

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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>{F 000}</p> <p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/13/10.</p> <p>Survey dates: February 4, 7, and 9, 2011</p> <p>Facility number: 000365 Provider number: 155423 Aim number: 100287460</p> <p>Survey team: Sheila Sizemore, RN, TC Regina Sanders, RN Kelly Sizemore, RN</p> <p>Census bed type: SNF/NF: 68 Total: 68</p> <p>Census payor type: Medicare: 20 Medicaid: 38 Other: 10 Total: 68</p> <p>Sample: 9 Supplemental sample: 9</p> <p>These Deficiencies also reflect State findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2-15-11 Cathy Emswiler RN</p> <p>F 224 SS=D A N PS</p> <p>MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written</p>	<p>{F 000}</p> <p>F 224 483.13(c) Prohibit mistreatment/neglect/misappropriate</p> <p>The facility does and will continue to enforce the policies and procedures for mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>1. Steps taken for the alleged deficient practice.</p> <ul style="list-style-type: none"> - The facility followed all policies and procedures for abuse. - Resident #65 was immediately provided protection and the CNA was immediately suspended from work. - Resident # 65 was interviewed and counseled by the Executive Director, Director of Nursing and Social Service for psychosocial issues. - The ED and DON were immediately contacted by staff member and told of alleged occurrence. - The alleged incident was reported to state agencies as required in the approved time frame. - Upon investigation of the alleged incident the CNA was terminated by administration. - The terminated CNA had completed Abuse and Neglect
---	--

RECEIVED

FEB 28 2011

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Camp Moore, RN, MSN</i>	TITLE <i>Executive Director</i>	(X8) DATE <i>2/24/11</i>
---	------------------------------------	-----------------------------

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.

ENTERED FEB 28 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
F 224	<p>Continued From page 1</p> <p>policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a resident was free from abuse from a staff member, for 1 of 9 residents reviewed for abuse in a sample of 9. (Resident #69)</p> <p>Findings include</p> <p>1. During an observation, on 2/4/11 at 12:15 p.m., resident #69 was sitting up in his wheelchair in the dining room, was interacting well with other tablemates and voiced no concerns.</p> <p>Resident #69's record was reviewed on 2/7/11 at 11:05 a.m. Resident #69's diagnoses included, but were not limited to, hypertension, diabetes, congestive heart failure, and glaucoma.</p> <p>A Nurse's notes, dated 1/28/11 at 2 p.m., indicated "Res (resident) notified therapy that aide was mean to him on night shift. When res interviewed, family present he stated the aide took his call light away from him and she called him an a--hole Explained an investigation would start and thanked him for letting us know."</p> <p>A Nurse's notes, dated 1/28/11 at 10:45 p.m., indicated "...during assessment resident did state he was scared that the CNA who was mean to him was going to come back to the building and hurt him. This writer provided re-assurance to pt</p>	F 224	<p>policy training by administration during orientation on 5/12/10 and was fully informed and trained on abuse and neglect policies.</p> <p>2. All residents benefit and should be free of abuse and neglect.</p> <ul style="list-style-type: none"> - All in house residents have the potential to be affected. An audit of Guardian Angel Calls from 30 days prior to date of exit has been completed to ensure that the facility policy and procedures has been followed. There were no other issues identified through this audit. - Staff will be re-educated on abuse and neglect policies and techniques on how to recognize stress with self and co-workers and interventions on coping, reporting to supervisor with stress concerns of self or co-workers by administration. <p>3. Systems to prevent recurrence;</p> <ul style="list-style-type: none"> - The facility will continue to follow abuse and neglect policies for facility residents. - Staff will continue to be educated during orientation and quarterly on abuse and neglect. Any staff member encountering stress of self or co-worker significant to act outside the facility policy will be re-educated and communicated to their supervisor(s) by administration. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
--	---

(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
--------------------	--	---------------	---	----------------------

F 224	<p>Continued From page 2 (patient) that he was safe here that the employee wouldn't be allowed into the building..."</p> <p>A Social Service Progress Notes, dated 1/28/11, indicated "SSD (Social Service Director) was informed by PTA (Physical Therapy Aide) on (sic) today that resident stated that the CNA care (sic) for him on the midnight shift was verbally abusive to him. SSD went to talk with resident regarding incident. Resident stated that the staff person moved his call light out of his reach and also called him an a--hole. Resident was very upset and tearful. Resident was asked by SSD was he fearful of the CNA. resident stated yes he was. SSD informed the ED (Executive Director) and the DoN. SSD assured the resident that he would be safe at the facility. Resident verbalized understanding and agreed with SSD."</p> <p>A Social Service Progress Notes, dated 1/31/11, indicated "...the resident had no signs or symptoms of emotional distress over the weekend related to the incident on 1/28/11. SSD spoke with resident on today 1/31/11 to see how he was feeling emotionally and resident states that he is fine..."</p> <p>An untitled form, indicated the date of Resident #69 allegation was 1/28/11 and the ED (Executive Director) and DoN were made aware on 1/28 at 2 p.m.</p> <p>The facility completed an investigation and the abuse was substantiated on 1/31/11. Review of the investigation indicated the aide was placed on suspension 1/28/11, pending a full investigation. The investigation was completed and the staff member was terminated on 1/31/11.</p>	F 224	<p>- Staff will continue to be educated quarterly and as indicated on the facilities abuse and neglect policies by administration.</p> <p>4. Monitoring</p> <ul style="list-style-type: none"> - Staff will continue to observe for signs and symptoms for themselves and/or co-workers of burn out and/or stress and report immediately to supervision. - Five interviewable residents and five staff will be interviewed by administration weekly times 4 weeks then monthly times two regarding any concerns with staff treatment of residents and respond accordingly as indicated. - Five non-alert and non - oriented residents will be observed by Social Service Director weekly times four weeks during care to ensure no signs and symptoms of abuse and/or neglect then monthly times two months and respond accordingly if indicated. - Results will be brought to Executive Director immediately if indicated and discussed in PI monthly times three months and then quarterly. <p>5. Completion date: Feb. 23, 2011</p>	
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
F 224	Continued From page 3 A facility policy titled, " Protection of Residents: Reducing the Threat of Abuse and Neglect," dated 2/2009 and received as current from the DoN, on 2/7/11 at 12:30 p.m., indicated "...Regulations...(c)...Each resident has the right to be free from mistreatment, neglect and misappropriation of property..." 3.1-28(a) 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the	F 224	F 272 483.20, 483.20(b) Comprehensive assessments 1. Resident # 5 was treated and assessed for upper respiratory infection and is now symptom free. Resident #39 wound is healing and continues to be treated per plan of care/orders. Please note – wound was measured on 1/20/11 prior to podiatrist debriding on 1/21/11, which increases the size of a wound bed and does not indicate a wound has worsened. Licensed nurses have completed weekly measurements. Resident # 39 PICC insertion site remains free of signs and symptoms of infection. Measurements of circumference were completed on 2/7/2011 and documented. 2. Residents with infections, open non-pressure wounds and PICC access sites are at risk to be affected by the alleged deficient practice. Residents identified with these were assessed and have documented assessments to include measurements if indicated by licensed nurses. – Education will be provided by nursing administration regarding PICC IV line assessments and documentation; weekly measurements of non-pressure	1/21/11
{F 272} SS=D		{F 272}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 272}	<p>Continued From page 4 resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure ongoing assessments were completed related to an upper respiratory tract infection, PICC (Peripherally Inserted Central Catheter) line, and an open area on the skin for 2 of 9 resident's reviewed for assessments in a sample of 9. (Resident #5 and #39)</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 02/04/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A nurses' note, dated 01/20/11, indicated, "...lung sounds somewhat difficult to hear d/t (due to) her noisy (sic) mouth breathing, mild crackles heard thru (sic) out c/ (with) faint wheezes. Notified (Physician name). Order for CXR (chest x-ray)..."</p> <p>A chest x-ray, dated 01/21/11 indicated, "...Very slight left lower lobe atelectasis, no infiltrate..."</p> <p>A physician's progress note, dated 01/22/11, indicated, "...URTI (upper respiratory tract infection)/COPD (Chronic Obstructive Pulmonary Disease)...Add Robitussin DM (cough syrup)...& Albuterol nebs (nebulizer)..."</p> <p>A physician's order, dated 01/22/11, indicated an order for Robitussin DM (cough medication) 15</p>	{F 272}	<p>wounds and to include a description in the nurses notes if it becomes worse or weekly documentation if wound is healing. Assessments of infection conditions to be completed at least daily pertinent to physical assessment and treatment and any changes as indicated. Assessment of non-pressure wounds to be documented upon admission with notification of the physician to obtain orders as indicated and to include measurement and description of non pressure wound. Non-pressure wounds will be assessed and documented if worsened by staff nurse.</p> <p>3. Systems to ensure compliance. - Infections will have documented assessments every shift during the treatment of that infection in the nurses notes and /or plan of care by the licensed nurse. - IV PICC sites will be documented in the nurses notes and/or plan of care according to infusion site policy by the licensed nurse. - Non-pressure wounds will be assessed and include description and measurements weekly and as indicated if wound worsens or treatment changes by the licensed nurse. The licensed nurse will</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 272}	<p>Continued From page 5</p> <p>milliliters three times a day for five days and Albuterol (breathing medication) 0.083% via nebulizer, four times a day for five days then as needed four times a day, for upper respiratory tract infection.</p> <p>The resident's nurses' notes, dated 1/22/11 through 1/25/11 (last nurses' note in record), lacked documentation to indicate ongoing assessments were completed related to the resident's upper respiratory tract infection.</p> <p>During an interview on 02/04/11 at 12:20 p.m., the RN Consultant indicated the nurses' notes did not have documentation about the resident's upper respiratory tract infection.</p> <p>2. Resident #39's record was reviewed on 2/7/10 at 9:47 a.m. Resident #39's diagnoses included, but were not limited to, hypertension, hypoxia, and left foot wound infection. Resident #39 was admitted to the facility on 1/11/11.</p> <p>A. The Initial Data Collection Tool/Nursing Service (admission assessment), dated 1/11/11 indicated Resident #39's skin was warm and intact.</p> <p>A nurses' note, dated 1/18/11 at 1:30 p.m., indicated Resident #39 had a hard callus on the bottom of the left foot. The nurses' note indicated she would let Social Service know so she could refer the resident to the podiatrist.</p> <p>A nurses' note, dated 1/20/11 at 2:45 p.m., indicated "Son stated that resident would not walk in therapy today because of the blister on his left foot. Left foot assessed. On the middle of the bottom of resident's left foot, a 2 cm (centimeter) x (by) 1 cm round dry area noted with a depth of</p>	{F 272}	<p>notify physician if non-pressure wounds and obtain treatment orders as indicated.</p> <p>- Nursing administration will review nursing note for antibiotic infection documentation daily M - F in change of condition meeting and educate license nurses as indicated ongoing for non-compliance with system.</p> <p>- Nursing staff will be re-educated by nursing administration regarding; infection assessments and documentation in plan of care, IV PICC line site documentation, non-pressure wound assessment and documentation, reporting non-pressure wounds if identified to charge nurse and/or physician for follow up on going in orientation and as indicated for compliance with systems.</p> <p>4. Monitoring</p> <p>- Licensed nurses will continue to treat non-pressure wounds as ordered. Document as indicated for measurements weekly on the non-pressure wounds and as indicated if wound worsens. Nursing administration will review non-pressure wound status reports weekly and PRN for healing process.</p>	
---------	---	---------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 272}	<p>Continued From page 6</p> <p>0.75 cm. Area has no redness, drainage, nor swelling. Resident states area is tender to touch. Son stated that resident has had this area since before admission." The nurses' note indicated the resident's physician was notified of the condition of the resident's foot and new orders were received. The nurses' note indicated Social Services was notified of the resident's need to see the podiatrist.</p> <p>A physician's telephone order, dated 1/20/11 at 2:45 p.m., indicated the resident was to see the podiatrist for an evaluation of the left foot wound.</p> <p>A nurses' note, dated 1/21/11 at 4:00 p.m., indicated the podiatrist had seen the resident and new orders were received.</p> <p>A physician's telephone order, dated 1/21/11 at 4:00 p.m., indicated "1. culture left foot. 2. x-ray 3 views left heels. 3. clean with normal saline. 4. Iodoform wound packing (medicated wound packing) qd (everyday)."</p> <p>A podiatrist note, dated 1/21/11 indicated the resident had a history of surgery on the left foot years ago and had a callus on the incision site. The note indicated upon debridement the overlying area revealed tunnels of pus pockets. The podiatrist indicated a saline wound wash with sterile dressing and iodoform packing everyday.</p> <p>A nursing note, dated 1/21/11 at 7:00 p.m., indicated the dressing was dry and intact. There was a lack of documentation of an assessment or measurement of the left foot wound.</p> <p>A nurses' note, dated 1/22/11 at 4:00 p.m., indicated the dressing was dry, clean and intact.</p>	{F 272}	<ul style="list-style-type: none"> - Nursing administration will documentation of assessments for non-pressure wounds, infections process, treatments, and IV PICC line site assessment daily Monday – Friday during change of condition meeting on-going. – Review of this monitoring will be discussed monthly in PI for tracking and trending on assessment and documentation of the above times 6 months. Threshold 100%. – Plan to be updated as indicated. <p>5. Completion date: Feb. 23, 2011</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 272}	Continued From page 7 There was no documentation of an assessment of the wound or measurements of the wound. A nurses' note, dated 1/23/11 at 2:12 p.m., indicated the "bandage clean dry and intact..." There was a lack of documentation of an assessment or measurements of the wound. A nurses' note, dated 1/24/11 at 4:00 a.m., indicated the treatment to left heel was in "progress as ordered." There was a lack of documentation of an assessment or measurements of the wound. A wound culture, dated 1/24/11, indicated "staphylococcus aureus (mrsa)..this is a multiple drug resistant organism." A physician's order, dated 1/24/11, indicated "vancomycin 500 mg (milligrams) IV (intravenous) every 12 hours x (times) 10 days pharmacy to dose." A nurses' note, dated 1/25/11 at 8:30 p.m., indicated the dressing to the left foot was dry and intact and had no swelling or redness to the left foot. A nurses' note, dated 1/27/11 at 8:00 p.m., indicated the left foot had no redness or swelling and the dressing was dry and intact. A nurses' note, dated 1/28/11 at 2:30 p.m. and 10:00 p.m., indicated the bandage to the left foot was clean, dry and intact. There was a lack of documentation of an assessment or measurements of the wound. A nurses' note, dated 1/29/11 at 7:00 p.m.,	{F 272}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 272}	<p>Continued From page 8</p> <p>indicated the resident's dressing was dry and intact. There was a lack of documentation of an assessment or measurements of the wound.</p> <p>Nurses' notes, dated 1/30/11 at 4:00 a.m., 1/31/11 at 8:00 p.m. 2/1/11 at 6:00 a.m. and 2/2/11 at 5:00 a.m., indicated the resident had no redness, swelling or drainage noted.</p> <p>A nurses' note, dated 2/3/11 at 10:00 p.m., indicated the left foot dressing was dry and intact. There was a lack of documentation of an assessment or measurements of the wound.</p> <p>A nurses' note, dated 2/4/11 at 10:00 a.m., indicated the dressing was intact. There was a lack of documentation of an assessment or measurements of the wound.</p> <p>Nurses' notes, dated 2/4/11 at 9:00 p.m., 2/5/11 at 4:00 a.m., 2/6/11 at 4:00 a.m. and 2/7/11 at 9:00 a.m., indicated the dressing was dry and intact and the left foot had no redness or swelling.</p> <p>During an interview on 2/7/11 at 10:20 a.m., LPN #4 indicated there were no weekly skin assessments done on Resident #39's left foot. LPN #4 indicated there were no measurements done on the left foot wound since 1/20/11. LPN #4 indicated the area to the left foot was not noted on the admission assessment. LPN #4 indicated she did not know why a non-pressure skin condition record had not been started on the resident.</p> <p>An observation on 2/7/11 at 11:13 a.m., the Unit Manager measured the resident's left foot. The area measured 3.8 cm in length (an increase of 1.8 cm) and .5 cm in width. The depth was 1 cm,</p>	{F 272}		
---------	---	---------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 272}	<p>Continued From page 9</p> <p>this was an increase of .25 cm since 1/20/11. This was the first measurement of the wound since 1/20/11.</p> <p>During an interview on 2/7/11 at 12:43 p.m., the Nurse Consultant, indicated a non-pressure skin condition should have been started on the resident. The Nurse Consultant indicated the non-pressure skin condition was completed weekly</p> <p>Review of a non-pressure skin condition record provided by Medical Records on 2/7/11, indicated an area to be completed for the site, size, depth, drainage, odor, tunneling, appearance of wound, and response to treatment.</p> <p>A facility policy, dated 5/21/04, titled "Wound Care/Treatment Guidelines" provided by the Nurse Consultant on 2/7/11 at 1:20 p.m., indicated "Complete a weekly assessment on all wounds...."</p> <p>B. Record review indicated Resident #39 received a PICC line on 1/24/11 to the right upper arm.</p> <p>The resident's nurses' notes lacked documentation from 1/24/11 to 2/7/11 of a thorough assessment of the PICC line to the resident's right arm of temperature, tenderness and the length of the external catheter and upper arm circumference.</p> <p>Review of the MAR (Medication Administration Record) and the TAR (Treatment Administration Record) for January and February 2011 lacked documentation of the PICC line being assessed.</p>	{F 272}		
---------	--	---------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 272}	Continued From page 10 A facility policy, provided by the DoN (Director of Nursing) on 2/7/11 at 12:30 p.m., titled "Peripherally Inserted Central Catheter" indicated "assessment is to include, but not limited to....change in temperature, tenderness at the site or along vein tract, and the length of external catheter and upper arm circumference is obtained." During an interview on 2/7/11 at 12:10 p.m., the Nurse Consultant indicated the PICC line should have been placed on the treatment record to show the nurses were assessing the PICC line. The nurse consultant indicated measurements of the upper arm had not been completed. This tag was cited on 12/13/10. The facility failed to implement a systemic plan of correction to prevent recurrence.	{F 272}		
{F 282} SS=E	3.1-31(a) 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure physician's orders were followed, related to medications, sutures, laboratory tests, gastrostomy feeding (g-tube), and vital signs for 6 of 9 residents in a sample of 9 reviewed for following physician's orders. (Resident #5, #12, #18, #39, #52, and	{F 282}		4/12/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 282}	<p>Continued From page 11 #69)</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 02/04/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A) A physician's progress note, dated 01/22/11, indicated, "...URTI (upper respiratory tract infection)/COPD (Chronic Obstructive Pulmonary Disease)...Add Robitussin DM (cough syrup)...& Albuterol nebs (nebulizer)..."</p> <p>A physician's order, dated 01/22/11, indicated an order for Robitussin DM (cough medication) 15 milliliters three times a day for five days and Albuterol (breathing medication) 0.083% via nebulizer, four times a day for five days then as needed four times a day, for upper respiratory tract infection.</p> <p>A Medication Administration Record (MAR), dated 01/11, indicated the Robitussin had been given three times a day January 23 through January 31, 2011. The MAR lacked documentation to indicate the Albuterol had been administered as ordered by the physician.</p> <p>The Nurses' notes, dated 1/22/11 through 1/25/11 (last nurses' note in record), lacked documentation the resident received the Albuterol as ordered.</p> <p>During an interview on 02/04/11 at 12:20 p.m., the RN Consultant indicated the Robitussin had been administered more than five days. She indicated the Albuterol had not been administered</p>	{F 282}	<p>F 282 483.20(k)(3)(ii) Services by qualified persons/per care plan</p> <ol style="list-style-type: none"> 1. Resident #5's physician was contacted for clarification orders of Robitussin and Albuterol.. Both medications have been ordered PRN. Resident #5 has G-tube feeding running at 70 cc/hr as per current physician order. <ul style="list-style-type: none"> - Resident #18 sutures were removed on 2/7/11 and physician was made aware. Residents folic acid and Omeprozole has been discontinued. - Resident # 12 no longer resides at this facility. - Resident #39's MD contacted and the vanco trough was clarified and no new orders received. - Resident #52 currently has blood pressure and heart rate assessed per physician orders. - Resident # 69 no longer resides in this facility 2. Residents receiving medication, readmitted from the hospital for medical update, requiring suture removal as ordered, labs as ordered, tube feedings rates as ordered and / or blood pressure completed as ordered for required medication are at risk to be affected by the alleged 	
---------	---	---------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 282}	<p>Continued From page 12</p> <p>as ordered by the physician. She indicated the nurses' notes did not have documentation to indicate the resident was receiving the Albuterol.</p> <p>B) Resident #5's physician's recapitulation orders, dated 01/11, indicated an order, originally dated, 03/31/10, for Jevity 1.2 per g-tube at 70 cc's (cubic centimeter) per hour.</p> <p>During an observation on 02/07/11 at 11:30 a.m., LPN #3 reattached the resident's g-tube feeding after the resident's care had been completed. LPN #3 set the rate at 60 cc's per hour.</p> <p>During an observation on 02/07/11 at 1:25 p.m., resident #5 was sitting in her wheelchair in the hallway, her g-tube feeding rate was set at 60 cc's per hour. During an interview at the time of the observation, LPN #3 indicated the feeding rate was set at 60 cc per hour and should have been set on 70 cc's per hour.</p> <p>2. Resident #18's record was reviewed on 02/07/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, fracture of the left wrist and left hip, and dementia.</p> <p>A) The Nurses' notes, dated 01/26/11 at 6:20 p.m., indicated the resident had fallen and had received a laceration to the left forehead.</p> <p>The Nurses' notes, dated 01/26/11 at 7:35 p.m., indicated the resident had been transferred to the hospital emergency room.</p> <p>The Nurses' notes, dated 01/27/11 at 6:45 p.m., indicated the resident had been readmitted into the facility from the hospital.</p>	{F 282}	<p>deficient practice. In-house resident physician orders and labs were reviewed to ensure competed as ordered and readmission residents had prior medication reviewed and clarified if not reordered by physician by the licensed nurse(s). Any findings of the above will be reported to the nursing administration and corrected as ordered.</p> <ul style="list-style-type: none"> - Licensed nurses will be educated on all of the above bulleted points and system below by nursing administration, nurse consultant. <p>3. Licensed nurses will receive education from nursing administration and /or nurse consultant during orientation and/or compliance and every six months for the following:</p> <ul style="list-style-type: none"> - Lab requisitions will be completed by licenses nurses for labs ordered by physician. Nursing administration will review orders daily Monday – Friday to ensure requisition completed accurately, labs obtained and follow up completion as ordered from physician. - Licensed nurses will check tube feeding rates as ordered prior to restarting tube feeding pump. 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011	
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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
{F 282}	<p>Continued From page 13</p> <p>The Nurses' notes, dated 01/28/11 at 1:30 p.m., indicated the resident had five sutures on her left forehead.</p> <p>A physician's order, dated 01/28/11 at 4:30 p.m., indicated to remove the resident's sutures, 7-10 days from 01/26/11.</p> <p>During an observation on 2/7/11 at 12:20 p.m., with LPN #4, the resident was sitting in her wheelchair in her room, there were 2 sutures located about the resident's left eye. During an interview at the time of the observation, LPN #4 indicated the resident had picked at her sutures and had removed some of them herself. She indicated the other sutures should have been removed by 02/05/11.</p> <p>B) Resident #18's MAR (Medication Administration Record), dated 02/11, indicated the resident had been receiving Folic Acid (supplement) 1 mg (milligram daily) and omeprazole DR (Prilosec) (stomach medication) 20 mg daily, since 02/01/11.</p> <p>The resident's re-admission orders from the hospital, dated 01/27/11, indicated an order for Protonix (stomach medication) 40 mg daily for a gastric ulcer. There was a lack of documentation the resident had an order to continue the Folic Acid 1 mg daily and the omeprazole DR daily as was previously ordered on the original admission on 01/21/11.</p> <p>During an interview on 02/07/11 at 12:35 p.m., LPN #4 indicated the resident did not have Protonix, omeprazole, or Folic Acid in the medication cart. She indicated she had put a bunch of medication boxes in the shredder, but</p>	{F 282}	<p>– Suture removal will be placed on the treatment record for the day it is to be removed. Nursing administration to ensure during change of condition meeting that suture removal orders are followed.</p> <p>– Residents readmitted to the facility will have a list of their medications received prior to discharge reviewed with the attending physician with the current admissions orders within the first 24 hours by the admitting nurse(s). The nursing administration team will review readmission orders within 72 hours after admission and ensure the medications prior to discharge were reviewed with attending physician.</p> <p>– Nursing administration will check new orders daily Monday – Friday to ensure medication orders have been transcribed correctly on the MAR and medication is being administered as ordered.</p> <p>4. Monitoring: - Nursing administration will audit medications requiring heart rate and/or blood pressure 5 times/week times 4 weeks, then 3 times/week times 8 weeks then weekly times 8 weeks to ensure documented per orders. 100 % threshold</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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)
{F 282}	<p>Continued From page 14</p> <p>was not sure if any of those were the Protonix, omeprazole, or Folic Acid boxes. She indicated she had given the resident a Folic Acid during the morning medication pass. She indicated the omeprazole on the MAR was scheduled for 6:30 a.m. so she would not give the medication to the resident. LPN #4, then attempted to notify the night shift nurse by telephone and was unable to reach the night shift nurse. LPN #4 then notified the pharmacy by telephone and indicated the pharmacy had sent over a seven day supply of the generic Protonix on 01/28/11 evening, so the medication would have been started on 01/29/11 in the morning. LPN #4 indicated the pharmacy did not have a record of the omeprazole or Folic Acid medications being sent back to the pharmacy for credit and did not have a reorder for the Protonix. LPN #4 indicated the boxes of the omeprazole and Folic Acid medication had been left in the medication cart after the resident had been discharged to the hospital on 01/26/11, and they were giving the omeprazole and Folic acid to the resident from those boxes. She indicated there was no receipt located to show the medications had been returned to the pharmacy. She indicated even if the resident had received the Protonix, the medication would have ran out on 02/04/11.</p> <p>3. Resident #12's record was reviewed on 02/07/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A physician's order, dated 01/16/11, indicated an order for a CBC (complete blood count), BMP (basic metabolic profile) (electrolytes), pre-albumin (protein), Vitamin D, and a FBS (fasting blood sugar) laboratory tests to be done</p>	{F 282}	<p>- Nursing administration will audit continuous tube feeding orders five time/week times 4 weeks then 3 times/week times 8 weeks then weekly times 8 weeks to ensure correct flow rate being administered per orders. 100% threshold.</p> <p>- Labs will be obtained as ordered by the licensed nurses. Nursing administration will review labs orders Monday – Friday to ensure requisition has been completed correctly per physician orders. Nursing administration will follow labs orders daily Monday – Friday in change of condition meeting to ensure notification and orders obtained as indicated. 100 % threshold.</p> <p>-Orders for sutures will be placed on TAR for removal per physician orders by the licensed nurse. Nursing administration will follow suture removal during change of condition meeting Monday – Friday to ensure removed on correct date. Nursing administration will follow suture orders daily for removal Monday – Friday in change of condition meeting. 100% threshold.</p> <p>- Audits of above systems will be reviewed in PI times six months to</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 282}	<p>Continued From page 15 01/27/11.</p> <p>The record indicated a CBC, BMP, FBS, pre-albumin, magnesium level, and phosphorus had been completed on 01/17/11. There was a lack of documentation to indicate a Vitamin D level had been completed as ordered.</p> <p>The lab requisition, completed by the facility, dated 01/17/11, indicated the resident was to receive a CBC, BMP, FBS, calcium, magnesium, phosphorus and a pre albumin. There was a lack of documentation to indicate the facility had ordered the Vitamin D on the requisition.</p> <p>During an interview on 02/07/11 at 9:50 a.m., LPN #3 indicated there was not a lab result for the Vitamin D in the resident's record. She then notified the lab company per telephone and they indicated they had not completed a Vitamin D lab.</p> <p>4. Resident #39's record was reviewed on 2/7/10 at 9:47 a.m. Resident #39's diagnoses included, but were not limited to, hypertension, hypoxia, and left foot wound infection. Resident #39 was admitted to the facility on 1/11/11.</p> <p>A physician's telephone order, dated 1/31/11, indicated "...Please draw vanco (vancomycin antibiotic) trough (level of medication in the blood) 30 min (minutes) prior to a.m. dose on Wednesday 2-2..."</p> <p>Review of Resident #39's record lacked documentation of the vanco trough being completed.</p> <p>During an interview on 2/7/11 at 10:08 a.m., Staff #8 indicated she did not have a lab for the resident on 2/2/11.</p>	{F 282}	<p>ensure compliance.</p> <p>- Plan to be updated as indicated.</p> <p>5. Completion date: February 23, 2011</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 282}	Continued From page 16 During an interview on 2/7/11 at 10:13 a.m., Staff #8 indicated the nurse had not placed the lab order in the lab book to be done. Staff #8 indicated it was the nurses responsibility to place the order for the lab in the lab book. Staff #8 indicated the nurse had not followed the doctor's order by not placing the lab in the lab book. 5. Resident #52's record was reviewed on 2/4/11 at 11:16 a.m. Resident #52's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, congestive heart failure, and hypertension. Readmission orders, dated 1/14/11, indicated "...amlodipine (sic) (blood pressure medication) 10 mg (milligrams) p.o. (by mouth) Daily hold if SBP (systolic blood pressure) < (less than) 110...metoprolol (blood pressure medication) 75 mg (milligrams) p.o. (by mouth) BID (twice a day) Hold if SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 60..." A Medication Administration Record (MAR), dated 1/14/11 through 1/31/11, indicated amlodipine (sic) 10 mg p.o. daily hold if SBP <110 and metoprolol 75 mg p.o. twice a day hold if SBP < 100 or HR <60. The January 2011, MAR lacked documentation to indicate blood pressures or heart rates were obtained as ordered. During an interview with LPN #2, on 2/7/11 at 9:50 a.m., she indicated the blood pressures and	{F 282}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 282}	Continued From page 17 heart rates were not taken as ordered. 6. Resident #69's record was reviewed on 2/7/11 at 11:05 a.m. Resident #69's diagnoses included, but were not limited to, hypertension, diabetes, congestive heart failure, and glaucoma. A physician's order was written at the bottom of lab results which were collected on 1/17/11. The order indicated "1-17-11 Repeat CBC and BMP in 1 week ..." Nurse's notes, dated 1/17/11 at 4:30 (a.m. or p.m. not indicated), indicated "lab received MD (doctor) notified new orders given and noted." The record lacked documentation of an order for the CBC and BMP in one week or results of the tests. During an interview with the DoN, on 2/7/11 at 12:05 p.m., she indicated there was not a telephone order written for the labs and the labs were not done as ordered. This tag was cited on 12/13/10. The facility failed to implement a systemic plan of correction to prevent recurrence.	{F 282}			
{F 309} SS=G D bb	3.1-35(g)(2) 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.	{F 309}		1/12/11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 309}	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a non-pressure area was assessed and treated in a timely manner which resulted in the resident being unable to ambulate in therapy and the non-pressure area enlarging for 1 of 1 residents with a non-pressure area in a sample of 9. (Resident #39) Findings include: Resident #39's record was reviewed on 2/7/10 at 9:47 a.m. Resident #39's diagnoses included, but were not limited to, hypertension, hypoxia, and left foot wound infection. Resident #39 was admitted to the facility on 1/11/11. The Initial Data Collection Tool/Nursing Service (admission assessment), dated 1/11/11 indicated Resident #39's skin was warm and intact. A nurses' note, dated 1/18/11 at 1:30 p.m., indicated Resident #39 had a hard callus on the bottom of the left foot. The nurses' note indicated she would let Social Service know so she could refer the resident to the podiatrist. A nurses' note, dated 1/20/11 at 2:45 p.m., indicated "Son stated that resident would not walk in therapy today because of the blister on his left foot. Left foot assessed. On the middle of the bottom of resident's left foot, a 2 cm (centimeter) x (by) 1 cm round dry area noted with a depth of 0.75 cm. Area has no redness, drainage, nor	{F 309}	F 309 483.25 Provide care/services for highest well being 1. Resident # 39 on 1/21/11 had a "thick callous on incision area from prior left charcot foot surgery years ago. Upon examination no signs of inflammation, edema negligible. Debridement of overlying area revealed tunneling pus pockets." The resident was placed on IV antibiotic. The wound was not opened until 1/21/11 when it was debrided by the podiatrist. Prior to 1/21/11 there was no indication of a wound nor was it open prior to 1/21/11 – it was concave in appearance, "round, dry area". X-rays completed as ordered and all treatments were completed as ordered. Resident #39 continues with skilled therapy and is "making marked improvement." - Per Life Care policy resident # 39 assessment of non-pressure wound will be documented weekly. 2. Residents with non-pressure wounds are at risk for the alleged deficient practice. - Full in-house skin sweep will be conducted by nursing administration and any non-pressure wounds will be assessed to included	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 309}	<p>Continued From page 19</p> <p>swelling. Resident states area is tender to touch. Son stated that resident has had this area since before admission." The nurses' note indicated the resident's physician was notified of the condition of the resident's foot and new orders were received. The nurses' note indicated Social Services was notified of the resident's need to see the podiatrist.</p> <p>A physician's telephone order, dated 1/20/11 at 2:45 p.m., indicated the resident was to see the podiatrist for an evaluation of the left foot wound.</p> <p>A nurses' note, dated 1/21/11 at 4:00 p.m., indicated the podiatrist had seen the resident and new orders were received.</p> <p>A physician's telephone order, dated 1/21/11 at 4:00 p.m., indicated "1. culture left foot. 2. x-ray 3 views left heels. 3. clean with normal saline. 4. Iodoform wound packing qd (everyday)."</p> <p>A podiatrist note, dated 1/21/11 indicated the resident had a history of surgery on the left foot years ago and had a callus on the incision site. The note indicated upon debridement the overlying area revealed tunnels of pus pockets. The podiatrist indicated a saline wound wash with sterile dressing and iodoform packing everyday.</p> <p>A nursing note, dated 1/21/11 at 7:00 p.m., indicated the dressing was dry and intact. There was a lack of documentation of an assessment or measurement of the left foot wound.</p> <p>A nurses' note, dated 1/22/11 at 4:00 p.m., indicated the dressing was dry, clean and intact. There was no documentation of an assessment of the wound or measurements of the wound.</p>	{F 309}	<p>documentation, notification of physician and orders obtained if indicated.</p> <p>- Licensed nurses will be educated by nursing administration on the importance of assessing feet of diabetics and noting callused areas on the feet, documenting size and description of non-pressure wounds and calluses. Callous will be included on the care plan problem and size and location; non-pressure wounds will be documented upon occurrence, admission, if worsens and weekly to include size and healing process. Nurses will be responsible for documentation to include measurement in the resident plan of care of non-pressure wounds. Education to be included with orientation of licensed nurses and as indicated for compliance.</p> <p>3. Systems:</p> <p>- Weekly non-pressure status measurements will be completed on non-pressure wounds; this will also include upon admission and per incident by the licensed nurse.</p> <p>- Licensed nurses will document non-pressure wound status in the nursing notes upon discovery to include description and measurements and if the wound</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 309}	Continued From page 20 A nurses' note, dated 1/23/11 at 2:12 p.m., indicated the "bandage clean dry and intact..." There was a lack of documentation of an assessment or measurements of the wound. A nurses' note, dated 1/24/11 at 4:00 a.m., indicated the treatment to left heel was in "progress as ordered." There was a lack of documentation of an assessment or measurements of the wound. A wound culture, dated 1/24/11, indicated "staphylococcus aureus (mrsa)..this is a multiple drug resistant organism." A physician's order, dated 1/24/11, indicated "vancomycin 500 mg (milligrams) IV (intravenous) every 12 hours x (times) 10 days pharmacy to dose." A care plan, dated 1/24/11, indicated "Resident Need, wound infect. (infection), Relating To Vancomycin 500 IV q (every) 12 0 (hours) x (times) 10 days." The goal or target date and the interventions were left blank. There was a lack of documentation of the non-pressure area of the resident's left foot. A nurses' note, dated 1/25/11 at 8:30 p.m., indicated the dressing to the left foot was dry and intact and had no swelling or redness to the left foot. A nurses' note, dated 1/27/11 at 8:00 p.m., indicated the left foot had no redness or swelling and the dressing was dry and intact. A nurses' note, dated 1/28/11 at 2:30 p.m. and	{F 309}	becomes worsened with notification to physician. 4. Monitoring: - Incident data, Physician orders, initial admission assessments, skin assessments and non-pressure status tool will be reviewed by nursing administration daily Monday – Friday in change of condition meeting ongoing. - Change of condition meeting audits will be completed daily Monday – Friday ongoing and reviewed for tracking and trending by the interdisciplinary team. - Plan to be updated as indicated 5. Completion date: February 23, 2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 309}	<p>Continued From page 21</p> <p>10:00 p.m., indicated the bandage to the left foot was clean, dry and intact. There was a lack of documentation of an assessment or measurements of the wound.</p> <p>A nurses' note, dated 1/29/11 at 7:00 p.m., indicated the resident's dressing was dry and intact. There was a lack of documentation of an assessment or measurements of the wound.</p> <p>Nurses' notes, dated 1/30/11 at 4:00 a.m., 1/31/11 at 8:00 p.m. 2/1/11 at 6:00 a.m. and 2/2/11 at 5:00 a.m., indicated the resident had no redness, swelling or drainage noted.</p> <p>A nurses' note, dated 2/3/11 at 10:00 p.m., indicated the left foot dressing was dry and intact. There was a lack of documentation of an assessment or measurements of the wound.</p> <p>A nurses' note, dated 2/4/11 at 10:00 a.m., indicated the dressing was intact. There was a lack of documentation of an assessment or measurements of the wound.</p> <p>Nurses' notes, dated 2/4/11 at 9:00 p.m., 2/5/11 at 4:00 a.m., 2/6/11 at 4:00 a.m. and 2/7/11 at 9:00 a.m., indicated the dressing was dry and intact and the left foot had no redness or swelling.</p> <p>During an interview on 2/7/11 at 10:20 a.m., LPN #4 indicated there were no weekly skin assessments done on Resident #39's left foot. LPN #4 indicated there were no measurements done on the left foot wound since 1/20/11. LPN #4 indicated the area to the left foot was not noted on the admission assessment. LPN #4 indicated she did not know why a non-pressure skin condition record had not been started on the</p>	{F 309}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 309}	Continued From page 22 resident. An observation on 2/7/11 at 11:13 a.m., the Unit Manager measured the resident's left foot. The area measured 3.8 cm in length (an increase of 1.8 cm) and .5 cm in width. The depth was 1 cm, this was an increase of .25 cm since 1/20/11. This was the first measurement of the wound since 1/20/11. During an interview on 2/7/11 at 12:43 p.m., the Nurse Consultant, indicated a non-pressure skin condition should have been started on the resident. The Nurse Consultant indicated the non-pressure skin condition was completed weekly Review of a non-pressure skin condition record provided by Medical Records on 2/7/11, indicated an area to be completed for the site, size, depth, drainage, odor, tunneling, appearance of wound, and response to treatment. A facility policy, dated 5/21/04, titled "Wound Care/Treatment Guidelines" provided by the Nurse Consultant on 2/7/11 at 1:20 p.m., indicated "Complete a weekly assessment on all wounds...." This tag was cited on 12/13/10. The facility failed to implement a systemic plan of corrections to prevent recurrence.	{F 309}		
{F 323} SS=D	3.1-37(a) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	{F 323}		1/12/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
{F 323}	<p>Continued From page 23 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure alarms were applied as ordered for 2 (Residents #12 and #18) of 6 residents who had an order for a bed/chair alarms in a sample of 9, and for 1 resident (Resident #18) who had fallen recently and had received a fractured left wrist and laceration to the left forehead. The facility also failed to ensure geri-sleeves were applied as ordered for 1 (Resident #5) of 3 residents with orders for geri-sleeves in the sample of 9.</p> <p>Findings include:</p> <p>1. During an observation on 02/04/11 at 11:55 a.m., resident #18 was sitting in her wheelchair in the dining room. The resident had two clip alarms on her wheelchair. Neither of the clip alarms were attached to the resident. During an interview at the time of the observation, CNA #5 indicated the alarms had not been attached to the resident.</p> <p>Resident #18's record was reviewed on 02/07/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to, fracture of the left wrist and left hip, and dementia.</p> <p>The resident's admission orders, dated 01/21/11, indicated an order for a bed and chair alarm.</p>	{F 323}	<p>F 323 483.25(h) Free of accident Hazards/Supervision/ Devices.</p> <ol style="list-style-type: none"> 1. Resident # 12 no longer resides at this facility. -Resident #18 had alarm placed during survey and plan of care will be updated as indicated. - Resident # 5 had geri-sleeves placed during survey and continues to wear them. 2. Residents requiring alarms for fall prevention, residents requiring use of geri-sleeves are at risk for the alleged deficient practice. Nursing and facility administration will be educated on ensuring fall prevention alarms, ensuring placement of geri-sleeves for skin tear prevention by Nurse Consultant. - DON and Interdisciplinary team will be educated by nurse consultant on making rounds to ensure alarms are on and working; making rounds at least daily to ensure geri-sleeves are on residents who have them ordered; fall alarms; investigation of fall alarms and geri-sleeves and including function of alarm if used if a fall occurs. Nursing and facility staff will be educated regarding alarm and geri-sleeve use, rounds with care guides to ensure fall 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 323}	<p>Continued From page 24</p> <p>A fall risk assessment, dated 01/21/11, indicated a score of 19 (a score of 10 or higher is a high risk for falls).</p> <p>A care plan, dated 01/21/11, indicated the resident had a risk for injury related to falls and the interventions included, chair and bed alarms.</p> <p>A nurses' note, dated 01/26/11 at 6:20 p.m., indicated, "CNA staff came to north unit and states this resident was on the floor in dining room. Upon approaching dining room I observed this resident laying on floor...bleeding from the forehead. Evening shift supervisor was present c/ (with) resident...a laceration to left forehead, swollen left wrist, and swollen index and middle finger of right hand..."</p> <p>A nurses' note, dated 01/26/11 at 7:35 p.m., indicated the resident had been transferred to the hospital.</p> <p>A fall investigation, dated 01/27/11, received from the Director of Nursing, indicated, "...Res (resident) stood up from w/c (wheelchair) in dining room & fell hitting head & hurting wrist...Spoke with (CNA #6) who was in the dining room and stated that he was on the restorative side and he heard the noise and went to see what had happened. He did not see her stand up. Spoke to (supervisor's name) and she was in the dining room had seen the resident stand up but she was across the room..."</p> <p>The fall investigation lacked documentation to indicate if the resident's alarm was on and functioning at the time of the fall.</p>	{F 323}	<p>alarms and geri sleeves are applied and in use.</p> <p>3. System:</p> <ul style="list-style-type: none"> - Charge nurses will be expected to ensure fall alarms and geri sleeves are on residents as indicated. - Fall alarms and geri sleeves will be reviewed using care guides by the charge nurse at the beginning of their shift. - MARs and/or TARs will be updated with fall alarm checks and geri sleeves every shift to ensure placement and function. - Central supply will replace batteries to fall alarms monthly and PRN. Extra batteries will be available at each nurse's station. - CNA care guides will be updated as indicated for geri sleeves and fall alarms by charge nurses and/or nursing administration. - Interdisciplinary team will review fall alarms monthly to assess if fall alarm intervention continues to be appropriate. <p>4. Monitoring:</p> <p>Rounds with care guides and safety device list will be made daily Monday - Friday for 30 days across different shifts by facility administration, then 3 times/ week times 20 weeks to ensure</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 323}	<p>Continued From page 25</p> <p>During an interview on 02/07/11 at 1:10 p.m., the Director of Nursing indicated she had not asked if the alarm was on at the time of the fall.</p> <p>During an interview on 02/07/11 at 1:40 p.m., CNA #6 indicated he had his back turned to the resident when she fell. He indicated all he had heard was someone saying help and then he got the nurse. He indicated he did not hear an alarm. He indicated the alarm had not been activated.</p> <p>The resident's re-admission physician orders, dated 01/27/11, indicated the resident had a fractured left wrist and sutures on the left forehead due to a laceration. The orders indicated the resident was to have a bed and chair alarm on at all times.</p> <p>The resident's care plan, dated 01/27/11, indicated the resident was a fall risk. The interventions included, chair and bed alarm.</p> <p>2. During the initial tour of the facility with LPN #1, on 02/04/11 from 11 a.m. through 11:25 a.m., LPN #1 indicated Resident #5 had an order for geri-sleeves. During an observation of the resident at the time of the interview, Resident #5 was sitting in her wheelchair in her room. The resident did not have geri sleeves on. During an interview at the time of the observation, LPN #1 indicated the resident's geri sleeves were not on.</p> <p>LPN #1 reviewed Resident #5's record at 11:25 a.m., she indicated there was a physician's order for geri sleeves. She indicated the geri sleeves were not on.</p> <p>Resident #5's record was reviewed on 02/04/11 at 12:30 p.m. The resident's diagnoses included,</p>	{F 323}	<p>compliance. Tracking and trending of rounds for geri sleeves and fall alarms will be completed weekly times six months and reviewed in monthly PI meeting. 100% threshold.</p> <p>5. Completion date: February 23, 2011</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 323}	<p>Continued From page 26 but were not limited to, dementia and hypertension.</p> <p>A care plan, last reviewed on 11/10/10, indicated the resident had fragile skin. The approaches included, "...will wear geri-sleeves except during care"</p> <p>The resident's physician's recapitulation orders, dated 1/11, indicated an order dated 12/07/09, for, "Derma saver sleeves (geri sleeves) to both arms at all times."</p> <p>3. During the initial tour of the facility with LPN #1, on 02/04/11 from 11:00 a.m. through 11:25 a.m., Resident #12 was observed lying in bed, the bed was in low position, and there was no alarm attached to the resident or to the bed. LPN #1 indicated resident #12 had a low bed and floor pads. She indicated she was not sure if the resident had an order for a bed alarm. She indicated the resident did not have a bed alarm on the bed.</p> <p>During an interview on 02/04/11 at 11:25 a.m., LPN #1 indicated the resident had an order for a bed alarm.</p> <p>Resident #12's record was reviewed on 02/07/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>The physician's recapitulation orders, dated 02/11, indicated an order for a bed alarm.</p> <p>A fall risk assessment, dated 01/13/11, indicated a score of 17 (a resident who scores a 10 or higher is at risk for falls).</p>	{F 323}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 323}	Continued From page 27	{F 323}			
F 328 SS=D	<p>A care plan, dated 01/13/11, indicated the resident was at risk for falls. The interventions included a chair and bed alarm.</p> <p>This tag was cited on 12/13/10. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2) 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure oxygen was applied as ordered by the physician for 2 of 3 residents with oxygen orders in a sample of 9 (Resident #5 and #39)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility with LPN #1, on 02/04/11 from 11:00 a.m. through 11:25 a.m., resident #5 was sitting in her wheelchair in her</p>	F 328	<p>F 328 483.25(k) Treatment/Care for special needs.</p> <ol style="list-style-type: none"> Resident # 5 and # 39 had oxygen applied during survey by nursing according to physician orders. – Full in-house audit was immediately conducted during survey by nursing administration to assure O2 was being administered as ordered. Licensed nurses have been educated by nursing administration on ensuring oxygen is applied as ordered for continuous use and documentation is recorded on TAR. System: – Residents refusing oxygen use will have physician notified for continued use and plan of care updated as indicated by nursing. – New Nursing staff will be educated by nursing administration on ensuring residents with oxygen 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394	
(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
F 328	<p>Continued From page 28</p> <p>room. The resident did not have her oxygen on.</p> <p>Resident #5's record was reviewed on 02/04/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>The signed physician's recapitulation orders, dated 01/11, indicated an order written 10/02/10 for oxygen at three liters per minute per nasal cannula.</p> <p>The resident was observed on 02/04/11 at 12:35 p.m. The resident was sitting in her room in her wheelchair. The resident did not have oxygen on. During an interview at the time of the observation, LPN #1 indicated the resident did not have oxygen on.</p> <p>2. Resident #39 was observed on 2/4/11 at 12:10 p.m., laying in bed. Resident #39 did not have his oxygen on.</p> <p>Resident #39 was observed on 2/7/11 at 9:45 a.m., sitting up in his wheelchair in the therapy room. Resident #39 was not observed to have his oxygen on.</p> <p>Resident #39's record was reviewed on 2/7/10 at 9:47 a.m. Resident #39's diagnoses included, but were not limited to, hypertension, hypoxia, and left foot wound infection. Resident #39 was admitted to the facility on 1/11/11.</p> <p>A physician order recapitulation, dated January 2011, indicated "o2 (oxygen) 2L (liters) NC (nasal canula)."</p> <p>The January 2011, Treatment Administration Record (TAR) lacked documentation of the</p>	F 328	<p>orders have oxygen applied as ordered. Educate for non-compliance.</p> <ul style="list-style-type: none"> - Licensed nurses are responsible for ensuring oxygen is applied as ordered and initialed on the TAR. - Licensed nurses will be expected to ensure oxygen is on residents as ordered during rounds. <p>4. Monitoring:</p> <ul style="list-style-type: none"> -Nursing and facility administration will make rounds five times/week times 4 weeks then 3 times/week times 8 weeks to ensure oxygen is applied then weekly times two months as ordered. - Tracking and trending of oxygen use will be completed then monthly times 6 months in PI. 100% threshold. -Plan to be updated as indicated. <p>5. Completion date: February 23, 2011</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
--	---

(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
--------------------	--	---------------	---	----------------------

F 328	<p>Continued From page 29 resident's oxygen.</p> <p>The February 2011, TAR indicated the nurses were initialing the resident was receiving his oxygen.</p> <p>During an interview on 2/7/11 at 1:50 p.m., the DoN indicated Resident #39 should have had his oxygen on.</p> <p>A facility policy, provided by the Nurse Consultant on 2/7/11 at 1:20 p.m., titled "Oxygen Use, General," indicated "...Oxygen therapy is administered to the resident only upon the written order of a licensed physician...."</p>	F 328		
{F 425} SS=E	<p>3.1-47(a)(6) 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p>	{F 425}	<p>F 425 483.60 (a), (b) pharmaceutical svc-accuratge procedures, RPH</p> <ol style="list-style-type: none"> 1. Residents # 69, 27, 34, 45, 46, 47, 53, 54, 65, and 68 had insulin discarded and new insulin reordered. No residents were adversely affected. 2. Licensed nurses were educated by nursing administration regarding dating of insulin bottles when opened and shelf life not to exceed 28 days. 3. Systems to ensure compliance. <ul style="list-style-type: none"> - New licensed nurses will be educated on dating insulin bottles when opened and expiration within 28 days and must reorder prior to 	4/2/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011	
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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
{F 425}	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure multi dose vials of insulin were dated when opened and discarded within 28 days upon being first opened in 2 of 2 medication rooms (north and south). This had the potential to affect 1 of 3 residents who received insulin in a sample of 9 (Resident #69) and 9 residents who received insulin from the vials of insulins in a supplemental sample of 9 (Residents #27, #34, #45, #46, #47, #53, #54, #65, and #68)</p> <p>Findings include:</p> <p>A) During an observation of the north medication room, with LPN #1, on 02/04/11 at 1 p.m., there was an opened vial of Novolin insulin for resident #34 with an open date of 01/01/11, an opened vial of Lantus insulin for resident # 27 with no date documented when the vial was opened, and an opened vial of Novolog for resident #69, with an open date of 12/22/10.</p> <p>During an interview at the time of the observation, LPN #1 acknowledged the above dates when the insulins were opened. She indicated resident #27's Lantus looked like it had only been opened a few days ago.</p> <p>B) During an observation of the south medication room, with LPN #2, on 02/04/11 at 1:05 p.m. the following was observed: One opened vial of Lantus with an open date of 01/02/11 and an opened vial of Novolin insulin</p>	{F 425}	<p>expiration. Education during orientation and for non-compliance will be completed by nursing administration.</p> <ul style="list-style-type: none"> - Licensed nurses will date insulin bottles when opened and reorder new insulin prior to day 28. Left over insulin will be discarded by licensed nurses on day 28. - Nursing administration will check insulin bottles for dating and expiration dates during rounds in facility <p>4. Monitoring -Nursing administration will audit insulin bottle for dating and monitoring expiration five times/week times 4 weeks then three times / week times 8 weeks then weekly times 3 months to ensure appropriate dating and expiration guidelines are followed. Tracking and trending will be completed in PI weekly times three months then monthly times 3 months. 100% threshold. - Plan to be updated as indicated.</p> <p>5. Completion date: Feb. 23, 2011</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 425}	<p>Continued From page 31 with an open date of 01/04/11 for resident #53.</p> <p>One opened vial of Novolog insulin with an open date of 12/31/10 for resident # 47.</p> <p>One opened vial of Novolog insulin with an open date of 01/05/11 for resident #45</p> <p>One opened vial of Lantus insulin with an open date of 01/03/11 for resident #46.</p> <p>One opened vial of Novolin insulin without a date of when opened for resident #54.</p> <p>One opened vial of Lantus insulin without a date of when opened and an open bottle of Novolin insulin with an open date of 01/01/11 for resident #68.</p> <p>One opened vial of Lantus insulin without a date of when opened for resident #65.</p> <p>During an interview at the time of the observation, LPN #2 acknowledged the above findings. She indicated the Infection Control Nurse was suppose to check the medication rooms for the dates.</p> <p>A facility policy, dated 05/10, titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles", received as current from the Director of Nursing, indicated, "...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..."</p>	{F 425}		
---------	--	---------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 425}	Continued From page 32 Information obtained from the US Food and Drug Administration Web site on 02/08/11 at 6:26 a.m., indicated Novolog insulin vials could be stored up to 28 days after they were opened. Information obtained from web site, "www.care.diabetesjournals.org", on 02/08/11 at 6:34 a.m., indicated the American Diabetes Association indicated, "...opened vials, whether or not refrigerated, must be used within 28 days. They must be discarded if not used within 28 days..." This tag was cited on 12/13/10. The facility failed to implement a systemic plan of correction to prevent recurrence.	{F 425}			
{F 441} SS=D	3.1-25(o) 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	{F 441}	F 441 483.65 Infection control, prevent spread, linens 1. LPN #3 was immediately educated 1/12/11 by nursing administration according to facility policy regarding hand washing before and after wound care, before and after providing tube feeding care. Unit manager was educated immediately by nursing administration on facility dressing change policy regarding infection control guidelines, appropriate use of scissors and appropriate dressing application. - CNA #6 was immediately educated regarding washing hands before and after direct contact with residents, prior to leaving room and upon entering room.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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
{F 441}	<p>Continued From page 33</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure nurses changed gloves and washed their hands during 2 of 2 dressing changes and 2 CNAs observed providing resident care for 2 of 2 residents in a sample of 9. This had the potential to affect 40 Residents, who resided on the North Unit. (Residents #5 and #39, Unit Manger, LPN #3, CNA #6 and CNA #7)</p> <p>Findings include:</p> <p>1. Resident #39's record was reviewed on 2/7/10 at 9:47 a.m. Resident #39's diagnoses included, but were not limited to, hypertension, hypoxia, and left foot wound infection. Resident #39 was admitted to the facility on 1/11/11.</p>	{F 441}	<p>– CNA #7 was immediately educated by nursing administration regarding hand washing before and after providing pericare, using appropriate disposal of soiled briefs and not to place on floor.</p> <p>–Resident #39 and #5 were not adversely affected by the alleged deficient practice.</p> <p>2. Residents receiving oral care, incontinent care, wound care have the potential to be affected by the alleged deficient practice.</p> <p>–Nursing staff have been and will continue to be educated by nursing administration regarding infection control during wound care per standards and LCCA policy, hand washing before and after glove use, cleaning scissors per infection control standards, application of wound packing and dressings. Appropriate use of alcohol gel versus hand washing, barrier set up for wound care, placing soiled briefs into leak resistant bags and not on floors, washing hands after incontinent care.</p> <p>3. Systems to ensure compliance.</p> <p>– Licensed nursing staff will be expected to follow wound care infection control standards and policies as outlined.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 441}	<p>Continued From page 34</p> <p>During an observation on 2/7/11 at 11:05 a.m., of Resident #39's dressing change the Unit Manager was observed to remove the resident's shoes and socks and roll the resident's pant legs up. The Unit Manager did not wash her hands before placing on her gloves. The Unit Manager began removing the resident's dressing to his left foot, tearing at the Kerlix (gauze dressing) as she had not brought scissors with her. The Unit Manager placed the pieces of dressing that she had removed into her right glove, removed her right glove and threw the glove containing the bits of dressing into the garbage can. The Unit Manager left the resident's room without removing the left glove and washing her hands. At 11:13 a.m., the Unit Manager returned to the resident's room with CNA #6. The Unit Manager placed a towel on the floor under the resident's foot. The Unit Manager placed the plastic measuring tool, dressing and iodoform medication on the seat of a chair without a barrier. The Unit Manager placed gloves on without washing her hands and removed the rest of the dressing using a Q-tip to remove the wound packing. Without washing her hands or changing gloves the Unit Manager then used a syringe containing normal saline to clean the wound. The Unit Manager then dried the wound area with gauze. The Unit Manager measured the wound area and used a second Q-tip to measure the depth of the wound. The Unit Manager opened the bottle of iodoform packing strip and pulled out some of the medicated strip. The Unit Manager did not have scissors to cut the medication strip and tried to place some of the medicated strip back in the bottle using the Q-tip she measured the depth of the resident's wound with. CNA #6 left the room and returned with scissors. The Unit</p>	{F 441}	<ul style="list-style-type: none"> - Nursing staff will be expected to follow infection control policies and standards for use of alcohol gel, hand washing after direct contact with blood and body fluids. - Soiled briefs will be placed into leak proof bags and not on floor. - Licensed nurses will use appropriate treatment techniques with packing and wound dressings, use of scissors and barrier set up. - Licensed nurses will follow infection control policy related to hand washing and glove use before and after tube feedings and equipment use. - Competencies regarding infection control during wound care and tube feedings will be completed for licensed nurse during orientation and quarterly by nursing administration and as indicated. - Competencies will be completed for nurse aides regarding infection control during incontinent care and oral care during orientation and quarterly and as indicated for compliance by nursing administration. <p>4. Monitoring</p> <ul style="list-style-type: none"> - Audits will be completed on (5) nursing staff per week times 8 weeks for infection control during 	
---------	---	---------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
--	---

(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
--------------------	--	---------------	---	----------------------

{F 441}

Continued From page 35
 Manager did not clean the scissors prior to cutting the medicated packing strip. The Unit Manager then poked the medicated strip into the resident's wound using the Q-tip she used to measure the depth of the wound. The Unit Manager did not place all of the medicated packing strip into the wound, leaving some of the strip out and touching the surrounding skin areas. The Unit Manager placed squares of gauze on the bottom of the foot and wrapped the resident's left foot with Kerlix. The Unit Manager did not have tape with her so she proceeded to twist the Kerlix and tuck the Kerlix inside. CNA #6 after assisting the Unit Manager placed the resident's coat in his lap without removing his gloves or washing his hands. CNA #6 and the Unit Manager removed their gloves and used alcohol gel on their hands as they left the room.

A wound culture, dated 1/24/11, indicated "staphylococcus aureus (mrsa)..this is a multiple drug resistant organism."

During an interview on 2/7/11 at 1:50 p.m., the Nurse Consultant indicated that was not the correct way to do a dressing change and the Unit Manager should have washed her hands.

A facility policy, titled "Wound Care/Treatment Guidelines," dated 5/21/04, indicated "...Place supplies on a clean surface. A blue pad or wax paper provides a nice clean surface. Clean hands as outlined in the Hand Hygiene procedure...Do not allow a medication tube or bottle lip to touch any item...Bag trash in the room and again in the bag on the cart. Dispose of this bag in the soiled utility room." "Wound Care Procedure For Major Wounds," dated 5/21/04, "...3. Set up the supplies on a clean surface at the

{F 441}

wound, tube feeding, oral and incontinent care then (3) weekly times four months then (5) quarterly ongoing by nursing administration.
 - Tracking and trending will be completed weekly times six months in PI then quarterly ongoing. 100% threshold.
 - Plan to be updated as indicated.
 5. Completion date: Feb. 23, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 441}	<p>Continued From page 36</p> <p>bedside (cover the surface with a clean impervious barrier before putting the supplies on...5. Clean your hands following Hand Hygiene Guidelines. 7. Cut the tape with clean scissors. 8. Put gloves on. 9. Remove the soiled dressing and place in a bag at bedside. Place the soiled scissors on one corner of your setup not touching supplies. 10. Remove gloves and discard the bag. 11. Clean scissors with 60 seconds of contact with alcohol and place on a clean corner of you setup. 12. Clean your hands following Hand Hygiene Guidelines. 13. Put on clean gloves. 14. Clean the wound according to the order. 15. Place soiled gauze used for cleaning in the bag. 16. Remove gloves and place in bag. 17. put on new gloves. 18. Apply a clean dressing as ordered. 19. Remove gloves and place in bag...22. Close the bag and place in large plastic bag attached to the cart. 23. Clean your hands following Hand Hygiene Guidelines...."</p> <p>2. Resident #5's record was reviewed on 02/04/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A care plan, last reviewed on 11/11/10, indicated the resident required total assistance for care.</p> <p>During an observation of resident #5's care on 02/07/11 at 11 a.m. through 11:30 a.m., with CNA #7 and LPN #3, the following was observed:</p> <p>CNA #7 washed her hands and applied gloves, she then removed the resident's brief and provided peri-care. The soiled brief was observed on the floor next to the resident's bed. When the CNA started to apply the clean brief, the resident's dressing came off of the resident's</p>	{F 441}		
---------	---	---------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
{F 441}	Continued From page 37 coccyx. The CNA informed the LPN #3, then applied the clean brief. CNA #7 then changed her gloves and obtained a toothette for oral care. The CNA was stopped prior to giving the oral care. During an interview at this time, the CNA indicated she was getting ready to do the resident's mouth care. She indicated she should have washed her hands. After the oral care was completed, LPN #3 applied gloves and applied a new dressing to the resident's coccyx area. LPN #3 then unhooked the resident's feeding tube without changing her gloves or washing her hands. During an interview at the time of the observation, LPN #3 indicated she had not washed her hands yet. An undated facility policy, titled, "Enteral Feeding Tube (Care of)", received as current from the RN nurse consultant on 02/07/11 at 2:15 p.m., indicated, "...Wash your hands before and after all procedures..." This tag was cited on 12/13/10. The facility failed to implement a systemic plan of correction to prevent recurrence.	{F 441}		
F 504 SS=D	3.1-18(l) 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by:	F 504	F 504 483.75(j)(2)(i) Lab services only when ordered by physician. 1. Resident # 12 no longer resides in this facility. 2. Residents receiving labs as ordered are at risk to be affected by the alleged deficient practice. In-house residents' labs were reviewed to ensure completed as ordered. By the licensed nurse(s). Any findings of the above will be reported to the nursing administration and corrected as ordered. – Licensed nurses will be educated regarding accurate completion for labs requisitions and follow up to ensure labs are completed accurately as ordered by nursing administration and/or nurse consultant.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
--	---

(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>F 504</p> <p>{F 514} SS=D</p>	<p>Continued From page 38</p> <p>Based on record review and interview, the facility failed to ensure laboratory services were done only when ordered by the resident's physician for 1 of 9 residents reviewed for laboratory tests in a sample of 9 residents. (resident #12)</p> <p>Findings include:</p> <p>Resident #12's record was reviewed on 02/07/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>A physician's order, dated 01/16/11, indicated an order for a CBC (complete blood count), BMP (basic metabolic profile) (electrolytes), pre-albumin (protein), Vitamin D, and a FBS (fasting blood sugar) laboratory tests to be done 01/27/11.</p> <p>The record indicated a CBC, BMP, FBS, pre-albumin, magnesium level, and phosphorus had been completed on 01/17/11.</p> <p>The lab requisition, completed by the facility, dated 01/17/11, indicated the resident was to receive a CBC, BMP, FBS, calcium, magnesium, phosphorus and a pre albumin.</p> <p>During an interview on 02/07/11 at 10:20 a.m., LPN #4 indicated the resident's physician had not ordered a magnesium and phosphorus level for the resident.</p> <p>3.1-49(f)(1) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p>	<p>F 504</p> <p>{F 514}</p>	<p>3. Licensed nurses will receive education from nursing administration and /or nurse consultant during orientation and/or compliance and every six months for the following:</p> <ul style="list-style-type: none"> - Lab requisitions will be accurately completed by licenses nurses for labs ordered by physician. Nursing administration will review orders daily Monday – Friday to ensure requisition completed accurately, labs obtained and follow up completion as ordered from physician. <p>4. Labs will be obtained as ordered by the licensed nurses. Nursing administration will review labs orders Monday – Friday to ensure requisition has been completed correctly per physician orders. Nursing administration will follow labs orders daily Monday – Friday in change of condition meeting to ensure notification and orders are obtained as indicated. 100 % threshold. Audits of the above systems will be reviewed in PI times six months to ensure compliance. This plan to be amended when indicated.</p> <p>5. Completion date: February 23, 2011</p>	<p>#12/11</p>
--------------------------------------	---	-----------------------------	--	---------------

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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	
{F 514}	<p>Continued From page 39</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident's records were complete and accurate related to insulin administration, for 2 of 9 resident's reviewed for complete and accurate clinical records in a sample of 9. (Residents #39 and #69)</p> <p>Findings include:</p> <p>1. Resident #69's record was reviewed on 2/7/11 at 11:05 a.m. Resident #69's diagnoses included, but were not limited to, hypertension, diabetes, congestive heart failure, and glaucoma.</p> <p>A Physician's Order, dated 1/15/11, indicated "blood glucose monitoring before meals and at bedtime..."</p> <p>A Physician's Order, dated 1/16/11, indicated "Novolog (insulin)100 unit/milliliter vial, inject sq (subcutaneous) per sliding scale (insulin given per blood sugar results), 0-150 give 0 units, 151-200 give 1 unit, 201-250 give 2 units,</p>	{F 514}	<p>F 514 483.75(l)(1) Res records-complete/accurate/accessible</p> <ol style="list-style-type: none"> Resident #69 no longer resides in this facility. - CNA #39 physician was contracted and no new orders received regarding insulin administration. Nursing was immediately in-serviced during survey to document amount of insulin given when doing an accucheck with sliding scale coverage Resident receiving sliding scale insulin have the potential to be affected -Licensed nurses were educated regarding documenting amounts of units given per sliding scale insulin on the MAR by nursing administration. - Full facility audit was completed by nursing administration to ensure documentation was completed per policy and no other resident was affected. Systems to ensure compliance. - Licensed nurses will document on the MAR amount of insulin units given for sliding scale orders. - New or changed sliding scale insulin orders will be reviewed by 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/09/2011
NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394		
(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
{F 514}	<p>Continued From page 40 251-300 give 3 units."</p> <p>A Medication Administration Record (MAR), dated 1/15/11, indicated "Novolog Insulin subq (subcutaneous) before meals and at HS (bedtime) per sliding scale, 0-150 give 0 units, 151-200 give 1 unit, 201-250 give 2 units, 251-300 give 3 units."</p> <p>The following dates and times lacked documentation of how much insulin was given as outlined in the sliding scale:</p> <p>At 11 a.m. on 1/26 and 1/31 At 5 p.m. on 1/22, 1/26, and 1/31 At 9 p.m. on 1/31</p> <p>During an interview with the DoN (Director of Nursing), on 2/7/11 at 1:55 p.m., she indicated "I don't know how much insulin was given because it's not written."</p> <p>2. Resident #39's record was reviewed on 2/7/10 at 9:47 a.m. Resident #39's diagnoses included, but were not limited to, diabetes, hypertension, hypoxia, and left foot wound infection.</p> <p>A physician order, dated 1/11/11 indicated Resident #39 had a sliding scale insulin order for Novolin R (fast acting insulin). The sliding scale indicated if the resident's blood sugar was 200-300 administer 5 units and 301-400 administer 10 units of the Novolin R insulin. The sliding scale was to be used four times a day.</p> <p>The January 2011, Medication Administration Record lacked documentation of the amount of insulin given on the 16 at 6:00 a.m., 17 at 9:00 p.m., 21 at 6:00 a.m. and 11:30 a.m., 22 at 11:30</p>	{F 514}	<p>nursing administration during clinical meeting to ensure the MAR indicates amounts of sliding scale coverage to be documented. Education will be given regarding any non-compliance by nursing administration.</p> <p>4. Monitoring -Nursing administration will audit insulin sliding scale order documentation weekly times six months then monthly ongoing. - Tracking and trending will be completed monthly times six months and reviewed in PI then quarterly ongoing.. 100% threshold. - Plan to be updated as indicated.</p> <p>5. Completion date: Feb. 23, 2011</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/09/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH STREET WHITING, IN 46394
---	---

(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
--------------------	--	---------------	---	----------------------

{F 514}	<p>Continued From page 41</p> <p>a.m. and 9:00 p.m., 23 at 4:00 p.m., 25 at 11:30 a.m., 26 at 11:30 a.m. and 4:00 p.m., 27 at 4:00 p.m., 28 at 6:00 a.m., and 30 at 11:30 a.m.</p> <p>The February 2011, Medication Administration Record lacked documentation of the amount of insulin administered on the 3rd at 5:00 p.m.</p> <p>During an interview on 2/7/11 at 11:35 a.m., LPN #4 indicated the nurse should write down the amount of insulin she gave or "you wouldn't know."</p> <p>This tag was cited on 12/13/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>	{F 514}		
---------	--	---------	--	--