

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

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

F000000	<p>This visit was for the Investigation of Complaint IN00144836.</p> <p>Complaint IN00144836-Substantiated. Federal/State deficiencies related to the allegations are cited a F225, F226, F250, F279, and 9999.</p> <p>Survey Dates: March 10 and 11, 2014</p> <p>Facility number: 000216 Provider number: 155323 AIM number: 100267580</p> <p>Survey team: Regina Sanders, RN-TC Jennifer Redlin, RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census Payor type: Medicare: 6 Medicaid: 36 Other: 6 Total: 48</p> <p>Sample: 5</p> <p>These deficiencies reflect State</p>	F000000	<p>Submission of the Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept is plan of correction as our credible allegation of compliance.</p>	
---------	---	---------	---	--

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 15, 2014, by Janelyn Kulik, RN.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	1.Resident #B no longer resides	03/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>interview, the facility failed to report an allegation of abuse to the Indiana State Department of Health (ISDH), related to an allegation of staff to resident abuse and resident to resident abuse, for 1 of 4 residents reviewed for abuse allegations in a total sample of 5 (Resident #B).</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 03/11/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Guillin Barre Syndrome and peripheral neuropathy.</p> <p>The resident's Significant Change Minimum Data Set Assessment, dated 02/04/14 indicated the resident's cognition was intact, had no behaviors, and required no assistance with ambulation.</p> <p>A) A Report of Concern, dated 01/20/14, indicated, "...Verbal threat on the life of another resident. Resident stated she could kill (Resident Name), and get away with it...She stated the reason she could 'get off' because of psych reasons."</p> <p>A Social Service Note, dated 01/20/14 at 12:30 p.m., indicated,</p>		<p>at the facility. A. This was brought to the facilities attention during a recent survey process that, although not clearly specified in the guidance, the event (s) would be considered unusual, thus reportable. This incident was reported to the ISDH on 3-19-14. B. This was brought to the facilities attention during a recent survey processthat, although not clearly specified in the guidance, the event (s) would be considered unusual, thus reportable. This incident was reported to the ISDH on 3-14-14. 2. All residents have the potential to be affected. The report of concerns and behavior memos for the last three months have been reviewed to determine if any other concerns or behaviors would fall under the reportable/unusual guidelines. Any concerns or behaviors meeting reporting criteria have been reported to ISDH. The facility's policy for Abuse Prohibition, Reporting, and Investigation has been reviewed and no changes are indicated at this time. (See Attachment A). The staff has been re-educated on this policy with special focus on reporting allegations. An Investigation and Reporting form has been implemented (See Attachment C). The Administrator or designee will be responsible to complete the Investigation and Reporting form on scheduled work days as follows: daily for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"Received report of concern from staff...resident verbally told her that she could kill another resident (Resident Name) and get away with it due to psych meds (medications) that she is on. Writer took report of concern to Admin (Administrator). Admin instructed writer to have (Psychiatric Consult) do immediate or (sic) eval (evaluation) or send to ER for psych eval. Resident was put on 15 minute checks..."</p> <p>The ER evaluation, dated 01/20/14, indicated, "...pt (patient) states she was in physical therapy today and said aloud to another resident that she could kill her...pt said she would kill the other resident and 'it would all be ok'...pt denies actually wanting to hurt anyone..."</p> <p>During an interview on 03/11/14 at 1:50 p.m., Administrator #1 indicated the threat had not been reported to the ISDH. She indicated she had not seen the report of concern and the resident had never made the threat to the resident, just made the statement to the therapist.</p> <p>B) A Mood and Behavior Communication Memo, dated 01/26/14, indicated, "...Res (resident told DoN (Director of Nursing) that</p>		two weeks, weekly for two weeks, then monthly thereafter. If concerns arenoted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000226 SS=D	<p>nurse slapped other res. hands in DR (dining room) yesterday. Administrator also aware of accusation..."</p> <p>During an interview on 03/11/13 at 1:50 p.m., Administrator #1, indicated the incident had not been reported to the ISDH because it was investigated and it was unsubstantiated.</p> <p>This Federal Tag relates to complaint IN00144836.</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the facility's abuse policy and procedures were implemented,</p>	F000226	1.Resident #B no longer resides at the facility. A.This was brought to the facilities attention during a recent survey process that,although not clearly specified in the guidance, the event (s) would beconsidered unusual,	03/26/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>related to not reporting the allegation of abuse to the Indiana State Department of Health (ISDH) for 1 of 4 residents reviewed for abuse in a total sample of 5 (Resident #B).</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 03/11/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Guillin Barre Syndrome and peripheral neuropathy.</p> <p>The resident's Significant Change Minimum Data Set Assessment, dated 02/04/14 indicated the resident's cognition was intact, had no behaviors, and required no assistance with ambulation.</p> <p>A) A Report of Concern, dated 01/20/14, indicated, "...Verbal threat on the life of another resident. Resident stated she could kill (Resident Name), and get away with it...She stated the reason she could 'get off' because of psych reasons."</p> <p>A Social Service Note, dated 01/20/14 at 12:30 p.m., indicated, "Received report of concern from staff...resident verbally told her that she could kill another resident</p>		<p>thus reportable. This incident was reported to the ISDH on 3-19-14.B.This was brought to the facilities attention during a recent survey processthat, although not clearly specified in the guidance, the event (s) would be considered unusual, thus reportable. This incident was reported to the ISDH on 3-14-14. 2.All residents have the potential to be affected. The report of concerns and behavior memos forthe last three months have been reviewed to determine if any other concerns orbehaviors would fall under the reportable/unusual guidelines. Any concerns orbehaviors meeting reporting criteria have been reported to ISDH. The facility's policy for Abuse Prohibition, Reporting, andInvestigation has been reviewed and no changes are indicated at this time (See Attachment A). The staff has beenre-educated on this policy with special focus on reporting allegations. An Investigationand Reporting form has been implemented (See Attachment C).TheAdministrator or designee will be responsible to complete the Investigation andReporting form on scheduled work days as follows: daily for two weeks, weekly for two weeks,then monthly thereafter. If concerns arenoted, immediate corrective action will occur. Results of these reviews will be discussed during the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(Resident Name) and get away with it due to psych meds (medications) that she is on. Writer took report of concern to Admin (Administrator). Admin instructed writer to have (Psychiatric Consult) do immediate or (sic) eval (evaluation) or send to ER for psych eval. Resident was put on 15 minute checks..."</p> <p>The ER evaluation, dated 01/20/14, indicated, "...pt (patient) states she was in physical therapy today and said aloud to another resident that she could kill her...pt said she would kill the other resident and 'it would all be ok'...pt denies actually wanting to hurt anyone..."</p> <p>During an interview on 03/11/14 at 1:50 p.m., Administrator #1 indicated the threat had not been reported to the ISDH. She indicated she had not seen the report of concern and the resident had never made the threat to the resident, just made the statement to the therapist.</p> <p>B) A Mood and Behavior Communication Memo, dated 01/26/14, indicated, "...Res (resident) told DoN (Director of Nursing) that nurse slapped other res. hands in DR (dining room) yesterday. Administrator also aware of</p>		<p>facility's quarterly QA meetings and the plan adjusted if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>accusation..."</p> <p>During an interview on 03/11/13 at 1:50 p.m., Administrator #1, indicated the incident had not been reported to the ISDH because it was investigated and it was unsubstantiated.</p> <p>A facility policy, dated 11/12, titled, "Abuse Prohibition, Reporting and Investigation Policy and Procedure", received from Administrator #1 as current, indicated, "This facility will ensure that all alleged violations...are reported immediately to the administrator (sic) of the facility. Violations of the aforementioned will be reported to other officials in accordance with state law through established procedures (including to the state survey and certification agency)...The facility Administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations and for assuring that all policies and procedures are followed..."</p> <p>A facility policy, dated 02/10, titled, "Reporting Unusual Occurrences to the State", received from Administrator #1 as current,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated, "...This facility shall insure that the division is immediately informed...of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents...The facility will ensure that all alleged violations involving ...abuse are reported immediately to the Administrator of the facility and to other officials as applicable...initial notification will be made to applicable agencies by the Administrator...immediately upon determining a situation exists (or existed)...All allegations of abuse should be reported...VERBAL ABUSE...threats of harm...Resident to resident verbal threats of harm..."</p> <p>This Federal Tag relates to complaint IN00144836.</p> <p>3.1-28(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident, related to identifying behaviors, thoroughly assessing behaviors, implementing behavioral interventions, and evaluating the outcome of the interventions to support the residents' individual needs, for 2 of 4 residents reviewed with behaviors. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. During an interview on 03/10/14 at 6:35 p.m., the Director of Nursing indicated there was a conflict between Resident #B and Resident #C related to issues outside of the facility. She indicated Resident #B resided on C/D Unit and Resident #C resided on A/B Unit. She indicated both residents had been discharged to home.</p> <p>Resident #B's record was reviewed</p>	F000250	<p>1. Resident #B and #C no longer reside at the facility. 2. All residents have the potential to be affected. All report of concerns and behavior memos for last three months have been reviewed and if a behavior is noted, it has been assessed, interventions implemented and evaluated to support the residents' individual needs if indicated. 3. The facility's Behavior Management Program has been reviewed and no changes are indicated at this time. (See Attachment D). A new Social Service Designee began on 3-11-14 and has been educated on the behavior program. Facility staff have been re-educated on the behavior management program. A Behavior Management Review form has been implemented (See Attachment E). 4. The Administrator or designee will be responsible for completing the Behavior Management Review form on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. If concerns are noted, immediate corrective action will occur. Results of these reviews will be discussed during the</p>	03/26/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>on 03/11/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Guillin Barre Syndrome and peripheral neuropathy.</p> <p>The resident's Significant Change Minimum Data Set Assessment, dated 02/04/14 indicated the resident's cognition was intact, had no behaviors, and required no assistance with ambulation.</p> <p>A) During an interview on 03/10/14 at 6:35 p.m., Administrator #1 indicated the staff had found drug paraphernalia and drugs in Resident #B's room. She indicated there were syringes with a clear substance in them, a pipe and spoons. Administrator #1 indicated the resident had admitted to hoarding her medications. She indicated the resident had been on supervised visits with all visitors. She indicated the Police were notified and they came and confiscated all the drug paraphernalia.</p> <p>A Report of Concern, dated 12/04/13, indicated, "...called to check (checkmark) pt (patient) out R/T (related to) medication, needle, etc (etcetera) found in room...Res placed on supervised visits, meds</p>		<p>facility's quarterly QA meetings and theplan adjusted if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(medications) are being crushed, random room searches being conducted."</p> <p>A Social Service Progress Note, dated 12/6/13 at 11 a.m., 12/10/13 at 4 p.m., 12/12/13 at 2:30 p.m., and 12/16/13 at 3:36 p.m. indicated the resident's room and belongings were searched and no further drugs or drug paraphernalia was found.</p> <p>There was a lack of documentation to indicate Social Service had further assessments and involvement in the resident's mood and behavior or had documented interventions for the resident's mood and behavior status.</p> <p>There was a lack of documentation to indicate the resident had a care plan implemented for her behaviors and moods.</p> <p>B) A Report of Concern, dated 01/20/14, indicated, "...Verbal threat on the life of another resident. Resident stated she could kill (Resident #C), and get away with it...She stated the reason she could 'get off' because of psych reasons."</p> <p>A Social Service Note, dated 01/20/14 at 12:30 p.m., indicated, "Received report of concern from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>staff...resident verbally told her that she could kill another resident (Resident #C) and get away with it due to psych meds (medications) that she is on. Writer took report of concern to Admin (Administrator). Admin instructed writer to have (Psychiatric Consult) do immediate or (sic) eval (evaluation) or send to ER for psych eval. Resident was put on 15 minute checks..."</p> <p>A Social Service Note, dated 01/21/14 at 11 a.m. indicated the 15 minute checks were discontinued. This was the last note in the resident's record.</p> <p>There was a lack of documentation to indicate Social Service had further assessments of the resident's mood or behavior or had documented interventions for the resident's mood and behavior status.</p> <p>C) The Mood and Behavior Communication Memos indicated the following behaviors: On 12/25/13 there were three memos, 9:40 p.m. and two at 10 p.m. indicating the resident became angry and was cussing at nurse when the nurse explained she could not administer two different narcotic pain medications to the resident at</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the same time. The resident indicated the nurse was playing games and was shoving her things around, then was going to the A/B Unit. (Resident resided on the C/D Unit.)</p> <p>On 01/24/14 at 12:45 (no a.m. or p.m. documented), indicated the resident was on A/B Unit headed down to another resident's room and the Nurse and Social Service Director were notified.</p> <p>On 01/25/14 at day shift, indicated the resident was behind the Nurses' Station, was getting self ice water from the pitcher on the medication cart, was yelling down the hall for pain medications, was asking personal questions about other residents and had voiced to the Nurse she did not want to talk to her because she was angry with her.</p> <p>On 01/26/14 on days, indicated the resident was found looking at other resident's pages in the Leave of Absence Book, was getting self ice water from the pitcher on the medication and had been stating she was depressed.</p> <p>On 02/07/14 at 6:30 to 6:40 p.m., indicated the resident had been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>complaining loudly the nurse was late with her medications.</p> <p>On 02/11/13 at 12:45 p.m., indicated the resident was undressing with her room door open.</p> <p>On 02/21/14 at 6:50 p.m., indicated Resident #B and Resident #C were in the main lobby and Resident #C yelled, "If I have something to say I'll say it I'm not shy" and Resident #B then began yelling at the CNA and put her hand in the CNA's face. The Note indicated the CNA asked Resident to remove her hand out of her face and to go to her end of the building and Resident #B started yelling more.</p> <p>On 02/22/14 at 8:30 p.m., indicated Resident #B was upset over what had happened on 02/21/14 and began yelling and using obscenities. The resident had pulled papers off the wall and began throwing the papers.</p> <p>On 02/26/14 at 6:25 p.m., indicated the resident had been bossing other residents around and was yelling at the staff.</p> <p>There was a lack of documentation to indicate Social Service had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>assessed or had been involved in the resident's mood and behavior or had documented interventions for the resident's mood and behavior status.</p> <p>There was a lack of documentation to indicate the resident had a care plan implemented for her behaviors and moods.</p> <p>During an interview on 03/11/14 at 1:50 p.m., Administrator #1 indicated the Social Service Director at the time was no longer employed at the facility. She indicated other than the notes of the room search and when the resident had made the threat of another resident, which the last note was 01/21/14 at 11 a.m., there was no other documentation about the resident's moods and behaviors. She indicated there were no care plans with interventions for the staff to use when the resident had behaviors or mood concerns.</p> <p>2. Resident #C's record was reviewed on 03/11/14 at 11:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and Bowen's Disease (type of skin cancer).</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The Admission Minimum Data Set Assessment, dated 12/30/13, indicated the resident had no cognition problems and no behaviors.</p> <p>A) During an interview on 03/10/14 at 6:35 p.m., Administrator #1 indicated prescription medications, methamphetamine, and drug paraphernalia had been found in Resident #C's room. She indicated there had been two incidents where drugs had been found and the Police were notified and intervened both times the drugs were found in the resident's room. She indicated she did not have the Police Reports on the incidents. She indicated the resident had been on supervised visitation.</p> <p>There was a lack of documentation in the resident's record and in the facility to indicate when the drugs were first found in the resident's room and when the resident was placed on supervised visits.</p> <p>The Physician's Recapitulation orders, dated 03/14, included the following orders: Adderall (amphetamine) 10 mg (milligrams), three tablets twice a day</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>MS Contin (narcotic pain medication) 15 mg, three tablets every 12 hours.</p> <p>Neurontin (pain medication) 300 mg three times a day</p> <p>Tizanidine (muscle relaxer) 4 mg three times a day</p> <p>Xanax (anti-anxiety) 0.25 mg three times a day for anxiety</p> <p>A Nurses' Note, dated 02/07/14, no time documented, indicated, "observed guests of resident placing bags in resident's room. Resident informed guests could not go into her room..."</p> <p>A Report of Concern, dated 02/17/14, indicated the resident was non-compliant with supervised visitations and the family had been in the resident's room repeatedly with the door closed, despite being reminded the resident was on supervised visits. The follow up action indicated the family had been informed of the need for supervised visitation.</p> <p>A Nurses' Note, dated 02/25/14 at 10 p.m., indicated, "...Son took to scheduled appt (appointment) c/ (with) (Physician's Name) this afternoon. Call recv'd (received" from (Physician's Name) stating</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident did not show up for her appt as scheduled...Resident returned from LOA (leave of absence) at 8:30 p.m. et (and) states she did see Dr...no return papers. Administrator notified..."</p> <p>During an interview on 03/11/14 at 2:15 p.m., Administrator #1 indicated she notified the Physician's office and the resident did not go to the appointment as scheduled.</p> <p>A Nurses' Note, dated 02/27/14 at 6:45 a.m., indicated the yelled for help and had indicated she could not catch her breath, the resident was assessed and treated with nebulizer treatment, the physician was notified and orders were received to transfer the resident to the hospital Emergency Room at 7:50 a.m.</p> <p>A Nurses' Note, dated 02/27/14 at 7:50 a.m., indicated medications were found in the resident's possession, which appeared to be Percocet (narcotic pain medication), oxycontin (narcotic pain medication), Norco (narcotic pain medication), and Adderall (amphetamine). the note indicated the resident had Methamphetamine in her room several weeks ago.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

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

	<p>A Nurses' Note, dated 02/27/14 at 2 p.m. indicated Morphine which the resident had prescribed had also found in the resident's room and the Director of Nursing had been notified.</p> <p>There was a lack of documentation to indicate a care plan had been initiated for interventions for staff related to the resident's behaviors.</p> <p>During an interview on 03/11/14 at 2:15 p.m., Administrator #1 indicated there was no documentation to indicate when the methamphetamine had been found (first incident). She indicated the Social Service Director had spoke with the resident but no investigation had been completed. She indicated there was no Social Service notes or involvement and no care plans had been written.</p> <p>B) During an interview on 03/10/14 at 6:35 p.m., the Director of Nursing indicated there was a conflict between Resident #B and Resident #C related to issues outside of the facility. She indicated Resident #B resided on C/D Unit and Resident #C resided on A/B Unit. She indicated both residents had been discharged to home.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A Mood and Behavior Communication Memo, dated 02/21/14 at 6:50 p.m., indicated Resident #B and Resident #C were in the main lobby and Resident #C yelled, "If I have something to say I'll say it I'm not shy".</p> <p>A Mood and Behavior Communication Memo, dated 03/02/14, indicated the resident had verbalized anger about the staff searching her room while she was in the hospital.</p> <p>A Mood and Behavior Communication Memo, dated 03/03/14 at 2:15 p.m., indicated the resident was making false accusations that the staff had framed her and planted drugs in her room. The Memo indicated the resident had started yelling at the staff.</p> <p>There was one Social Service Progress Note, dated 12/29/13 at 4:30 p.m., which indicated the resident had adapted to the facility well. There was a lack of documentation to indicate Social Service was involved with the resident's behavior.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an interview on 03/11/14 at 2:15 p.m., Administrator #1 indicated Social Service had no documentation of involvement when the resident had mood and behaviors. She indicated there was no care plan for the moods and behaviors.</p> <p>A facility policy, dated 07/10, titled, "Mood and Behavior Program Procedures", received as current from Administrator #1, indicated, "...Social Service Director...will collect the Mood and Behavior Communication Memo's...and present all occurrences to the interdisciplinary team during the facility's stand up meetings...A new or Worsening Mood and Behavior Problem assessment will be initiated by social services or nursing...A written plan of care will be developed to address the mood(s) and/or behaviors(s), including interventions to address any noted intrinsic and/or extrinsic factors precipitating the mood(s) and/or behaviors(s) by social service and/or the interdisciplinary team...Social Service...will be responsible to record all mood(s) and/or behavior(s) that have been identified..."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	This Federal Tag relates to complaint IN00144836. 3.1-34(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>Based on record review and interview, the facility failed to develop care plans related to moods and behaviors, for 2 of 4 residents reviewed for behaviors in a total</p>	F000279	1.Resident #B and #C no longer reside at the facility. 2.All residents with moods and behaviors have the potential to be affected. All report of concerns and behavior memos forlast three	03/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>sample of 5. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. During an interview on 03/10/14 at 6:35 p.m., the Director of Nursing indicated there was a conflict between Resident #B and Resident #C related to issues outside of the facility. She indicated Resident #B resided on C/D Unit and Resident #C resided on A/B Unit. She indicated both residents had been discharged to home.</p> <p>Resident #B's record was reviewed on 03/11/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Guillin Barre Syndrome and peripheral neuropathy.</p> <p>The resident's Significant Change Minimum Data Set Assessment, dated 02/04/14 indicated the resident's cognition was intact, had no behaviors, and required no assistance with ambulation.</p> <p>A) During an interview on 03/10/14 at 6:35 p.m., Administrator #1 indicated the staff had found drug paraphernalia and drugs in the Resident #B's room. She indicated there were syringes with a clear</p>		<p>months have been reviewed to determine if any other concerns or behaviors need to be care planned Careplans have been updated if indicated. 3.The facility's Care Plan Development policy has been reviewed and no changes are indicated at this time (See Attachment F). A new Social Service Designee began on 3-11-14 and has been educated on the care plan development policy. Facility staff have been re-educated on the care plan development policy. A Behavior Management Review form has been implemented (See Attachment E). 4. The Administrator or designee will be responsible for completing the Behavior Management Review form on scheduled work days as follows: Daily for two weeks, weekly for two weeks, monthly for two months, then quarterly thereafter. If concerns are noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>substance in them, a pipe and spoons. Administrator #1 indicated the resident had admitted to hoarding her medications. She indicated the resident had been on supervised visits with all visitors. She indicated the Police were notified and they came and confiscated all the drug paraphernalia.</p> <p>A Report of Concern, dated 12/04/13, indicated, "...called to check (checkmark) pt (patient) out R/T (related to) medication, needle, etc (etcetera) found in room...Res placed on supervised visits, meds (medications) are being crushed, random room searches being conducted."</p> <p>A Report of Concern, dated 01/20/14, indicated, "...Verbal threat on the life of another resident. Resident stated she could kill (Resident #C), and get away with it...She stated the reason she could 'get off' because of psych reasons."</p> <p>A Social Service Note, dated 01/20/14 at 12:30 p.m., indicated, "Received report of concern from staff...resident verbally told her that she could kill another resident (Resident #C) and get away with it</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>due to psych meds (medications) that she is on. Writer took report of concern to Admin (Administrator). Admin instructed writer to have (Psychiatric Consult) do immediate or (sic) eval (evaluation) or send to ER for psych eval. Resident was put on 15 minute checks..."</p> <p>The Mood and Behavior Communication Memos indicated the following behaviors: On 12/25/13 there were three memos, 9:40 p.m. and two at 10 p.m. indicating the resident became angry and was cussing at nurse when the nurse explained she could not administer two different narcotic pain medications to the resident at the same time. The resident indicated the nurse was playing games and was shoving her things around, then was going to the A/B Unit. (Resident resided on the C/D Unit.)</p> <p>On 01/24/14 at 12:45 (no a.m. or p.m. documented), indicated the resident was on A/B Unit headed down to another resident's room and the Nurse and Social Service Director was notified.</p> <p>On 01/25/14 at day shift, indicated the resident was behind the Nurses'</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Station, was later getting self ice water from the pitcher on the medication cart, was yelling down the hall for pain medications, was asking personal questions about other residents and had voiced to the Nurse she did not want to talk to her because she was angry with her.</p> <p>On 01/26/14 on days, indicated the resident was found looking at other resident's pages in the Leave of Absence Book, was getting self ice water from the pitcher on the medication and had been stating she was depressed.</p> <p>On 02/07/14 at 6:30 to 6:40 p.m., indicated the resident had been complaining loudly the nurse was late with her medications.</p> <p>On 02/11/13 at 12:45 p.m., indicated the resident was undressing with her room door open.</p> <p>On 02/21/14 at 6:50 p.m., indicated Resident #B and Resident #C were in the main lobby and Resident #C yelled, "if I have something to say I'll say it I'm not shy" and Resident #B then began yelling at CNA and put her hand in the CNA's face. The Note indicated the CNA asked Resident to remove her hand out of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>her face and to go to her end of the building and Resident #B started yelling more.</p> <p>On 02/22/14 at 8:30 p.m., indicated Resident #B was upset over what had happened on 02/21/14 and began yelling and using obscenities. The resident had pulled papers off the wall and began throwing the papers.</p> <p>On 02/26/14 at 6:25 p.m., indicated the resident had been bossing other residents around and was yelling at the staff.</p> <p>There was a lack of documentation to indicate the resident had care plans implemented for her behaviors and moods.</p> <p>During an interview on 03/11/14 at 1:50 p.m., Administrator #1 indicated there were no care plans with interventions for the staff to use when the resident had behaviors or mood concerns.</p> <p>2. Resident #C's record was reviewed on 03/11/14 at 11:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and Bowen's Disease (type of skin</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>cancer).</p> <p>The Admission Minimum Data Set Assessment, dated 12/30/13, indicated the resident had no cognition problems and no behaviors.</p> <p>During an interview on 03/10/14 at 6:35 p.m., Administrator #1 indicated prescription medications, methamphetamine, and drug paraphernalia had been found in Resident #C's room. She indicated there had been two incidents where drugs had been found and the Police were notified and intervened both times the drugs were found in the resident's room. She indicated the resident had been on supervised visitation.</p> <p>A Report of Concern, dated 02/17/14, indicated the resident was non-compliant with supervised visitations and the family had been in the resident's room repeatedly with the door closed, despite being reminded the resident was on supervised visits. The follow up action indicated the family had been informed of the need for supervised visitation.</p> <p>A Mood and Behavior</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Communication Memo, dated 02/21/14 at 6:50 p.m., indicated Resident #B and Resident #C were in the main lobby and Resident #C yelled, "If I have something to say I'll say it I'm not shy".</p> <p>A Nurses' Note, dated 02/25/14 at 10 p.m., indicated, "...Son took to scheduled appt (appointment) c/ (with) (Physician's Name) this afternoon. Call recv'd (received" from (Physician's Name) stating resident did not show up for her appt as scheduled...Resident returned from LOA (leave of absence) at 8:30 p.m. et (and) states she did see Dr...no return papers. Administrator notified..."</p> <p>During an interview on 03/11/14 at 2:15 p.m., Administrator #1 indicated she notified the Physician's office and the resident did not go to the appointment as scheduled.</p> <p>A Nurses' Note, dated 02/27/14 at 7:50 a.m., indicated medications were found in the resident's possession, which appeared to be Percocet (narcotic pain medication), oxycontin (narcotic pain medication), Norco (narcotic pain medication), and Adderall (amphetamine). the note indicated the resident had</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Methamphetamine in her room several weeks ago.</p> <p>A Nurses' Note, dated 02/27/14 at 2 p.m. indicated Morphine which the resident had prescribed had also found in the resident's room and the Director of Nursing had been notified.</p> <p>A Mood and Behavior Communication Memo, dated 03/02/14, indicated the resident had verbalized anger about the staff searching her room while she was in the hospital.</p> <p>A Mood and Behavior Communication Memo, dated 03/03/14 at 2:15 p.m., indicated the resident was making false accusations that the staff had framed her and planted drugs in her room. The Memo indicated the resident had started yelling at the staff.</p> <p>There was a lack of documentation to indicate the resident had care plans implemented for her behaviors and moods.</p> <p>During an interview on 03/11/14 at 2:15 p.m., Administrator #1 indicated there were no care plans for the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident's moods and behaviors.</p> <p>A facility policy, dated 07/10, titled, "Mood and Behavior Program Procedures", received as current from Administrator #1, indicated, "...A written plan of care will be developed to address the mood(s) and/or behaviors(s), including interventions to address any noted intrinsic and/or extrinsic factors precipitating the mood(s) and/or behaviors(s) by social service and/or the interdisciplinary team..."</p> <p>This Federal Tag relates to complaint IN00144836.</p> <p>3.1-35(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F009999	<p>3.1-13 Administration and management</p> <p>The responsibilities of the administrator shall include, but are</p>	F009999	<p>1.Resident #B and #C no longer resides at the facility. This was brought to the facilities attention during a recent survey process that, although not clearly specified in the guidance, the event (s) would be considered unusual,</p>	03/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) Fires; or (D) major accidents.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to thoroughly investigate and report incidents of unusual occurrences to the Indiana State Department of Health (ISDH), related to drugs and drug paraphernalia being found a residents rooms, for 2 of 4 residents reviewed for behaviors in a total sample of 5. (Residents #B and #C)</p> <p>Findings include</p> <p>1. During an interview on 03/10/14 at 6:35 p.m., Administrator #1 indicated the staff had found drug paraphernalia and drugs in the Resident #B's room. She indicated there were syringes with a clear</p>		<p>thusreportable. These incidents were reported to the ISDH on 3-14-14. 2.All residents have the potential to be affected. All report of concerns and behavior memos forlast three months have been reviewed to determine if any other concerns orbehaviors would fall under the reportable/unusual guidelines. If found to meet criteria, the concern hasbeen reported to ISDH. 3. The facility's policy for Abuse Prohibition, Reporting,and Investigation has been reviewed and no changes are indicated at this time (See Attachment A). The staff has been re-educated on this policy with special focus on reporting allegations. An Investigation and Reporting form has been implemented (See Attachment C).4.The Administrator or designee will be responsible to complete the Investigationand Reporting form on scheduled work days as follows: daily for two weeks, weekly for two weeks,then monthly thereafter. If concerns arenoted, immediate corrective action will occur. Results of these reviews will be discussed during the facility'squarterly QA meetings and the plan adjusted if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>substance in them, a pipe and spoons. Administrator #1 indicated the resident had admitted to hoarding her medications. She indicated the resident had been on supervised visits with all visitors. She indicated the Police were notified and they came and confiscated all the drug paraphernalia.</p> <p>Resident #B's record was reviewed on 03/11/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Guillin Barre Syndrome and peripheral neuropathy.</p> <p>The resident's Significant Change Minimum Data Set Assessment, dated 02/04/14 indicated the resident's cognition was intact, had no behaviors, and required no assistance with ambulation.</p> <p>A Report of Concern, dated 12/04/13, indicated, "...called to check (checkmark) pt (patient) out R/T (related to) medication, needle, etc (etcetera) found in room...Res placed on supervised visits, meds (medications) are being crushed, random room searches being conducted."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A Social Service Progress Note, dated 12/6/13 at 11 a.m., 12/10/13 at 4 p.m., 12/12/13 at 2:30 p.m., and 12/16/13 at 3:36 p.m. indicated the resident's room and belongings were searched and no further drugs or drug paraphernalia was found.</p> <p>There was a lack of documentation to indicate interviews had been completed, what and how many drugs and paraphernalia was found, and a thorough investigation had been completed by the facility.</p> <p>There was a lack of documentation to indicate the ISDH had been notified of the drugs, the drug paraphernalia, and the Police being notified.</p> <p>During an interview on 03/11/14 at 1:50 p.m., Administrator #1 indicated the staff found syringes with a liquid substance in them, spoons, elastic tourniquet and oxycodone (narcotic pain medication) in the resident's room. She indicated the incident had not been reported to the ISDH because the resident wasn't harmed She indicated there was a potential for harm. She indicated there was no further documentation except that the resident's room had been searched.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. Resident #C's record was reviewed on 03/11/14 at 11:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and Bowen's Disease (type of skin cancer).</p> <p>The Admission Minimum Data Set Assessment, dated 12/30/13, indicated the resident had no cognition problems and no behaviors.</p> <p>During an interview on 03/10/14 at 6:35 p.m., Administrator #1 indicated prescription medications, methamphetamine, and drug paraphernalia had been found in Resident #C's room. She indicated there had been two incidents where drugs had been found and the Police were notified and intervened both times the drugs were found in the resident's room. She indicated she did not have the Police Reports on the incidents. She indicated the resident had been on supervised visitation.</p> <p>There was a lack of documentation in the resident's record and in the facility to indicate when the drugs were first found in the resident's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>room and when the resident was placed on supervised visits. There was a lack of documentation to indicate an investigation had been completed by the facility to determine where the drugs had come from.</p> <p>A Nurses' Note, dated 02/27/14 at 7:50 a.m., indicated medications were found in the resident's possession, which appeared to be Percocet (narcotic pain medication), oxycontin (narcotic pain medication), Norco (narcotic pain medication), and Adderall (amphetamine). the note indicated the resident had Methamphetamines in her room several weeks ago.</p> <p>A Nurses' Note, dated 02/27/14 at 2 p.m. indicated Morphine which the resident had prescribed had also found in the resident's room and the Director of Nursing had been notified.</p> <p>During an interview on 03/11/14 at 2:15 p.m., Administrator #1 indicated there was no documentation to indicate when the methamphetamines had been found (first incident). She indicated the Social Service Director had spoke with the resident but no investigation</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>had been completed. She indicated the incidents had not been reported to the ISDH.</p> <p>A facility policy, dated 02/10, titled, "Reporting Unusual Occurrences to the State", received as current from Administrator #1, indicated, "This facility shall insure that the division is immediately informed, within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including, but not limited to, any: epidemic outbreaks, poisonings, fires, or major accidents..."</p> <p>3.1-13(g)(1)</p> <p>This Federal Tag relates to complaint IN00144836.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
--	---

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