

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F000000	<p>This visit for the Investigation of Complaint IN00137664.</p> <p>Complaint IN00137664-Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F250, F314, F325, and F329.</p> <p>Survey Dates: October 15, 16, & 17, 2013</p> <p>Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940</p> <p>Survey team: Heather Tuttle, RN, TC Lara Richards, RN Heather Hite, RN</p> <p>Census Bed Type: SNF/NF: 112 Total: 112</p> <p>Census Payor Type: Medicare: 18 Medicaid: 68 Other: 26 Total: 112</p> <p>Sample: 11</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 23, 2013, by Janelyn Kulik, RN.</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the residents' Physician was notified in a timely manner related to Registered Dietitian (RD)</p>	F000157	F157 1. With respect to Resident #K, physician and family notified of weight loss on 9/4/13. With respect to resident #B,	11/04/2013			

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	<p>recommendations, weight loss, and pressure ulcers for 3 of 11 sampled residents. (Residents #B, #C, and #K)</p> <p>Findings include:</p> <p>1. The record for Resident #K was reviewed on 10/15/13 at 3:20 p.m. The resident's diagnosis included, but was not limited to, Alzheimer's Dementia. An entry in the Nursing progress notes dated 8/31/13, indicated the resident had a re-weight completed and a 13 pound weight loss was confirmed. The resident's Physician was faxed at that time.</p> <p>Documentation in the Nursing progress notes dated 9/3/13 at 4:10 p.m., indicated the resident's Physician was called and notified of the resident's weight loss.</p> <p>Interview with the Director of Nursing on 10/16/13 at 1:50 p.m., indicated staff should have called the resident's Physician on 8/31/13 to notify him of the weight loss rather than sending a fax.</p>		<p>physician notified of RD recommendations on 10/15/13 and new orders received and implemented to increase water flush. With regards to resident #C, physician and family notified of pressure area, new treatment orders received and noted 10/17/13. 2. All residents have the potential to be affected by this citation. Physician will be contacted via phone versus facsimile regarding any and all significant weight changes. Will review all weights and recommendations with dietician to ensure proper physician notification completed by 11/4/13. RD recommendations will be discussed with unit managers and physicians will be notified accordingly. Upon finding any new pressure areas, facility will ensure physician and family are notified and treatment is obtained. All current pressure areas reviewed to ensure proper treatment in place for each area. 3. Nursing staff will be in-serviced on facility policy regarding physician notification related to resident change in status, including but not limited, significant weight change, RD recommendations, and any and all new pressure areas by the Director of Nursing and/or Nursing Supervisory staff on or prior to 11/4/13. 4. Random audits of three resident weights and physician orders will be completed three times a week for</p>				

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	<p>2. The record for Resident #B was reviewed on 10/15/13 at 1:20 p.m. The resident's diagnoses included, but were not limited to, dysphagia, brain injury, and Percutaneous Endoscopic Gastrostomy (PEG) tube.</p> <p>Review of the Registered Dietitian (RD) Progress Note dated 9/12/13, indicated the resident had just returned from a hospital stay with the diagnoses of pneumonia and was</p>		<p>2 weeks, then two times a week for 2 months and/or until 100% compliance obtained by the Director of Nursing and /or Nursing Supervisor. During morning meeting, clinical IDT team will review all 24 hour nurses notes and physician orders to ensure timely follow-up and completion. Any significant changes in residents' status requiring physician/family notification found incomplete will be completed by Nursing Staff. Residents' physician/family will be notified, new orders will be processed, and care plan updated to reflect status. The findings will be reported to the Quality Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, MDS Coordinator, Maintenance, Environmental Services, Therapy Director, Activities Director, Dietary Manager and Medical Director.</p>		

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	<p>currently on antibiotics. She addressed the resident's weight, medications, and calories the PEG tube was providing. She also addressed the resident's free water flushes of 200 cubiccentimeters (cc) four times a day. The RD recommended to increase the free water flushes to 300 cc every four hours.</p> <p>Review of RD report dated 9/12/13, which was provided by the Director of Nursing and the Rehab Unit Manager, indicated the area of concern for Resident #B was readmit and tube feeding. Her recommendation was to increase the water flush through the PEG tube to 300 cc every four hours.</p> <p>Review of Physician Orders dated 9/12-10/15/13 indicated there was no current order for the water flush of 300 cc every 4 hours.</p> <p>Review of the Medication Administration Record (MAR) for 9/2013 indicated the resident received 200 cc of water flushes four times a day from 9/1-9/30/13. Review of the 10/2013 MAR indicated the resident received 200 cc of water flushes four times a day from 10/1-10/15/13.</p>			

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	<p>Review of Nursing Progress Notes dated 9/12-10/15/13 indicated there was no documentation the resident's Physician had been notified of the RD recommendations to increase the water flush from 200 cc to 300 cc every four hours.</p> <p>Interview with the Rehab Unit Manager on 10/15/13 at 3:30 p.m., indicated she received the RD recommendations for the water flush to be increased, however, the Physician was not notified to increase the water flushes.</p> <p>Interview with the RD on 10/16/13 at 2:00 p.m., indicated she did recommend the increase of water flushes as it would have been beneficial for the resident for hydration.</p> <p>3. The record for Resident #C was reviewed on 10/15/13 at 2:55 p.m. The resident was admitted to the facility on 9/6/13. The resident's diagnoses included, but were not limited to, total hip replacement, high blood pressure, and recent left hip fracture.</p> <p>Review of the Wound/Skin healing record indicated the resident acquired a pressure sore to her right buttock</p>			

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	<p>on 10/3/13.</p> <p>Review of the Nursing Progress Notes dated 10/3/13 indicated there was no evidence of any documentation the resident developed a pressure sore to her right buttock. Further review of the 10/3/13 Nursing Progress Note indicated there was no evidence the resident's Physician and/or responsible party had been notified of the newly developed pressure sore.</p> <p>Review of the current 3/2010 Physician Notification for Change in Condition Policy provided by the Assistant Director of Nursing indicated the resident's primary Physician will be notified immediately of any change in the resident's physical or mental condition. Examples of significant change include, but were not limited to: Skin breakdown.</p> <p>Interview with the Rehab Unit Manager on 10/16/13 at 10:00 a.m., indicated there was no evidence the resident's Physician had been notified of the newly developed pressure sore.</p> <p>This Federal Tag relates to Complaint IN00137664.</p>				

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	3.1-5(a)(3)			

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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.</p> <p>Based on record review and interview, the facility failed to ensure medically related social services were provided related to a social service referral for weight loss and depression for 1 of 5 residents reviewed who were being seen in the Nutrition at Risk meetings in the sample of 11. (Resident #F)</p> <p>Findings include:</p> <p>The record for Resident #F was reviewed on 10/15/13 at 1:30 p.m. Documentation in the Social Service Progress Notes dated 9/5/13 at 6:12 p.m., indicated the resident's daughter had passed away. A grief care plan was initiated and Social Service staff notified Nursing to direct any concerns or issues the resident may have to her office.</p> <p>The next documented Social Service Progress Note on 9/18/13, indicated there was no documentation as to how the resident was coping with his daughter's death.</p>	F000250	<p>With respect to resident #F, resident no longer resides at facility as of 10/25/13. All residents have the potential to be affected by this citation. Facility reviewed all residents charting to ensure proper social service documentation is present as warranted. Social service director will receive in-servicing on timely documentation and assisting resident with grieving process on or prior to 11/4/13 by the Administrator or Designee. Random audit of three residents social service documentation will be completed by administer and/or designee three times a week for two weeks, then two times a week for 1 month and/or 100% compliance. The findings will be reported to the Quality Assurance Committee times 3 months or until 100% compliance is achieved by the Director of Nursing. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, MDS Coordinator, Maintenance, Environmental Services, Therapy Director, Activities Director, Dietary Manager and Medical</p>	11/04/2013

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	<p>On 9/4/13, the resident's weight was documented as 142 pounds. On 10/2/13, the resident's weight was documented as 134 pounds. The resident was reviewed in the Nutrition at Risk (NAR) meeting on 10/3/13. The resident's weight loss was addressed and one of the contributing factors was identified as "recent daughter death." The committee recommended Med Pass (a nutritional supplement) and a Social Service referral.</p> <p>A Physician's order dated 10/3/13, indicated an order was obtained for Med Pass 120 milliliters (mls) three times a day.</p> <p>Review of the Social Service progress notes for the month of October 2013, indicated no documentation had been completed.</p> <p>Interview with the Social Service Director on 10/16/13 at 2:15 p.m., indicated the resident had been experiencing difficulty with his daughter's death and some nutrition issues had been identified. She indicated she had contacted the resident's other daughter to set up a care plan conference. She indicated the resident's daughter had not gotten back to her and nothing had been</p>		Director.		

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	<p>scheduled. She indicated that she does not document anything until the family gets back to her. She indicated the resident's daughter had not been contacted until 10/14 or 10/15/13.</p> <p>This Federal Tag relates to Complaint IN00137664.</p> <p>3.1-34(a)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure each resident was monitored and assessed following a medication error related to an excessive dose of Hydrocodone for 1 of 3 residents reviewed for unnecessary medications in the sample of 11. (Resident #M)</p> <p>Findings include:</p> <p>The record for Resident #M was reviewed on 10/16/13 at 9:10 a.m. The resident's diagnoses included, but were not limited to right broken radius, Alzheimer dementia, anxiety, depression, and osteoarthritis.</p> <p>Review of Physician Orders dated 7/12/13 and on the current 10/2013 recap indicated Hydrocodone 7.5-325 milligrams (mg) three times a day at 8:00 a.m., 12:00 p.m., and 4:00 p.m. Another Physician's Order dated 1/13/13 and on the current 10/2013 recap indicated Hydrocodone 5-325</p>	F000309	F309 1. With respect to Resident M, receiving current prescribed scheduled and PRN pain medication as ordered. 2. All residents have the potential to be affected by this citation. Audit of all resident's PRN pain medications will be conducted to ensure proper dosage per physician order completed by nursing supervisory team by 11/4/13. 3. Nursing staff will be in-serviced on pain and medication error follow-up by Director of nursing and/or designee by 11/4/13. 4. Random audits of three resident's PRN pain medications and any medication errors to ensure proper follow up by the Director of Nursing and/or Nursing Supervisory staff 2 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. During morning meeting, clinical IDT team will review all 24 hour nurses notes and physician orders to ensure timely follow-up and completion. Results of findings will be reported to the Quality Assurance Committee	11/04/2013			

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	<p>mg every six hours prn knee pain.</p> <p>Review of Nursing Progress Notes dated 9/18/13 indicated the resident's right wrist was swollen. An xray was obtained and the resident had fractured her right wrist. The resident was sent to the hospital where a splint was applied.</p> <p>Review of the Controlled Substance Record indicated on 9/18/13 the resident received a dose of the Hydrocodone 7.5-325 mg on 9/18/13 at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Further review of the Controlled Substance Record indicated on 9/22/13 the resident received the Hydrocodone 7.5-325 mg at 8:00 a.m., 12:00 p.m., 3:15 p.m., and 9:15 p.m. On 9/23/13 the resident received the Hydrocodone 7.5-325 mg at 6:30 a.m., 8:00 a.m., 12:00 p.m., and 4:00 p.m.</p> <p>Review of Nursing Progress Notes dated 9/25/13 at 12:13 p.m., indicated "Physician notified of resident's status and medication concern. New orders received to hold the 12:00 p.m. dose of Hydrocodone on 9/25/13 only and resume the 12:00 p.m. dose on 9/26/13. New order was also obtained to discontinue the Hydrocodone 5-325 mg one tab every</p>		<p>consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director.</p>		

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	<p>six hours prn knee pain." This Federal Tag relates to Complaint IN00137644.</p> <p>3.1-37(a)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident with a pressure ulcer received the necessary treatment and services to prevent further breakdown related to obtaining treatments and ensuring bandages were on the pressure ulcers for 1 of 3 residents reviewed for pressure ulcers in the sample of 11. (Resident #C)</p> <p>Findings include:</p> <p>On 10/17/13 at 9:25 a.m., Resident #C was taken to the bathroom for a skin assessment. The Assistant Director of Nursing (ADoN) pulled the resident's pants and incontinent brief down to reveal her buttocks and coccyx areas. At that time, there were no bandages on the resident's open areas. There were two open areas observed, one to the resident's</p>	F000314	<p>F314 1. With respect to resident C, physician and family notification completed on 10/17/13 and new treatment orders received and noted. 2. All residents had the potential to be affected by this citation. All current pressure areas reviewed to ensure proper treatment in place for each area by 11/4/13. 3. Nursing staff will be in-serviced on physician treatment orders regarding each individual pressure area noted by director of nursing and/or designee by 11/4/13. 4. Random audits of three residents pressure areas and corresponding physician orders will be completed two times a week for 2 weeks, then once a week for 2 months and/or until 100% compliance obtained by the Director of Nursing and /or Nursing Supervisor. During morning meeting, clinical IDT team will review all 24 hour nurses notes and physician orders to ensure timely follow-up</p>	11/04/2013			

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	<p>coccyx which was pink in color and the other to the resident's right buttock which was light blue to red in color. The Assistant Director of Nursing indicated that both areas were to be covered with gauze sponges.</p> <p>Interview with CNA #1 at that time, indicated she had not taken the resident to the bathroom at all since she had been here.</p> <p>Interview with CNA #2 at that time, indicated she had taken the resident to the bathroom before breakfast and she stated she was "pretty sure" the resident had bandages to the open areas, but was not 100% sure.</p> <p>Interview with LPN#1 at 9:45 a.m., indicated the treatment was completed on the evening shift, so he had not seen the areas in some time. He further indicated he had not toileted the resident today, nor was he made aware the resident was in need of new bandages to the open areas. He indicated both CNAs nor the therapy department had informed him the resident needed her treatment done.</p> <p>The record for Resident #C was reviewed on 10/15/13 at 2:55 p.m.</p>		<p>and completion. Any significant changes in residents' status requiring physician/family notification found incomplete will be completed by Nursing Staff. Residents' physician/family will be notified, new orders will be processed, and care plan updated to reflect status.</p>		

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	<p>The resident was admitted to the facility on 9/6/13. The resident's diagnoses included, but were not limited to, recent left hip fracture, total hip replacement, and high blood pressure.</p> <p>Review of the Nursing Admission record dated 9/6/13 indicated the resident was admitted to the facility with a pressure ulcer to the coccyx area. The open area was measured at that time in which it measured 1.5 centimeters (cm) by 1 cm and was identified as a stage two pressure ulcer.</p> <p>Review of Wound/Skin record indicated the last recorded measurement for the coccyx pressure ulcer was on 10/10/13. The area measured 1 cm by 1 cm and was pink with no drainage.</p> <p>Review of Physician Orders dated 9/6/13 indicated Silvadene to open area to coccyx. Cover with dry dressing daily until healed.</p> <p>Review of the 9/2013 Treatment Administration Record (TAR) indicated the treatment was signed out everyday. Review of the 10/2013 TAR indicated the treatment was signed out as being completed</p>			

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	<p>10/1-10/16/13. There was only one treatment ordered and being done for the resident's open area.</p> <p>Review of the Wound/Skin Record indicated on 10/3/13 the resident had acquired a stage two pressure ulcer to the right buttock. The area measured 1 cm by .8 cm by less than .1 cm. The area was identified as having slough, however, there was no drainage. The pressure ulcer was again measured on 10/10/13 in which it measured 1 cm by .8 cm it was identified as pink with no drainage.</p> <p>Review of Physician Orders dated 10/3-10/16/13 indicated there was no treatment ordered for the newly acquired pressure ulcer to the right buttock.</p> <p>Review of the 10/2013 TAR indicated there was only one treatment being completed and that was for the coccyx pressure ulcer.</p> <p>Review of Nursing Progress Notes dated 10/3/13 indicated there was no evidence of any documentation or assessment of the newly acquired pressure ulcer to the right buttock.</p> <p>Review of the current 6/2013 Skin/Wound Policy provided by the</p>			

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	<p>Director of Nursing indicated the nurse will be responsible for notifying the responsible party, Physician, and documentation on the 24 hour report. The wound protocol will be discussed with the Physician for any new ulcers identified.</p> <p>Interview with the ADoN on 10/17/13 at 9:45 a.m., indicated the stage two to the right buttock now measured 1 cm by .8 cm by less than .2 cm. She further indicated the coccyx pressure ulcer was now a stage one and measured 1 cm by .5 cm. The ADoN indicated the Nurses were providing a treatment to the right buttock pressure ulcer of Silvadene the same one as the coccyx. She further indicated Nursing staff did not obtain a new Physician's Order for the right buttock pressure ulcer, they just used the same treatment as the coccyx. She further indicated it was the facility's protocol to notify the Physician and obtain a new treatment for newly identified pressure ulcers.</p> <p>This Federal Tag relates to Complaint IN00137664.</p> <p>3.1-40(a)(2)</p>				

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure weight loss was monitored and Nutrition at Risk meetings were conducted weekly for 2 of 5 residents reviewed for weight loss in the sample of 11. (Residents #C and #K)</p> <p>Findings include:</p> <p>1. The record for Resident #K was reviewed on 10/15/13 at 3:20 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Dementia, thyroid disease and depression.</p> <p>An entry in the Nursing Progress Notes dated 8/13/13, at 11:11 p.m., indicated a pressure area was observed to the resident's coccyx, buttock, and sacrum areas. Review of the Wound/Skin healing record indicated on 8/14/13, the area to the</p>	F000325	<p>F325 1. With respect to resident K, With respect to Resident #K, physician and family notified of weight loss on 9/4/13. Resident being followed in NAR since 9/12/13 to current. With regards to resident #C, physician and family notified of pressure area, new treatment orders received and noted 10/17/13. Resident resumed NAR 10/3/13 and remains currently on NAR. 2. All residents have the potential to be affected by this citation. Physician will be contacted via phone versus facsimile regarding any and all significant weight changes. Will review all weights and recommendations with dietician to ensure proper physician notification completed by 11/4/13. RD recommendations will be discussed with unit managers and physicians will be notified accordingly. Upon finding any new pressure areas, facility will ensure physician and family are notified and treatment is</p>	11/04/2013	

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	<p>coccyx measured 0.8 centimeters (cm) x 0.6 cm x 0.6 cm and was identified as a Stage 3 pressure ulcer (full thickness tissue loss).</p> <p>The resident was reviewed in the Nutrition at Risk (NAR) meetings on 8/15, 8/22, and 8/29/13. The recommendation on 8/29/13, was to continue to monitor in NAR.</p> <p>Documentation in the Nursing Progress Notes dated 8/31/13, indicated a re-weight was completed and a 13 pound weight loss was confirmed for the resident and the Physician was faxed at that time.</p> <p>Review of the NAR minutes, indicated the resident was not seen in NAR until 9/12/13 and her weight loss was addressed at that time. The resident was seen on 9/18 and then not again until 10/3/13.</p> <p>Interview with the Director of Nursing on 10/16/13 at 1:50 p.m., indicated the NAR committee was supposed to meet weekly, however, the meetings had not been conducted weekly in August and September 2013 due to staff issues.</p> <p>2. The record for Resident #C was reviewed on 10/15/13 at 2:55 p.m. The resident was admitted to the</p>		<p>obtained. All current pressure areas reviewed to ensure proper treatment in place for each area. 3. Nursing staff will be in-serviced on facility policy regarding physician notification related to resident change in status, including but not limited, significant weight change, RD recommendations, and any and all new pressure areas by the Director of Nursing and/or Nursing Supervisory staff on or prior to 11/4/13. 4. Random audits of residents change in status and corresponding physician notification will be completed on three residents two times a week for two weeks then 1 time a week for 2 months and/or 100% compliance. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved.</p>		

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	<p>facility on 9/6/13. The resident's diagnoses included, but were not limited to, recent hip fracture, total hip replacement, and high blood pressure.</p> <p>Review of the Nursing Admission record dated 9/6/13 indicated the resident was admitted to the facility with a Stage two pressure ulcer to the coccyx area.</p> <p>Review of the weight record indicated the resident weighed 108 pounds on admission. Further review of the weight record indicated the resident weighed 103 pounds on 10/3 and 104 pounds on 10/10/13.</p> <p>Review of the Registered Dietitian's (RD) report dated 9/7/13 indicated the resident was newly admitted to the facility with a pressure ulcer. The RD recommended to add Vitamin C 500 milligrams (mg) daily times 30 days. The resident was to be seen in Nutrition at Risk.</p> <p>Review of the Nutrition at Risk sheet indicated the resident was seen on 9/12, 9/18, 10/3, and 10/10/13.</p> <p>Review of the current 1/2012 Nutrition at Risk Program provided by the Assistant Director of Nursing</p>				

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	<p>indicated "The Nutrition at Risk Program serves to assure that each resident's nutritional status and needs; potential nutritional risk and deficiencies, are assessed, planned for and evaluated. The committee will place residents on the Nutrition at Risk Program who fall under the following risk categories: New admissions, skin integrity conditions: pressure ulcers (stage 2, 3, and/or 4)."</p> <p>Interview with the RD on 10/16/13 at 2:00 p.m., indicated the resident had not been seen on a weekly basis in the Nutrition at Risk, due to Unit Managers not available and staff turnover.</p> <p>Interview with the Assistant Director of Nursing on 10/17/13, at 10:00 a.m., indicated the Nutrition at Risk committee was to meet weekly to discuss the resident's nutritional concerns.</p> <p>This Federal Tag relates to Complaint IN00137664.</p> <p>3.1-46(a)(1)</p>			
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from significant medication errors related to excessive dose of Hydrocodone (narcotic pain medication) for 1 of 3 residents reviewed for unnecessary medications in the sample of 11. (Resident #M)</p> <p>Findings include: The record for Resident #M was</p>	F000329	F329 1. With respect to resident M, receiving current prescribed scheduled and PRN pain medication as ordered. 2. All residents have the potential to be affected by this citation. Audit of all resident's PRN pain medications will be conducted to ensure proper dosage per physician order completed by nursing supervisory team by 11/4/13. 3. Nursing staff will be in-serviced on pain and medication error follow-up by Director of nursing and/or designee by 11/4/13. 4. Random	11/04/2013			

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	<p>reviewed on 10/16/13 at 9:10 a.m. The resident's diagnoses included, but were not limited to right broken radius, Alzheimer Dementia, anxiety, depression, and osteoarthritis.</p> <p>Review of Physician Orders dated 7/12/13, and on the current 10/2013 recap indicated Hydrocodone 7.5-325 milligrams (mg) three times a day at 8:00 a.m., 12:00 p.m., and 4:00 p.m. Another Physician's Order dated 1/13/13, and on the current 10/2013 recap indicated Hydrocodone 5-325 mg every six hours as needed (prn) knee pain.</p> <p>Review of Nursing Progress Notes dated 9/18/13 indicated the resident's right wrist was swollen. An X-ray was obtained and the resident had fractured her right wrist. The resident was sent to the hospital where a splint was applied.</p> <p>Review of the Controlled Substance Record indicated on 9/18/13 the resident received a dose of the Hydrocodone 7.5-325 mg on 9/18/13 at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. On 9/21/13 the resident received the Hydrocodone at 8:00 a.m., 12:00 p.m., and 8:00 p.m. Further review of the Controlled Substance Record indicated on</p>		<p>audits of three resident's PRN pain medications and any medication errors to ensure proper follow up by the Director of Nursing and/or Nursing Supervisory staff 2 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. During morning meeting, clinical IDT team will review all 24 hour nurses notes and physician orders to ensure timely follow-up and completion. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director.</p>		

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	<p>9/22/13 the resident received the Hydrocodone 7.5-325 mg at 8:00 a.m., 12:00 p.m., 3:15 p.m., and 9:15 p.m. On 9/23/13 the resident received the Hydrocodone 7.5-325 mg at 6:30 a.m., 8:00 a.m., 12:00 p.m., and 4:00 p.m. On 9/24/13 the resident received the Hydrocodone at 8:00 a.m., 12:00 p.m., and 8:00 p.m.</p> <p>Review of Nursing Progress Notes dated 9/23/13 at 8:37 a.m., indicated "At 6:30 a.m., resident crying and complaining of pain related to fracture right wrist. Norco 5/325 PRN was given...."</p> <p>Continued review of Nursing Progress Notes dated 9/25/13 at 4:09 p.m., indicated there was no assessment of the resident regarding the medication error of receiving too much Hydrocodone including vital signs. The next entry on 9/25/13 at 8:24 p.m., indicated the resident had no signs or symptoms of pain. There were two entries in Nursing Progress Notes on 9/26/13 and neither one had evidence of any documentation of an assessment and/or the resident being monitored after the medication error including vital signs.</p> <p>Review of the blood pressure log indicated there was no documentation</p>				

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	<p>the resident's blood pressure was obtained on 9/25 and 9/26/13 after the medication error. Further review of the vital signs record indicated the resident's pulse nor respirations were recorded for 9/25 and 9/26/13.</p> <p>Review of the current and undated Medication and Treatment Incidents and Drug Reactions provided by the Timbre Unit Manager indicated "The patient is kept under constant observation."</p> <p>Review of Nursing Progress Notes dated 9/25/13 at 12:13 p.m., indicated "Physician notified of resident's status and medication concern. New orders received to hold the 12:00 p.m. dose of Hydrocodone on 9/25/13 only and resume the 12:00 p.m. dose on 9/26/13. New order was also obtained to discontinue the Hydrocodone 5-325 mg one tab every six hours prn knee pain."</p> <p>Review of the weight record indicated the resident's weight was 144 pounds on 9/3/13. The resident weighed 132 pounds on 10/2 and was reweighed on 10/3 and still weighed 132 pounds.</p> <p>Review of the food consumption log dated 9/20/13 indicated the resident ate none of her dinner. There was no</p>			

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	<p>intake available for the breakfast and lunch meal on 9/21/13. The resident at 1-25% of her dinner meal on 9/21/13. The resident ate none of her breakfast on 9/22/13, 26-50% of lunch and no dinner meal was recorded for 9/22/13. The resident ate 1-25% of breakfast and lunch on 9/23/13 and the dinner meal was not recorded. The resident ate 1-25% of breakfast on 9/24/13. On 9/25/13 the resident ate no breakfast and 76-100% of lunch and no dinner meal was recorded. The resident at 1-25% of breakfast, lunch and dinner on 9/26/13.</p> <p>Interview with the Timbre Unit Manager on 10/16/13 at 10:30 a.m., indicated on the Physician recap there was an order for Hydrocodone 5-325 mg every six hours as needed for knee pain. The order was obtained from the Physician on 1/13/13. The Unit Manager further indicated the facility did not have that dosage of Hydrocodone for the resident due to the Pharmacy had never sent it because they never received a written script of the Physician Order for the lower dosage of Hydrocodone. She further indicated the nurses were administering the 7.5-325 mg dose of the Hydrocodone prn as well</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2013
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383		
(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>administering the narcotic three times a day as ordered by the Physician. The Unit Manager also indicated the resident received the prn doses of the Hydrocodone earlier than six hours apart from the regular scheduled doses.</p> <p>Interview with the Timbre Unit Manager on 10/16/13 at 1:30 p.m., indicated there was no follow up assessment or constant monitoring of the resident documented in her clinical record.</p> <p>This Federal Tag relates to Complaint IN00137664.</p> <p>3.1-48(a) 3.2-48 (a)(3)</p>				