

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 05/31/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00129035.</p> <p>Complaint IN00129035-Substantiated. No deficiencies related to the allegation were cited.</p> <p>Survey dates: May 27, 28, 29, 30, and 31, 2013</p> <p>Facility number: 000216 Provider number: 155323 AIM number: 100267580</p> <p>Survey team: Regina Sanders, RN, TC (May 28, 29, 30, and 31, 2013) Shannon Pietraszewski, RN (May 29, 30, and 31, 2013) Amber Bloss, QIDP (May 28, 29, 30, and 31, 2013) Janelyn Kulik, RN (May 27 and 28, 2013) Cyndy Stramel, RN (May 28, 29, 30, and 31, 2013) Janet Adams, RN (May 28, 29, 30, and 31, 2013)</p> <p>Census bed type: SNF/NF: 48 Total: 48</p>	F000000	<p>Submission of this 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.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p>	
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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>Census Payor type: Medicare: 05 Medicaid: 38 Other: 05 Total: 48</p> <p>There deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 6, 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, the facility failed to notify a resident's physician, related to a resident's poor appetite and fluid intake for 4 days, which the resident was then transferred to the</p>	F000157	<p>F157</p> <p>1. Resident #26-The resident's attending physician assessed the resident on 4/24/13 and the IV fluids were discontinued. The resident was assessed for dehydration with</p>	06/30/2013	

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	<p>was 360 cc 4/21/13: breakfast- 25% and fluid intake was 240 cc lunch-25% and fluid intake was 60 cc supper- 25% and fluid intake was 60 cc total fluid intake for the day was 360 cc 4/22/13: breakfast- refused food and fluid lunch- 25% and fluid intake was 180 cc supper- refused total fluid intake for the day was 180 cc 4/23/13: breakfast- refused lunch- refused (then resident sent to the hospital)</p> <p>The Nurses Notes indicated: 4/19/13 at 4:35 p.m.- "MD (physician) contacted r/t (related to) her (sic) wound...request sent to start mvi (multiple vitamin) et (and) vit (vitamin) C for wound healing..."</p> <p>4/21/13 at 10 p.m.-"...refused all of eve (evening) meal & substitute."</p> <p>4/22/13 at 3 p.m.-"...decreased (arrow down) ability to perform ADLs (activities of daily living). MD notified c/ (with) response pending..."</p>			

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	<p>4/23/13 at 11:50 a.m.- "Res (resident) displaying increased (arrow up) weakness, change (triangle) in LOC (level of conscienceness), overall decline c/ (with) ADL's. Res has requested to be seen in er...Report called to ER..."</p> <p>There was a lack of documentation to indicate the resident's physician had been notified of the resident's poor food and fluid intake.</p> <p>A facility policy, dated 01/06, titled, "Physician & Family Notification Procedure", received from the Director of Nursing as current, indicated, "...To keep the physician, resident and family appraised of all condition changes...Telephone: 1. Telephone notification is required for all emergencies or all condition changes that require an immediate response...Document information to be faxed...Include all assessment information that the physician will need to make his decisions..."</p> <p>3.1-5(a)(3)</p>				

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F000176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, record review and interview the facility failed to ensure a resident was assessed to self-administer medications related to arthritis cream kept in a resident's room for 1 of 26 residents reviewed for self-administration of medications in a total sample of 26.(Resident # 37).</p> <p>Findings include:</p> <p>On 5/30/13 at 8:30 a.m. there were two tubes of an over the counter (OTC) arthritis cream observed in the resident's bedside table drawer. One tube was half empty, the other was unopened. The resident indicated he used the cream on his knees.</p> <p>On 5/31/13 at 8:00 a.m. there were two tubes of an OTC arthritis cream in the resident's bedside table drawer.</p> <p>The record for Resident # 37 was reviewed on 5/30/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes, neuropathy, and dementia.</p>	F000176	<p>F176</p> <ol style="list-style-type: none"> Resident # 37-The OTC arthritis cream was removed from the room when the facility became aware. The resident was re-educated on not obtaining medications while out on leave. The MD was contacted and an order was obtained for the arthritis cream. A self-administration assessment was completed and it was determined the arthritis cream would be applied by the nursing staff. The facility completed an observation of all other resident rooms to ensure no other medications were present at the bedside. Any identified concerns were immediately corrected. The Administrator and/or designee will conduct a visual inspection of the resident rooms including drawers, with resident/responsible party permission, at least 1x weekly to ensure compliance. The Administrator and/or designee will report the findings of these inspections and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted. 	06/30/2013	

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	<p>The resident's record lacked documentation to indicated the resident had an order for the arthritis cream and an order to self-administer the arthritis cream.</p> <p>There was a lack of documentation in the resident's record to indicate an assessment was completed by the facility to determine if the resident could safely self administer medications.</p> <p>During an interview with LPN # 1 on 5/30/13 at 2:15 p.m. she indicated the resident would go to the store with family members and sometimes bring back items that the staff would have to remove from his room. The LPN indicated she did not know the resident had OTC arthritis cream in his room.</p> <p>During an interview with the Administrator on 5/31/13 at 8:17 a.m., she indicated resident's were to have an assessment for self administration of medications and a physician's order for OTC medications kept in their room.</p> <p>During an interview with DoN (Director of Nursing) on 5/31/13 at 8:50 a.m., she indicated the resident</p>		5. 6/30/13				

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	<p>was not assessed to self-administer medications.</p> <p>The document titled "Self Administration of Medication Procedure" dated 9/05 was provided by the Director of Nursing on 5/31/13 at 2:50 p.m. and was identified as current policy. The policies procedure indicated "...2. An assessment of the residents abilities to self-administer meds (medications) [sic] will be completed prior to initiation of training. 3. Training for self-administration will begin after the HCP team, Physician and responsible party have deemed appropriate...5. Until a determination is made the facility will administer all medications."</p> <p>3.1-11(a)</p>				

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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 provide supportive documentation and followed their policy in relation to notifying Social Service of a resident's behaviors for 1 of 10 residents reviewed for unnecessary medications in a total sample of 26. (Resident #49)</p> <p>Findings include:</p> <p>Resident #49's clinical record was reviewed on 5/29/13 at 12:30 p.m. Resident #49's diagnoses included, but were not limited to, aphasia/dysphasia with aspiration, Alzheimer's/dementia, depression, acute renal failure, and acute delirium.</p> <p>A) An admission physician's order, dated 01/11/13 indicated an order for Xanax (antianxiety medication) 0.25 mg as needed twice a day.</p> <p>A PRN (as needed) Medication sheet, dated 1/11/13 at 11:00 p.m., indicated the resident had increased anxiety</p>	F000250	<p>F250</p> <ol style="list-style-type: none"> Resident #49-The facility was unable to make any corrections from the information cited in the 2567 from January of 2013. All physician orders for the last 30 days were reviewed to identify any other psychoactive orders and to ensure Social Service involvement. All staff were re-educated on the facility policy and procedure for Mood and Behavior Monitoring. The DON or designee will audit the physician orders, the 24 hour report sheets and the nurses notes 5x weekly to ensure compliance. The behavior sheets will be brought to the daily stand-up meeting for review and comparison to the DON findings. This will occur 5x weekly. The DON will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted. 6/30/13 	06/30/2013			

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	<p>and Xanax 0.25 mg was given. There was no attempted interventions indicated.</p> <p>A nursing note dated, 1/11/13 at 11:00 p.m., lacked documentation to indicate the resident had behaviors/anxiety and the resident received the Xanax.</p> <p>A nursing note, dated 1/12/13 at 4:25 a.m., indicated the resident was cooperative and pleasant with her care. There was no documentation regarding the resident having anxiety.</p> <p>A PRN Medication sheet, dated 1/12/13 at 10:00 a.m., indicated the resident had increased anxiety and Xanax 0.25 mg was given. The attempted interventions indicated/circled was position change, behavioral, dietary, other and refused.</p> <p>A nursing note, dated 1/12/13 with 7:00 a.m. to 3:00 p.m., indicated for time, did not indicate the resident having any behaviors/anxiety and did not indicate the Xanax had been given.</p> <p>A physician's order, dated 1/12/13, indicated to discontinue Xanax 0.25 mg prn and to start Xanax 0.25 mg twice a day routinely for anxiety.</p>			

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	<p>A Social Service Admission Note, dated 1/14/13, indicated the resident appeared frail, weak/not responsive, cognitively impaired, and rarely verbal per family (1-2 words). There was a lack of documentation to indicate the resident had anxiety/behaviors and required the Xanax to be increased to twice a day routinely.</p> <p>B) A nursing note, dated 1/15/13 at 12:30 a.m., indicated the resident was displaying purple discoloration in her toes and the resident was picking at the air.</p> <p>A Social Service progress note, dated 1/15/13 at 4:00 p.m., indicated a 72 hour care plan meeting with the family was not completed due to a sudden change in condition. The progress note indicated the physician was contacted and a one time order for seroquel 50 mg was ordered. The progress note indicated to keep the resident comfortable and update the physician in the morning. There were no other entries by Social Service after this date.</p> <p>A Physician's Order dated, 1/15/13 at 7:00 p.m., indicated to give Seroquel (antipsychotic medication) 50 mg, one time dose, per g/tube (feeding tube)</p>			

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	<p>and to update the physician in the morning. The order did not indicate a reason for the Seroquel use.</p> <p>A Nursing Note, dated 1/15/13 at 11:00 p.m., indicated the resident had purple mottling to all toes, the physician was notified with a new order for a one time dose of Seroquel 50 mg. The note indicated the resident had often been reaching up into the air at things that were not there.</p> <p>An Initial Social Service Assessment, dated 1/18/13, indicated the resident was having trouble concentrating, no behavioral symptom and indicated the Abilify (antipsychotic medication) was for depression.</p> <p>A Physician's Progress note, dated 1/25/12 [sic], indicated the resident's care was discussed with the family and they requested/voiced for comfort measures. "Will monitor." The progress note lacked documentation to indicate the intended use for the Abilify</p> <p>A Mood and Behavior Monthly Monitoring Summary, dated 1/14/13, did not indicate mood or behaviors for 1/11/13 and 1/12/13.</p>			
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	<p>A Mood and Behavior Monthly Monitoring Summary, dated 2/26/13, did not indicate mood or behaviors.</p> <p>A quarterly Social Service Assessment, dated 4/18/13, indicated the resident had no mood indicators or behavioral symptoms and indicated the Abilify was for dementia.</p> <p>A Mood and Behavior Monthly g Summary, dated 4/29/13, did not indicate mood or behaviors.</p> <p>An interview with the Social Service Consultant on 5/29/13 at 2:25 p.m., indicated behaviors are monitored on a flow record in a binder. The Consultant indicated the staff would fill out a Mood and Behavior Communication form and would give the form to Social Services. Social Services would take the form to the morning meeting and discuss the behavior, log the behavior in the Mood and Behavior log, care plan the behavior, review the interventions and plan of action, such as a referral for psych. The Consultant indicated he did not have Mood and Behavior Communication Forms in January, or any other documentation indicating why the Xanax 0.25 mg prn (as needed) was changed to twice a day and did not have a Mood and</p>				

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	<p>Behavior Communication Form to indicate why the the Seroquel was ordered. The consultant also indicated he did not have a Mood and Behavior Communication form to indicate why the Abilify was ordered to be restarted. The Consultant indicated the Social Service Director "retired a week or so ago."</p> <p>Another interview with the Social Service Consultant on 5/29/13 at 3:15 p.m., indicated the Seroquel was given for hallucinations. The Consultant indicated he was not a physician and was not sure if "picking at the air" at end of life was an adequate reason for Seroquel. The Consultant indicated the resident had exhibited tearfulness on 5/20/13, as to why the Abilify was restarted. The Consultant indicated he did not have a Mood and Behavior Communication form to indicate an increase in tearfulness.</p> <p>An interview with LPN #1 on 5/29/13 at 5:00 p.m., indicated the resident was having a lot of tearfulness. LPN #1 indicated the resident indicated she wanted to go home. LPN #1 indicated the resident had a difficult time with adjusting to the facility in January. LPN #1 indicated the resident came from another facility.</p>						

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	<p>LPN #1 indicated she thought the scheduled Xanax was a pharmacy recommendation. LPN #1 indicated she had not informed the Social Service Director nor had she filled out a Mood and Behavior Communication form.</p> <p>An interview with the DoN on 5/30/13 at 1:30 p.m., indicated if a resident had behaviors, the nurses would fill out the Mood and Behavior forms and there would be monthly behavior meetings. The DoN indicated the resident was thought to be actively dying as for the one time dose of Seroquel. The DoN indicated the facility has had inservices on "End Of Life" with hospice and felt "picking at the air" was a behavior. The DoN was not able to indicate why the Xanax 0.25 mg was changed from prn to scheduled. The DoN indicated the Abilify was restarted due to the resident was being tearful and was yelling out for her husband who had passed away a long time ago. The DoN indicated she was not aware there was no supporting documentation.</p> <p>An interview with the Social Service Consultant on 5/30/13 at 4:30 p.m., indicated the Mood and Behavior Monthly Monitoring Summary were</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>initiated for all residents who were on psychotropic medications.</p> <p>A Mood and Behavior Program Procedures policy dated July 2010, was provided by the Administrator on 5/30/13 at 7:20 a.m., and verified as a current policy. The policy indicated the Mood and Behavior Communication memo forms would be completed by any staff members witnessing a mood and/or behavior. Non-pharmacological interventions must be attempted and documented prior to any PRN (as needed) psychotropic medication being given. The policy indicated the Social Service Director or designee would collect the communication memos' and present all occurrences to the IDT (Interdisciplinary Team) during the morning meetings. The 24 hour Condition Report would be reviewed during the facility's morning meetings. A New and Worsening Mood and Behavior Problem Assessment would be initiated by social service or nursing and completed by the IDT, in an attempt to identify any intrinsic or extrinsic factors which would be causing or precipitate the mood(s) or behavior (s). The policy indicated a Mood and Behavior Monthly Flow Record would be implemented by social service and placed in the</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>monthly flow record notebook. Social Service will be responsible to record all mood(s) and/or behavior(s) that had been identified on the Monthly Flow Record. IDT would meet monthly or prn (as needed) to review the Monthly Flow Records.</p> <p>3.1-34(a)(2)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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 observation, record review and interview, the facility failed to develop care plans, related to a risk for dehydration and skin conditions for 2 of 18 residents reviewed for care plans in a total sample of 26. (Residents #10 and #26)</p> <p>Findings include:</p> <p>1. Resident #26's record was reviewed on 05/30/13 at 9:45 am. The resident's diagnoses include, but were not limited to, dementia, diabetes mellitus, congestive heart</p>	F000279	<p>F279</p> <p>1. Resident #26- A care plan was developed related to risks for dehydration and chronic purpura. Resident #10-The care plan for the resident picking at her skin was re-initiated.</p> <p>2. Skin assessments were completed on all residents and the care plans were reviewed to determine accuracy. The food and fluid records for all residents were reviewed to determine any other residents at risk for dehydration and care plans were developed, if indicated.</p> <p>3. The Director of Nursing</p>	06/30/2013	

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	<p>failure, and chronic kidney disease.</p> <p>A) The Physician's Recapitulation Orders, dated 05/13, indicated orders for Zaroxolyn (diuretic) 2.5 mg (milligrams) every Monday, Wednesday, and Friday for fluid retention and Demadex (diuretic) 20 mg every morning for congestive heart failure (CHF). Both of the orders were originally ordered on 04/12/13.</p> <p>An Admission Minimum Data Set Assessment (MDS), dated 04/19/13, indicated the resident had received a diuretic for the past seven days.</p> <p>An Emergency Room Physician Record, dated 04/23/13, indicated a diagnosis of dehydration.</p> <p>A care plan, dated 05/18/13, indicated the resident had CHF and was at risk for edema.</p> <p>There was a lack of documentation to indicate the resident had a care plan for being at risk for dehydration.</p> <p>During an interview on 5/30/13 at 11:43 a.m., MDS Nurse #1 indicated there was no dehydration or risk for dehydration care plan for the resident. She indicated there needed to be</p>		<p>(DON) or designee will audit the 24hr report 5x weekly, the weekly skin assessments 5x weekly and the food and fluid consumption records 2x weekly to ensure care plans are developed and/or updated with new or changed conditions.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 6/30/13</p>				

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	<p>more than just a diagnosis to initiate a care plan.</p> <p>B) During an observation on 05/28/2013 at 10:06 a.m. the resident had a skin tear on the left forearm and a purple colored bruise on the back of his right hand at the base of his fore finger. At the time of the observation, the resident indicated his skin tears easily.</p> <p>During an interview with the ADoN (Assistant Director of Nursing on 5/30/13 at 1:20 p.m., she indicated the resident's bruises for him is purpura (red or purple discoloration of the skin), they can get bigger.</p> <p>During an observation on 5/30/13 at 2:35 p.m., with LPN #1 present, LPN #1 indicated the area on the resident's left forearm had been opened and had dried bloody drainage. She indicated the area looked like it had been caused by the resident's watch. She indicated the area had a three centimeter healing line. LPN #1 indicated the bruise on the back of right hand was 1.6 by 2 centimeters and was purplish/red in color. She indicate she did not know where or when the bruise occurred.</p> <p>There was a lack of documentation to</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>indicate the resident had a care plan for the skin tear or the bruise. There was a lack of documentation to indicate the resident had a care plan for purpura.</p> <p>2. During an observation on 05/28/13 at 8 a.m., Resident #10 had three areas on her left forearm, which appeared to be skin tears, which were reddish in color.</p> <p>During an interview, on 5/29/13 at 2:57 p.m., Resident #10 indicated she was nervous and indicated she picks at her skin. She indicated she picks the areas open</p> <p>During an observation of the resident's arms on 05/30/13 at 2:28 p.m., with LPN #1 present, LPN #1 indicated there were areas on the resident's right upper forearm which were scabbed and the resident had picked opened. She indicated there were four areas on the resident's left arm and two areas on the resident's face, which were opened and or scabbed.</p> <p>There was a lack of documentation to indicate the resident had a care plan initiated for the picking at the skin and the open areas.</p>			

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	<p>During an interview on 05/29/13 at 4:10 p.m., the MDS Nurse #1 indicated the resident had a care plan for skin picking, but it had been discontinued and not initiated on the current care plan.</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 05/31/2013	
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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, record review, and interviews, the facility failed to ensure each resident received the necessary treatment and services related to assessments for dehydration for resident who received diuretics and had poor food and fluid intake (Resident #26), failed to thoroughly assess the reason for a resident's continual moaning (Resident #46) and failed to monitor and assess for a bruise and non-pressure open areas for 2 of 3 residents reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non pressure related. (Residents #10 and #26)</p> <p>Findings include:</p> <p>1. Resident #26's record was reviewed on 05/30/13 at 9:45 am. The resident's diagnoses include, but were not limited to, dementia, diabetes mellitus, congestive heart failure, and chronic kidney disease.</p>	F000309	<p>F309</p> <p>1. Resident #26-The resident was assessed for dehydration and a care plan was developed for at risk for dehydration related to diuretic use. A skin assessment was completed on the resident and a care plan was developed for chronic purpura and any identified areas. Resident #10-A skin assessment was completed on the resident. A care plan was developed to reflect the resident's current skin issues. Resident #46-The MD was notified and an order was obtained to administer Tylenol routine for 7 days and re-evaluate the resident. Psych services was also contacted to review the resident.</p> <p>2. The food and fluid consumption records for all residents have been reviewed to determine if any other residents require physician intervention. Skin assessments were completed on all residents and the care plans were reviewed to determine accuracy. Residents were observed during routine care for any signs and symptoms of pain. Any concerns</p>	06/30/2013			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>was 360 cc (cubic centimeters) total fluid intake for the day was 360 cc 4/21/13: breakfast- 25% and fluid intake was 240 cc lunch-25% and fluid intake was 60 cc supper- 25% and fluid intake was 60 cc total fluid intake for the day was 360 cc 4/22/13: breakfast- refused food and fluid lunch- 25% and fluid intake was 180 cc supper- refused total fluid intake for the day was 180 cc 4/23/13: breakfast- refused lunch- refused (then resident sent to the hospital)</p> <p>The Nurses Notes indicated: 4/19/13 at 4:35 p.m.- "MD (physician) contacted r/t (related to) her (sic) wound...request sent to start mvi (multiple vitamin) et (and) vit (vitamin) C for wound healing..."</p> <p>4/21/13 at 10 p.m.-"...refused all of eve (evening) meal & substitute."</p> <p>4/22/13 at 3 p.m.-"...decreased (arrow down) ability to perform ADLs (activities of daily living). MD notified</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>c/ (with) response pending..."</p> <p>4/23/13 at 11:50 a.m.- "Res (resident) displaying increased (arrow up) weakness, change (triangle) in LOC (level of conscienceness), overall decline c/ (with) ADL's. Res has requested to be seen in er...Report called to ER..."</p> <p>There was a lack of documentation to indicate the resident had been assessed for dehydration.</p> <p>An Emergency Room Physician Record, dated 04/23/13, indicated the resident had dry mucous membranes, was disoriented to time, had weakness, the BUN (blood urea nitrogen-kidney function test) of 120 (normal 7-25), Creatinen (kidney function) was 2.26 (normal 0.7-1.3), had mild CHF and was given a diagnosis of dehydration.</p> <p>The electrolytes blood test completed at the hospital on 04/13/13, also indicated the residents sodium was 139 (normal 136-145), potassium was 4.2 (normal 3.5-5.1), and the Glomeruler Filtration Rate (kidney function) was 23 (normal 75).</p> <p>The Emergency Room Physician's Orders indicated the resident was</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>treated with 0.9% normal saline given intravenously, an urinary catheter was anchored, and the resident was discharged back to the facility.</p> <p>A Physician's Progress Note, dated 04/24/13 indicated the resident was lethargic and was seen in the Emergency Room. He indicated the lethargy was metabolic and unlikely to improve and added the diagnosis of failure to thrive.</p> <p>There was a lack of documentation the resident had been assessed for further signs of dehydration from when the resident returned to the facility on 04/23/13 through 05/06/13.</p> <p>There was a lack of documentation to indicate a care plan for dehydration/risk for dehydration had been initiated for the resident.</p> <p>During an interview on 5/30/13 at 11:09 am, LPN #2 indicated the resident only signs and symptom was a change in his level of conscienceness. She indicated the resident did not have a dry mouth or problems with his skin turger. She indicated she completed an assessment but did not document the assessment.</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>During an interview on 5/30/13 at 11:43 a.m., MDS Nurse #1 indicated there was no dehydration or risk for dehydration care plan for the resident. She indicated there needed to be more than just a diagnosis to initiate a care plan.</p> <p>The facility policy titled "Nursing Department Charting Policy and Procedure" was reviewed on 5/30/13 at 10:30 a.m. The policy had a revise date of 1/08. The policy was received from the Nurse Consultant and identified as current. The policy indicated pertinent charting included areas of condition changes</p> <p>B) During an observation on 05/28/2013 at 10:06 a.m. the resident had a skin tear on the left forearm and a purple colored bruise on the back of his right hand at the base of his fore finger. At the time of the observation, the resident indicated his skin tears easily.</p> <p>During an interview with the ADoN (Assistant Director of Nursing on 5/30/13 at 1:20 p.m., she indicated the resident's bruises for him is purpura (red or purple discoloration of the skin), they can get bigger. She indicated the areas would not be measured weekly. She indicated she</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>was not aware of the areas on the resident's skin.</p> <p>During an observation on 5/30/13 at 2:35 p.m., with LPN #1 present, LPN #1 indicated the area on the resident's left forearm had been opened and had dried bloody drainage. She indicated the area looked like it had been caused by the resident's watch. She indicated the area had a three centimeter healing line. LPN #1 indicated the bruise on the back of right hand was 1.6 by 2 centimeters and was purplish/red in color. She indicate she did not know where or when the bruise occurred. She indicated when an area is found, they should measure the area, document, notify the physician, the Director of Nursing (DoN), and the Assistant Director of Nursing (ADoN) so they are aware. She indicated the area on the left arm was old and should have been found and documented.</p> <p>There was a lack of documentation in the resident's Nurses' Notes to indicate when the resident received the skin tear to his left arm or the bruise on the back of his right hand.</p> <p>There was a lack of documentation to indicate the resident had a care plan</p>			

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

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	<p>for the skin tear or the bruise. There was a lack of documentation to indicate the resident had a care plan for purpura.</p> <p>2. During an observation on 05/28/13 at 8 a.m., Resident #10 had three areas on her left forearm, which appeared to be skin tears, which were reddish in color.</p> <p>During an interview, on 5/29/13 at 2:57 p.m., Resident #10 indicated she was nervous and indicated she picks at her skin. She indicated she picks the areas open</p> <p>During an observation on 05/30/13 at 2:28 p.m. with LPN #1 present, LPN #1 indicated there were areas on the resident's right upper forearm which were scabbed and the resident had picked opened. She indicated there were four areas on the resident's left arm and two areas on the resident's face, which were opened and or scabbed. The Resident indicated at the time of the observation, the areas had been present for a long time.</p> <p>A skin assessment, dated 5/27/13 (no time documented) indicated there were no skin alterations.</p> <p>A Nurses' Note, dated 5/29/13 at 2</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 05/31/2013
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.m. indicated the resident's skin was warm, dry and intact.</p> <p>There was a lack of documentation in the Nurses' Notes to indicate the resident's areas on her arms and face had been assessed by the facility</p> <p>There was a lack of documentation to indicate the resident had a care plan initiated for the picking at the skin and the open areas.</p> <p>During an interview with LPN #2 on 5/20/13 at 8:30 a.m., she indicated when an area is found it is cleaned, the physician is called, the area is measured, a skin sheet is initiated, and they inform the ADoN. She indicated she had informed the ADoN the resident picked at her skin. She indicated there had been no measurements assessments of the areas.</p> <p>During an interview on 5/30/13 at 1:20 p.m., the ADoN indicated she was not aware of the resident's skin issues.</p> <p>A facility policy, dated 03/10, titled, "Skin Management Program", received from the Corporate Nurse Consultant as current, indicated, "...2. Residents who receive assistance</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 05/31/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	with bathing and/or peri-care will be observed daily by nursing staff and any note of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations will be reported to the licensed nurse for further assessment...9. Skin alterations will be documented on the appropriate flow sheet...upon initial finding and at least weekly thereafter until healed...13. Skin conditions will be reviewed weekly by the DoN or designee for progression or regression of healing and treatments will be re-evaluated to ensure appropriateness..."			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>3. During an observation of Resident #46 on 5/28/13 at 9:30 a.m., the resident was seated in her wheelchair in her room. The resident would mumble and moan constantly. She was unable to answer questions or verbalize words. The resident had a splint on her left hand and rolled cloth protector in her right hand.</p> <p>An observation was made on 5/29/13 at 1:30 p.m. in the resident's room. The Director of Nursing (DoN) and CNA # 3 transferred the resident from the wheelchair into the bed. The DoN and CNA changed the resident's brief and positioned her in bed. The resident was moaning and mumbling during care. She grimaced at times when being turned in bed.</p> <p>During an observation on 5/31/13 at 1:50 p.m., Restorative Aide (RA) #1 removed the splint from Resident #46's left hand and provided skin care to hands. The resident was tearful and grimaced during splint removal and hand care. The resident attempted to sit forward during care. An interview with the RA and CNA # 2 at that time, indicated that was normal behavior for the resident. The resident was laughing intermittently after care. The RA indicated she assessed the resident for pain by</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>resistance to care or a change in behavior.</p> <p>The resident's record was reviewed on 5/29/13 at 1:05 p.m. Diagnoses included but were not limited to, Parkinson's disease, late effects of CVA (stroke), osteoarthritis, depressive disorder and past knee and hip replacements.</p> <p>The Minimum Data Set (MDS) Quarterly Assessment, dated 4/18/13, indicated the resident's functional status required full assistance for all activities of daily living.</p> <p>The Physician's Orders, indicated the following orders: Zyprexa (antipsychotic) 5 mg (milligrams) every bedtime (07/31/12) Lexapro (anti-depressant) 10 mg daily (10/16/12) Lamictal (antipsychotic) 25 mg, twice a day (03/13/13) Exelon Patch (Alzheimer's/dementia) 9.5 mg/24 hours (07/16/11) Tylenol 325 mg, two tablets every 6 hours prn (as needed) for mild pain (07/06/11)</p> <p>The Medication Administration Records (MARs) and the PRN Medication Records lacked documentation to indicate the</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>resident received the PRN Tylenol in February 2013, March 2013, and April 2013, and Mary 2013.</p> <p>A care plan for antipsychotic drugs was updated on 5/1/13. It indicated Zyprexa was used to treat dementia with delusions, agitation and behaviors. Interventions included, but were not limited to, monitor for adverse side effects such as sedation, agitation, insomnia, nervousness and hostility.</p> <p>A care plan for psychotropic drugs was updated on 5/1/13. It indicated Lexapro was used to treat depression. Interventions included, but were not limited to, monitor for adverse reactions such as somnolence, dry mouth, insomnia and dizziness.</p> <p>A care plan updated 5/1/13 indicated the problem of potential for pain related to osteoarthritis and decreased mobility. Interventions included, "...monitor for signs of pain such as: facial grimacing, moaning, restlessness... Assess pain on a scale of 0-10...Complete pain assessment on admission, with significant change and quarterly...Tylenol as ordered".</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>During an interview with LPN #2 on 5/29/13 at 4:25 p.m., she indicated the behavior the resident was being treated for was moaning. LPN #2 indicated she believed the resident was in pain "if she was tearful". She indicated behaviors were documented on a behavior sheet and turned into social services for behavior tracking, or in nursing notes.</p> <p>An interview with the Social Service Consultant on 5/29/13 at 4:40 p.m. indicated the resident had one behavior dated 2/19/13 related to tearfulness. The resident had one behavior of pinching staff in January and refusing medications at times.</p> <p>During an interview on 5/31/13 at 8:40 a.m. the DoN indicated a Tylenol trial had been done in August of 2011. She agreed contractures and osteoarthritis were painful conditions and would not confirm or deny if she believed the resident was having pain. She was unable to demonstrate how staff was to differentiate between the resident's behaviors and signs of pain.</p> <p>3.1-37(a)</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview the facility failed to provide adequate supervision to prevent potential hazards, related to padding not in place to side rails to prevent possible entrapment for 4 of 5 residents with side rails with gaps in between the bars in the sample of 26 and 2 of 2 unoccupied beds in the facility. (Residents #5, #16, #30, and #40) (Rooms D6-D and A3-W) The facility also failed to ensure adequate supervision was provided related to not properly storing smoking materials and not providing supervision while residents were smoking for 5 of 6 residents with smoking privileges in the facility. (Residents #3, #10, #21, #24, and #50)</p> <p>Findings include:</p> <p>1. On 5/28/13 at 3:26 p.m., Resident #16's bed was observed. There were 1/2 upper side rails on both sides of the bed. There were no pads over the rails or between the three</p>	F000323	<p>F323</p> <p>1. The beds identified in the survey had the padded covers applied to prevent the gap identified. Instructions were applied to each rail identifying the need for the cover to be present. The facility re-educated the nursing staff on the appropriate storage of smoking supplies.</p> <p>2. All beds in the facility were inspected to ensure the measurements were within the required guidance. Any beds identified as applicable had the padded covers applied to prevent injury.</p> <p>3. All staff were re-educated on the use of the padded rail covers and monitoring to ensure they remain in place. The Maintenance Director was re-educated on the facility policy and procedure related to side rails. A side rail measurement will be performed on all beds at least quarterly to ensure continued compliance. All staff were re-educated on the facility policy and procedure related to smoking. The Administrator and/or designee will make rounds at least</p>	06/30/2013			

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 05/31/2013	
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	<p>openings in the side rails. The three openings were measured at this time. The openings between the bars of the side rails were measured by the Maintenance Director as follows: First section: 8 inches x 7 1/2 inches Second section: 7 1/2 inches x 7 1/2 inches Third section: 7 1/2 inches x 7 1/2 inches.</p> <p>The record for Resident #16 was reviewed on 5/29/13 at 3:30 p.m. The 4/23/13 Side Rail Screen indicated one 1/2 side rail was to be used on the resident's bed. The resident's diagnoses included, but were not limited to, congestive heart failure, osteoarthritis, and osteoporosis.</p> <p>A care plan initiated on 1/21/13 indicated the resident was at risk for falls related to impaired cognition, poor safety awareness, and impaired vision. The care plan was last updated on 5/15/13.</p> <p>2. On 5/28/13 at 3:30 p.m., Resident #30's bed was observed. There were 1/2 upper side rails on both sides of the bed. There were no pads over the rails or between the three openings in the side rails. The three openings were measured at this time. The openings between the bars of the</p>		<p>3x weekly to ensure the padded covers are on the designated bed rails and that smoking materials are stored in a secured area.</p> <p>4. The Administrator and/or designee will report the findings of these observations and any corrective action taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 6/30/13</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>side rails were measured by the Maintenance Director as follows: First section: 7 1/2 inches x 7 inches Second section: 7 1/2 inches x 7 inches Third section: 7 1/2 inches x 5 1/2 inches.</p> <p>The record for Resident #30 was reviewed on 5/29/13 at 12:24 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, high blood pressure, atrial fibrillation (an irregular heart beat), and degenerative joint disease.</p> <p>Review of the 4/16/13 Side Rail Screen indicated two 1/2 side rails were to used on the resident's bed.</p> <p>3. On 5/31/13 at 8:15 a.m., Resident #5's bed was observed. One side of the bed was against the wall. The side rail on the other side was not up at this time.</p> <p>The openings between the bars of the side rails were measured by the Maintenance Director as follows: First section: 8 inches x 7 1/2 inches Second section: 7 1/2 inches x 7 1/2 inches Third section: 7 1/2 inches x 7 1/2 inches.</p>			
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>The record for Resident #5 was reviewed on 5/29/13 at 3:40 p.m. The resident's diagnoses included, but were not limited to, glaucoma, macular degeneration, high blood pressure, and stoke.</p> <p>Review of the 4/23/13 Side Rail Screen indicated one 1/2 side rail was to be used on the resident's bed.</p> <p>4. On 5/31/13 at 9:26 a.m., Resident #40 was observed in bed. One side of the resident's bed was up next to a wall. There was a 1/2 side rail up at the head of the bed. There was a blue pad over the side rails and the spaces between the bars of the side rail were covered.</p> <p>The openings between the bars of the side rail against the wall was measured by the Maintenance Director as follows: First section: 8 inches x 7 1/2 inches Second section: 7 1/2 inches x 7 1/2 inches Third section: 7 1/2 inches x 7 1/2 inches.</p> <p>The record for Resident #40 was reviewed on 5/29/13 at 12:07 p.m. The resident's diagnoses included, but were not limited to, mental</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>retardation and schizophrenia.</p> <p>A care plan initiated on 6/26/12 indicated the resident suffered from cognitive loss, short and long term memory problems, and poor decision making. The care plan was last updated on 5/29/13.</p> <p>Review of the 3/15/13 Side Rail Screen indicated two 1/2 side rails were to be on the resident's bed.</p> <p>When interviewed on 5/28/13 at 3:30 p.m., the Maintenance Director indicated the facility had blue padded covers which were to be placed over the side rails on all beds which have the above type of 1/2 side rails.</p> <p>When interviewed on 5/29/13 at 8:00 a.m., the facility Nurse Consultant indicated there were currently two other beds with 1/2 side rails. The Nurse Consultant indicated no residents currently resided in these beds. The beds were in Room D-6W and A-3W.</p> <p>The openings between the bars of the uncovered side rails were measured by the Maintenance Director as follows: First section: 8 inches x 7 1/2 inches Second section: 7 1/2 inches x 7 1/2</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>inches Third section: 7 1/2 inches x 7 1/2 inches.</p> <p>When interviewed on 5/30/13 at 7:35 a.m., the facility Administrator indicated all the side rails in the building should be checked at least quarterly. The Administrator also indicated all the beds which have the 1/2 side rails with gaps between the bars were to have the blue pads over the rails to cover the spaces.</p> <p>When interviewed on 5/30/13 at 8:35 a.m., the facility Administrator indicated an inspection of the side rails was last completed by the Maintenance Director in March 2013. The Administrator indicated the Maintenance Director did not report any concerns with side rails or pads at that time.</p> <p>The policy titled "Bed Side Rail Inspection" was reviewed on 5/30/13. The policy was provided by the Administrator. The policy was dated January 2013. The policy indicated the spaces between the bars on the bed side rails were to be less then 4 3/4 inches.</p> <p>The 3/10/2006 FDA (Food and Drug Administration) "Hospital Bed System</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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(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>Dimensional and Assessment Guidance to Reduce Entrapment" indicated the space between bars of bed side rails were recommended to be less than 4 3/4 inches.</p> <p>5. Resident #24's record was reviewed on 5/31/13 at 7:23 a.m. The resident's diagnosis include, but were not limited to, multiple sclerosis.</p> <p>The Quarterly Minimum Data Set Assessment, dated 05/18/13, indicated the resident was cognition was intact.</p> <p>During an interview on 05/28/13 at 11:02 a.m., Resident #24 indicated the past week-end, the staff did not get the resident's cigarettes out at the designated smoking time, so she went behind the Nurses' Desk and got the basket which contained all the resident's cigarettes and lighters. She indicated then everyone went out to the smoking area and smoked without staff being present.</p> <p>During an interview with the Administrator on 05/30/13 at 8 a.m., she indicated the staff intervened and took the cigarettes away from Resident #24. She indicated sometimes the nurse is not at the desk and the CNA will set the cigarettes and lighters on the desk</p>			

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	<p>and when the nurse gets back she locks them in the medication room. She indicated the ADoN (Assistant Director of Nursing) investigated the incident.</p> <p>During an interview on 05/30/13 at 1:20 p.m., the ADoN indicated she had came into the facility on Sunday (05/26/13) to assist with a new admission around 3 p.m. She indicated she was approached by CNA #4) about the smoking situation. She indicated the CNA told her she was getting ready to take the residents out to smoke when a call light came on and the CNA told the resident she would be right back after she answered the call light. She indicated the CNA left the cigarettes and lighters on the desk and left the station to answer the call light. She indicated the CNA told her the resident took all the residents out to the smoking room with the cigarettes and lighters. The ADoN indicated when she went out to the smoking room no one was smoking, but had been smoking. The ADoN indicated she collected all the cigarettes and lighters and took them inside and locked them in the medication room. The ADoN indicated the CNA had filled out the concern form and it was given to the Administrator. She</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
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	<p>indicated she had called the Administrator and informed her what had happened. She indicated by the time she got out there, the residents had already had their cigarettes smoked. She indicated the residents had smoked unsupervised.</p> <p>During an interview on 05/30/13 at 1:30 p.m., CNA #4 indicated when the smoking incident happened, it was lunch time and she was answering call lights. She indicated she watched Resident #24 go behind the Nurses' Desk and get the cigarettes out of the unlocked closet at the desk. She indicated the nurse left the cigarettes on the shelf in the closet behind the desk and they should have been locked in the medication room. She indicated she saw Resident #24 and the others go out into the smoking room and she went to tell the nurse, but the nurse was on the phone and when she saw the ADoN come in she told her about the residents smoking. She indicated some of the nurses put the cigarettes/lighters in the closet during the day.</p> <p>During an interview on 05/30/13 at 1:40 p.m., Resident #24 indicated she went behind the desk and retrieved the cigarettes/lighters from the closet,</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 05/31/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>then 5 of the resident went outside to smoke. She indicated who the resident's were by names (Residents #3, #10, #21, and #50) She indicated she assisted the residents in lighting their cigarettes. She indicated they were all through smoking by the time the ADoN came to the smoking room.</p> <p>During an interview on 05/30/13 at 2 p.m., the Administrator indicated they spoke to Resident #24 about going behind the desk. She indicated no one is suppose to be behind the desk, she then indicated the cigarettes/lighters were to be kept locked in the medication room.</p> <p>During an interview on 5/31/13 at 8:47 a.m., the ADoN indicated Resident #24 did not have a smoking apron on and she was unsure about the rest of the residents.</p> <p>During an interview on 5/31/13 at 9:15 am, CNA #4 indicated none of the residents had smoking aprons on.</p> <p>The resident's smoking assessment were reviewed on 05/31/13 at 8 a.m.</p> <p>Resident #24's smoking assessment, dated 04/01/13, indicated the resident could smoke with supervision and with a smoking apron.</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 05/31/2013
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
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	<p>Resident #50's smoking assessment, dated 04/23/13, indicated the resident could smoke with supervision and with a smoking apron.</p> <p>Resident #10's smoking assessment, dated 04/02/13, indicated the resident could smoke with supervision and a smoking apron.</p> <p>Resident #21's smoking assessment, dated 04/10/13, indicated the resident could smoke with supervision.</p> <p>Resident #3's smoking assessment, dated 04/23/13, indicated the resident was blind and could smoke with supervision.</p> <p>A facility policy, dated 07/12, titled, "Resident Smoking Policy", received from the Corporate Nurse Consultant as current, indicated, "...3. Resident/Families/Responsible parties will be instructed that all smoking materials must be brought to the nurses' station and will be distributed by staff only...5. Residents may not have cigarettes or lighters in their possession...All smoking residents will have their smoking material...kept at the nurse's (sic) station in a locked box or cabinet..."</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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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 05/31/2013	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 residents' remained free of unnecessary drugs related to lack of indications for the administration of antipsychotic, anti anxiety medications, and antidepressant medications for 2 of 10 residents reviewed for unnecessary drugs in the sample of 26. (Residents #33 and #49)</p> <p>The facility also failed to ensure the resident's drug regime was monitored</p>	F000329	<p>F 329</p> <p>1. Resident #11-The resident had an abdominal assessment completed with no abnormal findings.</p> <p>Resident #49-The resident's medications were reviewed to ensure appropriateness. The MD was notified for a possible reduction in the Xanax and to re-attempt the discontinuation of the Abilify.</p> <p>Resident #33-The physician was contacted and orders were clarified. The current orders are Tylenol for temperature and Tramadol routine</p>	06/30/2013			

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	<p>for possible side effects of an anticoagulant medications for 1 of 10 residents reviewed for unnecessary drugs in the sample of 26.(Resident # 11)</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 5/29/13 at 2:12 p.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease, deep vein thrombosis, diabetes mellitus, stroke, coronary artery disease, and congestive heart failure.</p> <p>Review of the 5/2013 Physician Order Sheet indicated there was an order for the resident to receive Lovenox (an injectable medication to prevent blood clots) 40 milligrams injected subcutaneous twice a day. There was also an order for he resident to receive Plavix (an oral medication to prevent blood clots) 75 milligrams by mouth daily. There was also an order for a stool specimen to be checked for occult blood once annually in May.</p> <p>Review of the 5/2013 Nurses' Notes indicated an entry was made on 5/23/13 at 8:30 a.m. This entry indicated the staff completed a hemoccult test of the stool and the</p>		<p>as well as PRN.</p> <p>2. All residents receiving anti-coagulant medications were reviewed with no findings. All residents receiving psychoactive medications were reviewed and any identified concerns were addressed.</p> <p>3. The licensed nursing staff was re-educated on assessment of the resident receiving anti-coagulant medications, the PRN administration policy and the policy and procedure for Mood and Behaviors with focus on documentation and the completion of the Mood and Behavior memo. The DON or designee will audit the physician orders, the 24 hour report sheets and the nurses notes 5x weekly on scheduled days of work to ensure compliance. The behavior sheets will be brought to the daily stand-up meeting for review and comparison to the DON findings. This will occur 5x weekly.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 6/30/13</p>		

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	<p>results were positive. Review of the Nurses' Notes from 5/23/13 through 5/25/13 indicated there was no documentation of staff completing an abdominal assessment or any monitoring of the resident for evidence of bleeding.</p> <p>During an interview on 05/31/13 at 8:40 a.m., the DoN (Director of Nursing) indicated there was no assessment for bleeding completed by the nurses.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated adverse reactions of Lovenox included bleeding tendencies and hemorrhage. The Nursing Spectrum Drug Handbook also included instructions to monitor for signs of bleeding and bruising.</p> <p>The 2010 Nursing Spectrum Drug Handbook also indicated adverse reactions of Plavix included gastrointestinal bleeding, gastritis, diarrhea, and abdominal pain. The Nursing Spectrum Drug Handbook also included instructions to monitor for bleeding and to assess for occult gastrointestinal bleeding.</p> <p>The facility policy titled "Nursing Department Charting Policy and</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>Procedure" was reviewed on 5/30/13 at 10:30 a.m. The policy had a revise date of 1/08. The policy was received from the Nurse Consultant and identified as current. The policy indicated pertinent charting included areas of condition changes</p> <p>2. Resident #49's clinical record was reviewed on 5/29/13 at 12:30 p.m. Resident #49's diagnoses included, but were not limited to, aphasia/dysphasia with aspiration, Alzheimer's/dementia, depression, acute renal failure, and acute delirium.</p> <p>A) An admission physician's order, dated 01/11/13 indicated an order for Xanax (antianxiety medication) 0.25 mg as needed twice a day.</p> <p>A PRN (as needed) Medication sheet dated 1/11/13 at 11:00 p.m., indicated the resident had increased anxiety and Xanax (antianxiety medication) 0.25 mg (milligrams) was given. There was no attempted interventions indicated.</p> <p>A Nursing Note, dated 1/11/13 at 11:00 p.m., lacked documentation to indicate the resident had behaviors/anxiety and the Xanax had been given.</p>			

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	<p>A Nursing Note, dated 1/12/13 at 4:25 a.m., indicated the resident was cooperative and pleasant with her care. There was no documentation regarding the resident having anxiety.</p> <p>A PRN Medication Form, dated 1/12/13 at 10:00 a.m., indicated the resident had increased anxiety and Xanax 0.25 mg was given. The attempted interventions indicated/circled was position change, behavioral, dietary, other and refused.</p> <p>A Nursing Note, dated 1/12/13 with 7:00 a.m. to 3:00 p.m., indicated for time, did not indicate the resident having any behaviors/anxiety and did not indicate the Xanax had been given.</p> <p>A physician's order, dated 1/12/13, indicated to discontinue prn Xanax 0.25 mg and to start Xanax 0.25 mg twice a day for anxiety.</p> <p>A Social Service Admission Note, dated 1/14/13, indicated the resident appeared frail, weak/not responsive, cognitively impaired, and rarely verbal per family (1-2 words).</p> <p>A Mood and Behavior Monthly Monitoring Summary dated 1/14/13, lacked documentation to indicate the</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>resident had mood or behavioral concerns on 1/11/13 and 1/12/13.</p> <p>The resident's record lacked documentation to indicate the reasons for the increase in the Xanax to twice a day.</p> <p>B) Resident #49's Nursing Note, dated 1/15/13 at 12:30 a.m., indicated the resident had displayed a purple discoloration in her toes and the resident was picking at the air.</p> <p>A social service progress note dated 1/15/13 at 4:00 p.m., indicated the physician was contacted about the change in condition and a one time order for Seroquel 50 mg was ordered.</p> <p>A physician's order, dated 1/15/13 at 7:00 p.m., indicated to give Seroquel (antipsychotic medication) 50 mg, one time dose, per g/tube (feeding tube) and to update the physician in the morning. The order did not indicate a reason for the Seroquel use.</p> <p>A Nursing Note, dated 1/15/13 at 11:00 p.m., indicated the resident had purple mottling to all toes, the physician was notified with a new order for a one time dose of Seroquel 50 mg. The note indicated the</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>resident had often been reaching up into the air at things that were not there.</p> <p>A Nursing Note, dated 1/16/13 at 2:00 p.m., indicated the resident's toes were purple. The note did not indicate if the physician had been updated regarding the resident's condition.</p> <p>An Initial Social Service Assessment dated 1/18/13, indicated the resident was having trouble concentrating, no behavioral symptom and indicated the resident was receiving Abilify (antipsychotic medication) for depression.</p> <p>A physician's order, dated 2/13/13, indicated to change the diagnosis of dementia to depression for indication of use for the medication Abilify. The physician also added a diagnosis of delirium.</p> <p>A physician's progress note, dated 2/20/13, indicated the resident's condition was unchanged since 1/25/12 [sic], in no distress and was asleep.</p> <p>A quarterly Social Service Assessment dated 4/18/13, indicated the resident had no mood indicators</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>or behavioral symptoms and indicated the Abilify was for dementia.</p> <p>A physician's order dated 5/09/13, indicated to discontinue the Abilify, due to a Pharmacy recommendation.</p> <p>A Nursing Note, dated 5/20/13 at 3:00 p.m., indicated the resident was "tearful today, wanting to go home, verbalizes feeling of 'being lost' with emotional distress/anxiety noted. Distracted with family visit et (and) 1:1 x (for) 1 1/2 hours. MD (physician) updated. N.O. (new order) rcv'd (received) to restart Abilify 3 mg per g/tube QD (every day). There were no other nursing documentation indicating the resident had been tearful. There was no indication of social service being informed of tearfulness.</p> <p>A physician's order dated 5/20/13, indicated to restart the Abilify 3 mg per g-tube (feeding tube) daily. There was a lack of documentation to indicate why the Ability had been restarted except for the one episode of tearfulness.</p> <p>A Psychoactive Medication Monitoring Side Effects Checklists, dated 1/13, 2/13, 3/13, 4/13, and 5/13, lacked documentation of what medications</p>						

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	<p>and behaviors were being monitored.</p> <p>A Mood and Behavior Monthly Monitoring Summary dated 1/14/13, 2/26/13, and 4/29/13 lacked documentation to indicate there were mood or behavioral concerns.</p> <p>An Interdisciplinary Care Plan conference Record dated 5/2/13, indicated the resident had a diagnosis of depression and anxiety. There had been no mood/behaviors.</p> <p>A care plan updated on 5/2/13, indicated a diagnosis of depression, but was symptom free at the time. The interventions indicated to "observe for depressive symptoms such as crying, change in sleeping..., restlessness...social service to complete a depression assessment as needed, social service/nursing to provide mental health services (prn) as ordered, encourage activities of choice and interest (visits with family, bird watching, music), notify the physician...of any significant changes in condition, meds (medications) per order (Prozac-Abilify)."</p> <p>A care plan updated on 5/2/13, indicated a diagnosis of anxiety. The interventions indicated to "ensure environment was calm, all basic</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>needs been met, encourage activities of preference (bird watching, music, and visits with family), provide mental health services as ordered, encourage resident to express thoughts and feelings, provide reassurance and comfort prn (as needed), provide relaxation tech (techniques) prn (as needed), meds (medications) as ordered, if applicable."</p> <p>A separate care plan updated on 5/21/13, indicated the resident required the use of an anti anxiety medication (Xanax) to treat anxiety. The interventions indicated to "administer med (medication) as ordered, monitor for s/e (side effects)..., observe for changes in mood or behavior, notify the charge nurse of noted problems for further eval (evaluation)...refer for psych eval (evaluation) as indicated." There were no non-pharmacological interventions.</p> <p>An interview with the Social Service Consultant on 5/29/13 at 2:25 p.m., indicated behaviors are monitored on a flow record in a binder. The Consultant indicated the staff would fill out a Mood and Behavior Communication form and would give the form to Social Services. Social</p>			

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	<p>Services would take the form to the morning meeting and discuss the behavior, log the behavior in the Mood and Behavior log, care plan the behavior, review the interventions and plan of action, such as a referral for psych. The Consultant indicated he did not have Mood and Behavior Communication Forms in January, or any other documentation indicating why the Xanax 0.25 mg prn (as needed) was changed to twice a day and did not have a Mood and Behavior Communication Form to indicate why the the Seroquel was ordered. The consultant also indicated he did not have a Mood and Behavior Communication form to indicate why the Abilify was ordered to be restarted. The Consultant indicated the Social Service Director "retired a week or so ago."</p> <p>Another interview with the Social Service Consultant on 5/29/13 at 3:15 p.m., indicated the seroquel was given for hallucinations. The Consultant indicated he was not a physician and was not sure if "picking at the air" at end of life was an adequate reason for Seroquel. The Consultant indicated the resident had exhibited tearfulness on 5/20/13, as to why the Abilify was restarted. The Consultant</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>indicated he did not have a Mood and Behavior Communication form to indicate an increase in tearfulness.</p> <p>An interview with LPN #1 on 5/29/13 at 5:00 p.m., indicated the resident was having a lot of tearfulness. LPN #1 indicated the resident indicated she wanted to go home. LPN #1 indicated the resident had a difficult time with adjusting to the facility in January. LPN #1 indicated the resident came from another facility. LPN #1 indicated she thought the scheduled Xanax was a pharmacy recommendation. LPN #1 indicated she had not informed the Social Service Director or had she filled out a Mood and Behavior Communication form.</p> <p>An interview with the resident's daughter 5/29/13 at 5:15 p.m., indicated the resident had a history of being tearful and the doctor did not want to increase the Prozac (antidepressant medication) back up but wanted to put the resident back on Abilify (antipsychotic). The daughter indicated she thought Resident #49 was having an infection brewing when she was having hallucinations, which caused her change in condition. The daughter indicated the resident did become</p>			
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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 05/31/2013	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>more alert when the the Prozac was decreased and the Abilify was discontinued.</p> <p>An interview with the Nursing Consultant on 5/30/13 at 10:00 a.m., indicated there was no policy regarding psychotropic medications. The Nursing Consultant indicated the Behavior Policy was followed.</p> <p>An interview with the DoN on 5/30/13 at 1:30 p.m., indicated if a resident had behaviors, the nurses would fill out the Mood and Behavior forms and there would be monthly behavior meetings. The DoN indicated there was a meeting with Resident #49's family in January, but the meeting ended abruptly due to a change in condition. The DoN indicated the resident was thought to be actively dying as for the one time dose of seroquel. DoN indicated the facility has had inservices on "End Of Life" with hospice and felt "picking at the air" was a behavior. The DoN was not able to indicate why the Xanax 0.25 mg was changed from prn to scheduled. The DoN indicated the Abilify was restarted due to the resident was being tearful and was yelling out for her husband who had passed away a long time ago. The DoN indicated she was not aware</p>						

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	<p>there was no supporting documentation.</p> <p>An interview with the Social Service Consultant on 5/30/13 at 4:30 p.m., indicated the Mood and Behavior Monthly Monitoring Summary are initiated for all residents who are on psychotropic medications.</p> <p>3. Resident #33's record was reviewed on 5/29/13 at 12:14 p.m. Resident #33's diagnoses, included but were not limited to, gout, depression, chronic anemia, gerd, hyperlipidemia, hypertension, anxiety, UTI (urinary tract infection), chronic kidney disease, Type 2 Diabetes, COPD (chronic obstructive pulmonary disease), and osteoarthritis.</p> <p>A care plan indicated Resident #33 was at risk for potential pain in the areas of joints, bilateral feet, esophageal, and general pain and discomfort. The interventions included to monitor for signs of pain such as facial grimacing, moaning, restlessness, assess pain on a scale of 0-10, provide a calm environment, attempt to make resident comfortable, other interventions such as massage or repositioning, administer pain</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>medication as ordered and monitor efficacy, complete pain assessment upon admission, with significant change, and at least quarterly, notify physician of changes, Tylenol per orders, and Ultram as ordered.</p> <p>The MAR (Medication Administration Record) dated for 5/13 indicated Resident #33 had a physician's order dated 1/09/13 for Ultram (pain reliever) 50 mg tablet, three times daily at 6 a.m., 12 p.m., and 8 p.m. for pain. The MAR indicated a physician's order dated 11/28/12 for two tablets of Tylenol 325 mg PRN (as needed) for pain/fever. The MAR indicated a physician's order dated 1/9/13 for Ultram 50 mg tablet every six hours PRN for pain.</p> <p>Resident #33's MAR and "PRN Medication Flow Sheet " dated 3/13 through 5/13 indicated Resident #33 had been administered her scheduled Ultram 50 mg at 6 a.m., 12:00 p.m., and 8:00 p.m. in addition to the following PRN medications for pain:</p> <p>3/2/13 Tylenol 650 mg and Ultram 50 mg at 9:30 a.m. by LPN #4, pain rating 6.</p> <p>3/7/13 Tylenol 650 mg and Ultram 50</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>mg at 8:00 a.m. by LPN #4, pain rating 5.</p> <p>3/7/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 5.</p> <p>3/13/13 Tylenol 650 mg and Ultram 50 mg at 7:35 a.m. by LPN #4, pain rating 5.</p> <p>3/14/13 Ultram 50 mg at 2:00 a.m. by RN #1, pain rating 5.</p> <p>3/16/13 Tylenol 650 mg and Ultram 50 mg at 7:15 a.m. by LPN #4, pain rating 6.</p> <p>3/16/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 5.</p> <p>3/17/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 6.</p> <p>3/17/13 Tylenol 650 mg at 12:30 p.m. by LPN #4, pain rating 5.</p> <p>3/21/13 Tylenol 650 mg and Ultram 50 mg at 8:00 a.m. by LPN #4, pain rating 6.</p> <p>3/24/13 Tylenol 650 mg at 3 a.m. by LPN #6, pain rating 4.</p> <p>3/26/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 6.</p> <p>3/26/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 4.</p> <p>3/30/13 Tylenol 650 mg and Ultram</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>50 mg at 8:00 a.m. by LPN #4, pain rating 6.</p> <p>3/31/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 5.</p> <p>3/31/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 4.</p> <p>4/5/13 Tylenol 650 mg and Ultram 50 mg at 8:45 a.m. by LPN #4, pain rating 5.</p> <p>4/9/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 7.</p> <p>4/9/13 Tylenol 650 mg at 12:30 p.m. by LPN #4, pain rating 5.</p> <p>4/10/13 Tylenol 650 mg at 10:00 a.m. by LPN #5, pain rating 4.</p> <p>4/11/13 Tylenol 650 mg at 10:00 a.m. by LPN #5, no pain rating.</p> <p>4/13/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 6.</p> <p>4/13/13 Tylenol 650 mg at 12:00 p.m., LPN #4, pain rating 5.</p> <p>4/14/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 7.</p> <p>4/14/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 6.</p> <p>4/23/13 Tylenol 650 mg and Ultram</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>50 mg at 8:30 a.m. by LPN #4, pain rating 5.</p> <p>4/27/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 7-8.</p> <p>4/27/13 Tylenol 650 mg at 12:00 p.m. LPN #4, pain rating 6.</p> <p>5/2/13 Tylenol 650 mg and Ultram 50 mg at 8 a.m. by LPN #4, pain rating 6-7.</p> <p>5/2/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 5.</p> <p>5/11/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 7.</p> <p>5/12/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN#4, pain rating 5.</p> <p>5/12/13 Tylenol 650 mg and Ultram 50 mg administered at 1:00 p.m. by LPN #4, pain rating 6.</p> <p>5/21/13 Tylenol 650 mg and Ultram 50 mg administered at 9:30 a.m. by LPN #4, pain rating 7.</p> <p>5/22/13 Tylenol 650 mg at 2:10 a.m. by RN #1, pain rating 6.</p> <p>On 5/30/13 at 10:00 a.m., the Nurse Consult was interviewed and indicated the facility did not have a PRN medication policy. The Nurse Consult indicated nurses are taught in school to be able to assess pain and know which PRN medications to use for which severity of pain without</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>facility policy. The Nurse Consult indicated many residents are able to request specific pain PRN medications as well.</p> <p>On 5/31/13 at 9:13 a.m., Resident #33 was interviewed and was unable to answer whether she was in pain or whether she understood her PRN pain medications. Resident #33's daughter was interviewed and indicated Resident #33 might have been able to ask for Tylenol if she was in pain. Resident #33's daughter indicated Resident #33 would not have asked for Ultram for pain because she does not know what that medication is.</p> <p>On 5/31/13 at 9:20 a.m., LPN #5 was interviewed and indicated she only gives Resident #33 a PRN pain medication if she complains of pain. LPN #5 indicated Resident #33 never asked for her for PRN pain medication because she has physician order for Ultram 50 mg three times daily. LPN #5 indicated she personally would not have given Resident #33 both PRN pain medications (Tylenol and Ultram) at the same time. LPN #5 indicated she would be concerned about administering Resident #33's PRN for Ultram too close to the scheduled Ultram 50 mg.</p> <p>On 5/31/13 at 9:30 a.m., the</p>			
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>Administrator was interviewed and indicated she would expect the nursing staff to give the weaker PRN pain medication for mild pain and the stronger PRN pain medication for severe pain. The Administrator indicated the DoN (Director of Nursing) and ADoN (Assistant Director of Nursing) review resident MARs at the beginning of every month to review for accuracy and to identify potential unnecessary medications.</p> <p>On 5/31/13 at 9:45 a.m., LPN #4 was interviewed and indicated she administered Resident #33's PRN pain medication based on the way Resident #33 rates her pain. LPN #4 indicated she has given Resident #33 both her PRN pain medications (Tylenol and Ultram) simultaneously because the physician order did not contraindicate it. LPN #4 indicated she administered PRN pain medication for effectiveness and indicated Resident #33 had chronic pain issues. LPN #4 indicated when Resident #33 had a behavior, she would ask her if she was in pain. LPN #4 indicated she noticed when Resident #33 had behaviors, she would be in pain.</p> <p>On 5/31/13 at 10:15 a.m., the ADoN was interviewed and indicated she would not have administered two</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>PRN pain medications simultaneously unless ordered by the physician. The ADoN indicated the nursing staff should assess the residents for pain using the pain scale. The ADoN indicated if able, nursing staff should administer the lower potency PRN pain medication first, then reassess the resident, and then administer the stronger PRN pain medication next if the resident is still experiencing pain. The ADoN indicated it would have been beneficial to clarify the physician orders for Resident #33's PRN pain medication. The ADoN indicated the facility would be reviewing Resident #33's use of PRN pain medications.</p> <p>On 5/31/13 at 2:44 p.m., the DoN was interviewed and indicated the facility did not have a PRN policy.</p> <p>3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(4)</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 05/31/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure an ointment was labeled with name and instructions and failed to</p>	F000431	<p>F431</p> <p>1. The items identified in the survey were immediately destroyed. The narcotics brought in by the family were returned to the family</p>	06/30/2013			

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 05/31/2013
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	<p>dispose of expired and/or opened supplies in the medication storage room for 1 of 2 medication storage rooms (A/B Unit). The facility also failed to return or destroy a bottle of narcotic's brought from home for 1 of 2 medication carts (A/B Unit).</p> <p>Findings include:</p> <p>Observation of the A/B Unit medication room with the ADoN (Assistant Director of Nursing) on 5/29/13 at 2:30 p.m., the follow items were observed to be expired opened and not disposed of:</p> <p>a. Five boxes/containers of Contour Blood Glucose test strips (50 count) and one opened box was observed to be expired on 3/2012. This had the potential to affect 10 of 10 residents who receive accu checks (blood sugar checks).</p> <p>b. Two prefilled NS syringes were observed to be expired on 01/13. The ADoN indicated no one had an IV (intravenous catheter).</p> <p>c. Sixty-Seven Hypodermic 23Gx1 inch needles were observed to be expired on 01/11. The ADoN indicated there was approximately 5 residents who would receive B 12</p>		<p>per policy.</p> <p>2. All other storage areas in the facility were audited to ensure no other expired items were present. Any items identified were removed.</p> <p>3. The licensed staff were re-educated on the policy and procedure related to medications brought in from home and the monitoring of the medication room which includes monitoring of expiration dates prior to use. The DON and/or designee will audit the medication room and the medication carts at least weekly for compliance and corrective action taken should non-compliance be observed.</p> <p>4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 6/30/13</p>		

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>(vitamin) IM (Intramuscularly) injections on the unit.</p> <p>d. Seventy-Three AddiPak Unit dose vials of 3 ml (milliliters) of Sterile 0.9% NaCl (Sodium Chloride) solution were observed to be expired on 03/13. The ADoN indicated the vials were used to clean wounds and there was only one person with a wound treatment on the unit.</p> <p>e. Two full boxes (100 count each box) and 24 packages in a third box of Medtrol Gluco-Chlor 3 x 3 bleach wipes were observed to be expired on 04/12. The ADoN indicated 8 residents received accu checks daily on the A/B unit.</p> <p>f. One tube of Vasolex ointment was observed to be used with no label on it. The ADoN indicated she did not know who it belonged to.</p> <p>g. One culturette was observed to be expired on 11/12.</p> <p>h. In the medication cart for the B-hall, a sticky note was observed on a bottle secured with a rubberband. The sticky note indicated, "Hydrocodone (narcotic pain medication) #5 (5 tablets) 5/500 mg (milligrams) with date of 4/10/13, and</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>signatures of the DoN (Director of Nursing) and LPN #3". There was no name and no direction for use. The ADoN indicated the bottle was for Resident #21. The ADoN indicated the resident came into the facility with the medications and her son was suppose to have picked it up. Resident #21 was admitted to the facility on 4/10/13.</p> <p>A "Medication Administration Policy and Procedure" dated 01/10, was provided by the Nursing Consultant on 5/30/13 at 10:30 a.m., indicated "...Nurses/QMA's will count narcotics at the shift change per facility policy..."</p> <p>A "Supplies/Expiration Dates" policy undated, but developed by the Nursing Consultant on 5/30/13, was provided by the ADoN on 5/30/13 at 1:25 p.m. The policy indicated "...If there is an expiration date, and the item has expired, all other applicable items/supplies of that type within the same box, bin or drawer shall be assessed for expiration and discarded accordingly, along with the initially identified expired item/supply."</p> <p>A "Drugs Brought to Facility by Resident or Family Member" policy [undated], was provided by 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 05/31/2013	
NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>Administrator on 5/31/13 at 7:25 a.m. The policy indicated "Drugs brought into the facility by a resident or family member will be used only upon specific written order by the resident's attending physician authorizing such use and only in a sealed, unopened, properly labeled container. All other unauthorized drugs will be sent home with the resident's family...Medication container is clearly labeled in accordance with all federal and state regulations and with the facility procedure for drug labeling. Drugs not ordered by the resident's physician are to be either returned to the family or designated agent immediately or destroyed in accordance with facility drug disposal procedures."</p> <p>A "Drug Labels" policy [undated], was provided by the Administrator on 5/31/13 at 7:25 a.m. The policy indicated "Drugs will be labeled in compliance with federal and state laws and standards of pharmacy practice...Nursing supplies...skin preparations and emollients are to be kept in the original manufacturer's labeling intact and are exempt from other labeling requirements."</p> <p>3.1-25 (k)(5) 3.1-25 (o)</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	F441 1. The residents identified in	06/30/2013			

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	<p>disinfect the glucometer machine per manufacturing instructions, failed to wash hands in between g/tube (feeding tube) and eye drop administration, and failed to clean stethoscope before and after resident use. (Resident #3, #10, and #49)</p> <p>Findings included:</p> <p>1. On 5/29/13 at 11:07 a.m., LPN #2 was observed wiping the accu check strip insertion site with Gluco-Chlor apply towelette for 2 to 3 seconds then set the timer to allow the accu check machine to dry. LPN #2 was observed obtaining Resident #3's blood sugar, returned to the medication cart and cleaned the machine by wiping the check strip insertion area for approximately two seconds and placed the towelette in the trash.</p> <p>Review of the Gluco-Chlor towelette package during this time, indicated to apply the towelette, wipe the surface, allow the treated surface to remain wet for 5 minutes, discard the towelette and allow the surface to air dry.</p> <p>LPN #2 then was observed to have picked up a different accu check machine and then completed</p>		<p>the survey were assessed and no findings were noted related to the concerns identified in the survey.</p> <p>2. No other residents were affected.</p> <p>3. The licensed nursing staff was re-educated on the policy and procedures related to disinfection of the glucometer, medication administration which included handwashing during administration and cleaning of personal equipment between resident usage. The Director of Nursing and/or designee will conduct observations on all nurses for blood glucose monitoring. The DON and/ or designee will monitor handwashing and cleaning of personal equipment during random rounds completed 5x weekly on different shifts.</p> <p>4. The DON and/or designee will report the findings of these audits, observations, and any corrective actions taken to the QA committee monthly x 3 and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5. 6/30/13</p>		

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>Resident #10's blood sugar check. LPN #2 returned to the medication cart and cleaned the machine by wiping the check strip insertion area for approximately two seconds and placed the towelette in the trash.</p> <p>An interview with LPN #2 during this time indicated her accu check training was on a video. LPN #2 indicated she was not checked off after watching the video. LPN #2 indicated she was instructed to wipe the test strip area only unless the machine was soiled, then the whole machine would be wiped with the towelette.</p> <p>An interview with the Nursing Consultant and the DoN on 5/29/13 at 11:30 a.m., indicated the facility had always cleaned their machines by wiping with the towelette and not keeping the surfaced moist.</p> <p>A letter titled "Clarification Regarding Glucometer Cleaning" was provided by the Nursing Consultant on 5/29/13 at 11:40 a.m., indicated "...in order for the EPA to approve the use of the wipe to disinfect for the listed organisms, they must list on the packet the longest amount of time it takes to kill said organisms. A "wet test" was completed and the towelette contains enough moisture for the</p>			

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	<p>device being cleaned to stay wet, under normal climate conditions, for 5 minutes..." The letter did not indicate what constituted "normal climate conditions."</p> <p>2. On 5/29/13 at 5:00 p.m., LPN #1 was observed obtaining a stethoscope from basket of equipment located at the nurses station, and put the stethoscope around her neck. LPN #1 was observed to place the stethoscope on Resident #49's abdomen to verify g-tube (feeding tube) placement. LPN #1 then placed the stethoscope on top of the resident bed while she administered medications.</p> <p>Once LPN #1 was finished, she placed the stethoscope back around her neck. LPN #1 rinsed the syringe and then placed the syringe back in the bag at the bedside, removed her gloves and walked back to her medication cart and documented the medications given.</p> <p>LPN #1 then realized she had forgotten to administer the eye drops to Resident #49, so she removed gloves from the glove box, removed the eye drops from the medication drawer, reapplied gloves, administered the eye drops, removed</p>				

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	<p>her gloves, and returned to the medication cart.</p> <p>LPN #1 did not wash her hands from the completion of the g-tube medication administration to administering the eye drops.</p> <p>An interview with LPN #1 during this time, indicated she should have washed her hands and cleaned the stethoscope before and after use.</p> <p>A Nasogastric/Enteral Tube, Checking Placement policy [undated] was provided by the Nursing Consultant on 5/30/13 at 10:30 a.m. The policy indicated to wash hands before and after procedure and to use alcohol swabs to clean the earpieces and diaphragm of the stethoscope.</p> <p>3.1-18 (b)(4)</p>				

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review and interview, the facility failed to identify and implement plans of action to correct quality deficiencies related to non-pressure skin conditions for 2 of 3 residents reviewed, change of condition status for 1 of 18 residents reviewed and unnecessary medications for 3 of 10 residents reviewed in a total sample of 26, which had the potential to effect 48 of 48 residents who reside in the facility.</p>	F000520	<p>F520</p> <p>1. Corrective actions as described in the Plan of Correction were taken for Resident s#26, Resident #10, #11, #49, and #33 relative to non-pressure skin conditions, change of condition, and unnecessary medications.</p> <p>2. As all residents could be affected, the following corrective action(s) have been taken.</p> <p>3. Administrative staff have reviewed the current Quality Assurance Committee procedures,</p>	06/30/2013	

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	<p>Findings include:</p> <p>1A) Resident #26's record was reviewed on 05/30/13 at 9:45 am. The resident's diagnoses include, but were not limited to, dementia, diabetes mellitus, congestive heart failure, and chronic kidney disease.</p> <p>During an observation on 05/28/2013 at 10:06 a.m. the resident had a skin tear on the left forearm and a purple colored bruise on the back of his right hand at the base of his fore finger. At the time of the observation, the resident indicated his skin tears easily.</p> <p>During an interview with the ADoN (Assistant Director of Nursing on 5/30/13 at 1:20 p.m., she indicated the resident's bruises for him is purpura (red or purple discoloration of the skin), they can get bigger. She indicated the areas would not be measured weekly. She indicated she was not aware of the areas on the resident's skin.</p> <p>During an observation on 5/30/13 at 2:35 p.m., with LPN #1 present, LPN #1 indicated the area on the resident's left forearm had been opened and had dried bloody</p>		<p>adding monthly meetings (exceeding the quarterly requirement) to include audits of specific care areas including, but not limited to, skin conditions, change of condition/physician notification and unnecessary medication(s). Administrative nursing shall be responsible to conduct and/or delegate said audits in an effort to identify quality of care areas of concern and address with the QA committee in an effort to formulate an action plan should deficient practice be identified.</p> <p>4. As a means of quality assurance, the DON shall report findings of aforementioned audits and immediate corrective actions taken to the QA committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next Quality Assurance meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>5. 6/30/13</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 05/31/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>drainage. She indicated the area looked like it had been caused by the resident's watch. She indicated the area had a three centimeter healing line. LPN #1 indicated the bruise on the back of right hand was 1.6 by 2 centimeters and was purplish/red in color. She indicate she did not know where or when the bruise occurred. She indicated when an area is found, they should measure the area, document, notify the physician, the Director of Nursing (DoN), and the Assistant Director of Nursing (ADoN) so they are aware. She indicated the area on the left arm was old and should have been found and documented.</p> <p>There was a lack of documentation in the resident's Nurses' Notes to indicate when the resident received the skin tear to his left arm or the bruise on the back of his right hand.</p> <p>There was a lack of documentation to indicate the resident had a care plan for the skin tear or the bruise. There was a lack of documentation to indicate the resident had a care plan for purpura.</p> <p>B) During an observation on 05/28/13 at 8 a.m., Resident #10 had three areas on her left forearm, which</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>appeared to be skin tears, which were reddish in color.</p> <p>During an interview, on 5/29/13 at 2:57 p.m., Resident #10 indicated she was nervous and indicated she picks at her skin. She indicated she picks the areas open</p> <p>During an observation on 05/30/13 at 2:28 p.m., with LPN #1 present, LPN #1 indicated there were areas on the resident's right upper forearm which were scabbed and the resident had picked opened. She indicated there were four areas on the resident's left arm and two areas on the resident's face, which were opened and or scabbed. The Resident indicated at the time of the observation, the areas had been present for a long time.</p> <p>A skin assessment, dated 5/27/13 (no time documented) indicated there were no skin alterations.</p> <p>A Nurses' Note, dated 5/29/13 at 2 a.m. indicated the resident's skin was warm, dry and intact.</p> <p>There was a lack of documentation in the Nurses' Notes to indicate the resident's areas on her arms and face had been assessed by the facility</p>			

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	<p>There was a lack of documentation to indicate the resident had a care plan initiated for the picking at the skin and the open areas.</p> <p>During an interview with LPN #2 on 5/20/13 at 8:30 a.m., she indicated when an area is found it is cleaned, the physician is called, the area is measured, a skin sheet is initiated, and they inform the ADoN. She indicated she had informed the ADoN the resident picked at her skin. She indicated there had been no measurements assessments of the areas.</p> <p>During an interview on 5/30/13 at 1:20 p.m., the ADoN indicated she was not aware of the resident's skin issues.</p> <p>A facility policy, dated 03/10, titled, "Skin Management Program", received from the Corporate Nurse Consultant as current, indicated, "...2. Residents who receive assistance with bathing and/or peri-care will be observed daily by nursing staff and any note of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations will be reported to the licensed nurse for further assessment...9. Skin alterations will be documented on the</p>			

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	<p>appropriate flow sheet...upon initial finding and at least weekly thereafter until healed...13. Skin conditions will be reviewed weekly by the DoN or designee for progression or regression of healing and treatments will be re-evaluated to ensure appropriateness..."</p> <p>During an interview on 05/31/13 at 9:54 a.m., the DoN indicated skin conditions are monitored weekly. She indicated the pressure areas are monitored by the ADoN and the non-pressure areas are monitored weekly by floor staff. She indicated there was no auditing to ensure the skin conditions were followed up on. She indicated the ADoN and the DoN review the skin conditions weekly and negative findings are reviewed monthly Quality Assurance (QA). She indicated the skin concerns was just brought to her attention yesterday. She indicated Resident #10's areas were just started to be monitored yesterday.</p> <p>2. Resident #26's record was reviewed on 05/30/13 at 9:45 am. The resident's diagnoses include, but were not limited to, dementia, diabetes mellitus, congestive heart failure, and chronic kidney disease.</p>						

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	<p>total fluid intake for the day was 360 cc 4/21/13: breakfast- 25% and fluid intake was 240 cc lunch-25% and fluid intake was 60 cc supper- 25% and fluid intake was 60 cc total fluid intake for the day was 360 cc 4/22/13: breakfast- refused food and fluid lunch- 25% and fluid intake was 180 cc supper- refused total fluid intake for the day was 180 cc 4/23/13: breakfast- refused lunch- refused (then resident sent to the hospital)</p> <p>The Nurses Notes indicated: 4/19/13 at 4:35 p.m.- "MD (physician) contacted r/t (related to) her (sic) wound...request sent to start mvi (multiple vitamin) et (and) vit (vitamin) C for wound healing..."</p> <p>4/21/13 at 10 p.m.-"...refused all of eve (evening) meal & substitute."</p> <p>4/22/13 at 3 p.m.-"...decreased (arrow down) ability to perform ADLs (activities of daily living). MD notified c/ (with) response pending..."</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>4/23/13 at 11:50 a.m.- "Res (resident) displaying increased (arrow up) weakness, change (triangle) in LOC (level of conscienceness), overall decline c/ (with) ADL's. Res has requested to be seen in er...Report called to ER..."</p> <p>There was a lack of documentation to indicate the resident had been assessed for dehydration.</p> <p>An Emergency Room Physician Record, dated 04/23/13, indicated the resident had dry mucous membranes, was disoriented to time, had weakness, the BUN (blood urea nitrogen-kidney function test) of 120 (normal 7-25), Creatinen (kidney function) was 2.26 (normal 0.7-1.3), had mild CHF and was given a diagnosis of dehydration.</p> <p>The electrolytes blood test completed at the hospital on 04/13/13, also indicated the residents sodium was 139 (normal 136-145), potassium was 4.2 (normal 3.5-5.1), and the Glomeruler Filtration Rate (kidney function) was 23 (normal 75).</p> <p>The Emergency Room Physician's Orders indicated the resident was treated with 0.9% normal saline given</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 05/31/2013	
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	<p>intravenously, an urinary catheter was anchored, and the resident was discharged back to the facility.</p> <p>A Physician's Progress Note, dated 04/24/13 indicated the resident was lethargic and was seen in the Emergency Room. He indicated the lethargy was metabolic and unlikely to improve and added the diagnosis of failure to thrive.</p> <p>There was a lack of documentation the resident had been assessed for further signs of dehydration from when the resident returned to the facility on 04/23/13 through 05/06/13.</p> <p>There was a lack of documentation to indicate a care plan for dehydration/risk for dehydration had been initiated for the resident.</p> <p>During an interview on 5/30/13 at 11:09 am, LPN #2 indicated the resident only signs and symptom was a change in his level of conscienceness. She indicated the resident did not have a dry mouth or problems with his skin turger. She indicated she completed an assessment but did not document the assessment.</p> <p>During an interview on 5/30/13 at</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>11:43 a.m., MDS Nurse #1 indicated there was no dehydration or risk for dehydration care plan for the resident. She indicated there needed to be more than just a diagnosis to initiate a care plan.</p> <p>The facility policy titled "Nursing Department Charting Policy and Procedure" was reviewed on 5/30/13 at 10:30 a.m. The policy had a revise date of 1/08. The policy was received from the Nurse Consultant and identified as current. The policy indicated pertinent charting included areas of condition changes.</p> <p>During an interview on 05/31/13 at 9:54 a.m., the Administrator indicated she was unsure if they discussed Resident #26's condition and his dehydration diagnosis in the last QA meeting. The DoN indicated if there is a change of condition the resident is put on, "alert charting". She indicated they review all orders every morning. She indicated the resident's physician came in the next day. She indicated the resident had not been monitored, but he was had not displayed any signs or symptoms.</p> <p>3A) The record for Resident #11 was reviewed on 5/29/13 at 2:12 p.m. The resident's diagnoses included, but</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>were not limited to, peripheral vascular disease, deep vein thrombosis, diabetes mellitus, stroke, coronary artery disease, and congestive heart failure.</p> <p>Review of the 5/2013 Physician Order Sheet indicated there was an order for the resident to receive Lovenox (an injectable medication to prevent blood clots) 40 milligrams injected subcutaneous twice a day. There was also an order for he resident to receive Plavix (an oral medication to prevent blood clots) 75 milligrams by mouth daily. There was also an order for a stool specimen to be checked for occult blood once annually in May.</p> <p>Review of the 5/2013 Nurses' Notes indicated an entry was made on 5/23/13 at 8:30 a.m. This entry indicated the staff completed a hemocult test of the stool and the results were positive. Review of the Nurses' Notes from 5/23/13 through 5/25/13 indicated there was no documentation of staff completing an abdominal assessment or any monitoring of the resident for evidence of bleeding.</p> <p>During an interview on 05/31/13 at 8:40 a.m., the DoN (Director of Nursing) indicated there was no</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>assessment for bleeding completed by the nurses.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated adverse reactions of Lovenox included bleeding tendencies and hemorrhage. The Nursing Spectrum Drug Handbook also included instructions to monitor for signs of bleeding and bruising.</p> <p>B) Resident #49's clinical record was reviewed on 5/29/13 at 12:30 p.m. Resident #49's diagnoses included, but were not limited to, aphasia/dysphasia with aspiration, Alzheimer's/dementia, depression, acute renal failure, and acute delirium.</p> <p>An admission physician's order, dated 01/11/13 indicated an order for Xanax (antianxiety medication) 0.25 mg as needed twice a day.</p> <p>A PRN (as needed) Medication sheet dated 1/11/13 at 11:00 p.m., indicated the resident had increased anxiety and Xanax (antianxiety medication) 0.25 mg (milligrams) was given. There was no attempted interventions indicated.</p> <p>A Nursing Note, dated 1/11/13 at</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>11:00 p.m., lacked documentation to indicate the resident had behaviors/anxiety and the Xanax had been given.</p> <p>A Nursing Note, dated 1/12/13 at 4:25 a.m., indicated the resident was cooperative and pleasant with her care. There was no documentation regarding the resident having anxiety.</p> <p>A PRN Medication Form, dated 1/12/13 at 10:00 a.m., indicated the resident had increased anxiety and Xanax 0.25 mg was given. The attempted interventions indicated/circled was position change, behavioral, dietary, other and refused.</p> <p>A Nursing Note, dated 1/12/13 with 7:00 a.m. to 3:00 p.m., indicated for time, did not indicate the resident having any behaviors/anxiety and did not indicate the Xanax had been given.</p> <p>A physician's order, dated 1/12/13, indicated to discontinue prn Xanax 0.25 mg and to start Xanax 0.25 mg twice a day for anxiety.</p> <p>A Social Service Admission Note, dated 1/14/13, indicated the resident appeared frail, weak/not responsive, cognitively impaired, and rarely verbal</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>per family (1-2 words).</p> <p>A Mood and Behavior Monthly Monitoring Summary dated 1/14/13, lacked documentation to indicate the resident had mood or behavioral concerns on 1/11/13 and 1/12/13.</p> <p>The resident's record lacked documentation to indicate the reasons for the increase in the Xanax to twice a day.</p> <p>B2) Resident #49's Nursing Note, dated 1/15/13 at 12:30 a.m., indicated the resident had displayed a purple discoloration in her toes and the resident was picking at the air.</p> <p>A social service progress note dated 1/15/13 at 4:00 p.m., indicated the physician was contacted about the change in condition and a one time order for Seroquel 50 mg was ordered.</p> <p>A physician's order, dated 1/15/13 at 7:00 p.m., indicated to give Seroquel (antipsychotic medication) 50 mg, one time dose, per g/tube (feeding tube) and to update the physician in the morning. The order did not indicate a reason for the Seroquel use.</p> <p>A Nursing Note, dated 1/15/13 at</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
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	<p>11:00 p.m., indicated the resident had purple mottling to all toes, the physician was notified with a new order for a one time dose of Seroquel 50 mg. The note indicated the resident had often been reaching up into the air at things that were not there.</p> <p>A Nursing Note, dated 1/16/13 at 2:00 p.m., indicated the resident's toes were purple. The note did not indicate if the physician had been updated regarding the resident's condition.</p> <p>An Initial Social Service Assessment dated 1/18/13, indicated the resident was having trouble concentrating, no behavioral symptom and indicated the resident was receiving Abilify (antipsychotic medication) for depression.</p> <p>A physician's order, dated 2/13/13, indicated to change the diagnosis of dementia to depression for indication of use for the medication Abilify. The physician also added a diagnosis of delirium.</p> <p>A physician's progress note, dated 2/20/13, indicated the resident's condition was unchanged since 1/25/12 [sic], in no distress and was</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>asleep.</p> <p>A quarterly Social Service Assessment dated 4/18/13, indicated the resident had no mood indicators or behavioral symptoms and indicated the Abilify was for dementia.</p> <p>A physician's order dated 5/09/13, indicated to discontinue the Abilify, due to a Pharmacy recommendation.</p> <p>A Nursing Note, dated 5/20/13 at 3:00 p.m., indicated the resident was "tearful today, wanting to go home, verbalizes feeling of 'being lost' with emotional distress/anxiety noted. Distracted with family visit et (and) 1:1 x (for) 1 1/2 hours. MD (physician) updated. N.O. (new order) rcv'd (received) to restart Abilify 3 mg per g/tube QD (every day). There were no other nursing documentation indicating the resident had been tearful. There was no indication of social service being informed of tearfulness.</p> <p>A physician's order dated 5/20/13, indicated to restart the Abilify 3 mg per g-tube (feeding tube) daily. There was a lack of documentation to indicate why the Ability had been restarted except for the one episode of tearfulness.</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960			
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	<p>A Psychoactive Medication Monitoring Side Effects Checklists, dated 1/13, 2/13, 3/13, 4/13, and 5/13, lacked documentation of what medications and behaviors were being monitored.</p> <p>A Mood and Behavior Monthly Monitoring Summary dated 1/14/13, 2/26/13, and 4/29/13 lacked documentation to indicate there were mood or behavioral concerns.</p> <p>An Interdisciplinary Care Plan conference Record dated 5/2/13, indicated the resident had a diagnosis of depression and anxiety. There had been no mood/behaviors.</p> <p>An interview with the Social Service Consultant on 5/29/13 at 2:25 p.m., indicated behaviors are monitored on a flow record in a binder. The Consultant indicated the staff would fill out a Mood and Behavior Communication form and would give the form to Social Services. Social Services would take the form to the morning meeting and discuss the behavior, log the behavior in the Mood and Behavior log, care plan the behavior, review the interventions and plan of action, such as a referral for psych. The Consultant indicated he did not have Mood and Behavior</p>						

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960		
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	<p>Communication Forms in January, or any other documentation indicating why the Xanax 0.25 mg prn (as needed) was changed to twice a day and did not have a Mood and Behavior Communication Form to indicate why the the Seroquel was ordered. The consultant also indicated he did not have a Mood and Behavior Communication form to indicate why the Abilify was ordered to be restarted. The Consultant indicated the Social Service Director "retired a week or so ago."</p> <p>Another interview with the Social Service Consultant on 5/29/13 at 3:15 p.m., indicated the seroquel was given for hallucinations. The Consultant indicated he was not a physician and was not sure if "picking at the air" at end of life was an adequate reason for Seroquel. The Consultant indicated the resident had exhibited tearfulness on 5/20/13, as to why the Abilify was restarted. The Consultant indicated he did not have a Mood and Behavior Communication form to indicate an increase in tearfulness.</p> <p>An interview with the Nursing Consultant on 5/30/13 at 10:00 a.m., indicated there was no policy regarding psychotropic medications.</p>				

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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(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 Nursing Consultant indicated the Behavior Policy was followed.</p> <p>An interview with the DoN on 5/30/13 at 1:30 p.m., indicated if a resident had behaviors, the nurses would fill out the Mood and Behavior forms and there would be monthly behavior meetings. The DoN indicated there was a meeting with Resident #49's family in January, but the meeting ended abruptly due to a change in condition. The DoN indicated the resident was thought to be actively dying as for the one time dose of seroquel. DoN indicated the facility has had inservices on "End Of Life" with hospice and felt "picking at the air" was a behavior. The DoN was not able to indicate why the Xanax 0.25 mg was changed from prn to scheduled. The DoN indicated the Abilify was restarted due to the resident was being tearful and was yelling out for her husband who had passed away a long time ago. The DoN indicated she was not aware there was no supporting documentation.</p> <p>An interview with the Social Service Consultant on 5/30/13 at 4:30 p.m., indicated the Mood and Behavior Monthly Monitoring Summary are initiated for all residents who are on</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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(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
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	<p>psychotropic medications.</p> <p>C) Resident #33's record was reviewed on 5/29/13 at 12:14 p.m. Resident #33's diagnoses, included but were not limited to, gout, depression, chronic anemia, gerd, hyperlipidemia, hypertension, anxiety, UTI (urinary tract infection), chronic kidney disease, Type 2 Diabetes, COPD (chronic obstructive pulmonary disease), and osteoarthritis. A care plan indicated Resident #33 was at risk for potential pain in the areas of joints, bilateral feet, esophageal, and general pain and discomfort. The interventions included to monitor for signs of pain such as facial grimacing, moaning, restlessness, assess pain on a scale of 0-10, provide a calm environment, attempt to make resident comfortable, other interventions such as massage or repositioning, administer pain medication as ordered and monitor efficacy, complete pain assessment upon admission, with significant change, and at least quarterly, notify physician of changes, Tylenol per orders, and Ultram as ordered.</p>			
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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 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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(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 MAR (Medication Administration Record) dated for 5/13 indicated Resident #33 had a physician's order dated 1/09/13 for Ultram (pain reliever) 50 mg tablet, three times daily at 6 a.m., 12 p.m., and 8 p.m. for pain. The MAR indicated a physician's order dated 11/28/12 for two tablets of Tylenol 325 mg PRN (as needed) for pain/fever. The MAR indicated a physician's order dated 1/9/13 for Ultram 50 mg tablet every six hours PRN for pain.</p> <p>Resident #33's MAR and "PRN Medication Flow Sheet " dated 3/13 through 5/13 indicated Resident #33 had been administered her scheduled Ultram 50 mg at 6 a.m., 12:00 p.m., and 8:00 p.m. in addition to the following PRN medications for pain:</p> <p>3/2/13 Tylenol 650 mg and Ultram 50 mg at 9:30 a.m. by LPN #4, pain rating 6.</p> <p>3/7/13 Tylenol 650 mg and Ultram 50 mg at 8:00 a.m. by LPN #4, pain rating 5.</p> <p>3/7/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 5.</p> <p>3/13/13 Tylenol 650 mg and Ultram 50 mg at 7:35 a.m. by LPN #4, pain</p>			

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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(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>rating 5.</p> <p>3/14/13 Ultram 50 mg at 2:00 a.m. by RN #1, pain rating 5.</p> <p>3/16/13 Tylenol 650 mg and Ultram 50 mg at 7:15 a.m. by LPN #4, pain rating 6.</p> <p>3/16/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 5.</p> <p>3/17/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 6.</p> <p>3/17/13 Tylenol 650 mg at 12:30 p.m. by LPN #4, pain rating 5.</p> <p>3/21/13 Tylenol 650 mg and Ultram 50 mg at 8:00 a.m. by LPN #4, pain rating 6.</p> <p>3/24/13 Tylenol 650 mg at 3 a.m. by LPN #6, pain rating 4.</p> <p>3/26/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 6.</p> <p>3/26/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 4.</p> <p>3/30/13 Tylenol 650 mg and Ultram 50 mg at 8:00 a.m. by LPN #4, pain rating 6.</p> <p>3/31/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 5.</p> <p>3/31/13 Tylenol 650 mg at 12:00 p.m.</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 05/31/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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	<p>by LPN #4, pain rating 4.</p> <p>4/5/13 Tylenol 650 mg and Ultram 50 mg at 8:45 a.m. by LPN #4, pain rating 5.</p> <p>4/9/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 7.</p> <p>4/9/13 Tylenol 650 mg at 12:30 p.m. by LPN #4, pain rating 5.</p> <p>4/10/13 Tylenol 650 mg at 10:00 a.m. by LPN #5, pain rating 4.</p> <p>4/11/13 Tylenol 650 mg at 10:00 a.m. by LPN #5, no pain rating.</p> <p>4/13/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 6.</p> <p>4/13/13 Tylenol 650 mg at 12:00 p.m., LPN #4, pain rating 5.</p> <p>4/14/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 7.</p> <p>4/14/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 6.</p> <p>4/23/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 5.</p> <p>4/27/13 Tylenol 650 mg and Ultram 50 mg at 8:30 a.m. by LPN #4, pain rating 7-8.</p> <p>4/27/13 Tylenol 650 mg at 12:00 p.m.</p>			

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	<p>LPN #4, pain rating 6. 5/2/13 Tylenol 650 mg and Ultram 50 mg at 8 a.m. by LPN #4, pain rating 6-7. 5/2/13 Tylenol 650 mg at 12:00 p.m. by LPN #4, pain rating 5. 5/11/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN #4, pain rating 7. 5/12/13 Tylenol 650 mg and Ultram 50 mg at 7:30 a.m. by LPN#4, pain rating 5. 5/12/13 Tylenol 650 mg and Ultram 50 mg administered at 1:00 p.m. by LPN #4, pain rating 6. 5/21/13 Tylenol 650 mg and Ultram 50 mg administered at 9:30 a.m. by LPN #4, pain rating 7. 5/22/13 Tylenol 650 mg at 2:10 a.m. by RN #1, pain rating 6. On 5/30/13 at 10:00 a.m., the Nurse Consult was interviewed and indicated the facility did not have a PRN medication policy. The Nurse Consult indicated nurses are taught in school to be able to assess pain and know which PRN medications to use for which severity of pain without facility policy. The Nurse Consult indicated many residents are able to request specific pain PRN medications as well. On 5/31/13 at 9:13 a.m., Resident #33 was interviewed and was unable to answer whether she was in pain or</p>						

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	<p>whether she understood her PRN pain medications. Resident #33's daughter was interviewed and indicated Resident #33 might have been able to ask for Tylenol if she was in pain. Resident #33's daughter indicated Resident #33 would not have asked for Ultram for pain because she does not know what that medication is.</p> <p>On 5/31/13 at 9:20 a.m., LPN #5 was interviewed and indicated she only gives Resident #33 a PRN pain medication if she complains of pain. LPN #5 indicated Resident #33 never asked for her for PRN pain medication because she has physician order for Ultram 50 mg three times daily. LPN #5 indicated she personally would not have given Resident #33 both PRN pain medications (Tylenol and Ultram) at the same time. LPN #5 indicated she would be concerned about administering Resident #33's PRN for Ultram too close to the scheduled Ultram 50 mg.</p> <p>On 5/31/13 at 9:30 a.m., the Administrator was interviewed and indicated she would expect the nursing staff to give the weaker PRN pain medication for mild pain and the stronger PRN pain medication for severe pain. The Administrator indicated the DoN (Director of</p>			

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	<p>Nursing) and ADoN (Assistant Director of Nursing) review resident MARs at the beginning of every month to review for accuracy and to identify potential unnecessary medications.</p> <p>On 5/31/13 at 9:45 a.m., LPN #4 was interviewed and indicated she administered Resident #33's PRN pain medication based on the way Resident #33 rates her pain. LPN #4 indicated she has given Resident #33 both her PRN pain medications (Tylenol and Ultram) simultaneously because the physician order did not contraindicate it. LPN #4 indicated she administered PRN pain medication for effectiveness and indicated Resident #33 had chronic pain issues. LPN #4 indicated when Resident #33 had a behavior, she would ask her if she was in pain. LPN #4 indicated she noticed when Resident #33 had behaviors, she would be in pain.</p> <p>On 5/31/13 at 10:15 a.m., the ADoN was interviewed and indicated she would not have administered two PRN pain medications simultaneously unless ordered by the physician. The ADoN indicated the nursing staff should assess the residents for pain using the pain scale. The ADoN indicated if able, nursing staff should administer the lower potency PRN</p>			

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	<p>pain medication first, then reassess the resident, and then administer the stronger PRN pain medication next if the resident is still experiencing pain. The ADoN indicated it would have been beneficial to clarify the physician orders for Resident #33's PRN pain medication. The ADoN indicated the facility would be reviewing Resident #33's use of PRN pain medications.</p> <p>On 5/31/13 at 2:44 p.m., the DoN was interviewed and indicated the facility did not have a PRN policy.</p> <p>During an interview on 5/31/13 at 9:54 am. The Administer indicated there was a log where they sign they reviewed the psychotropic medications. She indicated resident concerns are brought to QA and other concerns from the Behavioral Meeting. She indicated the facility only had one QA meeting in April, which was a quarterly meeting and realized there was a problem and have now scheduled QA meetings monthly.</p> <p>3.1-52(b)(2)</p>				

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