

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2013
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NAME OF PROVIDER OR SUPPLIER  LAKE COUNTY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F000000	<p>This visit was for the Investigation of Complaints IN00124258 and IN00124801.</p> <p>Complaint IN00124258-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F314.</p> <p>Complaint IN00124801-Substantiated. Federal/state deficiency related to the allegations is cited at F514.</p> <p>Survey dates: February 25 &amp; 26, 2012.</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 6 Medicaid: 68 Other: 2</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.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after March 28th, 2013.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Total: 76</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on March 1, 2013, by Janelyn Kulik, RN.</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the Physician was notified of dietary recommendations for supplements to aid wound healing for 1 of 3 residents</p>	F000157	<p><b>F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC)</b></p> <p>§483.10(b)(11) -- Notification of changes. (i) A facility must immediately inform the resident;</p>	03/28/2013			

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	<p>reviewed for pressure ulcers in the sample of 7. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 2/25/13 at 9:45 a.m. The resident was admitted to the facility on 7/2/12. The resident's diagnoses included, but were not limited to, cerebral vascular disease, dysphagia (difficulty swallowing), dementia, diabetes mellitus, and rheumatoid arthritis.</p> <p>The resident was sent to the hospital on 7/7/12 and was readmitted to the facility on 8/10/12. Four "Skin Integrity Condition" reports were completed on 8/13/12. The first report indicated a Stage II pressure ulcer (an ulcer with partial thickness loss of dermis presenting as a shallow open area with a red/ pink ulcer bed) was observed to the resident's right buttock area on 8/10/12. The report indicated the right buttock pressure ulcer measured 0.9 cm (centimeters) x (by) 0.7 cm x &lt;0.1 cm. The second report indicated an Unstageable pressure ulcer (an ulcer with full thickness tissue loss with the base of the ulcer covered by slough (necrotic or avascular tissue in the</p>		<p><b>consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is-- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a). (ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is-- (A) A change in room or roommate assignment as specified in §483.15(e)(2); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. (iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been</b></p>		

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	<p>process of separating from viable tissue) and/or eschar(thick leathery necrotic tissue) was observed to the resident's right heel on 8/10/12. The report indicated the right heel pressure ulcer measured 5.5 cm x 4.0 cm. The third report indicated a Stage II pressure ulcer was observed on the resident's left coccyx area on 8/10/12. The report indicated the left coccyx pressure ulcer measured 1.5 cm x 2.5 cm x &lt;0.1 cm. The fourth report indicated a Stage IV (an ulcer with full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer was observed to the right achilles on 8/10/12. The right achilles pressure ulcer measured 6.0 x 2.0 cm x 0.1 cm.</p> <p>A Dietary Progress note was completed by the Registered Dietitian on 8/16/12. The note indicated the Dietitian recommended the resident's tube feeding be increased to 75 cc (cubic centimeters) an hour for 20 hours a day. The progress note also indicated the Dietitian recommended the resident receive Pro-Stat (a liquid protein supplement) 30 cc's daily and MVI (a multivitamin) with minerals to aid in wound healing.</p> <p>The 8/2012 Nursing Progress Notes were reviewed. An entry made on</p>		<p><b>affected by the deficient practice</b></p> <p>Resident #D Registered Dieticians recommendations were completed and the physician was notified.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>Residents who currently reside at the facility with dietary recommendations are at risk to be affected by the same alleged deficient practice.</p> <p>All dietary recommendations for the month of February were audited by the Director of Nursing and/or designee to ensure all the recommendations were followed and the physicians were notified. Any issues were immediately addressed.</p> <p>Nurses were reeducated by the Director of Nursing and/or designee on 2/25/2013 and 3/5/2013 on following through on the dietary recommendations and notifying the physician.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p>				

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	<p>8/21/12 at 3:19 p.m. indicated the Physician was made aware of the Registered Dietitian's recommendations to increase the tube feeding and start Pro-Stat and a multivitamin daily.</p> <p>When interviewed on 2/26/13 at 1:00 p.m., the Director of Nursing indicated the Registered Dietitian currently places copies of her recommendations in the mailboxes of the Director of Nursing, the Assistant Director of Nursing, and the Dietary Manager. The Director of Nursing indicated prior to November 2012, the Wound Nurse was responsible for addressing the recommendations. The Director of Nursing indicated the recommendations should be addressed in a timely manner.</p> <p>This federal tag relates to Complaint IN00124258.</p> <p>3.1-5(a)(3)</p>		<p>The Director of Nursing and/or designee will continue to audit the dietary recommendations 100% x 4 weeks then 75 % ongoing to ensure ongoing compliance.</p> <p><b>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</b></p> <p>The Director of Nursing and/ or designee will use the start up log to audit ongoing to ensure continued compliance. Any issues found will be immediately corrected during the review.</p> <p>The audits will be submitted to the QA Committee for review as indicated. An action plan may be developed for identified issues.</p> <p>§ Noncompliance with facility procedures will result in education and/or disciplinary action.</p>		

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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 wound treatments were in place as ordered for 1 of 3 residents reviewed for pressure ulcers in the sample of 7. (Resident #F)</p> <p>Findings include:</p> <p>During Orientation Tour on 2/25/13 at 9:25 a.m., Resident #F was observed in bed. A staff member was feeding the resident breakfast. There was a low air loss mattress to the resident's bed. The Director of Nursing was present at this time and indicated the resident had a pressure ulcer to the coccyx area.</p> <p>On 2/25/13 at 9:50 a.m., Resident #F was observed in bed. The ADON (Assistant Director of Nursing) and</p>	F000314	<p><b>F314 TREATMENT AND SERVICES TO PREVENT PRESSURE SORES. in accordance with the comprehensive assessment and plan of care.</b></p> <p>Based on the comprehensive</p>	03/28/2013			

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	<p>LPN #1 turned the resident to her side and removed her incontinence brief. The resident had an open pressure area to her coccyx. The area measured approximately 1.0 cm (centimeter) x (by) 1.0 cm. There was no drainage observed from the ulcer. There was also an superficial circular open area to the left inner mid buttock area. The area was approximately 1 cm x 1 cm x &lt;0.1 cm. The wound was moist and red in color. There was no drainage observed from the wound. There were no dressings covering either of the open areas. There were no dressings observed in the resident's brief or anywhere in the resident's linens or bed.</p> <p>On 2/25/13 at 4:00 p.m., the resident was observed in bed. The Wound Nurse was present and repositioned the resident to observe her dressing. The dressing from the coccyx area had peeled off. There was no dressing on the red open area to the resident's left inner buttock area. When interviewed at this time, the Wound Nurse indicated she did not observe an open area to the buttock when she completed the treatment to the coccyx this morning. The Wound Nurse indicated the area was a Stage II ulcer (an ulcer with partial thickness loss of the dermis of the skin</p>		<p><b>Assessment of a resident, the facility must ensure that-- (1) 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 (2) A resident having pressure sores receives 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</b>Resident F area was assessed by a licensed professional nurse. The Physician was notified. New treatment orders were obtained . The Director of Nursing Services re-educated nursing staff on 2/25/13 and on 3/5/13 to notify the nurse when treatment orders are put into place. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> Residents who currently reside at the facility with wounds are at risk to be affected by the same alleged deficient practice. During the survey residents with wounds were checked to ensure the dressings were in place. No further issues were observed. A skin sweep was conducted on all</p>		

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	<p>presenting as a shallow open ulcer with a pink/red ulcer bed).</p> <p>The record for Resident #F was reviewed on 2/25/13 at 11:35 a.m. The resident's diagnoses included, but were not limited to, sacral pressure ulcer, urinary tract infection, Huntington's Chorea, high blood pressure, acute kidney failure, and convulsions.</p> <p>Review of the current 2/2013 Physician orders indicated there was an order to cleanse the coccyx ulcer with normal saline or wound wash, apply a moistened Prisma dressing to the wound bed and cover the area with foam and a dry dressing. The order indicated the treatment was to be completed every three days.</p> <p>The resident's record was reviewed again on 2/26/13 at 8:30 a.m. There was a new Physician's order written on 2/25/13. This order was to cleanse the left buttock area with normal saline or wound cleanser and apply a hydrocolloid dressing to the area every three days.</p> <p>When interviewed on 2/25/13 at 10:15 a.m., CNA #1 indicated he provided incontinence care for the resident at approximately 6:30 a.m.</p>		<p>the residents who reside at the facility. Any issues that were found were addressed. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> The Director of Nursing and/or designee will complete a skin assessment on 2 residents X 4 weeks then 5 monthly ongoing to ensure accurate skin assessments were completed. The Director of Nursing and/or designee will review 10 dressings weekly x 4 then 5 monthly ongoing to ensure continued compliance as indicated until QA determines compliance is met. <b>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</b> The Director of Nursing and/or designee will review 10 dressings weekly x 4 then 5 weekly ongoing to ensure continued compliance. The audit tools will be submitted to the QA Committee for review and follow up as indicated. Actions plans will be developed for thresholds that are not met. Noncompliance with facility procedures will result in education and/or disciplinary action.</p>		

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	<p>The CNA indicated when he removed the residents diaper the dressing came off . The CNA indicated he forgot to tell the nurse at that time. The CNA indicated he changed the resident again at approximately 8:20 a.m. and no dressing was observed.</p> <p>When interviewed on 2/25/13 at 10:30 a.m., LPN #1 indicated she was caring for the resident today. The LPN indicated she had not assessed or observed the resident's coccyx today prior to observing the resident this morning at 9:50 a.m. with the surveyor. The LPN indicated she was not informed the resident's dressing was not in place to the coccyx ulcer.</p> <p>When interviewed on 2/26/13 at 2:00 p.m., LPN #1 indicated she cared for the resident on 2/24/13 also. The LPN indicated she completed the treatment to the resident's coccyx area that day. The LPN indicated she did not observe any other open areas to the resident's buttock areas at that time.</p> <p>When interviewed on 2/26/13 at 2:05 p.m., the Director of Nursing indicated a dressing should have been on the coccyx wound. The Director of Nursing indicated she had observed the area on the resident's buttock and</p>			

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	<p>indicated she felt the area could have been caused from tape coming off a dressing.</p> <p>When interviewed on 2/16/13 at 2:15 p.m., the Wound Nurse indicated the wound care Physician was in to see the resident today. The Wound Nurse indicated the Physician's progress notes were not in the residents record at this time. The Wound Nurse indicated she spoke with the Physician and he indicated the area could have been caused by tape removal.</p> <p>This federal tag relates to Complaint IN00124258.</p> <p>3.1-40(a)(2)</p>				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure personal inventory records of the resident's belonging were completed for 1 of 1 resident reviewed for documentation of items upon recent admission to the facility in the sample of 7. (Resident #G)</p> <p>Findings include:</p> <p>The closed record for Resident #G was reviewed on 2/25/13 at 1:00 p.m. The resident was admitted to the facility on 12/9/12 and sent to hospital on 1/9/13. The resident returned to the facility on 1/16/13. There was no record of any personal inventory list of the resident's clothing or belongings upon admission to the</p>	F000514	<p><b>F 514 RESIDENT RECORDS – COMPLETE/ACCURATE/ASSES SIBLE</b> The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments, the plan of care and services provides; the results of any preadmission screening conducted by the state and progress notes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>	03/28/2013			

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	<p>facility.</p> <p>When interviewed on 2/26/13 at 12:00 p.m., the facility Administrator indicated the resident's items were to be listed electronically upon admission. The Administrator indicated there was no record of Resident #G's personal items brought to the facility upon admission or any record of the return of any items upon the resident's discharge.</p> <p>This federal tag relates to Complaint IN00124801.</p> <p>3.1-50(a)(1)</p>		<p><b>practice</b> Resident G no longer resides at the facility but the facility attempted to reach the family to replace the items that were reported missing without success. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> Residents who reside at the facility with personal items are at risk to be affected by the same alleged deficient practice. The current residents who are residing at our facility have had a new or updated personal inventory sheet completed. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> The nursing staff was re educated on completion of the personal inventory sheet upon admission on 2/25/2013 and 3/5/2013. <b>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</b> The Director of Nursing and/or designee will audit 100 % of all the new admission personal inventory sheets x 4 weeks and then 75 % ongoing using the personal inventory audit tool to ensure continued compliance The audit tools will be submitted to the QA Committee for review and follow up as</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 02/26/2013
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			indicated. Actions plans will be developed for thresholds that are not met. Noncompliance with facility procedures will result in education and/or disciplinary action.	