Stage 2 and measured 3 cm x 1 cm x 0.1 cm. No sheets were provided for the coccyx area.</p> <p>Interview with the Treatment Nurse on 3/12/12 at 8:45 a.m., indicated, that she had not been informed the resident had removed his dressing during the midnight shift. She indicated she would ensure the correct dressing was applied.</p> <p>This federal tag is related to Complaint IN00105332.</p> <p>3.1-40(a)(2)</p>			

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F0463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the facility failed to ensure a functioning call system was in working condition in 1 of 20 rooms observed related to the emergency call system in a bathroom. (Rooms 214)</p> <p>Findings include:</p> <p>1. On 3/05/2012 at 2:50 p.m., the emergency call light system in the bathroom of Room 214 was not working. At that time, the CNA indicated the emergency call light did not light up outside of the resident's room or light up at the nurse's station.</p> <p>On 3/6/12 8:17 a.m., the emergency call light in bathroom in Room 214 was still not functioning.</p> <p>Observation on 3/12/12 at 10:01 a.m., in Room 214, the Maintenance Supervisor was observed turning on the emergency call light in the bathroom. The call light did not light up outside of the room or at the nurses station. He further indicated</p>	F0463	<p><b>Lake County Nursing and Rehab F463 POC Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Room 214 call light has been fixed How will the facility identify other residents having the potential to be affected by the same alleged deficient practice? All residents are at risk for the alleged deficient practice What measures will the facility take systems the facility will alter to ensure that the problem will be corrected and will not recur?</b></p> <p>Staff have been in-serviced regarding the following; a) ensuring each resident has a functioning call system in working condition both in their room and bathroom b) notifying maintenance with any malfunctioning system is noted <b>What quality assurance plans</b></p>	04/06/2012			

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	<p>the call system was not functioning. Further interview with the Maintenance Supervisor at that time, indicated he was not made aware the emergency call light was not working.</p> <p>This Federal Tag relates to Complaint IN00105332</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>		<p><b>will be used to monitor the facilities performance to ensure corrections are achieved and permanent?</b> The Administrator or designee will audit twice weekly to ensure call systems are in working order in resident rooms and bathrooms. A summary of the findings will be presented to the Quality Assurance Committee monthly by the Administrator or designee for three months. Thereafter, if determined by the Quality Assurance Committee, monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p>		