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 05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES HEALTH CARE CENTER	3301 N CALUMET AVE VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaints IN00123305, IN00126432, IN00127175, IN00127227, and IN00127918. Complaint IN00123305-Substantiated. Federal/state deficiencies related to the allegations are cited at F465 and F441. Complaint IN00126432-Substantiated. Federal/state deficiency related to the allegation is cited at F282. Complaint IN00127175-Substantiated. Federal/state deficiencies related to the allegations are cited at F329 and F441. Complaint IN00127227-Unsubstantiated due to lack of evidence. Complaint IN00127918-Substantiated. Federal state deficiency related to the allegations is cited at F465. Survey dates: April 29 & 30, 2013	F000000	This plan of Correction constitutes the written allegation of compliance for the deficiencies cites. However, submission of this Plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet the requirements established by State and federal law. Whispering Pines requests thatthis Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective May15, 2013.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	May 1, 2013 Facility number: 000176 Provider number: 155277 Aim Number: 100288940 Survey team: Janet Adams, RN, TC Amber Bloss, QIDP April 29 & 30, 2013 Census bed type: SNF: 7 SNF/NF: 105 NCC: 2 Total: 114 Census payor type: Medicare: 17 Medicaid: 68 Other: 29 Total: 114 Sample: 16 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2 Quality review completed on May 5, 2013, by Janelyn Kulik, RN.			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record, review, and interview, the facility failed to ensure Physician orders were followed related to the administration of thickened liquid beverages for 1 of 3 residents reviewed for the administration of thickened liquids in the sample of 16. (Resident #S) (CNA #2 and CNA student #1) Findings include: On 4/29/13 at 8:10 a.m., Resident #S was observed sitting in a wheel chair at a dining table across from the Pines North unit Nursing Station. The resident was served her breakfast tray. The resident received thickened orange juice in a plastic sippy cup. CNA student #1 began feeding the resident her breakfast. The CNA student gave the resident several sips of the juice from the sippy cup. The CNA student did not use a spoon to feed the resident any of the juice during the breakfast meal. The dietary ticket that was served with the resident's meal tray indicated the	F000282	It is the policy of this facility that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **Specific Corrective Action** Resident #S hydration needs were assessed and physician order clarified to discontinue hydration by spoon. **Identification and correction of others** All charts of residents with altered thickened consistency were audited for compliance to physician orders(Exhibit F). Orders were clarified with the attending physician as needed. No other hydration by spoon orders exist. **Systemic Changes** Kitchen tray/diet identifiers were reviewed and altered to better identify residents on altered thickened fluids. Nursing staff educated on use of tray/diet identifiers and following physician diet orders. (Exhibit A) **Monitoring** Altered thickened consistency orders will be reviewed monthly by the NAR, Nutrition at Risk, Committee. Orders will be reviewed and appropriate clarification and/or remedy initiated. Remedy may include Speech pathologist screen/evaluation, physician	05/15/2013

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	resident was to receive "nectar thick liquids by spoon." CNA #2 was present at the table feeding another resident. The CNA did not instruct the CNA student to use a spoon while feeding Resident #S her beverages. On 4/29/13 at 12:00 p.m., Resident #S was observed sitting in a wheel chair at a dining table across from the North unit Nursing Station. The resident was served her lunch meal tray. The resident received thickened juice in a plastic sippy cup. CNA #2 began feeding the resident her lunch. The CNA also gave the resident several sips of the thickened juice from the sippy cup. The CNA did not use a spoon to feed the resident any of thickened juice during the meal. The record for Resident #S was reviewed on 4/30/13 at 9:20 a.m. The resident's diagnoses included, but were not limited to, dementia, malnutrition, failure to thrive, and coronary artery disease. A Physician's order was written on 4/24/13 for the resident to drink nectar thick liquids by spoon. Review of the 4/15/13 significant change MDS (Minimum Date Set) full assessment indicated the resident's cognitive skills for daily decision		order clarification, Care Plan modification. The Food Services Director or designee will weekly audit food (ExhibitB) trays for one month for 5% of residents per week for one month then monthly to ensure trays served are consistent with physician orders. Any noncompliance found will necessitate weekly monitoring until corrected. Further questions will be reviewed by the Director of Nursing Services and may include the Medical Director.	

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	making were severally impaired and the resident never or rarely made decisions. The MDS assessment also indicated the resident required extensive assistance of one staff person as the resident was involved in the activity with assistance from staff. The assessment also indicated the resident received a mechanically altered diet. When interviewed on 5/1/13 at 10:50 a.m., the Director of Nursing indicated staff should have fed the resident the thickened juices with a spoon as ordered by the Physician. This federal tag relates to Complaint IN00126423. 3.1-35(g)(2)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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.			
	Based on record review and interview, the facility failed to monitor the resident's drug regime related to the continued use of Heparin(a blood thinner medication) injections without adequate monitoring laboratory test levels for 1 of 1 resident's reviewed for receiving injectable blood thinners in the sample of 16. (Resident #C) Findings include:	F000329	It is the policy of this facility that 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 advanced consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. **Specific Corrective**	05/15/2013

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	The record for Resident #C was reviewed on 4/30/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, traumatic brain injury, depression, seizure disorder, congestive heart failure, respiratory failure, acute renal disorder, anemia, and thrombocytopenia. The resident was admitted to the facility on 2/4/13. Review of the 4/2013 Physician Order Statement indicated there was an order for the resident to receive Heparin 5000 units injected subcutaneous three times a day at 8:00 a.m., 4:00 p.m., and 12:00 a.m. The order was originally written on 2/5/13. Review of the laboratory test results indicated there were no PTT (Partial Thromboplastin Time) blood tests completed to monitor the resident's blood clotting time. A CBC (Complete Blood Count) laboratory test was done on 2/6/13. The following abnormal results were noted: Red Blood Cells: 3.35 (normal level 4.0-5.20) Hemoglobin: 9.5 (normal level 12-16) Hematocrit: 32.6 (normal level 37-47) Review of the 2010 Nursing Spectrum Drug Handbook indicated Heparin		**Action** Resident #C was discharged from the facility on 4/26/2013 **Identification and correction of others** One hundred percent chart audit on residents with anticoagulant therapy. Ensured appropriate lab monitoring per physician order. Nurses were educated on the established practice. **Systemic Changes** The twenty four hour communication form was altered to include verification of new lab orders. Nurses educated on use of the new reporting form. Any lab orders by the physician will be written on the Medication Admistration Record. **Monitoring** Unit managers will monitor all new orders per 24 hour report to ensure monitoring labs accompany medication orders. Medication and lab orders will be written on the Medication Administration Record for nurse check. Medication Administration Records are reviewed weekly by the unit managers and as a part of the Quality Assuranceprocess. Anti-coagulation Medication Audit Sheets (Exhibit C) will be utilized by the Unit Managers weekly and provided to the Director of Nursing Services or Designee for review. The DNS or designee will audit 5% of the residents on such therapy weekly for one month and monthly there after to ensure continued compliance.	

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	was an anticoagulant medication. Patient monitoring included to check Hematocrit levels, platelet count levels, and PTT levels frequently. Review of the PDR(Physician's Desk Reference).net Internet information site indicated Heparin sodium was used to prevent deep vein thrombosis and pulmonary emboli (a blood clot in the lungs). The mechanism of action of Heparin was listed as inhibiting reaction that leads to blood clotting and formation of fibrin clots, Contraindications to the use of Heparin included severe thrombocytopenia and uncontrollable active bleeding state. Warning/Precautions included to use with caution with patients with congestive heart failure and renal insufficiency. Adverse reactions included thrombocytopenia and hemorrhage. Assessment during use included assessing for thrombocytopenia, uncontrolled active bleeding sites, and coagulation test (PTT and clotting time levels). Required monitoring included periodic platelet blood tests and test for occult blood in the stools during the entire therapy course. When interviewed on 4/30/13 at 1:10 p.m., the Director of Nursing indicated			

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	laboratory tests should have been done to monitor the resident's clotting times as she had been receiving the Heparin injections since admission to the facility. This federal tag relates to Complaint IN00127175. 3.1-48(a)(3)			

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F000441 SS=D	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to	F000441	It is the policy of this facilitythat the facility must establish and	05/15/2013

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	ensure staff completed hand washing after providing incontinence care and also failed to sanitize the toilet in a bathroom shared by a resident with a recent stool infection and the residents roommate for 3 residents in the sample of 16. (Residents #E, #F, and #H) (CNA's #2, #3, & #6.) Finding include: 1. On 4/30/13 at 8:38 a.m., Resident #F was observed sitting in a wheel chair in the bathroom in her room. There was a sign posted on the wall above the toilet. The sign read "Please ensure that you are wiping the toilet with wipes prior to using it for any resident sharing a common bathroom." The resident's roommate (Resident #E) was in her bed in the room. CNA #3 was in the bathroom with the resident. The CNA assisted the resident to a standing position and the resident stood and held onto the grab bar next to the toilet. CNA #3 rolled down the resident's slacks and brief and assisted the resident to pivot again and the resident then sat on the toilet. The CNA did not clean or wipe the toilet seat prior to assisting the resident onto the toilet. The resident voided and the CNA then assisted the resident to a		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. **Specific Corrective Action** Resident #F toilet was sanitized. Residents #F, #H and #E were assessed for signs and symptoms of infection. Any necessary follow-up or physician intervention was provided as indicated by physician order. **Identification and correction of others** Infection Control Log was reviewed for any Resident with stool infection in a shared bathroom. Staff was educated on clean environment including equipment. Staff will ensure that necessary sanitary measures are taken to limit the transmission of disease or infection. Necessary cleaning/disinfection supplies are available to clean resident areas as needed to minimize transmission of disease or infection. All staff was educated on hand washing requirements and technique. Glove and sanitizer stations were reviewed and added as indicated **Systemic changes** Staff education will continueregarding awareness of infection control measures to limit transmission ofdisease and infection. The unit managerswill monitor all resident areas and educate as indicated. Unit managers will monitor hand washing eachworking day and	

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	standing position and then back into her wheel chair. The CNA did not wash or wipe the toilet seat after the resident was assisted back into the wheel chair. CNA#3 then washed his hands and wheeled the resident to the lounge area across from the Nursing Station and transferred the resident from the wheel chair into a stationary lounge chair. The CNA then proceeded towards another resident. CNA #3 did not return to Resident #F's bathroom. The record for Resident #F was reviewed on 4/29/13 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, anemia, edema (swelling), and dysphagia (difficulty swallowing). A care plan initiated on 6/19/12 indicated the resident had a self care deficit related to a diagnosis of Alzheimer's disease. The care plan was last updated with a goal date of 5/2013. Care plan approaches indicated Resident #F required assistance of staff for bathing, dressing, transfers, and toileting. The record for Resident #E was reviewed on 5/1/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, depression, bronchitis,		educate as indicated. **Monitoring** The Manager on Duty will alsomonitor resident rooms for indications of infectious risks as well as monitorhand washing of staff on routine rounds 5-7 days a week (Exhibit D). This is an ongoing process for the newlydeveloped Manager on Duty. Any riskareas will be immediately remedied. Further education or staff adjustments will be made as monitored by thequality assurance process. Noncompliance will be communicated to the Executive Director and Quality AssuranceCommittee for immediate remedy.	

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	pancreatitis, and coronary artery disease. Review of the laboratory test results indicated stool cultures were obtained on 3/22/13 and 4/12/13. The results for both of the stool cultures were positive for Vancomycin Resistant Enterocci (an infection). The 3/13 and 4/13 Physician orders were reviewed. An order was written on 3/25/13 for the resident to receive Macrobid (an antibiotic) 100 milligrams twice a day for 10 days. Another order was written on 4/14/13 for the resident to receive Macrobid 100 milligrams twice a day for 10 days for VRE (Vancomycin Resistant Enterocci). When interviewed on 4/30/13 at 9:15 a.m., CNA #3 indicated the resident's toilet was to be wiped with special wipes prior to and after the resident used the toilet. The CNA indicated the supplies were at the Nursing station. The CNA indicated he had not cleaned the toilet before or after Resident #F used the toilet. When interviewed on 4/30/13 at 9:18 a.m., the Unit Manager indicated there was a protocol to clean the resident's toilet with an antimicrobial			

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	wipe before and after each Resident #F and her roommate (Resident #E) use the toilet. The Unit Manager indicated Resident #E was currently in isolation. When interviewed on 5/1/13 at 9:50 a.m., the Director of Nursing indicated Resident #E had been diagnosed with VRE in the stool and was in isolation for the infection. The Director of Nursing indicated the toilet should have been cleansed. 2. On 4/29/13 at 2:00 p.m., CNA #2 and CNA #6 were observed transferring Resident #H from a rolling recliner chair into her bed. The CNA's used a Hoyer lift (a mechanical lift) to transfer the resident. After the resident was transferred into bed the CNA's removed the resident's slacks and brief to provide incontinence care. Both the CNA's were wearing disposable gloves at this time. CNA #6 cleansed the resident's perineal area with a disposable wipe. CNA #2 applied a moisture barrier cream on the resident's buttock area. CNA #6 removed her gloves and tied up the plastic trash bag and exited the resident's room with the bag. The CNA did not wash her hands prior to exiting the room. CNA #2 also removed his gloves and exited the			

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	resident's room without washing his hands. The facility policy titled "Handwashing" was reviewed on 5/1/13 at 10:50 a.m. There was no date on the policy. The Director of Nursing identified the policy as current at this time. The policy indicated hand washing was to be performed before and after all resident care activities which included incontinence care. When interviewed on 5/1/13 at 10:50 a.m., the Director of Nursing indicated the CNA's should have washed their hands after providing incontinence care. This federal tag relates to Complaints IN00123305 and IN00127175. 3.1-18(B)(2) 3.1-18(l)			

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 05/01/2013
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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F000465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a clean and sanitary environment for residents related to stained privacy curtains, stained table clothes, accumulation of dried debris and dirt on chair cushions, chair wheels, tables, and plastic storage container for 2 of 3 Dining areas on the second floor and one resident room on the second floor. Findings include: 1. In the South Pines unit Dining area across from the Nursing station there were stains on the blue colored tablecloths on two of the tables on 4/29/13 at 5:45 a.m. 2. On 4/29/13 at 10:50 a.m., there were stains on three pink privacy curtains in Room 1. Two of the curtains were around Bed 1 and the other curtain was around Bed 3. Three residents resided in this room. There was a rolled up disposable glove on the counter between the closets. There was dust and dirt on a small plastic container with drawers at	F000465	It is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **Specific Corrective Action** Stained privacy curtains, tablecloths were removed and cleaned or replaced. Dirt on chair cushions, debris on wheels, tables and the plastic storage container were cleaned. **Identification and correction of others** Audit form implemented for facility audit of cleanliness, sanitary, and comfortable environment. Staff adjusted to immediately addressed areas as indicated by audit. Manager on Duty,Unit managers and other department heads audited the facility for areas requiring immediate action. **Systemic Changes** Education of housekeeping/laundry staff and Manager regarding clean, sanitary and comfortable environment(5/10/2013). Audit form provided to Manager for weekly audit (Exhibit E). Correction/education will be made immediately as indicated per audit. Staff adjustments as indicated. **Monitor** Manager on Duty will monitor for cleanliness and sanitation on routine rounds	05/15/2013

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	the bed side of the resident in Bed 1. There were respiratory supplies in the drawers. 3. On 4/29/13 at 8:05 a.m., three residents were observed around a table in the lounge area waiting for breakfast. There was an accumulation of dust and dirt on the top of the white counter between the windows. There was dust and debris on the top of and sides of a small clear plastic container on the counter. There was dried spillage on the drawers of the cabinet. The white plastic garbage container next to the counter was dirty. There was an accumulation of dust and dirt on the wheel covering on the wheel of the rolling lounge chair Resident #H was sitting in. This federal tag relates to Complaints IN00123305 and IN00127918. 3.1-19(f)		daily (Exhibit D). The Manager On Duty rounds will be daily and ongoing. Findings will be reported to the unit manager and the AM manager meeting for immediate follow up. The Executive Director will be alerted of anynon compliance for immediate remedy. The Complaint/Suggestion box will be utilized for further input.	