

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00189994</p> <p>Complaint IN00189994- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F282.</p> <p>Survey dates: January 5 & 6, 2015.</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payer type: Medicare: 21 Medicaid: 43 Other: 7 Total: 71</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on</p>	F 0000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the January 06, 2016 Complaint Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community.</p> <p>The Plan of Correction submitted on January 24, 2016 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Kimberly Ready Executive Director</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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F 0157 SS=D Bldg. 00	<p>January 13, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			
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	<p>Based on record review and interview, the facility failed to ensure the Physician was notified of residents not receiving medications as ordered for 2 of 3 residents reviewed for medication administration in a Sample of 10. (Residents #C and #M)</p> <p>Findings include:</p> <p>1. The record for Resident #M was reviewed on 1/5/16 at 7:25 a.m. The resident's diagnoses included, but were not limited to, thyroid cancer, high blood pressure, and congestive heart failure.</p> <p>Review of the 12/1/2015 Admission Physician orders indicated there was an order for the resident to receive Levothyroxine (a Thyroid medication) 75 mcg (micrograms) one tablet daily.</p> <p>On 12/4/15 a Physician's order was written to increase the Levothyroxine to 100 mcg once daily.</p> <p>The 12/2015 Medication Administration Record was reviewed. The first dose of Levothyroxine was signed out on 12/4/15 at 6:00 a.m. for 75 mcg. There was no documentation indicating the Physician had been notified of the resident not receiving the medication on 12/2/15 and 12/3/15. The 12/2015 Nursing Progress</p>	F 0157	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Physician was immediately notified for Resident #C with no new orders received. Physician was immediately notified for Resident #M with no new orders received. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: DON/designee will conduct a full facility audit of the Medication Administration Records (MAR) and clinical record for all current residents during the previous 90 days (October 6, 2015 through January 6, 2016) to ensure the physician was notified of resident not receiving medications as ordered. Any identified issues will be immediately addressed along with documentation and physician/family notifications made as needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education for licensed nursing staff will be completed by February 5, 2016 by the Staff Development Coordinator and/or designee on the five rights of medication administration along with physician notification as needed. How the corrective</p>	02/05/2016			

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	<p>Notes were reviewed. There was no record of the Physician being notified of the resident not receiving the doses of the Levothyroxine as ordered.</p> <p>When interviewed on 1/6/15 at 12:30 p.m., the Director of Nursing indicated the Physician had not had been notified the resident not receiving the medication as ordered.</p> <p>2. The record for Resident #C was reviewed on 1/6/16 at 2:00 p.m. The resident's diagnoses included, but not limited to, epilepsy (a seizure disorder), high blood pressure, and non traumatic brain injury.</p> <p>Review of the 12/2015 Medication Administration Record indicated there was a Physician's order for the resident to receive 15 milligrams of Phenobarbital (a medication to control seizure activity) elixir every eight hours. The doses were circled as not given on the following dates/times: 12/25/15 at 2:00 p.m. and 10:00 p.m. 12/26/15 at 6:00 a.m., 2:00 p.m. and 10:00 p.m. 12/28/15 at 6:00 a.m.</p> <p>The back page of the Medication Record indicated the resident spit out her medications on 12/27/15 at 8:00 p.m. and 10:00 p.m. and 12/28/15 at 6:00 a.m.</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to complete an audit of the resident's MAR and clinical record at least 3 times weekly for the next six months to ensure documentation and physician notification is complete for medications not received as ordered. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>The 12/2015 Medication Administration Record also indicated there was a Physician's order for the resident to receive Risperadone (an antipsychotic medication) 0.25 milligrams two times a day at at 8:00 a.m. and 8:00 p.m. The following doses were circled as not given on the following dates/times: 12/27/15 at 8:00 p.m. 12/28/15 at 8:00 a.m. and 8:00 p.m. 12/29/15 at 8:00 a.m. and 8:00 p.m. 12/30/15 at 8:00 a.m. and 8:00 p.m. The back page of the Medication Record did not indicate why the medication was not given.</p> <p>The 12/20/15 Nursing Progress Notes were reviewed. A late entry for 12/28/15 at 6:00 a.m. indicated the resident spit out the 6:00 a.m. dose of Phenobarbital. A late entry for 12/27/15 at 9:00 p.m. indicated the resident spit out her medications on the shift. There was no record of Physician notification of the resident missing her medication doses as above.</p> <p>When interviewed on 1/6/15 at 4:00 p.m., the Director of Nursing indicated the facility did not have a policy to indicate when the Physician was to be notified of medications not given.</p>			

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F 0282 SS=D Bldg. 00	<p>This Federal tag relates to Complaint IN00189994.</p> <p>3.1-5(a)(3)</p> <p>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.</p> <p>Based on record review and interview, the facility failed to follow Physician's orders related to ordered medication not initiated in a timely manner for 1 of 3 resident reviewed for medication administration as ordered. (Resident #M).</p> <p>Finding includes:</p> <p>The record for Resident #M was reviewed on 1/5/16 at 7:25 a.m. The resident's diagnoses included, but were not limited to, thyroid cancer, high blood pressure, and congestive heart failure.</p> <p>Review of the 12/1/2015 Admission Physician orders indicated there was an order for the resident to receive</p>	F 0282	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Physician was immediately notified for Resident #M with no new orders received.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: DON/designee will conduct a full facility audit of the Medication Administration Records (MAR) and clinical record for all current residents during the previous 90 days (October 6, 2015 through January 6, 2016) to ensure physician orders related to ordered medication were initiated in a timely manner. Any identified</p>	02/05/2016	

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	<p>Levothyroxine (a thyroid medication) 75 mcg (micrograms) one tablet daily. An order was written on 12/4/15 to increase the Levothyroxine to 100 mcg once daily.</p> <p>The 12/2015 Medication Administration Record was reviewed. The first dose of Levothyroxine was signed out on 12/4/15 at 6:00 a.m. There was no indication why the Levothyroxine had not been administered until 12/4/15.</p> <p>Review of the Nursing Progress Notes from 12/1/2015 indicated there was no documentation of the Levothyroxine not being administered on 12/2/15 and 12/3/15. A 12/4/2015 Laboratory test results form was reviewed. The resident's TSH (Thyroid Stimulating Hormone) level was 8.3. (Normal 0.34-4.82). Hand witting on the results form indicted the Physician viewed the lab results and wrote a Physician's order to increase the thyroid medication to 100 mcg daily.</p> <p>When interviewed on 1/6/2016 at 3:40 p.m., the Director of Nursing indicated the Physician was not notified the resident did not receive the medication as ordered.</p> <p>This Federal tag relates to Complaint IN00189994.</p>		<p>issues will be immediately addressed along with documentation and physician/family notifications made as needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education for licensed nursing staff will be completed by February 5, 2016 by the Staff Development Coordinator and/or designee on the five rights of medication administration along with physician notification as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Administration to complete an audit of the resident's MAR and clinical record at least 3 times weekly for the next six months to ensure physician orders related to ordered medication are initiated in a timely manner. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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

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	3.1-35(g)(2)				