

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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00154062 completed on August 20, 2014.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00155222 and IN00156791.</p> <p>Complaint IN00154062- Not Corrected.</p> <p>Survey dates: September 23, 24 & 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 NCC: 2 Total: 87</p> <p>Census payor type: Medicare: 12 Medicaid: 56</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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F000323 SS=D	<p>Other: 19 Total: 87</p> <p>Sample: 20</p> <p>This deficiency reflects 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(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>	F000323	<p>F323</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	10/10/2014			

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	<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 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</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> <p>1) Immediate actions taken for those residents identified:</p> <p>New automatic latching mechanism placed on gate to Pines Dining Room kitchenette while surveyors still present in the facility.</p> <p>Residents M, S and T were without negative effect from gate being open.</p> <p>2) How the facility identified other residents:</p> <p>No other residents were identified.</p>	

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	<p>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 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</p>		<p>3) Measures put into place/ System changes:</p> <p>Staff have been re-educated on the importance of making sure that the gate to kitchenette is closed properly.</p> <p>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 audits.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 10/10/2014</p>	

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	<p>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 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</p>			

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	<p>was being put on the gate of the kitchenette.</p> <p>This deficiency was cited on August 20, 2014. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(1)</p>				