STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145809	A. BUILDING _____ B. WING _____	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COOK TERRACE NURSING CTR	263 SKOKIE BOULEVARD NORTHBROOK, IL 60062

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F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint #1093801/IL49737 - No deficiency.	F 000		
F 221 SS=D	Licensure Survey for Subpart S: SMI 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide documentation on the least restrictive restraints tried, time frames for use, assessment of effectiveness for 3 residents (R9, R17, R19) using a lap belt, and/or failed to assess and obtain orders for the use of the bolster pads for 3 of 6 residents (R9, R17, R19) reviewed for restraints in a sample of 24 and 15 residents (R25 through R37) of the supplemental sample. Findings include: 1) On 8/23/11 through 8/26/11, every day of the survey and all day long, R9 was propelling herself throughout the facility in her wheel-chair. R9 had a lap belt that went across her waist and tied behind her wheel-chair. R9 is severely demented and is non-verbal. As she would propel herself through the halls of the facility, she would grab	F 221		10/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1 people, other wheel-chairs, carts, anything or anyone who would get within arms reach. Physician order sheet documented an order dated 8/2/11 for a restraint belt on wheel-chair. Initial assessment (8/2/11)documents use of a safety lap belt to prevent injury to self and others. There was no documentation found for a least restrictive device tried prior to the lap belt or time frames for its use. 2) On 8/24/11 at 3 p.m. R19 was laying in the bed with her husband (Z1) at the bedside. R19 was not interviewable and orient to self only. There were bolster pad on each side of her body preventing her from getting out of the bed. The pads do not deflate when pressure is applied. Z1 stated R19 has the bolster pad because she fell out of bed one time. Z1 stated the lap belt is used when R19 is up in the wheel-chair and it has been used since the beginning of admission. On 8/25/11 at 8/25/11 at 11:15 a.m., R19 was in the bed with the bolster pad on each side of her. R19 was moving around in the bed, her legs were bent up toward her body and she had removed her pants and adult incontinent brief. E4, the assigned C.N.A.(certified nurse aide) and E5 (nurse aide) were asked why R19 was in bed. E4 stated another staff person must of put her to bed. E4 stated R19 has the bolster pad due to falling out of bed and has used them for a while. E4 stated the lap belt is applied when R19 is up in wheel-chair and has been used since admission. On 8/25/11 at 11:50 a.m., R19 was up in her wheel-chair with lap belt around her waist and	F 221		

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F 221	Continued From page 2 tied in the back of the chair as she was pushed in wheel-chair by Z1. Restraint assessment dated 8/3/11 documents the safety lap belt in use when in wheel-chair and is used for to prevent injury to self and from falling. There was no assessment provided on the bolster pads nor was there an order. There was no assessment of a least restrictive device used prior to the lap belt. 3) On 8/23/11 between 9:35 a.m. to 10:33 a.m. during the initial tour of the South Unit with E3 (Assistant Director of Nursing), the bilateral bolster pads were in the beds with the residents, R27 and R8. On 8/25/11 at 3 p.m., R32 was in the bed with bilateral bolster pads in place. Review of the minimum data set (MDS) dated 7/28/11 for R8 documents two person extensive assistance for transfer and the MDS dated 8/9/11 for R19 documents one person extensive assistance for transfer. 4) On 8/23/11 at 10 a.m. during the initial tour, R17 was observed in dining room in wheelchair with safety lap belt tied on back of wheelchair. R17 has a diagnoses of dementia with anxiety and history of falls per the P.O.S.. Review of the restraint assessment dated 2/3/11 documents the safety lap belt is used to prevent injury and falls due to poor safety awareness and poor cognition. MDS dated 8/4/11 documents one person extensive assist with transfers and two person	F 221		

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F 221	Continued From page 3 extensive assist with ambulation when in hall. There is no documentation found for less restrictive device prior to the use of safety lap belt. R17 has a difficulty following directions and attempts to get up with out assist. On 8/26/11 at 12:00 p.m. R17 was observed in the dining room with safety lap belt on tied in back of wheelchair On 8/25/11 at 10:38 a.m., E2 (director of nursing) stated the least restrictive restraints used in the facility are bolster pads and the halos (round device at the side of the bed) in the beds. The least restrictive restraint in the wheel-chairs are the anti-tip devices on the wheel-chairs, an A-pad (inverted wedge used on the wheel-chair seat to prevent sliding out of chair) and the airplane-style safety belt for cognitively aware residents. For cognitively impaired residents, the anti-tippers on the wheel-chair, the A-pad on the seat of wheel-chair and an activity board. If these fail, the facility will go to a lap top cushion. On 8/25/11 at 3:15 p.m. and again on 8/26/11 at 9:20 a.m., E2 stated that when the physician was in the facility, he ordered and wanted the restraints on these residents. E2 stated there was no time to assess for least restrictive device. E2 stated the bolster pad are not assessed nor is there an order obtained because they are not considered a restraint. E2 provided a list of 15 residents who use the bolster pad, R25 through R37, R19 and R8.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		10/3/11

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to develop a comprehensive care plans for psychotropic medications and for delusional thinking for one resident (R11) of 10 reviewed for psychoactive medications in a sample of 24. Findings include: During initial tour on 8/23/11 at 10:10 AM with E9(Care Plan Coordinator), R11 observed lying in his bed with shoes and clothes on. Resident alert and oriented to name and place. Resident morbidly obese (weight 430 pounds).	F 279		

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F 279	Continued From page 5 During interview with R11 at 10:12 AM, resident stated he does not attend groups or activities because he likes to be alone. Resident stated he has been here for five years. Resident states that he may occasionally attend bingo or arts and crafts. On 8/24/11 at 11:AM, R11 said, "It's a couple of people that I want to hit because they (one female resident and one male resident) push my buttons. Resident stated he told the nurse and talked to one counselor about it. Resident stated the "voices" were telling me hurt them. Resident stated he told them to call the doctor and ask him to start him back on Haldol because of the voices. E7(PSRC) on 8/24/11 at 11:15 AM, stated that R11 had complained to staff of anger towards two residents and wanted to hurt them because they angered him. E7 stated resident requested nurse to call doctor to start him back on Haldol for the voices which tell him to hurt others. On 8/24/11 at 11:15 AM, E8(Nurse) stated that R11 complained of voices to nurse and doctor was notified. E8 showed surveyor nurses notes documenting phone calls to doctor about resident complaining of auditory hallucination with commands to hurt other residents. Facility failed to provide comprehensive care plan for psychosis (auditory hallucinations with commands to hurt others) for R11. Physician Progress notes dated 4/20/11 indicated resident has history of psychosis.	F 279		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	F 406		10/3/11

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F 406	Continued From page 6 If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to provide an Individual Treatment Plan (ITP) for two of three (R7 and R16) residents reviewed for serious mental illness in the sample of 24. Findings include: 1. A review of records shows the facility never initiated an ITP from the time of admission for R7 and R16. On 8/25/11 at 3:15 pm, E6 (Director of Admissions) did not understand what was asked of her and stated that they call it (the Individualized Interim Treatment Plan/ITP) a care plan. E6 was asked to provide the information and provided surveyor with a computer generated Comprehensive Care Plan. The computerized care plans failed to be individualized. The care plans did not reflect measurable goals and were not reviewed and approved by the treating Psychiatrist. The Care Plan failed to reflect communication between the interdisciplinary team about the care and goals of the resident.	F 406		

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F 406	Continued From page 7 2. On 8/23/11 and 8/24/11, R7 was noted wandering in hallway and sitting in her room watching television throughout the day. The only structured activity observed for R7 is leisure activities on Tuesday, Wednesday and Thursday from 10:00-10:45 AM. According to the Specialized Service Notes from 8/17/11, R7 continues to have negative outlook toward the long term facility and complains about her situation in the facility. These behaviors are not being addressed in the ITP. 3. On 8/24/11 at 1:00pm R16 was observed withdrawn in her room. The only structured activity observed for R16 was leisure activities at 10:00-10:45am. According to the Specialized Service Notes from 6/16/11, R16 was observed spending a lot of time idle in her room. Resident has a history of delusions and hallucinations. These behaviors are not being addressed in the ITP.	F 406		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.4030a) 300.4030b) 300.4030c) 300.4030d) 300.4030e) 300.4030f) 300.4030g) 300.4030h) 300.4030i) Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S	F9999		

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F9999	Continued From page 8 a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed: 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others); 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation; 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and 4) Other known factors having an impact on the resident's condition (e.g., family involvement, social interaction patterns, cooperation with treatment planning). b) An ITP shall be developed within seven days after completion of the comprehensive assessment.	F9999		

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F9999	Continued From page 9 c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed. d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall: 1) Be developed by the IDT; 2) Be based on the results obtained from the assessment process; 3) Be stated in measurable terms and identify specific performance measures to assess; and 4) Be developed with a projected completion or review date (month, day, year). e) Services designed to implement the objectives in the resident's ITP shall specify: 1) Specific approaches or steps to meet the objective; 2) Planned skills training, skill generalization technique, incentive/behavior therapy, or other interventions to accomplish the objectives, including the frequency (number of times per week, per day, etc.), quantity (in number of minutes, hours, etc.) and duration (period of time, i.e., over the next 6 months) and the support necessary for the resident to participate; 3) The evaluation criteria and time periods to be used in monitoring the expected results of the intervention; and	F9999		

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F9999	Continued From page 10 4) Identification of the staff responsible for implementing each specific intervention. f) Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific ITP objectives using techniques suited to individual needs. g) ITP Documentation: 1) Significant events that are related to the resident's ITP, and assessments that contribute to an overall understanding of his/her ongoing level and quality of functioning, shall be documented. 2) The resident's response to the ITP and progress toward goals shall be documented in progress notes. h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan. i) The resident's individual treatment plan shall be signed by all members of the IDT participating in its development, including the resident or the resident's legal guardian. These Regualtions were not met as evidenced by: Based on record review, interview and observation, the facility failed to provide an	F9999		

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F9999	Continued From page 11 Individual Treatment Plan (ITP) for two of three (R7 and R16) residents reviewed for serious mental illness in the sample of 24. Findings include: A review of records shows the facility never initiated an ITP from the time of admission for R7 and R16. On 8/25/11 at 3:15 pm, E6 (Director of Admissions) did not understand what was asked of her and stated that they call it (the Individualized Interim Treatment Plan/ITP) a care plan. E6 was asked to provide the information and provided surveyor with a computer generated Comprehensive Care Plan. The computerized care plans failed to be individualized. The care plans did not reflect measurable goals and were not reviewed and approved by the treating Psychiatrist. The Care Plan failed to reflect communication between the interdisciplinary team about the care and goals of the resident. On 8/23/11 and 8/24/11, R7 was noted wandering in hallway and sitting in her room watching television throughout the day. The only structured activity observed for R7 is leisure activities on Tuesday, Wednesday and Thursday from 10:00-10:45 AM. According to the Specialized Service Notes from 8/17/11, R7 continues to have negative outlook toward the long term facility and complains about her situation in the facility. These behaviors are not being addressed in the ITP. On 8/24/11 at 1:00pm R16 was observed withdrawn in her room. The only structured activity observed for R16 was leisure activities at 10:00-10:45am.	F9999		

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F9999	Continued From page 12 According to the Specialized Service Notes from 6/16/11, R16 was observed spending a lot of time idle in her room. Resident has a history of delusions and hallucinations. These behaviors are not being addressed in the ITP. (B)	F9999		