STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING _____ B. WING _____	**04/28/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide treatment as ordered, secure Physician orders and complete routine wound assessments necessary to promote healing of existing pressure ulcers for 3 of 3 residents reviewed for pressure ulcers. (Residents D, E, and F) Findings include: 1. Resident D was observed in his bed on 4/28/20 at 12:23 p.m. His right foot was wrapped in Kerlix gauze. The Kerlix had separated, exposing a red, beefy wound around the heel. The sheets around the foot of his bed were soiled with red and yellowish drainage. The resident's record was reviewed on 4/28/20 at 12:05 p.m. A Physician's order, dated [DATE]6/20, indicated the right ankle should be cleansed with normal saline, then place foam and negative pressure wound therapy at 125 mm (a wound vac), to be changed three times a week. There was no indication the order had been discontinued. There was no Physician order for [REDACTED]. She observed the dislodged dressing and wound at that time and instructed the nurse to change the dressing. She indicated there were no orders written to discontinue the wound vac or for new treatment to the right foot. She contacted the wound nurse by phone and indicated she would clarify orders. 2. Resident E was observed in bed on 4/28/20 at 1:50 p.m. He had a dressing to his right and left ankles, both dated 4/28, and was wearing protective padded boots. The resident's record was reviewed on 4/28/20 at 1:00 p.m. A Physician's order, dated [DATE]5/20, indicated the left ankle was to be cleansed with normal saline and a foam dressing applied three times a week. A Physician's order, dated 4/24/20, indicated the right ankle was to be cleansed with normal saline and a foam dressing applied three times a week. The Readmission Full Body Assessment, dated [DATE]5/20, did not indicate wounds to the ankles. The Weekly Skin Assessment, completed [DATE], did not indicate wounds to the ankles. There was no documentation or assessment of the ankle wounds. During an interview with the Administrator on 4/28/20 at 1:52 p.m., she indicated the wounds should be documented under the Weekly Skin Assessments. 3. Resident F was observed in bed on 4/28/20 at 2:55 p.m., her right heel and foot were wrapped in Kerlix gauze and she was wearing protective padded boots. The resident's record was reviewed on 4/28/20 at 2:28 p.m. A Physician's order, dated [DATE]3/20, indicated the right heel was to be cleansed with normal saline, apply calcium alginate and wrap with Kerlix gauze every other day for [DIAGNOSES REDACTED]. A Care Plan, dated 1/13/20, was in place for a pressure ulcer to her heel. A Weekly Skin Observation, dated 1/13/20, indicated a new DTI was found on her right heel. The next Weekly Skin Observation was dated 2/28/20 related to the DTI on the right heel with measurements included. There were no additional assessments on the right heel. During an interview with the Administrator at the time of observation, she was notified there were only two assessments of the heel in the resident's record. She indicated the wound nurse was responsible for doing the Skin Observations weekly, but she was going to do a house sweep of wounds today. The policy titled, Pressure/Skin Breakdown Clinical Protocol, dated January 2017, was received from the Administrator as current on 4/28/20 at 2;30 p.m. The policy indicated, 2. In addition, nurses shall assess and document/report the following: a. Full assessment of the skin condition including but not limited to location, stage or partial/full thickness, length, width and depth, presence of exudates or necrotic tissues . 7. The physician will authorize pertinent orders related to wound treatments, including pressure redistribution surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, ect) and application of topical agents This Federal tag relates to Complaint IN 978. 3.1-40

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.