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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155277 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/18/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>WHISPERING PINES HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3301 N CALUMET AVE<br>VALPARAISO, IN 46383 |
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| F0000              | <p>This visit was for the Investigation of Complaints IN00115762 and IN00115470.</p> <p>Complaint IN00115470 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00115762 - Substantiated. Federal/State deficiencies related to the allegations are cited at F164, F223, F225, F226, F309, and F314.</p> <p>This visit was in conjunction with a PSR (Post Survey Revisit) to the Investigation of Complaints IN00111937 and IN00112652 completed on 08/02/12.</p> <p>Survey dates: September 11, 12, 13, 17, and 18, 2012</p> <p>Facility number: 000176<br/>Provider number: 155277<br/>AIM number: 100288940</p> <p>Survey team:<br/>Marcia Mital, RN, TC<br/>Sheila Sizemore, RN</p> <p>Census bed type:<br/>SNF: 06<br/>SNF/NF: 110</p> | F0000         | <p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Whispering Pines desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on October 8, 2012.</p> |                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|                    | <p>Total: 116</p> <p>Census payor type:<br/>Medicare: 19<br/>Medicaid: 70<br/>Other: 27<br/>Total: 116</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 9/20/12 by Suzanne Williams, RN</p> |               |   |                      |

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| F0223<br>SS=A   | <p>483.13(b), 483.13(c)(1)(i)<br/>FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from abuse from a staff member, for 1 of 1 resident reviewed for abuse in a sample of 7. (Resident H)</p> <p>Findings include:</p> <p>Resident H's record was reviewed on 9/17/12 at 10:30 a.m. Resident H's diagnoses included, but were not limited to, dementia, osteoarthritis, and hypertension.</p> <p>A significant change MDS (minimum data set) assessment, dated 6/11/12, indicated the resident had severely impaired cognition, and required assistance of one staff member for ambulation.</p> <p>A Social Service note, dated 9/1/12, indicated "Social Services was contacted by the ADoN (Assistant Director of Nurses) stating that a CNA was holding</p> | F0223   | <p>It is the policy of this facility to ensure that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. <b>I. Specific Corrective Actions:</b> The certified nurse aide was sent home immediately and an investigation started. <b>II. Identification and correction of others:</b> All residents have the potential to be affected by an aide delivering care in a manner that is too rough or too hurried. No other incidents have been observed. The aide in question was terminated from his/her position when the investigation was substantiated that the aide was pulling the resident and roughly seated the resident. <b>III. Systemic Changes:</b> All staff will be in-serviced on the abuse and resident rights policy prior to October 8, 2012. <b>IV. Monitoring:</b> The Unit Manager or designee will do daily rounds to ensure there is appropriate interaction between staff and residents; they will</p> | 10/08/2012           |   |

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|   | <p>the resident's left arm and hurrying her to the table as she walked. The CNA then pushed on the top of the resident's shoulders to assist her to sit in dining chair. While the resident was being seated, she yelled 'ow' and then was observed crying ..."</p> <p>An investigation, dated 9/5/12, indicated "...After a thorough investigation, it was determined that Certified Nurse Aide (name) ...did physically abuse resident (H's name) due to the following reports...On September 1, 2012, the nurse (RN #4) for (Resident H)...reported that she witnessed CNA, (CNA #3's name) holding resident (H) left arm and hurrying her to the table as she walked. She states that (CNA #3) pushed on the top of the resident's shoulders to assist her to sit in a dining chair. While she was being seated the resident yelled 'ow!' Then (CNA #3's name) quickly left the dining room before the nurse could speak with her... (RN #4's name) explained that hurrying the resident meant that CNA (#3's name) was pulling the resident by the arm to the dining area and then forced her to sit down by pushing on her shoulders...(LPN #5) states that she was asked to have CNA, (#3's name) go home pending investigation of the way she rushed and how she seated a resident. She states (CNA #3's name) told her 'how could she</p> |   | <p>monitor for signs of frustration, burnout, or any other unusual behaviors from staff that might indicate a potential for an abusive situation. All concerns will be reported to Nurse Management and or ED immediately. After three (3) months the rounds will decrease to weekly for another four (4) months. [Attachment: Daily Rounds for Staff to Resident Interactions]</p> |   |  |   |  |

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|                    | <p>even see me, she wasn't even around.' and 'I told them that I can't work Maple.', (LPN #5) explained to her that she needed to go home and not return to work pending investigation....(LPN #5) states that (CNA #3) did not deny having rushed the resident, or how she seated her... (CNA #3's name) statement: She states I was on maple...I had two people left to get, (Resident H's name) being one of them...when standing her up she can barely walk because of her knee. she has a hard time standing and walking in the mornings. I finished getting her ready and walked her to the dining room. When walking her she kept wanting to fall over, so I grabbed her by the arm, we were arm and arm walking. She didn't have good balance so I held her left wrist. We made it to the dining room. I went to have her sit, when she sat her knee gave out on her so she sat in the chair, and when she did her knee gave out so she kinda (sic) plopped in the chair. I told her she was ok and everything's fine. Then I walked away. During the interview with CNA (#3's name) she was asked if she had notified the nurse of the residents crying upon getting up, that she was having trouble walking, and/or sitting? (CNA #3) states she did not. (CNA #3) was asked if she had sought help from the other aid or nurse with the resident? She stated she had not. (CNA #3) was asked if</p> |               |   |                      |

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|                    | <p>the resident had said 'ow! When she had sat her down, she stated she had. Again she was asked if she had notified the nurse and (CNA #3) stated no....After this thorough investigation, we are substantiating the abuse allegation... (CNA #3's name) has been terminated from employment..."</p> <p>During an interview on 9/13/12 at 2:18 p.m., the DoN indicated the CNA was terminated for being rough with the resident.</p> <p>This federal tag relates to complaint IN00115762.</p> <p>3.1-27(a)(1)<br/>3.1-27(b)</p> |               |   |                      |

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| F0225<br>SS=D   | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the</p> | F0225   | It is the policy of this facility not to  | 10/08/2012  |  |   |  |

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|   | <p>facility failed to ensure an allegation of misappropriation of a resident's property was reported to the Indiana State Department of Health and investigated in a timely manner, for 1 of 1 allegations of misappropriation of resident's property reviewed in the sample of 7. (Resident E)</p> <p>Findings include:</p> <p>Resident E's record was reviewed on 9/13/12 at 10:30 a.m. Resident E's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, respiratory failure, hypertension, and anxiety.</p> <p>Resident E's quarterly MDS (Minimum Data Set) assessment, dated 7/11/12, indicated Resident E was alert and oriented to person, place and time.</p> <p>A nurses' note, dated 9/10/12 at 6:15 p.m., indicated "resident's son @ (at) facility visiting. Son states mom is missing \$60. As writer is speaking c/ (with) son, res. (resident's) husband call (sic) this writer to inform her of resident missing money. Writer assured son/husband, will fill out a social service form &amp; (and) handle situation to the best of ability. Social Service form filled out &amp; message left on p.m. (voice mail) for S.S. (Social Service)...."</p> |   | <p>employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. <b>I. Specific Corrective Actions:</b> An investigation was initiated by social services per facility policy and per State law. The missing money was found within four (4) working days. The resident in question was given a lock box to use in future. <b>II. Identification and correction of others:</b> All residents have the potential to be affected by misplacement of funds. All residents were asked if there had been any misappropriation of property and directed to report to the nurse on duty if anything was noted to be missing. This will be reviewed at the Resident Council Meeting October 5, 2012. <b>III. Systemic Changes:</b> All staff will be in-serviced on the abuse and resident rights policy prior to October 8, 2012; with specific mention of misappropriation of funds. <b>IV. Monitoring:</b> Social Services will check with each nurse on each unit daily to discover if any missing resident money/valuables has been reported. Upon discovering an incident the investigation will start immediately and facility policy</p> |                      |   |

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|   | <p>An interview on 9/13/12 at 11:15 a.m., with Social Service #1, indicated she was informed about the missing money on 9/12/12. She indicated she was going to investigate the missing money today. Social Service #1 indicated it "was very unusual to have that much money and for it to come missing." She indicated it would be investigated today. She indicated she had been verbally told by another nurse and could not recall her name. She indicated it had not been investigated or reported.</p> <p>During an interview on 9/13/12 at 2:30 p.m., the DoN indicated she was not informed about the missing money. She indicated an investigation had been started. The DoN indicated the nurse had placed the form in a folder used by Social Services and therapy. The DoN indicated the nurse had placed the form in the wrong spot. She indicated "Anytime anything is missing we take steps." The DoN indicated Social Services should have told her about the missing money. She indicated it had not been reported to Indiana State Department of Health.</p> <p>During an interview on 9/13/12 at 2:40 p.m., the Administrator indicated the nurse had documented on 9/10/12 and placed the form in the wrong box. She</p> |   | <p>followed. All incidents will be reported to the Administrator/Executive Director immediately and outcomes of investigation will be reported to the Executive Director within five (5) working days and monthly at the QAPI (Quality Assurance Performance Improvement) meetings. After three (3) months the monitoring will decrease to weekly for another four (4) months. [Attachment: Missing Resident Belongings Monitoring Form]</p> |                      |   |

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|                    | <p>indicated the nurses had left a voice mail to the wrong Social Services person as she was on vacation and that is why it was missed. The Administrator indicated Social Service should have started an investigation when she found out about the missing money.</p> <p>This federal tag relates to complaint IN00115762.</p> <p>3.1-28(d)</p> |               |   |                      |

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| F0226<br>SS=D   | <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow their policy related to reporting allegations of misappropriation of resident's property to the the Indiana State Department of Health and investigating the allegation in a timely manner, for 1 of 1 allegation of misappropriation of residents property reviewed in the sample of 7. (Resident E)</p> <p>Findings include:</p> <p>Resident E's record was reviewed on 9/13/12 at 10:30 a.m. Resident E's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, respiratory failure, hypertension, and anxiety.</p> <p>Resident E's quarterly MDS (Minimum Data Set) assessment, dated 7/11/12, indicated Resident E was alert and oriented to person, place and time.</p> <p>A nurses' note, dated 9/10/12 at 6:15 p.m., indicated "resident's son @ (at) facility visiting. Son states mom is missing \$60.</p> | F0226   | <p>The facility develops and implements written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. <b>I. Specific Corrective Actions:</b> An investigation was initiated by social services per facility policy and per State law. The missing money was found within four (4) working days. The resident in question was given a lock box to use in future. <b>II. Identification and correction of others:</b> All residents have the potential to be affected by misplacement of funds. All residents were asked if there had been any misplaced funds and directed to report to the nurse on duty if anything was noted to be missing. This will be reviewed at the Resident Council Meeting October 5, 2012. <b>III. Systemic Changes:</b> All staff will be in-serviced on the abuse and resident rights policy prior to October 8, 2012; with specific mention of misappropriation of funds. <b>IV. Monitoring:</b> Social Services will check with each nurse on each unit daily to discover if any missing resident money/valuables has been</p> | 10/08/2012  |  |   |  |

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|                    | <p>As writer is speaking c/ (with) son, res. (resident's) husband call (sic) this writer to inform her of resident missing money. Writer assured son/husband, will fill out a social service form &amp; (and) handle situation to the best of ability. Social Service form filled out &amp; message left on p.m. (voice mail) for S.S. (Social Service)...."</p> <p>An interview on 9/13/12 at 11:15 a.m., with Social Service #1, indicated she was informed about the missing money on 9/12/12. She indicated she was going to investigate the missing money today. Social Service #1 indicated it "was very unusual to have that much money and for it to come missing." She indicated it would be investigated today. She indicated she had been verbally told by another nurse and could not recall her name. She indicated it had not been investigated or reported.</p> <p>During an interview on 9/13/12 at 2:30 p.m., the DoN indicated she was not informed about the missing money. She indicated an investigation had been started. The DoN indicated the nurse had placed the form in a folder used by Social Services and therapy. The DoN indicated the nurse had placed the form in the wrong spot. She indicated "Anytime anything is missing we take steps." The</p> |               | <p>reported. Upon discovering an incident the investigation will start immediately and facility policy followed. All incidents will be reported to the Administrator/Executive Director immediately and outcomes of investigation will be reported to the Executive Director within five (5) working days and monthly at the QAPI (Quality Assurance Performance Improvement) meetings. After three (3) months the monitoring will decrease to weekly for another four (4) months. [Attachment: Missing Resident Belongings Monitoring Form]</p> |                      |

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|                    | <p>DoN indicated Social Services should have told her about the missing money. She indicated it had not been reported to Indiana State Department of Health.</p> <p>During an interview on 9/13/12 at 2:40 p.m., the Administrator indicated the nurse had documented on 9/10/12 and placed the form in the wrong box. She indicated the nurses had left a voice mail to the wrong Social Services person as she was on vacation and that is why it was missed. The Administrator indicated Social Service should have started an investigation when she found out about the missing money.</p> <p>This federal tag relates to complaint IN00115762.</p> <p>3.1-28(a)</p> |               |   |                      |

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| F0309<br>SS=G      | <p><b>483.25</b><br/> <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b><br/>                     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.</p> <p>Based on record review and interview, the facility failed to ensure a resident's pain was assessed and treatment provided for pain, which resulted in the resident having unrelieved pain, for 1 of 7 residents reviewed for pain in a total sample of 7. (Resident D)</p> <p>Findings include:</p> <p>Resident D's closed record was reviewed on 9/13/12 at 9 a.m. Resident D's diagnoses included, but were not limited to, arthritis, respiratory failure, anemia, and failure to thrive.</p> <p>A significant change MDS (minimum data set) assessment, dated 6/29/12, indicated the resident had severely impaired cognition and had not had any complaints of pain.</p> <p>A Pain assessment, dated 6/22/12, indicated the resident was not having any pain. There was a lack of documentation of any further pain assessments in the</p> | F0309         | <p>It is the policy of this facility to ensure residents are provided the necessary care and services to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. <b><u>I. Specific Corrective Actions:</u></b> The nurse responsible for the resident's care on the date in question, related to pain, has been counseled/educated regarding standard policy and procedure that should have been followed regarding proper assessment and post assessment of pain. <b><u>II. Identification and correction of others:</u></b> All residents have the potential to be affected by assessments not completed per policy. All residents receiving PRN pain medications have been reviewed for proper pain assessment and post pain assessment. <b><u>III. Systemic Changes:</u></b> All nurses will be re-educated regarding appropriate documentation and assessment of prn pain medications prior to October</p> | 10/08/2012           |

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|   | <p>residents record.</p> <p>A care plan, dated 8/2/12, indicated "...has potential for pain...Observe for and record any non-verbal signs of pain...Administer medications as ordered...Evaluate effectiveness of pain management interventions. Adjust if ineffective...Receives routine et (and) prn (as needed) pain medications..."</p> <p>The resident's physician's order recapitulation, dated 8/12, indicated the resident received Tylenol 650 milligrams four times a day, at 6 a.m., 12 p.m., 6 p.m., and 12 a.m. The resident also had an order for Tylenol 650 milligrams four times a day as needed for pain.</p> <p>The nurses' notes indicated:</p> <p>8/16/12 at 6:45 p.m. "resident's son was in to visit this evening. he asked CNA questions about his father. after speaking c (with) the CNA resident's son approached writer questioning pain meds (medications). Writer informed son he is given Tylenol Q6o (every six hours). resident only s/s (signs and symptoms) of pain when we turn &amp; move him. I told him we notify (physician name) in the am as (another physician name) is on call this evening . He does not want a narcotic given at this time." There was a lack of</p> |   | <p>8,2012. <b>IV. Monitoring:</b> The nurse managers or designee will audit MARs weekly any PRN pain medication given, this will be placed on the PRN medication audit. Audits to be submitted on Fridays to DNS. Weekly audits for three months then monthly audits for four months for a total of seven months. [PRN Medication Administration Audit]</p> |                      |   |

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|                    | <p>documentation of an assessment of the resident's pain.</p> <p>8/16/12 at 7:15 p.m., "resident daughter-in-law called this writer demanding that I call DoN &amp; tell her we are not handling (Resident's name) pain effectively." There was a lack of documentation to indicate the nurse had assessed the resident's pain.</p> <p>8/16/12 at 7:20 p.m., "writer called on call MD- (name) &amp; told him that resident's daughter in law called demanding we give him something stronger than Tylenol. I explained to the MD on call our pharm's (pharmacy) procedure for narcotics that he would have to call pharm himself for narcotics. MD response was 'I don't call pharmacys (sic). They will have to call (resident's physician's name) in the a.m.'..."</p> <p>8/16/12 at 9:45 p.m., "resident's daughter-in-law @ (at) facility requesting writer call MD &amp; get an order for Tylenol 500 (milligrams) ii (two) tabs to equal 1000 q 4o until (resident's physician name) is available in a.m. so writer called on call MD he said okay to give Tylenol 1000 mg (milligrams)..." This was three hours after the son had first notified the nurse the resident was having pain.</p> |               |   |                      |

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|                    | <p>The resident's MAR (medication administration record), dated 8/12, indicated the resident had received the routine Tylenol at 6 p.m., but had not received any as needed Tylenol.</p> <p>8/17/12 at 8 a.m., "MD updated this am, N.O. (new order) Received...Norco (narcotic pain medication) 5/325 mg...q 4o/pain..." There was a lack of documentation to indicate the resident's pain had been assessed after receiving the Tylenol 1000 milligrams.</p> <p>During an interview on 9/13/12 at 1:05 p.m., the DoN indicated the resident should not have been in pain when being turned. She indicated it was not okay to have to wait until the morning to get an order for pain medication. She indicated she would have administered the as needed Tylenol to the resident. The nurse had not called her but had left her a message on her work voice mail. She indicated the nurse had not followed the facility policy. The Medical Director should have been called for pain medication, She indicated the nurses should have completed pain assessment on the resident. She indicated Norco was ordered to be given routinely the next day for the resident's pain.</p> <p>During an interview on 9/13/12 at 3:05</p> |               |   |                      |

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|                    | <p>p.m., LPN #2, who took care of the resident on 8/16/12, indicated the resident showed pain when being turned and repositioned. She indicated the resident had facial grimacing. She indicated on a non-verbal pain assessment, his pain level was between a 5 and a 6 on a scale of 1 to 10. She indicated she had gotten the order for the Tylenol 500 milligrams and had given the medication at 10 p.m. She indicated she did not know if the pain medication was effective because she was not there when the resident was turned and repositioned.</p> <p>A facility policy, dated 7/10, titled "Pain Assessment and Documentation Policy", received from the Administrator as current on 8/17/12 at 8:45 a.m., indicated "...Residents with newly developed pain will be assessed by the licensed nurse utilizing the appropriate pain scale and the MD shall be notified...The pain scale shall be used when PRN (as needed) pain medications are administered and the effect of the pain medication shall be documented on the MAR and or the nurses notes...Pain scales are to be used to determine that the medication given is appropriate for the level of pain the resident is having...1-5 Mild 6-10 Moderate to Severe..."</p> <p>This deficiency was cited on 8/2/12. The</p> |               |   |                      |

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|                    | <p>facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint IN00115762.</p> <p>3.1-37(a)</p> |               |   |                      |

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| F0314<br>SS=G   | <p>483.25(c)<br/>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure preventative measures were in place and failed to ensure a resident's skin was assessed when wearing a boot to prevent pressure, which resulted in the resident developing unstageable pressure ulcers, for 2 of 4 residents with pressure ulcers in a total sample of 7. (Residents B and D)</p> <p>Findings include:</p> <p>1. Resident D's closed record was reviewed on 9/13/12 at 9 a.m. Resident D's diagnoses included, but were not limited to, arthritis, respiratory failure, anemia, and failure to thrive.</p> <p>A significant change MDS (minimum data set) assessment, dated 6/29/12, indicated the resident had severely impaired cognition, and required extensive assistance of staff for bed</p> | F0314   | <p>It is the policy of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. <b>I. Specific Corrective Actions:</b> The foot drop device was immediately placed on resident B and monitored for compliance with scheduled removal and checks. For resident D the boot was removed, the attending contacted and order obtained for Wound Care physician to evaluate. <b>II. Identification and correction of others:</b> All residents have the potential to be affected by incomplete assessments and or treatments. All residents with pressure relieving splints or boot like</p> | 10/08/2012           |   |

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|   | <p>mobility and personal hygiene. The resident was always incontinent of bowel and bladder. The resident had one stage II pressure ulcer (partial thickness loss of dermis).</p> <p>A Braden Scale assessment, for predicting pressure sore risk, dated 6/22/12, indicated a total score of 13; the form indicated the resident was at moderate risk.</p> <p>A Care plan, dated 3/15/12 and updated 8/4/12, indicated "(Resident D's name) is at risk for impaired skin integrity r/t (related to) impaired mobility...Pressure relieving devices as indicated...Weekly and prn (as needed) skin assessments are to be done per nursing...6/29/12 Float heels as tolerated..."</p> <p>A wound record, dated 6/22/12, indicated the resident had a stage II pressure ulcer to his right heel, which measured 0.7 by 0.7 centimeters (cm).</p> <p>A physician's order, dated 6/26/12, indicated "Heel lift boot to RLE (right lower extremity) while in bed."</p> <p>A nurses' note, dated 7/24/12 at 8:30 a.m., indicated "(Physician name) in to see resident. MD shown new skin areas to bilateral lower extremities..."</p> |   | <p>devices were reviewed for proper documentation regarding proper placement, removal and site assessment every shift. All TAR's of residents with pressure relieving splints or boot like devices were reviewed and updated to check placement, removal and site assessment of device every shift. <b>III. Systemic Changes:</b> All nurses will be in-serviced, prior to October 8, 2012, regarding appropriate procedure and documentation related to monitoring pressure relieving splints or boot like devices for proper placement, positioning, removal and site assessment every shift. All TAR's of residents with pressure relieving splints or boot like devices were reviewed and updated to check placement, removal and site assessment of device every shift. <b>IV. Monitoring:</b> Nurses are to complete the daily round flow sheet by dating , initialing and checking placement of device twice per shift. The nurse will also be removing and assessing site once every shift. This audit tool will be kept in place at least seven months and reports provided monthly at the QAPI meeting. [Daily Round Flow Sheet]</p> |                      |   |

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|                    | <p>The resident's wound records indicated:</p> <p>Right lower posterior (back of) leg #1<br/>7/24/12, "Pressure ulcer... unstageable, SDTI (suspected deep tissue injury) 5 cm x (by) 2 cm ...wound bed epithelial tissue..."<br/>8/2/12, "Pressure ulcer...unstageable...5 x 2 cm...epithelial tissue..."<br/>8/9/12, "Pressure ulcer...unstageable...5 x 2 cm...epithelial tissue..."<br/>8/16/12, "Pressure ulcer...unstageable...5 x 2 cm...epithelial tissue..."</p> <p>Right lower posterior (back of) leg #2<br/>7/24/12, "Pressure ulcer... SDTI 8 cm x 2 cm ...wound bed epithelial tissue..."<br/>8/2/12, "Pressure ulcer...SDTI 8 cm x 2 cm ...wound bed epithelial tissue..."<br/>8/9/12, "Pressure ulcer...unstageable...8 cm x 2 cm...wound bed epithelial tissue..."<br/>8/16/12, "Pressure ulcer...8.5 cm x 2 cm...wound bed epithelial tissue..."</p> <p>8/23/12 "Previous areas have formed &amp; become one area."<br/>8/23/12, Right Lower Extremity Pressure Ulcer, "unstageable 21 cm x 2.2 cm, depth 0.2 cm...Black/Brown eschar (dead tissue)..."</p> |               |   |                      |

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|                    | <p>During an interview on 9/12/12 at 10 a.m., LPN #1 who took care of Resident D, indicated the resident wore a boot on his right lower extremity to prevent heel pressure. He indicated he was not able to say when the boot had been removed and the resident's skin was checked. He indicated he had completed a weekly skin assessment about 4 to 5 days prior to finding the pressure ulcers on the resident's right lower leg. He indicated that was the last time he knew the boot had been removed and the resident's skin checked. He indicated CNAs report any skin issues and the nurses did weekly skin assessments unless something comes up, then the nurse would go check. He indicated the resident's pressure ulcer developed on his right lower extremity from pressure from the boot.</p> <p>During an interview on 9/13/12 at 2:30 p.m., the ADoN (Assistant Director of Nurses) indicated when she had saw the pressure ulcers, they were dark in color and the skin was intact. She indicated there was not any epithelial tissue. She indicated the pressure ulcers were unstageable. She indicated the nurses were doing weekly skin assessments and one had been completed on 7/19/12 and the areas found on 7/24/12. She indicated the CNAs should have been taking the boot off while giving the resident a bath.</p> |               |   |                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHISPERING PINES HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3301 N CALUMET AVE<br>VALPARAISO, IN 46383 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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|  | <p>2. Resident B's record was reviewed on 9/12/12 at 10:35 a.m. Resident B's diagnoses included, but were not limited to, chronic respiratory failure, stroke, and ventilator dependence.</p> <p>An admission MDS assessment, dated 5/18/12, indicated the resident was not able to be assessed for long and short term memory problems and was severely impaired with decision making. The resident was dependent upon two staff members for bed mobility, toilet use, and personal hygiene.</p> <p>A Braden Scale assessment, dated 7/10/12, indicated a total score of 12, which the form indicated was at high risk for pressure ulcer development.</p> <p>A care plan, dated 5/25/12, indicated "(Resident B's name) is at risk for skin breakdown r/t impaired mobility...Stage II buttocks (R) [right]...Medi boots on at all times (remove for bathing)..."</p> <p>The physician's order recapitulation, dated 9/12, indicated "...Medi boots to be worn at all times- may remove for bathing..."</p> <p>Resident B was observed on 9/12/12 at 9:26 a.m. and 11:40 a.m., lying in bed with her heels resting on the bed and</p> |  |  |  |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155277 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/18/2012 |
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|                    | <p>without her medi boots on.</p> <p>Resident B was observed on 9/12/12 at 1:30 p.m., with LPN #1 present, lying in bed with her boots on both lower extremities. LPN #1 indicated the resident's boots should have been on earlier.</p> <p>During an interview on 9/12/12 at 2:15 p.m., with CNA #6 and CNA #7, who were taking care of Resident B, they indicated they had removed the boots at about 6 or 7 a.m. and had put them back on the resident today at about 12 or 12:30 p.m.</p> <p>This federal tag relates to complaint IN00115762.</p> <p>3.1-40(a)(1)<br/>3.1-40(a)(2)</p> |               |   |                      |