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 06/11/2013

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 IN00129066 and IN00129457. Complaint IN00129066-Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F314, and F323. Complaint IN00129457-Substantiated. Federal/state deficiency related to the allegation is cited at F328. Survey dates: June 10 & 11, 2013 Facility number: 000176 Provider number: 155277 AIM number: 100288940 Survey team: Janet Adams, RN Census bed type: SNF: 4 SNF/NF: 99 NCC: 3 Total: 106 Census payor type: Medicare: 15	F000000	N/A	

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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	Medicaid: 67 Other: 24 Total: 106 Sample: 11 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 14, 2013, by Janelyn Kulik, RN.			

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F000309 SS=D	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. Based on observation, record review, and interview, the facility failed to ensure treatment and services were provided related to completing wound care treatments as ordered for 1 of 3 residents reviewed for non pressure related skin conditions in the sample of 11. (Resident #C) Findings include: On 6/10/13 at 7:55 a.m., Resident #C was observed in bed. LPN #1 removed blue heel protector boots from the resident's feet. There was a small bandage in place to the resident's left lateral foot area near the last toe. The date of 6/7/13 was written on the bandage. The initials of LPN #1 were written on the bandage. The LPN removed the bandage. A round flat dried area with a dark red center was observed. The record for Resident #C was reviewed on 6/10/13 at 8:00 a.m. The	F000309	Resident C remains in the facility and his wound care orders have been clarified. LPN #1 has been reeducated on physicians' orders and wound care protocols. Resident's dressings were changed immediately. Resident's responsible party and physician were notified of this deficiency. This alleged deficient practice has the ability to affect all residents requiring wound care in our facility. A whole-house skin sweep was conducted. All residents with wound care orders had physicians' orders clarified.Licensed Nursing personnel were reeducated on wound care protocols. A daily interdisciplinary clinical team meeting now discusses all residents requiring wound care. All issues identified in the daily review will be processed in the Monthly Quality Assurance Meeting.	06/28/2013

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	resident's diagnoses included, but were not limited to, stroke, diabetes mellitus, anemia, and chronic respiratory failure. Review of the 6/2013 Physician Order Statement indicated there was an order to cleanse the left dorsal foot wound with normal saline, apply Bacitracin (an antibiotic ointment), and cover with a dressing every day. The order was written on 5/30/13. Review of the 6/2013 Treatment Administration Record indicated there was a check mark placed in the boxes dated 6/8/13 and 6/9/13 for the above treatment order to the left foot. There was no signature or initials in the area next to the check mark. A Non-Pressure Ulcer Skin Conditions form was initiated on 5/30/13. The form indicated a non intact blister was found on the resident's left dorsal foot area. The blister measured 0.8 cm (centimeters) x 0.7 cm and was pink with a scant amount of serous (bloody) drainage. The Physician and family were notified and treatment orders were obtained to apply Bacitracin and a dry dressing daily. When interviewed on 6/10/13 at 7:55			

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	a.m., LPN #1 indicated the initials on the resident's left foot area were her initials and she completed the treatment on 6/7/13. When interviewed on 6/10/13 at 8:35 a.m., the Unit Manager indicated when staff complete a treatment they are to sign their initials in the box on the date the treatment was completed. When interviewed on 6/10/13 at 2:00 p.m. , the Director of Nursing indicated the treatment should have been completed daily as ordered by the Physician. This federal tag relates to Complaint IN00129066. 3.1-37(g)(1)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview the facility failed to ensure the necessary treatment and services to treat pressure ulcers were in place related to pressure reducing chair cushions and wound care treatments not in place for 1 of 3 residents reviewed for pressure ulcers in the sample of 11. (Resident #L) Findings include: On 6/11/13 at 8:55 a.m., Resident #L was observed in the bathroom in her room. CNA #2 was present in the bathroom with the resident. The CNA assisted the resident to a standing position. A small round open area was noted to the resident's left gluteal fold area. The open area was approximately 1 cm (centimeter) in diameter with a red center. There	F000314	Resident L has been discharged from our facility. CNA#2, CNA#1, and LPN#2 have all been reeducated on appropriate wound care. The family and physician were notified. Resident L's wound care orders were clarified. The cushion required was placed in the wheelchair and a dressing was applied as ordered, along with the ordered barrier cream.CNA's and Licensed Nursing Personnel have been educated on following physicians' orders policy and wound care management. A daily review of wound care issues has been added to the Interdisciplinary Team Meeting. A whole-house skin sweep was conducted.All residents at risk for wound care issues have the potential to be affected by this alleged deficient practice.All issues identified in the Daily Review will be processed in the Monthly Quality Assurance Committee Meeting.	06/28/2013

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	was no dressing covering the wound and no dressing observed in the resident's incontinence brief. CNA #1 cleansed the resident's perineal area and pulled the resident's brief and pants up. The CNA then assisted the resident into the wheel chair and pushed the wheel chair out of the bathroom. There was no cushion on the seat of the wheelchair prior to the CNA assisting the resident into the wheel chair. On 6/11/13 at 11:00 a.m., the resident was observed sitting in a wheelchair in her room. The resident was not receiving any care at this time. LPN #2 entered the resident's room at 11:10 a.m. with CNA #2. The LPN and the CNA assisted the resident to a standing position in front of her wheelchair. There was no cushion of any type on the seat of the wheelchair. The record for Resident #L was reviewed on 6/11/13 at 8:20 a.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, anemia, macular degeneration, high blood pressure, and vascular dementia. The 6/2013 Physician Order Statement was reviewed. There was			

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	an order written on 5/23/13 to apply Embrace barrier cream to the left gluteal fold, cover the area with a 4 x 4 (type of gauze bandage) twice a day. There was also a Physician's order for the resident to have a Roho (a pressure reducing cushion) in place at all times when in the chair. A temporary care plan initiated on 5/23/13 indicated the resident had a Stage II (a partial thickness wound presenting as a shallow open area with a red or pink center) pressure ulcer to the left gluteal fold. Care plan interventions included for staff to administer the treatment as ordered. The 5/2013 and 6/2013 Wound/Skin Healing Records were reviewed. The following assessments were noted for the left gluteal fold pressure ulcer: 5/23/13- Stage II pressure ulcer, 1 cm (centimeter) x 0.9 cm. small amount of exudate. 5/30/13- Stage II pressure ulcer, 1 cm x 0.8 cm, no exudate. 6/06/13- Stage II pressure ulcer, 1 cm x 0.7 cm, no exudate. When interviewed on 6/11/13 at 11:12 a.m., the Unit Manager indicated there should have been a dressing in place to the resident's left gluteal fold. The Unit Manager also			

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	indicated a Roho cushion should have been in place to the resident's wheelchair as ordered by the Physician. This federal tag relates to Complaint IN0000129066. 3.1-40(a)(2)			

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F000323 SS=G	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 accidents and injury related to continued attempts to transfer a resident with one assist after the resident's knees buckled with the first attempt resulting in the resident being lowered to the floor. The facility also failed to provide adequate supervision to prevent accidents related to leaving the resident unattended after being lowered to the floor and not requesting a Nurse to complete a physical assessment of the resident prior to transferring the resident into a wheel chair. This resulted in the sustaining a spiral fracture of the femur. (Resident #B) (CNA's #4 and #5) The facility also failed to provide adequate supervision to prevent accidents related to fall and injury prevention devices not in place for 1 of 3 residents reviewed for falls and injuries in the sample of 11. (Resident #G)	F000323	Resident B remains in the facility at this time. All orders were clarified and resident received treatment for the fracture. She currently receives therapy for post-fracture management. The resident's responsible party as well as physician were notified.Resident G remains in the facility at this time. All of his orders were clarified. Resident's mat was immediately placed as per orders and all orders were subsequently followed for fall intervention. The resident's responsible party as well as physician were notified.CNA #4, #5, #2, and #3 were educated on appropriate usage of ordered interventions. LPN #1, #2, and LPN #3 were reeducated on these areas, as well.All clinical personnel were reeducated on ensuring appropriate 'assist' numbers are followed when executing care.All residents have the potential to be affected by the alleged deficient practice. Therefore, a whole-house review of safety interventions was conducted. A visual check of interventions every two hours for five days will be monitored to ensure compliance with	07/02/2013

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	Finding include: 1. The record for Resident #B was reviewed on 6/10/13 at 9:35 a.m. The resident's diagnoses included, but were not limited to, vascular dementia, rheumatoid arthritis, and high blood pressure. The 6/2013 Nurses' Notes were reviewed. An entry made on 6/1/13 at 6:30 a.m. indicated the resident was lowered to the ground by a CNA during morning care. The resident complained of right leg pain and the resident's right knee was noted to be slightly swollen. The Physician was paged. An entry made on 6/1/13 at 11:40 a.m. indicated an X-ray was completed at the facility. An entry made on 6/1/13 at 3:00 p.m. indicated the X-ray results were received, the Physician was notified, and orders were obtained to send the resident to the hospital. Review of the Radiology reports indicated an X-ray of the right femur was completed on 6/1/13. The results of the X-ray indicated there was a spiral fracture of the distal shaft of the right femur. A care plan initiated on 12/11/12		physician's orders and safety interventions.CNAs and Licensed Nursing Personnel have been inserviced on appropriate care plan intervention follow-through and safety interventions.All results from the audit will be processed in the monthly quality assurance committee meeting.	

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	indicated the resident had a self care deficit related to a diagnosis of rheumatoid arthritis. The care plan was last updated with a goal date of 8/2013. The previous goal date was 6/2013 Care plan interventions included the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of staff for bed mobility and transfers. The care plan did not indicate the number of staff needed. A care plan initiated on 12/11/12 indicated the resident was at risk for falling related to impaired mobility. The care plan was last updated with a goal date of 8/2013. The previous goal date was 6/2013. Care plan interventions indicated the resident required two person assist with toileting and extensive assist with transfers. The care plan did not indicate the number of staff required for transfers. An "Initial Report of Incident" was completed on 6/1/13. The report indicated the resident was lowered to the floor by a CNA during care, the resident complained of right leg pain, and the resident's right knee was noted to be slightly swollen. The Physician was notified. The immediate interventions taken included assessment of the resident			

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	and resident placed back into the wheel chair. A 6/1/13 Incident/Occurrence Report was reviewed. The form was completed by the facility Administrator. The report indicated two staff members were transferring Resident #B to the chair and the resident's legs gave away and the resident was lowered to the floor by staff. The Physician was notified and X-rays were obtained. A fracture to the femur was noted and the results were called to Physician and the resident was sent to the hospital. Written staff interviews were included with the above Incident/Occurrence Report. An statement written by CNA #5 indicated she went into Resident B's room in the morning and helped her out of bed and into the shower chair and the resident had no complaints of pain and no problems were noted. The CNA then took the resident to the shower room and completed the resident's shower. The CNA then assisted the resident to stand up next to the rail on the wall and the resident started telling the CNA her knees were buckling and the resident sat on the side of the wheel chair. The CNA then had the resident hold onto the rail to stand up and as			

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	the resident was trying she let out a yell and said she could not do it. The CNA then lowered the resident to the floor with the resident's body against hers. The CNA then went to get help of another staff member and when they came back into the shower room the resident "seemed to be okay" and the resident said she was okay. The two CNA's then proceeded to lift the resident up and placed her in the chair and the resident complained her leg hurting. The CNA looked at the resident's knee and "had her move her leg" and everything looked "normal." The CNA then went and told the Nurse what happened and the Nurse checked the resident. A written statement completed by CNA #4 indicated he was in a room taking care of another resident and CNA #5 came into the room and said she needed help with Resident #B. The CNA indicated he asked what had happened and CNA #5 replied she had to lay Resident #B down to the ground because she could not stand. The CNA's then went into the shower room and the resident was laying on the ground and CNA #4 asked the resident if she fell and the resident said "no". The two CNA's then picked up the resident and put her into the wheel chair.			

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	When interviewed on 6/10/13 at 1:30 p.m., the Director of Nursing indicated the facility Administrator completed the 6/1/13 Incident/Occurrence Report for Resident #B. The Director of Nursing indicated Resident #B was lowered to the floor in the shower room by CNA #5 on 6/1/13. The Director of Nursing indicated the statement on the Incident/Occurrence Report was incorrect as the resident was not initially transferred by two staff when the fall occurred. The Director of Nursing indicated after the resident was lowered to the floor CNA #5 went to find CNA #4 to assist her with the resident. The Director of Nursing indicated the two CNA's then transferred the resident into the wheel chair. The resident was already in the wheel chair when the Nurse was notified and assessed the resident. The Director of Nursing indicated the resident was an extensive assist for transfers and could be transferred with one staff member unless her care plan stated two person transfer. When interviewed on 6/10/13 at 2:00 p.m., the Director of Nursing indicated CNA #5 should have not have left the room to get the other CNA to assist her. The Director of Nursing indicated the CNA's probably should			

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	not have transferred the resident into the wheel chair before notifying the Nurse to assess the resident after the resident was lowered to the floor in the shower room. 2. On 6/10/13 at 1:15 p.m., CNA's #3 and #4 were observed transferring resident #G from the wheel chair into his bed. The CNA's used a gait belt to transfer the resident. There was a padded cushion on the seat of the wheel chair. There was no Dycem (a this liner to prevent sliding) on top of the cushion. CNA #4 lifted the cushion off the wheel chair seat. There was no Dycem under the cushion. On 6/11/13 at 11:20 a.m., the resident was observed in bed. There were no staff members or visitors in the resident's room. There were no floor mats in place on the floor next to the resident's bed. There was a floor mat standing up against the wall under the window. On 6/11/13 at 12:15 p.m., the Resident was observed sitting in wheel chair at a round table in the unit dining room. The resident's head was bent down. There was no padding on or around the edges of or			

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	on the table in front of the resident. The record for Resident #G was reviewed on 6/10/13 at 8:35 a.m. The resident's diagnoses included, but were not limited to, dementia, psychosis, and anemia. A 5/3/13 Fall Risk Assessment indicated the resident's score was 18. The assessment indicated a score of 15 or higher indicated the resident was at high risk for falls. A care plan initiated on 11/12/12 indicate the resident was at risk for falls related to cognitive loss, poor safety awareness, impaired balance, and the use of psychotropic medications. The care plan was last updated with a goal date of 8/2013. The previous goal date was 5/2013. Care plan interventions included for the resident to have a Dycem in place to all chairs and a low bed with a mat to the right side of the bed. The 5/2013 Nurses' Notes were reviewed. An entry was made on 5/7/13 at 7:45 a.m. The entry indicated a CNA informed the Nurse she observed an area to the resident's right brow area while sitting next to the resident in the dining room. The entry indicated a bluish area with a raised hematoma (raised			

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	area filled with blood) was observed and the resident was unable to say how it occurred. Cold compresses were applied and the Physician was notified. An "Incident Report of Incident" was initiated on 5/7/13. The report indicated the resident was observed with a hematoma and bruising. The report indicated actions taken to prevent further incidents were '"padded table." A 5/7/13 Follow Up Investigation for Injury report was reviewed. The investigation report indicated the staff were interviewed and reported the resident would fall asleep at the dining room table with his head on the table. Interventions put into place were to pad the dining room table where the resident sat. When interviewed on 6/10/13 at 8:40 a.m., LPN #3 indicated she was caring for Resident #G. The LPN indicated the resident recently was observed with a small hematoma around his eye. LPN #3 indicated the resident had been observed leaning forward in his wheel chair. When interviewed on 6/10/13 at 1:20 p.m., CNA #3 indicated she was			

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	assigned to care for Resident #G and had cared for the resident several times in the past. The CNA indicated she did not recall the resident having a Dycem pad on his wheel chair. When interviewed on 6/10/13 at 1:25 p.m., LPN #3 indicated she was caring for Resident #G. The LPN indicated the resident was to have a Dycem on his wheel chair, a low bed, and a mat on the floor on the right side of the bed. When interviewed on 6/11/13 at 12:20 p.m., the Unit Manager indicated the resident recently had a hematoma to his face and it was determined the resident had been observed leaning forward at the table. The Unit Manager indicated padding was to be placed around the edges/curves of the dining room table where the resident sits as it was felt the resident probably leaned and bumped his head on the table. The Unit Manager indicated this intervention was still to be in place. This federal tag relates to Complaint IN00129066. 3.1-45(a)(1) 3.1-45(a)(2)			

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F000328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review, and interview, the facility failed to ensure proper care and treatment were provided related to weaning procedures for 1 of 1 resident reviewed for ventilator use in the sample of 11. (Resident #K) Finding include: On 6/10/13 at 7:05 a.m., Resident #K was observed in bed. The resident had a tracheostomy tube (an tube placed into a surgical opening in the trachea to provide an airway) in place. The resident was receiving oxygen ventilation via a ventilator machine with tubing connected to the resident's tracheostomy tube. The record for Resident #K was reviewed on 6/10/13 at 9:45 a.m. The resident's diagnoses included, but	F000328	Resident K has been discharged to home with supportive services. Physician's orders were clarified, settings were turned as ordered, and no adverse reactions noted. Former administrator, as noted in the Statement of Deficiencies, is no longer associated with this facility. LPN#7 was reeducated on safety precautions.No residents have the potential to be affected by this deficient practice because the facility no longer has ventilator patients, and no longer accepts such.After detailed discussion in the Quality Assurance Committee Meeting, it was decided that no other ventilator patients would be accepted and all ventilator patients were discharged to appropriate settings.	06/28/2013

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	were not limited to, chronic respiratory failure, seizure disorder, subarachnoid hemorrhage, and stroke. Review of the 6/2013 Physician Order Statement indicated there was an order for the resident's ventilator setting to be at AC (assist control) 12, VT(volume tidal) 600, and 5 peep(expiratory pressure). There was also an order to wean PS (pressure support setting) 10/+5 peep as tolerated. There was no order noted to change or wean the AC (assist control) rate. When interviewed on 6/10/13 at 10:00 a.m., the facility Administrator indicated Resident #K had Physician ventilator orders for setting to be AC 12, TV 600, Peep 5 and PS of 10. The Administrator also indicated there was an order to wean(decrease) the Peep and PS. The Administrator indicated recently he was informed the Respiratory Therapist indicated they were weaning the resident as they had standing orders. The Administrator indicated on last Friday (6/7/13) it was brought to his attention the resident's ventilator setting were at IMV (intermittent mandatory ventilation) instead of AC as per the			

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	Physician's order in the chart. The Administrator indicated he switched the ventilator setting back to AC at that time based on the Physician orders he noted in the resident's record. The Administrator indicated he contacted the Respiratory Physician's office on 6/7/13 and the office Nurse instructed them to follow the Physician orders they had at this time. The Administrator also indicated there was an occurrence about a week prior to the above related to ventilator settings for Resident #K. The Administrator indicated LPN #7 who worked on Resident #K's hall had notified him after finding the resident's ventilator setting were at SMIV(synchronized intermittent mandatory ventilation) instead of AC and the Respiratory Therapist had left. The Administrator indicated he did not follow through with contacting the respiratory Physician to clarify the issues with Respiratory Therapy indicating they had orders to wean and the orders on the resident's order statement did not indicated order were to wean the mode from AC to IMV. When interviewed on 6/11/13 at 9:37 a.m., LPN #7 indicated about a week			

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	or so ago Monday, the Respiratory Therapist informed him in report the resident's mode was changed to IMV. The LPN indicated later in the day the resident's respiratory rate increased and at the time he informed the Administrator who was also a Respiratory Therapist. The Administrator indicated the resident needed to be back on AC mode until the orders could be clarified related to the mode. The LPN indicated he thought the Administrator then changed the mode. The LPN indicated the above occurred at the end of his shift. LPN #7 also indicated at the start of his shift on the above date the Respiratory Therapist informed him they had changed the rate mode on the resident's ventilator to SIMV. The LPN indicated he did not see an order in the resident's chart but Respiratory had informed him they had been doing it before. The LPN indicated the above occurred about a week ago. When interviewed on 6/11/13 at 10:45 a.m., the facility Administrator indicated on 6/7/13 a Home Health Agency was at the facility to provide the ventilator they were going to use when the resident discharged home. The Agency Respiratory Therapist set			

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	up a new ventilator and provided an inservice to the facility staff. The Administrator indicated the ventilator had been set on IMV mode on 6/7/13 when the Agency was here. The facility Administrator indicated the facility should have done more clarification after the discrepancy related to the weaning was first brought to his attention on 6/3/13. This federal tag relates to Complaint IN00129457. 3.1-47(a)(6)			