

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/25/2014
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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F000000	<p>This visit was for the Investigation of Complaints IN00155222 and IN00156791.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00154062 completed on August 20, 2014.</p> <p>Complaint IN00155222- Substantiated. Federal/State deficiencies related to the allegations are cited at F-323 and F-371.</p> <p>Complaint IN00156791- Substantiated. Federal/State deficiency related to the allegations is cited at F-312.</p> <p>Survey dates: September 23, 24 &amp; 25, 2014</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Survey Team: Janet Adams, RN-TC Regina Sanders, RN (September 23, 2014)</p> <p>Census bed type: SNF: 3 SNF/NF: 82</p>	F000000		

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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F000312 SS=D	<p>NCC: 2 Total: 87</p> <p>Census payor type: Medicare: 12 Medicaid: 56 Other: 19 Total: 87</p> <p>Sample: 20</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 28, 2014, by Janelyn Kulik, RN.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure staff provided oral care and grooming for 1 of 3 residents who were dependent on staff for care reviewed for ADL's</p>	F000312	<p><b>F312 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not</b></p>	10/10/2014			

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	<p>(Activities of Daily Living) in the sample of 20. (Resident #H) (CNA #1 and CNA #2)</p> <p>Findings include:</p> <p>On 9/23/14 at 10:45 a.m., Resident #H was observed sitting in a high back wheelchair in the lounge area in front of the Nurses' Station. The resident was dressed in a sweat shirt and pants. There was a dark tan colored accumulation on the resident's upper tooth on the right side. There were other residents sitting on each side of the resident.</p> <p>Continued observation from 10:45 a.m. to 11:40 a.m. indicated the resident remained in the same area. No staff members provided care to or offered care for the resident during this time.</p> <p>On 9/23/14 at 11:40 a.m., CNA #1 transported the resident to the Dining Room. The CNA placed the resident at a table and left. The accumulation on the resident's tooth remained. At 12:20 p.m. the resident was served her meal tray. CNA#1 then assisted the resident with her meal. The resident would hold onto the cup at times when the CNA handed her the cup. The CNA fed the resident her foods. The CNA continued to feed the resident until 12:52 p.m. CNA#1</p>		<p><i>constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified: Resident H was provided with oral care. Resident H's clothing was changed.</b></p> <p><b>2) How the facility identified other residents: Rounds were made to identify other residents needing oral care and grooming, and care was given as identified</b></p> <p><b>3) Measures put into place/ System changes: CNAS re-educated on oral care and post meal grooming. A minimum of 5 residents per week will be observed at varied times to ensure that they are provided with oral care and post meal grooming. Resident observations will be completed by DON or designee</b></p> <p><b>4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</b></p> <p><b>5) Date of compliance: 10/10/2014</b></p>		

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	<p>took the resident out of the Dining Room at 12:45 p.m. and transported her to the Lounge area she had been in before the meal service. No oral care was offered or provided to the resident during the above times.</p> <p>Continued observation indicated CNA #1 propelled the resident into her room at 1:09 p.m. CNA #2 entered the room also. The CNA's transferred the resident from the wheelchair into her bed. The CNA's used a gait belt when transferring the resident. Incontinence care was then provided by the two CNA's. The CNA's then repositioned the resident on her right side facing the wall and placed a body pillow behind her back. The CNA's did not provide oral care for the resident at this time. The accumulation of a tan colored substance was still observed on the resident's tooth.</p> <p>On 9/24/14 at 8:15 a.m., Resident #H was observed sitting in a high back wheelchair at a table in the Dining Room. The resident had not been served her breakfast meal tray yet. There was an accumulation of a tan colored substance noted on the resident's tooth on the upper right side.</p> <p>On 9/24/14 at 10:25 a.m., the resident was observed sitting in her wheelchair in</p>				

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	<p>the lounge area in front of the Nurses' Station. A stained area was noted on the front of the resident's sweatshirt near the right upper chest area. There were also areas on the sweat shirt along the waist line. An accumulation of a tan colored substance was still observed on an upper tooth on the right side. There were other residents' sitting beside the resident.</p> <p>On 9/24/14 at 1:20 p.m., the resident was observed in bed. The resident was wearing the same sweat shirt she had on at 10:25 a.m. An accumulation of a tan colored substance was still observed on an upper tooth on the right side. There were other resident's sitting beside the resident. There were no staff members or visitors in the resident's room at this time.</p> <p>On 9/24/14 at 1:25 p.m., the Nursing Supervisor checked the resident's mouth. There was an accumulation of a tan colored substance on the resident's tooth. The Nursing Supervisor put on a pair of disposable gloves and wiped across the resident tooth. The substance on the resident's tooth came off.</p> <p>The record for Resident #H was reviewed on 9/23/14 at 11:10 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, coronary artery disease, muscle weakness, dysphagia</p>			

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	<p>(difficulty swallowing) and adult failure to thrive.</p> <p>The 8/1/14 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills for decision making were severely impaired and the resident had both short and long term memory problems. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two staff members for dressing and personal hygiene. The assessment also indicated the resident required extensive assistance of one staff member for eating.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 3/19/14 indicated the resident displayed a self- care deficit related to a diagnosis of Alzheimer's disease. The goal date on the care plan was 11/15/14. Care plan approaches included for the resident to be up and ready for the day before 6:00 a.m. per her Health Care Representative. Other care plan approaches included for routine oral care to be provided.</p> <p>Review of the "Pocket Worksheet" (a list of care information for each resident) for Resident #H indicated the resident required the assistance of two staff members for transfers. The "Comments"</p>				

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	<p>section on the Pocket Worksheet for the resident indicated staff were to lay the resident down between meals and provide oral care.</p> <p>When interviewed on 9/24/14 at 1:25 p.m. , CNA #1 indicated the night shift provides a.m. care, dresses the resident, and gets her out of bed before the day shift started at 6:00 a.m. The CNA also indicated the resident was dressed and out of bed when she began her shift at 6:00 a.m. this morning. CNA #1 also indicated she and another CNA transferred the resident back to bed after lunch. The CNA indicated they provided incontinence care for the resident at that time. The CNA indicated they did not change the resident's clothing or provide oral care at that time.</p> <p>When interviewed on 9/25/14 at 7:40 a.m., the Director of Nursing indicated oral care should have been provided for the resident if it was needed.</p> <p>This Federal tag relates to Complaint IN00156791.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(3)(C)</p>			

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F000323 SS=D	<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, interview, and record review, the facility failed to ensure the residents environment remained free from accident hazards, related to a functioning hot steam table left unattended and accessible to 3 of 5 residents sitting in the Pines Dining Room, who had impaired cognition. (Residents #M, #S, and #T)</p> <p>Findings include:</p> <p>1. During an observation on 09/23/11 at 11:05 a.m., the gate to the Pines Dining Room Kitchenette was open. The steam table in the Kitchenette, had two areas turned on and were set at seven. The lids covering the areas were hot to touch and steam was coming out under the two lids. There were no staff in the Dining Room nor the Kitchenette.</p> <p>Resident #M was observed propelling herself in a wheelchair near the gate of</p>	F000323	<p><b>F323</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	10/10/2014
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	<p>the Kitchenette.</p> <p>Dietary Aide #1, then walked into the area and indicated the gate to the Kitchenette was to be locked. She further indicated there was an Activity Office located in the Kitchenette area.</p> <p>An observation indicated there was a partially opened door off the Kitchenette, which was the Activity Office. There were no staff members in the Activity Office.</p> <p>Dietary Aide #1, then opened the lid to one of the two areas of the steam table, which was turned on. There were no pans in the steam table and steam was coming from the water in the table. The Dietary Aide then preceded to obtain the temperature of the water and indicated the temperature was 150 degrees. She indicated the lid was hot to touch, and then stated, "they would have burned themselves".</p> <p>2. During an observation on 09/23/14 at 11:25 a.m., there were five residents in the Pines Dining Room. Residents #M, #S, and #T were three of the five, sitting in wheelchairs.</p> <p>The gate to the Kitchenette in the Dining room was again open. The door to the</p>		<p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>New automatic latching mechanism placed on gate to Pines Dining Room kitchenette while surveyors still present in the facility.</b></p> <p><b>Residents M, S and T were without negative effect from gate being open.</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>No other residents were identified.</b></p> <p><b>3) Measures put into place/ System changes:</b></p> <p><b>Staff have been re-educated on the importance of making sure that the gate to kitchenette is closed properly.</b></p> <p><b>Gate will be checked a minimum of five times per week at various times to ensure that it is properly latched. Administrator will be responsible for overseeing these</b></p>		

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	<p>Activity Office was partially closed and Activity Assistant #1 was in the office. The steam table in the Kitchenette was not visible to the Activity Office with the door partially closed.</p> <p>The steam table was still turned on and was hot to touch.</p> <p>During an interview, Activity Assistant #1 indicated she did not, "normally" leave the gate open.</p> <p>3. Resident #M's record was reviewed on 09/23/14 at 12:15 p.m. The resident's diagnosis included, but was not limited to, dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 08/18/14, indicated the resident's cognitive patterns were moderately impaired and the resident was independent with locomotion.</p> <p>The care plan indicated the resident was at risk for elopement.</p> <p>4. Resident #S's record was reviewed on 09/23/14 at 12:25 p.m. The resident's diagnosis included, but was not limited to, dementia.</p> <p>The significant change MDS assessment, dated 08/26/14, indicated the resident had</p>		<p><b>audits.</b></p> <p><b>4) How the corrective actions will be monitored:</b></p> <p><b>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</b></p> <p><b>5) Date of compliance: 10/10/2014</b></p>	

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	<p>short and long term memory problems, decisions were poor, and required supervised locomotion.</p> <p>The care plan indicated the resident would propel herself in the wheelchair out on the porch without notifying the staff.</p> <p>5. Resident #T's record was reviewed on 09/23/14 at 12:40 p.m. The resident's diagnosis included, but was not limited to, dementia.</p> <p>The quarterly MDS assessment, dated 08/09/14, indicated the resident's cognition was moderately impaired and required supervision for locomotion.</p> <p>During an interview on 09/23/14 at 2:05 p.m., the Administrator indicated a latch was being put on the gate of the kitchenette.</p> <p>This Federal tag relates to complaint IN00155222.</p> <p>3.1-45(a)(1)</p>			

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to store clean and ready to use dishes and utensils under sanitary conditions, related to a hole in the wall, peeling plaster on the wall and a dirty vent panel, located in the dish washing and storage area for 1 of 1 kitchen, which had the potential to affect 83 of 87 residents who are served food from the kitchen.</p> <p>Findings include:</p> <p>1. During an observation of the dish washing and storage area in the kitchen, on 09/23/14 at 10:20 a.m., with the Dietary Manager present, the following was observed:</p> <p>A. There was a hole on the lower wall behind one of two dish storage racks. There was dust and particle debris noted on the floor and in the hole on the wall. The tile on the floor was missing in front of the hole and there was peeling plaster</p>	F000371	<p><b>F371 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Hole in in the wall repaired while surveyors still present in the facility. Peeling plaster was repaired while surveyors still present in the facility. Dirty vent was cleaned while surveyors still present in the facility. 2) How the facility identified other residents: All residents that receive an oral diet have the potential to be affected. 3) Measures put</b></p>	10/10/2014			

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	<p>on the wall which was located behind two of two dish storage racks.</p> <p>The area on the wall was located just above the bottom shelf of the storage racks. There were two upside down plastic bins on one storage rack and coffee carafes, lids, syrup container and lids, and two handled cups and lids stored on the bottom rack of the second rack.</p> <p>During an interview at the time of the observation, the Dietary Manager indicated the hole was due to a pipe which was fixed and still needed to be fixed. She indicated they did not use the bottom rack of the first rack for drying dishes. She indicated the second rack had clean and ready to use dishes on the bottom shelf and indicated they would need rewashed.</p> <p>B. On the wall by the dishwasher, there was a large vent with an old piece of paper tape stuck on it. The vent was dirty and chipped paint was present.</p> <p>During an interview at the time of the observation, the Dietary Manager indicated she had asked Maintenance to remove the vent, "days ago", so she could power wash it.</p> <p>2. During an observation at 10:35 a.m.,</p>		<p><b>into place/ System changes:</b> <b>Staff re-educated on the importance of completing a maintenance request form when they identify something that requires repair or replacement. Environmental rounds will be made a minimum of three times per week to identify any areas that require repair. Maintenance request forms will be filled out for each identified item. Request forms will be submitted to the Director of Maintenance. Director of Maintenance and Administrator will coordinate the needed repairs. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 10/10/2014</b></p>				

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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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(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 Director of Maintenance indicated the hole in the wall behind the dish storage measured 6 3/4 inches wide by 16 inches high and 6 1/2 inches in depth. He indicated he had began working at the facility three weeks ago and was told about the area about a week and a half ago.</p> <p>A plumbing invoice, received from the Director of Maintenance, was reviewed on 09/23/14 at 12:30 p.m. and indicated the repair to the pipe was completed on 07/21/14.</p> <p>This Federal tag relates to complaint IN00155222.</p> <p>3.1-21(3)</p>			