

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 04/29/2014
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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 was for the Investigation of Complaints IN00147839, IN00147865, and IN00148335.</p> <p>Complaint IN00147839- Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F327.</p> <p>Complaint IN00147865- Substantiated. Federal/State deficiency related to the allegations is cited at F205.</p> <p>Complaint IN00148335- Substantiated. Federal/State deficiency related to the allegations is cited at F151.</p> <p>Survey dates: April 28 & 29, 2014</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Survey team: Janet Adams, RN-TC Regina Sanders, RN</p> <p>Census bed type: SNF/NF: 102 NCC: 1 Total: 103</p>	F000000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Whispering Pines requests that this Plan of Correction is considered the facility's Allegation of Compliance effective May 29, 2014.</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.

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F000151 SS=D	<p>Census payor type: Medicare: 19 Medicaid: 57 Other: 27 Total: 103</p> <p>Sample: 14</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 4, 2014, by Janelyn Kulik, RN.</p> <p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>Based on record review and interview, the facility failed to ensure a resident was able to exercise her rights for decisions about her treatment, related to not following a resident's request to be transferred to the hospital for treatment of an urinary tract infection (UTI), when the transfer was approved by the Physician</p>	F000151	<p>F 151 Rightto Exercise Rights – Free of Reprisal RESIDENTS FOUND TO BE AFFECTED: The staff of the facility makes every effort to have the resident exercise their rights. Resident F was sent out to the ER for antibiotic IV therapy, after previously refusing to go to</p>	05/29/2014

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	<p>on call for 1 of 3 residents reviewed for UTI's in the sample of 14. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's record was reviewed on 04/28/14 at 11:25 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and urinary retention.</p> <p>A 60-Day Minimum Data Set Assessment, dated 04/06/14, indicated the resident's cognition was intact.</p> <p>A urine culture, dated 04/25/14 and completed on 04/27/14, indicated the resident's urine had >100,000 enterococcus faecalis in the urine (organism causing the UTI).</p> <p>A Physician's Order, dated 04/27/14, indicated an order for amoxicillan (antibiotic) 875 mg (milligrams), give twice a day for 10 days.</p> <p>A Nurses' Progress Note, dated 04/27/14 at 10:29 a.m., indicated the resident refused to take the amoxicillan. The resident indicated amoxicillan did not work for her. She indicated the only thing that would help her UTI was an IV (intravenous) antibiotic in the hospital and she requested to go to the hospital.</p>		<p>thehospital. The resident was sent back to the facility with p.o. Amoxicillin which she had refused and said she couldn't take/refused in the facility.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED:</p> <p>The staff will bere-educated on resident rights, residents being free from reprisal when expressing concerns about anything they wish to complain about. The staff will also be re-educated on how to speak with residents in a respectful way and handle their concerns.</p> <p>SYSTEMIC MEASURES/CORRECTIVE ACTION:</p> <p>The staff will bere-educated on resident rights, residents being free from reprisal when expressing concerns about anything they wish to complain about. We will also educate the staff on how to speak with residents in a respectful way when the resident/families are upset and/or angry. A more structured concern process will be in place to better deal with concerns for a timely resolution for the residents or families.</p> <p>QUALITY ASSURANCE/MONITORING:</p> <p>The Administrator or his designee will interview ten percent of the alert residents weekly for four weeks, once a week for two months, then</p>	

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	<p>The note further indicated the Nurse notified the Physician on call and received an order to either transfer the resident to the hospital for evaluation and treatment or to wait until the next day for her Primary Care Physician to return. The note further indicated the resident was notified of the response from the Physician on call and became very angry about not being treated immediately for the infection.</p> <p>A Nurses' Progress Note, dated 04/27/14 at 2:36 p.m., indicated the resident was again requesting to be transferred to the Emergency Room for IV antibiotic treatment. The note indicated the Nurse reminded the resident the Doctor on call wanted the facility to call the Resident's Primary Care Physician in the morning. The resident then indicated the facility did not care about her health.</p> <p>A Nurses' Progress Note, dated 04/27/14 at 10 p.m. (12 hours later), indicated the Physician on call had called the facility and indicated the resident had called the Physician herself with concerns about the UTI and the facility would not do anything for her. The Nurse indicated she informed the Physician the resident requested an IV antibiotic and had refused the oral medication. The note further indicated the Physician indicated</p>		<p>every other week for two months, then monthly for six months with the results brought to the Quality Assurance Committee monthly. Resident that have had concerns in the past will be made part of the group residents to be interviewed. If compliance is achieved for two months consecutively, the QA Committee will determine if further auditing is required.</p> <p>DATE OF COMPLIANCE: May 29, 2014</p>				

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	<p>to continue the previous orders for the antibiotic.</p> <p>During an interview on 04/28/14 at 2:10 p.m., Unit Manager #1 indicated she had spoken to the Nurse on duty on 04/27/14 and had instructed her not to transfer the resident to the hospital and to call the hospital to find out what she had been treated with because the facility could do the IV therapy.</p> <p>During a telephone interview on 04/28/14 at 2:42 p.m., LPN #4 indicated the resident was in her sound mind and had refused to take the oral antibiotic. She indicated the resident requested to go to the Emergency Room for IV treatment. She indicated she notified the Physician and received an order to either send her to the Emergency Room or wait until the next day when the resident's Primary Care Physician was available. She indicated she then called her Unit Manager and was instructed to call the hospital to find out what type of IV antibiotic she had been on prior because the facility could do IV's and the resident would not need to be transferred to the Emergency Room. She indicated Medical Records was closed at the hospital and she could not get the information. She indicated she called the Unit Manager again and the Unit</p>			

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F000205 SS=A	<p>Manager instructed her to wait until the next morning and to not transfer the resident to the Emergency Room.</p> <p>This Federal Tag relates to complaint IN00148335.</p> <p>3.1-3(a)</p> <p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph</p>			

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	<p>(b)(1) of this section.</p> <p>Based on record review and interview, the facility failed to provide written information to the resident and a family member or legal representative explaining the bed-hold policy and reason for transfer, related to residents transferred and admitted to a hospital, for 2 of 4 residents reviewed for transfers in a total sample of 14. (Residents #G and #J)</p> <p>Findings include:</p> <p>1. Resident #G's record was reviewed on 04/28/14 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>A Physician's Order, dated 04/18/14, indicated an order to transfer the resident to a behavioral hospital for evaluation and treatment.</p> <p>A Transfer Form, dated 04/21/14, indicated the resident had been transferred to the hospital.</p> <p>There was a lack of documentation to indicate a Notice of Transfer/Bed Hold Policy form had been given to the resident and/or the responsible party.</p> <p>During an interview on 04/28/14 at 2:55</p>	F000205	<p>F 205 Notice of Bed-Hold Policy Before/Upon Transfer RESIDENTS FOUND TO HAVE BEEN AFFECTED:</p> <p>The facility make every effort to provide written information to the resident and a family member or legal representative explaining the bed-hold policy and the reason for transfer, related to residents transferred and admitted to a hospital or another facility or within the facility.</p> <p>Resident G was transferred to ER and did not return to the facility.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED:</p> <p>Any resident being transferred to a hospital, going to another facility, or a resident changing rooms within the facility may be affected. The Notice of Bed-Hold/Transfer Form will be attached to the transfer sheet so that the form is readily available.</p> <p>SYSTEMIC MEASURES/CORRECTIVE ACTION:</p> <p>The staff will be in-serviced on the Notice of Bed-Hold/Transfer Policy with a return test. The staff will also in-serviced the intra-facility policy form, and our transfer sheet. The transfer sheet will have a Notice of Bed-Hold /Transfer Policy attached to the transfer sheet so make it easier for the nursing to send it with the resident.</p> <p>QUALITY</p>	05/29/2014			

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	<p>p.m., the Consultant Administrator indicated a Notice of Transfer/Bed Hold Policy should have been given to the resident or the responsible party.</p> <p>2. Resident #J's record was reviewed on 04/28/14 at 11:45 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A Physician's Order, date 04/18/14, indicated to transfer the resident to the Emergency Room for evaluation and treatment for increased respirations.</p> <p>The Nurses' Progress Notes, dated 04/18/14 at 2 a.m., indicated the resident had been transferred by ambulance to the Emergency Room and the paperwork had been given to the driver of the ambulance.</p> <p>There was a lack of documentation to indicate a Notice of Transfer/Bed Hold Policy form had been given to the resident and/or the responsible party.</p> <p>During an interview on 04/28/14 at 11:30 a.m., the Consultant Administrator indicated the facility could not find where a Notice of Transfer/Bed Hold Policy form had been given to the resident and/or the responsible party.</p>		<p>ASSURANCE/MONITORING: The Administrator/ordesignee will audit all transfer/discharges out of the facility along with Intra-facility transfer to ensure that the proper forms are being made out and given to the resident/families at time of transfer/discharge. The audit will be done three times weekly for two months, once weekly for two months and twice monthly for two months. The results of the audit will be forwarded to the QA Committee. If compliance is achieved for six months consecutively, the QA Committee will determine if further auditing is required. DATE OF COMPLETION: May 29, 2014</p>				

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F000314 SS=D	<p>3. The facility policy titled "Notice of Bed Hold and Readmission" was reviewed. The policy was dated 1/11. The Interim Director of Nursing provided the policy and indicates the policy was current. The policy indicated "There is no bed hold provided by Medicare or Medicaid. If the resident/family wants to hold the bed during a hospitalization, the bed hold must be requested and agreed that the resident/family will pay the daily rate privately.... A resident/family may arrange privately to hold a bed if he/she is willing to pay in advance to hold a bed. This applies to Hospitalizations and Therapeutic Leaves of Absence...."</p> <p>This Federal Tag relates to complaint IN00147865.</p> <p>3.1-12(a)(25)(B)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without</p>			

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	<p>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 the necessary treatment and services to treat pressure ulcers were provided related to not providing treatments as ordered by the Physician for 1 of 3 residents reviewed for pressure ulcers in the sample of 14. (Resident #H)</p> <p>Findings include:</p> <p>During Orientation Tour on 4/28/14 at 8:50 a.m., Resident #H was observed in her room. The resident had a blue boot on her left lower leg and foot. The Community Nurse Manager removed the boot. There was a dressing in place to the resident's foot/ankle area. The date of 4/25/14 was written on the dressing. The Community Nurse confirmed the date on the dressing was 4/25/14.</p> <p>On 4/29/14 at 11:18 a.m., Resident #H was observed in her room. The resident had a blue boot on her left lower leg and foot. LPN #1 removed the boot from the</p>	F000314	<p>F 314 Treatment/SVCSto Prevent/Heal Pressure Sores RESIDENT FOUND TO HAVE BEEN AFFECTED:</p> <p>The staff of the facility make every effort to prevent and/or develop pressure sores. The facility also makes every effort to ensure necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Resident H is being seen by the wound physician weekly.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED:</p> <p>All residents are observed each shower day by the CNA and the nurse on duty to assess the skin condition. Any areas found will be reported to the attending physician and new orders will be obtained if the physician feels necessary. A skin assessment has been completed on every resident with documentation in the resident medical record. The attending physician will be notified with any new areas.</p> <p>SYSTEMIC MEASURES/CORRECTIVE ACTION:</p> <p>The nurses will be re-educated with return demonstration on how to do</p>	05/29/2014

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	<p>resident's foot. The LPN then removed a dressing from the resident's left foot/ankle area. The resident had a pressure ulcer to the left heel area. The pressure area was approximately 3 cm (centimeters) x 2 cm. The wound was open. The wound was yellow in color with several patches of pink tissue. The LPN cleansed the area with normal saline wound wash, dried the area with a gauze, and applied Santyl (a debriding ointment) and Bactroban (an antibiotic ointment) to the wound. The LPN then applied Hydrogel (a medicated ointment to treat wounds) and placed a new dressing on the wound.</p> <p>The record for Resident #H was reviewed on 4/28/14 at 11:40 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, osteoporosis, neuropathy, and high blood pressure.</p> <p>The 3/28/14 Quarterly MDS (Minimum Data Set) Assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (6). A score of (6) indicated the resident's cognitive patterns were severely impaired. The MDS also indicated the resident had one Stage III (a wound with full thickness tissue loss with no bone, tendon, or muscle exposed) pressure ulcer and was</p>		<p>a dressing change following the physician order. The nursing will be re-educated on infection control practices.</p> <p>The nursing staff will be re-education on prevention of pressure ulcers, treatment techniques and</p> <p>DATE OF COMPLIANCE: May29, 2014</p>	

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	<p>at risk for the development of pressure ulcers.</p> <p>Review of the 4/2014 Physician Order Statement indicated there was an order to cleanse the left heel wound with normal saline, apply Santyl/Bactroban 1:1 ointment, then cover with a foam dressing with Hydrogel and place over the wound, then secure with a dry dressing on the 7:00 a.m.-3:00 p.m. shift. The order was written on 2/12/14. A Physician's order was written on 4/1/14 for the resident to receive Septra (an antibiotic) 800 milligrams twice a day for (7) days.</p> <p>The 4/2014 Treatment Administration Record was reviewed. The above left heel ulcer treatment was signed out as completed on 4/25/14. The treatment was not signed out as completed on 4/26/14. The treatment was circled as not completed on 4/27/14. There was no documentation of the reasons the treatment was not completed on 4/26/14 and 4/27/14.</p> <p>The 4/2014 Nursing Progress Notes were reviewed. There was no documentation of the resident's left foot dressing being changed on 4/26/14 or 4/27/14.</p> <p>Laboratory tests results were reviewed.</p>						

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	<p>A wound culture was obtained on 3/28/14. The final results of the culture were completed on 3/31/14. The wound culture was positive for a moderate number of Coagulase Staphylococcus (an infection).</p> <p>A Resident Infection Report Form was completed on 4/6/14. The form indicated an order was written on 4/1/14 for the resident to receive Septra 800 milligrams twice a day for (7) days to treat an infection to the left heel wound.</p> <p>Review of the 4/2014 Wound/Skin Record indicated the resident's left heel was last measured on 4/22/14. The 4/22/14 entry indicated the resident had a Stage III pressure ulcer to the left heel. The ulcer measured 3.6 cm x 2.6 cm with .2 cm depth. The wound bed tissue was marked as granulation tissue and slough(necrotic or avascular tissue in the process of separating from viable tissue) with a small amount of exudate (drainage) with no odor.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 10/29/13 indicated the resident had a suspected deep tissue injury to the left heel. The care plan was last updated with a target goal date of 7/1/2014. Care plan interventions included for the resident to</p>			

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F000327 SS=D	<p>be seen by the Wound Care Physician and for the wound to be assessed weekly.</p> <p>When interviewed on 4/28/14 at 3:15 p.m., the Community Unit Manager indicated the treatment and dressing changes to the resident's left heel ulcer should have been completed daily as ordered by the Physician. The Unit Manager indicated a staff Nurse was assigned to take care of the resident on one of the days the treatment was not completed and an Agency Nurse was assigned the other day. The Community Unit Manager indicated she spoke with the staff Nurse today and the Nurse indicated the treatment had not been completed on 4/27/14 as ordered by the Physician. The Community Manager indicated she was unable to contact the Agency Nurse at this time.</p> <p>This Federal Tag relates to Complaint IN00147839.</p> <p>3.1-40(a)(2)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p>			

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	<p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on record review and interview, the facility failed to ensure residents' hydration status was monitored related to assessing residents for signs and symptoms of dehydration, monitoring the resident's oral intake and output, and providing IV (Intravenous) fluids as ordered by the Physician for 1 of 3 residents reviewed for dehydration in the sample of 14. (Resident #E)</p> <p>Findings include:</p> <p>The closed record for Resident #E was reviewed on 4/28/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, altered mental status, Alzheimer's Disease, chronic kidney disease, and dysphagia (difficulty swallowing).</p> <p>The resident was admitted to the facility from the hospital on 2/27/14. The resident was discharged to the hospital on 3/8/14 after staff were unable to start an IV for the resident to receive IV fluids ordered by the Physician on 3/7/14.</p> <p>The resident's hospital records from 2/20/14 through 2/27/14 were reviewed.</p>	F000327	<p>F 327 Hydration RESIDENTS FOUND TO HAVE BEEN AFFECTED:</p> <p>The facility make every effort to ensure resident's hydration status are monitored related to assessing residents for signs and symptoms of dehydration, monitoring the resident's oral intake and output and providing IV fluids as ordered by the physician. Resident E no longer resides in the facility.</p> <p>OTHER RESIDENTS POTENTIALLY AFFECTED:</p> <p>Any resident on a modified diet, thickened liquids, congestive heart failure, kidney disease, G-tube's, poor food and fluid intake and catheters. Skin assessments have been completed and pertinent labs ordered as needed.</p> <p>SYSTEMIC MEASURES/CORRECTIVE ACTION:</p> <p>The staff will be in-service on resident hydration assessments, the importance of I & O's and services available to start IV's through the Pharmacy. The nursing staff will be in-service on offering fresh water every shift, between meals and at meal time and medication passes. Fluid intake will be added to the nutrition sheets and the aides will be audited daily for proper documentation. The nursing</p>	05/29/2014

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	The hospital records were in the resident's record. The hospital records indicated the resident was admitted through the Emergency Department on 2/20/14. The 2/24/14 History & Physical note indicated the resident was lying in bed and was lethargic. The resident had been sent to the Emergency Room for an elevated sodium level of 162 (normal level 136-145) and was "found to be severely dehydrated". The History and Physical indicated laboratory tests performed noted the resident's Sodium level was 168, BUN (Blood Urea Nitrogen) level was 29 (normal 8-23), and Creatinine level was 1.5 (normal level 0.7-1.2). The Physician's plan included to administer IV fluids. The resident was admitted to the hospital from the Emergency Room. The hospital records also indicated the resident received IV fluids of D5% (Dextrose 5%) at 100 ml's (milliliters) per hour. A 2/21/14 Nutritional Service Initial Assessment was completed by the hospital Dietitian on 2/21/14. The assessment indicated the resident was admitted with a diagnosis of dehydration and hypernatremia (high sodium level). The Dietitian's assessment indicated the resident was at high nutritional risk due to reported poor oral intake and weight loss.		<p>staff will be trained on this.</p> <p>QUALITY ASSURANCE/MONITORING: The nutrition sheets, I & O's and IV's running for hydration will be audited five days a week for one month, then 3 times weekly for two months, then once weekly for 3 months with the results being forwarded to the QA Committee. If compliance is achieved for two months consecutively, the QA Committee will determine if further auditing is required.</p> <p>DATE OF COMPLETION: May 29, 2014</p>	

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	<p>The 2/27/14 Nursing Assessment was completed upon the resident's admission to the facility on 2/27/14 at 6:30 (no am or pm listed). The assessment indicated the resident was admitted with open areas and did not follow commands. The Oral/Dental Assessment section was not completed.</p> <p>The resident's care plans were reviewed. Initial care plans were started on 2/27/14. One of the care plans identified a Nutrition/Hydration concern was identified. Interventions marked included to weigh the resident weekly and offer liquids between meals.</p> <p>A (3) Day Elimination Pattern Assessment was initiated on 2/28/14. No entries were made on 2/28/14. Four entries were made on 3/1/14. These four entries indicated the resident was "already wet". No entries were made on 3/2/14.</p> <p>The electronic Vitals Report from 2/1/14 thru 3/7/14 indicated the resident's meal consumption intake was only recorded twice. The resident's breakfast and lunch intakes were recorded as 26-50% on 3/5/14.</p> <p>The March 2014 Daily Diet Monitor Record was reviewed. The resident's oral</p>			

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	<p>intake for the Breakfast and Lunch meals on 3/5/14 was not recorded. No oral intake was recorded for all three meals on 3/6/14. No oral intake was recorded for the Breakfast and Lunch meals on 3/7/14. The resident consumed 25% of his Supper meal on 3/7/14.</p> <p>The 2/27/14 Physician orders were reviewed. There were order for the resident to receive a pureed diet and nectar thick liquids. The 3/6/14 MDS (Minimum Data Set) Admission Assessment indicated the resident was rarely or never understood. No BIMS (Brief Interview for Mental Status) was completed. The MDS assessment indicated the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of one staff member for eating. The assessment also indicated the resident was always incontinent of bowel and bladder. The assessment also indicated the resident had a 5% weight loss in the last month or a 10% weight loss in the past (6) months.</p> <p>The 3/2014 Physician orders were reviewed. An order was written on 3/7/14 at 12:00 p.m. to administer IV fluids of 0.9% normal saline at 40 cc's (cubic centimeters) an hour for (2) days. A chest X-ray was also ordered at this time.</p>			

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	<p>The 3/2014 Medication Administration and Treatment Administration records were reviewed. The above ordered IV fluids was not signed out as administered on 3/7/14 or 3/8/14. There was no documentation of any Oral Assessments being completed on either the 2/2014 records or the 3/2014 records. There was no documentation of staff offering the resident fluids between meals.</p> <p>Review of the 3/2014 Nursing Progress Notes indicated the first entry made on 3/7/14 was at 5:04 a.m. This entry indicated the resident's lung sounds were clear and the resident was fed by staff. The next entry was made on 3/7/14 at 12:30 p.m. This entry indicated new orders were received to administer IV fluids of 0.9% normal saline at 40 cc's per hours for (2) days. There was no documentation of any assessment of the resident for signs or symptoms of dehydration in this entry.</p> <p>The next entry was made on 3/8/14 at 4:11 a.m. This entry indicated the writer (LPN #5) was informed in report by LPN #2 that an IV pump was on the way because the resident was dehydrated. The entry indicated LPN#2 reported that another Nurse would be available to start the IV when the pump and IV arrived.</p>			
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	<p>The pharmacy delivered the IV pump and saline bags at 5:30 p.m. The writer (LPN#5) informed the Nurse who was going to the start the IV and this Nurse indicated she would be "up "shortly" to start the IV. The entry also indicated at 7:00 p.m., the resident's daughter asked the Nurse about the IV and was told it would be shortly. LPN #5 then called the Nurse who was going to start the IV again and was again told it would be about an hour. LPN #5 informed the resident's daughter of the above and the daughter said "she did not want to wait an hour for the Nurse to start the IV and she wanted it done now." LPN #5 called the other unit again to inform the Nurse who was going to start the IV and no one answered the unit phone. The Daughter left and the Nurse never came up. The entry indicated LPN#5 stayed to work the midnight shift on another unit and gave the night shift Nurse report about the IV not being started. LPN #5 talked to daughter at 12:40 a.m. (3/8/14) and informed her the IV had not been started. LPN #5 returned to Resident #E's room at 2:30 a.m. (3/8/14) and the IV had not been started. The DON (Director of Nursing) was called. At 2:45 a.m. (3/8/14) LPN #5 went to another unit and a RN there agreed to come and start the IV. This Nurse attempted twice to get the IV in and was unsuccessful. At</p>			
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	<p>3:20 a.m. (3/8/14), a Valparaiso Police Officer arrived at the facility and said he was called by Resident #E's daughter to do a welfare check. The ambulance was called and the resident was sent to the hospital.</p> <p>A Nutrition Progress Note was completed by the RD (Registered Dietitian) on 3/6/14 at 2:00 p.m. The Progress Note was for an Initial Review. The RD indicated the resident was admitted with necrotic wounds and had a significant weight loss of 54 pounds over a period of time. The RD note indicated the resident's appetite had been good and he needed to consume 100% of most meals to meet his estimated nutritional requirements. The RD note indicated the resident's current estimated nutritional needs included 2244 ml's (milliliters) of fluids per day.</p> <p>When interviewed on 4/28/14 at 3:35 p.m., LPN #5 indicated she worked a double shift on 3/7/14. The LPN indicated she worked the 3:00 p.m.-11:00 p.m. on Resident #E's unit and then worked the 11:00 p.m.-7:00 a.m. shift on another unit. The LPN indicated when she started her shift at 3:00 p.m. she received report from LPN #6. LPN #6 reported a Physician's order had been obtained for Resident #E to receive IV</p>			

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	<p>fluids. the IV had not been inserted, and the IV fluid and supplies had not arrived at this time. LPN #6 also indicated arrangements had been made for a Nurse from another unit to insert the IV when the supplies arrived from the pharmacy. LPN #5 indicated the IV supplies arrived from the Pharmacy at 5:30 p.m. and she informed the Nurse on the other unit. The LPN indicated this Nurse did not come down to start the IV and she made several calls to her as documented in the Nursing Progress Notes. The LPN indicated the resident's family was upset the IV and IV fluids had not been started. LPN #5 indicated she completed her 3:00 p.m. to 11:00 p.m. shift and gave a report to the on coming night shift Nurse. LPN #5 indicated she informed the night shift Nurse that Resident E's ordered IV and IV fluids had not been started. LPN #5 also reported to the night shift Nurse that the Nurse who was supposed to start the IV never came to the unit to start Resident #E's IV after several calls were made to this Nurse from the other unit. LPN #5 indicated she then ran over to the unit was to work on for the 11:00 p.m. to 7:00 a.m. shift, got report, gave her first round of medications, and returned to check if Resident #E's IV had been started and noted it had not been. The LPN indicated she was a new Nurse and felt she was responsible to check. LPN</p>			
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	<p>#5 indicated she was not trained in IV insertion at the facility. The LPN indicated at 2:30 a.m. (3/8/14) or so she finally went over to the new Rehab Unit and found a Nurse there who said she would come over and try and start the IV. This Nurse went over to Resident #E's room and was unable to start the IV x 2 attempts. At that time the DON was called and then the Police arrived to check on the resident and the night shift Night Nurse took over.</p> <p>When interviewed on 4/29/14 at 9:30 a.m., the Interim DON (Director of Nursing) indicated IV fluid bags of 0.9% normal saline were kept in the facility EDK (Emergency Drug Kit). The Interim DON indicated IV tubing with a dial was also available and could have been used to deliver the ordered rate of fluids. The Interim DON also indicated supplies were also available to insert the IV catheter. The Interim Director of Nursing indicated the Nursing staff should have monitored the resident's food and fluid intake since hospital records indicated he was treated for dehydration prior to his admission to the facility. The Interim Director of Nursing indicated the provide Hydration policy was the only policy they could locate.</p> <p>The facility policy titled "Adequate</p>			
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	<p>Hydration of Residents was received from the Administrative Consultant on 4/28/14 at 2:30 p.m. There was no date on the policy. The policy indicated the purpose of the policy was " To minimize the potential for inadequate fluid status (dehydration) in those residents for whom we provide care." Procedures include for six to eight ounces of water to be offered to each resident at each meal, four ounces of fluid to be offered to each resident at each medication pass, and water to be provided at the bedside of each resident. Resident's dependent on staff to provide them fluids were to be identified via the MDS (Minimum Data Set) assessment and staff were to assist those residents to drink between meals. The policy also indicated all residents were to have an oral cavity assessment every day and verification of this oral assessment was to be documented on the Medication Record.</p> <p>The facility policy titled "Medication Ordering and Receiving From Pharmacy" was received from the Interim DON on 4/29/14 at 7:30 a.m. The policy was dated July 1, 2010. The policy indicated Emergency IM (intramuscular) or IV medications are kept at the Nurses' Station in a portable sealed container. Emergency infusion therapy kits are also kept at the Nurses' Station in a sealed</p>			

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	portable container. This Federal Tag relates to Complaint IN00147839. 3.1- 46(b)			