

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/10/2013
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00133825.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00135685.</p> <p>Complaint IN00133825-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date(s): September 3, 4, 5, 6, 9, and 10, 2013</p> <p>Facility number: 000176 Provider number: 155277 Aim number: 100288940</p> <p>Survey team: Yolanda Love, RN-TC Lara Richards, RN (9/3, 9/4, 9/5, 2013) Heather Tuttle, RN Cynthia Stramel</p> <p>Census bed type: SNF/NF 112 Total: 112</p> <p>Census payor type:</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Medicare 19 Medicaid 63 Other 30 Total 112</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 17, 2013, by Janelyn Kulik, RN.</p>			

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F000157 SS=D	<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> <p>Based on record review and interview, the facility failed to notify a Physician of a resident 's significant weight gain in a timely manner for 1</p>	F000157	F157 1. With respect to Resident #42, Physician has been notified of the 7.4 pound weight gain by Licensed Nursing Staff on	10/10/2013	

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	<p>of 3 residents reviewed for nutrition of the 7 who met the criteria for nutrition. (Resident #42)</p> <p>Findings include:</p> <p>The record for Resident #42 was reviewed on 9/5/13 at 10:45 a.m. Diagnoses included recent hip surgery, hypothyroidism and early dementia.</p> <p>A Nutritional Risk Assessment was done on 3/22/13 and indicated a score of 10-12. A score over 8 indicated a resident was at high risk for nutrition deficits. A care plan dated 3/22/13 indicated the resident was at risk for low body weight. The goal was to maintain a weight of 115 pounds, + or - 3 pounds. Approaches included to monitor weight and notify the Physician of significant changes. The resident's monthly weights were reviewed:</p> <p>3/17/13- 114.5 3/31/13- 113 4/14/13 -112.6 5/3/13- 111.2 7/1/13- 112 8/7/13- 112 9/1/13 -119.4</p> <p>There was no documentation that indicated the Physician had been notified of the 7.4 pound weight gain</p>		<p>9/6/13. New orders received, noted, and care plan updated accordingly. 2. All residents have the potential to be affected by this citation. The Nutrition at Risk team, consisting of Supervisory Licensed Nurses, Dietary Manager, and Dietician, completed a weight review on all current residents. Any recommendations, notifications, and/or new orders were processed and care plans updated accordingly on 10/3/13. 3. Nursing staff will be in-serviced on facility policy regarding physician notification of weight changes and nutrition at risk program criteria by the Director of Nursing and/or Nursing Supervisory staff on or prior to alleged compliance date of 10/10/13. 4. Random audits of three resident weights and physician orders will be completed three times a week for 2 weeks, then two times a week for 2 months and/or until 100% compliance obtained by the Director of Nursing and /or Nursing Supervisor. Any significant changes in residents' status requiring physician/family notification found incomplete will be completed by Nursing Staff. Residents' physician/family will be notified, new orders will be processed, and care plan updated to reflect status. The findings will be reported to the Quality Assurance Committee times 3 months or until 100%</p>				

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	<p>or that the resident had been reweighed the following day.</p> <p>Interview with LPN #3 on 9/5/13 at 11:05 a.m., indicated the policy was to reweigh a resident the following day if there was a 5 pound or greater difference from the previous weight. She indicated she had left a note for the weekend staff that this resident needed to be reweighed, but it had not been done.</p> <p>On Friday, 9/6/13 at 8:00 a.m., the resident had not been reweighed. The Unit Manager indicated during an interview at that time they would weigh her 9/6/13 and the following day 9/7/13.</p> <p>On Monday 9/9/13 at 8:30 a.m., the resident's record was further reviewed. Weights were: 9/6/13 - 121.8 9/7/13 - 124.0</p> <p>A nursing note dated 9/6/13 at 3:15 p.m., indicated the resident was noted to have edema (fluid retention) to both ankles. The Physician was notified and an order was received for Lasix (a diuretic) 20 mg for one dose, and to discontinue Norvasc (a blood pressure medication).</p>		<p>compliance is achieved by the Director of Nursing. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, MDS Coordinator, Maintenance, Environmental Services, Therapy Director, Activities Director, Dietary Manager and Medical Director. 5. Alleged Compliance: 10/10/13</p>				

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	<p>The Weight Evaluation Policy and Procedure was received from LPN #3 and identified as current. The Policy indicated, " Whispering Pines HCC will weigh all residents as recommended and notify the physician, dietician and responsible party of all significant weight loss or gain."</p> <p>Further interview on 9/9/13 at 9:01 a.m. with the Unit Manager indicated the resident had not been reweighed and the Physician had not been notified per policy and procedure.</p> <p>3.1-5(a)(2)</p>			

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure the privacy of a resident was maintained related to the monitoring of a blood glucose level in the dining room in front of other residents for 1 of 1 residents reviewed for privacy. (Resident #28)</p>	F000164	<p>F164 1. With respect to Resident #28, no negative outcome occurred. LPN #5 will receive reeducation regarding resident privacy by Unit Manager prior to working next shift due to vacation. 2. Residents have the potential to be affected by the citation. No residents were identified to be affected by this citation. On</p>	10/10/2013	

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	<p>Findings include:</p> <p>On 9/9/13 at 11:22 a.m., in the Maple Dining Room Resident #28 was observed seated in her wheelchair at the table with LPN #5. Further observation indicated the LPN was obtaining a glucometer reading (a device used to obtain a resident's blood to check the level of their sugar) while the resident was seated at the table. At that time, there were other residents seated at other tables as well as Resident #28's table while the nurse was obtaining her blood sugar.</p> <p>Interview with the Maple Unit Manager on 9/10/13 at 1:10 p.m., indicated it was not facility practice to perform blood glucose monitoring in the dining room and further indicated it should be done in privacy.</p> <p>3.1-3(o)</p>		<p>10/4/13, the Director of Nursing and/or Nursing Supervisory staff began monitoring licensed nursing staff for providing full visual privacy during glucometer checks. 3. Licensed Nurses, Certified Nursing Staff, Dietary Staff, Maintenance staff, and Housekeeping/Laundry will be in-serviced by 10/10/13 regarding resident personal privacy/confidentiality of records. 4. Licensed Nurses will be randomly audited one nurse completing glucometer checks on Residents each shift four times a week for 2 weeks, two times a week for 1 month then and/or until 100% compliance obtained by the Director of Nursing and /or Nursing Supervisor. The findings will be reported to the Quality Assurance Committee times 3 months or until 100% compliance is achieved by the Director of Nursing. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, MDS Coordinator, Maintenance, Environmental Services, Therapy Director, Activities Director, Dietary Manager and Medical Director. 5. Alleged Compliance Date:10/10/13</p>		

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F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each resident's dignity was maintained during dining in 1 of 6 dining rooms throughout the facility regarding 1 of 15 residents being called "sweetheart" and "honey" (Resident #42). The facility also failed to ensure resident names were not written on the back of wheelchairs for 3 of 4 residents reviewed for dignity of the 4 residents who met the criteria for dignity. (Residents #80, #87, and #88)</p> <p>Findings include:</p> <p>1. On 9/3/13 at 11:38 a.m., QMA #1 was overheard calling Resident #42 "sweetheart" while in the Elm dining room. At 12:05 p.m., LPN #1 called the resident "honey."</p> <p>Interview with the Timber Unit Manager on 9/5/13 at 8:30 a.m., indicated the residents were to be called by their first name and not by "sweetheart" and "honey".</p>	F000241	<p>F241 1. With respect to Resident #42, no negative outcome noted. QMA #1 and LPN #1 received reeducation regarding dignity and respect of individuality by 9/26/13 by Unit Supervisor. With respect to Resident #87, #88, #80 no negative outcome noted. The above mentioned Resident's name were removed from chair on 9/5/13 by facility staff. 2. All residents have the potential to be affected by this citation. Facility staff removed all of the resident names from Resident chairs on 9/5/13, with the exception of residents that requests their name on chair. All wheel chairs in facility inspected for labels by nursing supervisory staff and removed if possible. Nursing Care Planned those Residents who requested name to remain. Nursing supervisory staff observed staff to resident interactions, no dignity violations noted. 3. Administrative Staff, Licensed Nurses, Certified Nursing Assistants, Dietary Staff, Maintenance Staff, and Housekeeping/Laundry staff will be in-serviced regarding Resident Dignity and Respect of Individuality. 4. Random audits of</p>	10/10/2013

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	<p>2. On 9/03/2013 at 11:31 a.m., Resident #87 was observed sitting in her geri recliner. At that time, the resident's name was noted on the back of the chair in black marker on a piece of white tape. The name was written in large black letters.</p> <p>On 9/4/13 at 9:55 a.m. and 3:00 p.m., the resident was sitting up in the geri recliner chair. Her name was observed on the back of the chair in large black letters on a white piece of tape.</p> <p>On 9/5/13 at 8:30 a.m. and 2:05 p.m., the resident was observed sitting in the geri recliner chair. Her name was</p>		<p>staff to resident interactions and resident rights will be completed one time a week each shift for 1 months by the Director of Nursing and/or Nursing Supervisory staff until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance: 10/10/13</p>	

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	<p>observed on the back of the chair in large black letters on a white piece of tape.</p> <p>The record for Resident #87 was reviewed on 9/5/13 at 2:06 p.m. The resident was admitted to the facility on 12/30/13. Her diagnoses included, but were not limited to, Alzheimer's dementia.</p> <p>Review of the 8/20/13 quarterly Minimum Data Set (MDS) assessment indicated the resident had a memory problem, and she was not alert and oriented. The resident was severely impaired for decision making.</p> <p>Interview with LPN #4 on 9/5/13 at 2:45 p.m., indicated she was the primary nurse who worked on the Pines North Unit during the day shift. She indicated the wheelchairs, and the geri recliners were marked so that other staff knew whose chair belonged to who. She further indicated a lot of times the therapy department will just grab any chair and use it for another resident when it was not their chair.</p> <p>3. On 9/04/13 at 9:42 a.m., Resident #88 was observed sitting in her wheelchair. At that time, the</p>			

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	<p>resident's name was noted written on a piece of tape on the back of her wheelchair.</p> <p>On 9/5/13 at 8:25 a.m., the resident was up in her wheelchair eating breakfast, her name was in black magic marker on the back of her wheelchair.</p> <p>Interview with the Timber Unit Manager on 9/5/13 at 8:30 a.m., indicated all the resident's have their names on the chairs so they can identify the chairs and who they belong to.</p> <p>The record for Resident #88 was reviewed on 9/5/13 at 8:39 a.m. The resident's diagnoses included, but were not limited to, dementia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 8/28/13 indicated the resident was not alert and oriented, had memory problems, and was severely impaired for decision making.</p> <p>Interview with LPN #3 on 9/5/13 at 8:45 a.m., indicated she was the regular day nurse on the unit. She further indicated the problem with the wheelchairs was with the evening shift staff. She indicated they place</p>			

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	<p>the residents in other chairs like the reclining chairs and put all the wheelchairs in the storage room. When staff were ready to place residents back into the wheelchairs they grab the wrong one and use some other resident's wheelchair.</p> <p>4. On 9/4/13 at 9:39 a.m., Resident # 80 was observed seated in her wheelchair in the Linden dining room with her name written on a piece of masking tape on the back of her wheelchair.</p> <p>Interview with LPN # 5 on 9/5/13 at 3:18 p.m., indicated all names were removed from the back of residents' wheelchairs. During an observation at this time resident #80 was observed seated in the activity room in a recliner and her wheelchair was observed at her bedside, her name was no longer observed on the back of her chair.</p> <p>3.1-3(t)</p>			

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F000258 SS=D	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. Based on observation and interview the facility failed to ensure the resident's environment was free from unwanted noises related to the banging of an exit door for 1 of 1 residents reviewed for comfortable noise levels and for 1 of 3 units. (Resident #17 and the Rehab Unit) This had the potential to effect 17 of 17 residents who resided on the Rehab Unit.</p> <p>Findings include:</p> <p>On 9/03/13 at 11:21 a.m., Resident #17 had indicated the exit door next to his room slams shut and bangs very loudly when it was closed. The resident indicated his room was at the end of the hallway by the exit door.</p> <p>On 9/7/13 at 11:55 a.m., Resident #17 was observed lying in bed. The resident indicated he had heard the door slam many times last night. He stated, "it just scares the death out of you."</p> <p>On 9/7/13 at 12:00 p.m., The Rehab Unit Manager was asked to open the exit door which was located right</p>	F000258	<p>F258 1. With respect to Resident#17, resident no longer resides at facility as of 9/12/13. 2. All Residents' residing on the Rehab Unit had the potential to be affected. 3. Administrative Staff, Licensed Nurses, Certified Nursing Assistants, Dietary Staff, and Housekeeping/Laundry staff will receive serviced by alleged compliance date of 10/10/13 regarding timely completion of work orders to Maintenance Staff. Maintenance Staff received education on prompt attention and execution of work orders. 4. Maintenance Director and/or Assistant Director will conduct random checks on facility doors for proper closure and disturbance three times a week for 2 weeks, and then one time a week for 2 months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance</p>	10/10/2013			

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	<p>outside and next to the resident's room. The Unit Manager then was asked to open the door and walk through it without holding onto the door. At that time, the door was opened and slammed shut with a very loud banging noise. The right side of the door came back so hard and made such a loud noise it bounced back open.</p> <p>On 9/7/13 at 12:08 p.m. The Environmental Supervisor came onto the unit, she was asked to go through the door as well, she unlocked the door with the code and walked out. The door again came back so hard it bounced and made a loud slamming noise.</p> <p>Interview with the Unit Manager at the time, indicated the door slams that loud and happens on a daily basis.</p> <p>Interview with LPN #1 at the time, indicated he was aware the door slammed that hard and made a loud noise as well.</p> <p>3.1-19(f)</p>		is achieved. 5. Alleged Compliance: 10/10/13		

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to accurately assess a resident's incontinence status for 1 of 3 residents reviewed for incontinence of</p>	F000272	F272 1. With respect to Resident #134, soiled linens and clothing were laundered, bathroom was cleaned by housekeeping, and a new 3 day voiding diary as well as bowel and bladder assessment	10/10/2013

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	<p>the 7 who met the criteria for incontinence. (Resident #134)</p> <p>Findings include:</p> <p>On 9/3/13 at 3:13 p.m., there was an urine odor in Resident #134's bathroom. There were underwear and pajamas hanging over the waste basket.</p> <p>On 9/5/13 at 8:56 a.m., there was an urine odor noted again in the bathroom of Resident #134. A soiled pair of underwear was hung on the side of the waste basket. At 9:26 a.m., the bathroom had been cleaned and the soiled clothing was gone.</p> <p>On 9/6/13 at 9:07 a.m., there was an urine odor in the bathroom, and a pair of wet underwear hung on the side of the waste basket. There was a round, wet area on the resident's bed approximately the size of a dinner plate. This was observed with the Assistant Director of Nursing (ADoN).</p> <p>The record for Resident #134 was reviewed on 9/5/13 at 8:28 a.m. Diagnoses included, but were not limited to, dementia and congestive heart failure (CHF). The Minimum Data Set quarterly assessment dated 5/29/13 indicated the resident was</p>		<p>were completed by 9/8/13. Care plan was updated to reflect findings as well as CNA sheet updated to reflect resident's status by 9/12/13. 2. All residents have the potential to be affected by this citation. Nursing Staff completed a three day void diary and bowel and bladder assessment on all current residents to determine any changes in resident status. Care Plans adjusted as indicated. 3. Licensed nursing staff will be educated by the Director of Nursing and/or supervisory staff regarding 3 day void diary, bowel and bladder assessments, adequate care plan reflection of current urinary/bowel status, and communicating changes with physician, family, and nursing team. 4. Four random audits of residents comprehensive assessments to ensure care plan reflects residents current status will be completed by the Director of Nursing and/or Nursing Supervisory staff three times a weeks for two weeks, one time weekly for two weeks, and one time monthly and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager</p>				

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	<p>always continent of bowel and bladder.</p> <p>A care plan dated 3/18/13 indicated the problem of self care deficit related to CHF and dementia with the potential for decline. Approaches included to provide supervision with toileting.</p> <p>An initial admission care plan dated 11/21/12 indicated the resident was incontinent of bladder and continent of bowel. There was not a comprehensive care plan for incontinence.</p> <p>Interview with CNA #4 on 9/5/13 at 9:21 a.m., indicated the resident was continent of bowel and bladder, and she was able to use toilet by herself.</p> <p>Interview with the ADoN on 9/6/13 at 9:07 a.m., indicated nursing staff were notified of changes in continence status by CNA's. She indicated that housekeeping cleaned the resident's room. She indicated she was unaware of the resident's urinary incontinence and would do another bladder status assessment.</p> <p>3.1-31(a)</p>		<p>and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance: 10/10/13</p>	

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure a comprehensive care plan was developed related to urinary incontinence and unnecessary medications for 1 of 3 residents reviewed for urinary incontinence and for 2 of 6 residents reviewed for unnecessary medications. (Residents #B, #28, and #155)</p> <p>Findings include:</p> <p>1. The record for Resident #155 was reviewed on 9/9/13 at 8:54 a.m. The</p>	F000279	F279 1. With respect to Resident #155, a 3 day void diary and bowel and bladder assessment was completed by 9/8/13 and physician and family notifications were made as necessary as well as care plans adjusted to reflect current status. With respect to Resident #28, a care plan and behavior tracking for psychotropic drug use was initiated on 9/5/13 to reflect resident's current use of psychotropic medications. With respect to Resident B, constipation care plan was initiated 9/12/13. Routine bowel movements have been documented. 2. All residents	10/10/2013	

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	<p>resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, and memory loss.</p> <p>Review of the 3/15/13 admission Minimum Data Set (MDS) assessment indicated the resident was occasionally incontinent of bladder and was on no toileting program.</p> <p>Review of 6/14/13 quarterly MDS assessment indicated the resident was not on any toileting program and was now frequently incontinent of bladder. The resident had declined.</p> <p>Review of the current plans of care updated 6/14/13 indicated there was no care plan for the resident's bladder incontinence.</p> <p>Interview with the MDS Coordinator on 9/9/13 at 10:35 a.m., indicated the resident did trigger for a care plan to be done on the admission assessment, however, there was none completed at that time. She further indicated when a resident had a decline in urinary incontinence a care plan should be initiated.</p>		<p>have the potential to be affected by this citation. Bowel and bladder assessments along with 3 day voiding pattern diaries were completed on all resident in facility. All residents receiving psychotropic medications were reviewed. Care plans were updated and necessary to reflect incontinence and psychotropic medications. 3. Residents identified as a change in status from three day void diary and Bowel and Bladder Assessment completed, care plans were updated accordingly by MDS Licensed Staff. Licensed Nurses, MDS Nurses, and Social Service Director will be in serviced on or prior to alleged compliance date of 10/10/13 regarding care plan and behavior monitoring related to psychotropic drug use. In addition, Licensed Nurses will receive in-service regarding facility Bowel and Bladder program and the requirement of the facility to ensure all resident care plans effectively reflect resident's current status by Director of Nursing and/or Nursing Supervisors. 4. Director of Nursing and/or Nursing Supervisor will randomly audit three residents charts to identify care plan accurately reflects current status and medication regimen will be completed three times a week for 2 weeks, then two times a week for 2 months and/or until 100% compliance</p>	

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	<p>2. Resident #28 was observed on 9/5/13 at 9:52 a.m., she was in bed sleeping.</p> <p>The record for Resident #28 was reviewed on 9/5/13 at 9:54 a.m., she was admitted to the facility on 6/4/13. Her diagnoses included, but were not limited to, dementia with behaviors, acute kidney injury, leukocytosis, anemia, coronary artery disease, hypertension, and failure to thrive.</p> <p>Review of the Medication Administration Record (MAR), dated 9/13, indicated an order dated 8/23/13 for Seroquel (antipsychotic medication), 25 mg (milligrams) orally every day, an order dated 8/30/13 for Remeron (antidepressant</p>		<p>obtained by the Director of Nursing and /or Nursing Supervisor. The findings will be reported to the Quality Assurance Committee times 3 months or until 100% compliance is achieved by the Director of Nursing. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, MDS Coordinator, Maintenance, Environmental Services, Therapy Director, Activities Director, Dietary Manager and Medical Director. 5. Alleged Compliance Date: 10/10/13.</p>		

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	<p>medication), 7.5 mg orally every night, and an order dated 9/4/13 for Xanax (antianxiety medication), 0.5 mg orally three times a day.</p> <p>Review of the Care Plans indicated there was no evidence of any documentation for psychotropic medications and or behaviors.</p> <p>Interview with LPN #6 on 9/5/13 at 10:32 a.m., indicated there was no Care Plan for psychotropic medication use and/or behaviors. An interview with the Unit Manager on 9/5/13 at 10:39 a.m. also indicated there was no Care Plan for psychotropic medication use and/or behaviors.</p> <p>On 9/5/13 at 2:52 p.m., interview with the Social Services Director, indicated the staff completes morning rounds and if a resident was ordered new medications she was made aware during those rounds, and further stated, it was the responsibility of the nursing staff to create care plans.</p> <p>On 9/6/13 at 10:59 a.m., interview with the Unit Manager, indicated the resident was started on Seroquel on 8/23/13 and should have been stated on a temporary care plan for psychotropic and indicated there was</p>			

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	<p>no Care Plan initiated and placed in the resident's chart. She further indicated behaviors should be tracked for three months.</p> <p>3. Resident B's record was reviewed on 9/10/13 at 8:50 a.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's, constipation, and depression.</p> <p>Review of the Medication Administration Record (MAR) dated 8/13 indicated the resident had a Phycsian's Order for Docusate Sodium (constipation medication) 100 mg (milligrams) by mouth twice a day. The MAR further indicated the resident did not have a bowel moment dated 8/21/13 thru 8/25/13 and had not received any additional treatment for constipation as indicated by the facility bowel protocol.</p> <p>Review of the Care Plans indicated there was no evidence of any documentation for constipation.</p> <p>Interview with the ADoN on 9/10/13, at 11:05 a.m., indicated the resident did not have a care plan for constipation due to the constipation not being identified as a problem.</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, record review and interview, the facility failed to provide necessary services for a resident related to obtaining a dental consult for 1 of 1 residents reviewed for dental services. (Resident #16)</p> <p>Findings include:</p> <p>During an observation on 9/3/13 at 3:37 p.m., Resident #16 was observed to have small, dark, discolored bottom teeth. The resident would frequently put her hand up to her mouth. She denied pain to her mouth.</p> <p>The resident's record was reviewed on 9/5/13 at 9:51 a.m. The resident was originally admitted to the facility on 7/11/07. Diagnoses included, but were not limited to, Schizophrenia, anxiety, and dementia. A Minimum Data Set quarterly assessment dated 7/16/13 indicated the resident's BIMS (Brief Interview for Mental Status) score was 8, indicating mild cognitive impairment.</p>	F000282	F282 With respect to resident #16, social service arranged a dental consult to be completed on 9/30/13. Physician notified of current dental status, new orders received and noted. Resident referred to Speech therapy on 9/25/13 to ensure appropriate diet is ordered. Pain assessment completed by nursing staff which indicated no pain. Care plan updated to reflect current status. All residents have the potential to be affected by this citation. Pain assessments were completed on every resident in facility by Nursing staff and care plan updates were made as necessary. MDS were reviewed and any residents identified with dental problems were reviewed and care plans updated as necessary. Licensed nursing staff will be educated by Director of nursing and/or nursing supervisory staff on assessment of dental changes with regards to possible pain and weight loss and referral to dentist and/or speech therapy as deemed necessary. Education will also include importance on accurate reflection of resident's current dental status in the care plan and any weight loss secondary to dental status	10/10/2013

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	<p>A care plan dated 4/11/13 indicated the problem of nutritional risk related to chewing difficulties and teeth in poor condition. Approaches included a mechanical soft diet, to monitor and record weight, and monitor and document food consumption.</p> <p>A care plan dated 7/16/13 indicated a problem that the resident had some natural tooth loss. Approaches included to obtain a dental consult as needed and to provide assistance with oral care.</p> <p>The September 2013 Physician Order Statement indicated, under miscellaneous orders, that the resident could be seen by a dentist.</p> <p>There was no documentation in the resident's record that she had seen a dentist.</p> <p>The resident's weight record was reviewed. There was a 15 pound weight loss in the past four months. The Physician was notified of weight loss on 8/2/13, there were no new orders.</p> <p>5/4/13- 212 pounds 6/1/13 -208 pounds 7/1/13- 208 pounds 8/2/13- 200 pounds 9/1/13 -197 pounds</p>		<p>will be followed in Nutrition at Risk weekly meetings. Director of Nursing and/or Nursing Supervisory staff will complete 5 random care plan audits to ensure the care plan appropriately reflects resident's current status 3 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date: 10/10/13</p>	

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	<p>Interview with the Social Service Director on 9/5/13 at 12:48 p.m., indicated the resident had not been seen by a dentist since admission to the facility. She further indicated she was going to contact the family and attempt to schedule an appointment.</p> <p>Interview with the Activity Director (former Social Service Employee) on 9/5/13 at 1:15 p.m. indicated the care plan indicated the resident would be seen by a dentist as needed. She explained need was determined if the resident exhibited symptoms related to eating difficulties such as chewing problems, pain or weight loss. She further indicated the resident should have been seen by the house dentist, but was unable to produce documentation that the resident had been seen by the house dentist.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 observation, record review and interview, the facility failed to ensure a resident with contractures was adequately assessed and monitored for pain for 1 of 1 resident reviewed for pain. Also the facility failed to assess and monitor a resident with bruising for 1 of 3 residents reviewed for non-pressure related skin issues of the 4 that met the criteria for non-pressure related skin issues (Residents #1 and #112)</p> <p>Findings include:</p> <p>1. On 9/3/13 at 2:30 p.m., Resident #1 was heard yelling from her room. There were two staff members at her bedside that were working with the resident's hands. They indicated the resident was unable to speak and yelling was how she communicated.</p> <p>On 9/6/13 at 11:45 a.m., the resident was heard yelling from the shower room to the nurses' station. The yelling lasted for 6 minutes without</p>	F000309	<p>F309 1. With respect to Resident #1, pain assessment was completed on 9/20/13 indicating no pain at present. With respect to LPN#7 reeducated on proper splint application by nursing supervisory staff on 9/26/13. With regards to CNA #2 no longer employed with facility. With respect to resident #112, full body skin assessment was completed on 9/24/13 with physician and family notifications completed with no new orders received. 2. All residents have the potential to be affected by this citation 3. The facility conducted a full house pain assessment and will complete full house skin sweep by alleged compliance dated of 10/10/13. Any new concerns noted, physician and family notified, and orders obtained and care plan updated as necessary. All licensed nursing staff will be in-serviced by Director of Nursing and/or nursing supervisory staff regarding facility pain assessment and the proper completion of the non-pressure skin condition sheet. Therapy staff will in-service nursing staff regarding</p>	10/10/2013	

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	<p>stopping. Staff members in the hallway indicated the resident was getting a shower and she did this all the time. At 11:51 a.m., the resident and CNA #1 exited the shower room. The resident's face was contorted and she continued to yell while being wheeled to her room. Interview with the CNA at that time, indicated the resident was non-verbal and she would yell as her only means of communication. At 12:00 p.m., the resident was observed in her bed. She was quiet and showed no signs of distress. She would nod her head yes to every question asked.</p> <p>The resident's record was reviewed on 9/9/13 at 9:18 a.m. Diagnoses included brain injury related to a gun shot wound. The resident had been hospitalized in June, and was readmitted to the facility June 14, 2013. She had contractures to her legs and hands, and had a gastrostomy tube for feedings. A Minimum Data Set (MDS) significant change assessment on 5/17/13, indicated the resident was on scheduled pain medication, and had not received any as needed pain medications within 5 days of the assessment. The staff assessment indicated the resident showed no signs of pain. Medications included, a</p>		<p>proper splint application on or before alleged compliance date of 10/10/13. 4. Random audits of three resident's pain assessments, three non-pressure ulcer skin condition forms, and observation of 3 nursing staff application of splint will be completed by the Director of Nursing and/or Nursing Supervisory staff 2 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. 5. Alleged Compliance Date: 10/10/13</p>		

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	<p>Duragesic patch 25 micrograms for pain every 72 hours, Tramadol 50 milligrams (mg) every 4 hours as needed for pain, and Xanax .25 mg every 6 hours as needed for anxiety. The Duragesic patch was the same dosage as September 2012, it had not been changed.</p> <p>An Initial Pain Assessment form dated 6/15/13 indicated the resident was unable to answer questions. "0", indicating no pain, was circled on the pain scale.</p> <p>A care plan was updated on 6/14/13 for potential for pain related to general medical condition. The goal was for the resident to display relief of pain. Approaches included to monitor and record non-verbal signs of pains such as moaning and grimacing. Also to administer pain medications as ordered and to evaluate their effectiveness and adjust if ineffective.</p> <p>The Medication Administration Record for July, August and September 2013 was reviewed. Tramadol was given 7 times in August 2013 and 9 times in July 2013 for pain. Xanax was given 4 times in August and 1 time in July for anxiety. There was no Tramadol or Xanax given on 9/3/13 or 9/6/13, the days</p>						

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	<p>the resident was observed yelling.</p> <p>The Occupational Therapy (OT) Plan of Treatment dated 6/20/13 was reviewed. The resident was referred due to, "increased joint /soft tissue tightness and pain placing the resident at risk for increased contractures". The resident received manual therapy, diathermy (deep heat) and hand splint application through OT five times a week, for four weeks. She was discharged from OT on 7/31/13. The Occupational Therapy Assistant provided hand splint application training to the nursing staff on 7/30/13 and 7/31/13.</p> <p>On 9/9/13 at 10:15 a.m., LPN #7 and CNA #2 were observed putting hand splints on the resident. The splint on the right hand was put on without the fingers being extended; the brace was put on over her fingers. The CNA and LPN indicated she could not tolerate having her fingers extended. At 11:18 a.m. the Occupational Therapist (OT) indicated the splint on the right hand was not applied properly. She massaged the resident's fingers and was able to extend her fingers to get the splint on correctly. The resident was grimacing and nodded her head when asked if the splint was hurting her. The OT</p>			

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	<p>removed the splint and indicated she should be re-evaluated.</p> <p>Interview with the MDS Assistant, who assists with the Restorative Program, 9/9/13 at 10:26 a.m., indicated the resident was not put on the restorative program after discharge from OT on 7/31/13 because she could not tolerate it. She currently only received passive range of motion as tolerated during daily care and hand splinting daily.</p> <p>On 9/9/13 at 1:00 p.m., the resident's mother was in her room. The resident was positioned on her right side. Her mother repositioned the resident to the left side, the resident grimaced and she began to yell. The mother indicated she was having pain. She further indicated she believed her daughter was having pain frequently due to contractures and bedsores.</p> <p>The Assistant Director of Nursing and LPN #7 were interviewed on 9/9/13 at 1:20 p.m. They were unable to say how the resident's yelling was differentiated as a behavior or pain. The LPN indicated she would give the resident an anti-anxiety medication on shower days if she was yelling. The ADON indicated the resident needed</p>			

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	<p>to be reassessed for pain.</p> <p>2. Observation on 9/4/13 at 10:01 a.m., Resident #112 was observed seated in her wheelchair in the activity room. The resident was observed have 2 small purple bruises on the top of her left hand and one small purple bruise on the top of her right hand.</p> <p>Record review on 9/9/13 at 8:31 a.m., indicated the resident was admitted 11/11/11, diagnoses included, but were not limited to dementia with behavior disturbance, chronic obstructive pulmonary disease, and history of bruising.</p> <p>Review of the Non-Pressure Skin Condition sheet on 9/5/13 at 1:39 p.m., indicated there was no evidence of any documentation of bruising.</p> <p>Interview with LPN #3 on 9/5/13 at 1:42 p.m., indicated bruises were monitored and measured until they were healed. She also indicated on 9/3/13 there was documentation in the Nursing Notes that indicated a skin assessment had been completed and there were no new findings.</p> <p>On 9/5/13 at 2:03 p.m., LPN #3 was</p>				

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	<p>observed assessing the resident's bilateral hands and indicated she had two small purple bruises on the top of her left hand and one small purple bruise on the top pf her right hand. She then indicated there should be documentation of the bilateral bruises to the resident's hands.</p> <p>3.1-37(a)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident who was incontinent of bladder did not have a further decline in urinary incontinence for 1 of 3 residents reviewed for urinary incontinence of the 7 who met the criteria for urinary incontinence. (Resident #155)</p> <p>Findings include:</p> <p>On 9/9/13 at 9:45 a.m., CNA #3 took Resident #155 to the bathroom. At that time, the resident was wearing a pull up incontinent brief. The resident's brief was dry and not wet with urine. The resident indicated herself that she should probably go to the bathroom.</p> <p>The record for Resident #155 was reviewed on 9/9/13 at 8:54 a.m. The</p>	F000315	<p>F315 1. With respect to resident #155, a 3 day void pattern and bowel and bladder assessment was completed by 9/8/13 and care plan updated as necessary. 2. All residents have the potential to be affected. All residents obtained new 3 day voiding pattern diary and bowel and bladder assessment completed by nursing staff on 9/20/13 to indicate any change. Physician and family notification for any changes were conducted as well as care plan updates as necessary. 3. All licensed nursing staff will be in-serviced by Director of Nursing and/or nursing supervisory staff regarding facility 3 day voiding pattern diary and bowel and bladder program. All non-licensed nursing staff will be in-serviced on timely and accurate completion of ADL documentation. 4. Random audits completed on three resident's continent status will be conducted to ensure ADL</p>	10/10/2013			

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	<p>resident was admitted to the facility on 3/9/13. Her diagnoses included, but were not limited to, dementia, Alzheimer's disease, and memory loss.</p> <p>Review of the 3/15/13 admission Minimum Data Set (MDS) assessment the resident was occasionally incontinent of bladder and was on no toileting program.</p> <p>Review of 6/14/13 quarterly MDS assessment indicated the resident was not on any toileting program and was now frequently incontinent of bladder. The resident had declined in urinary incontinence.</p> <p>Review of the current plan of care updated 6/14/13, indicated there was no care plan for the resident's bladder incontinence.</p> <p>Review of the bladder incontinence assessment dated 3/9/13, indicated the resident goes to the bathroom with assistance, does not use the bedpan or a commode. She uses incontinent pads, and was usually incontinent one time weekly. The resident will be placed on a check and change program, and to monitor her voiding pattern for 3 days.</p>		<p>charting reflects current resident status. Care plans to be adjusted as necessary. Audits will be completed by the Director of Nursing and/or Nursing Supervisory staff 3 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date:10/10/13</p>				

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	<p>Review of the three day bladder elimination pattern assessment dated 3/9, 3/10, and 3/11/13 indicated on 3/9 the resident voided one time at 9:00 p.m., nothing else was marked for that day. On 3/10 it was checked the resident was already wet at 6:00 a.m., nothing else was marked for that day. On 3/11/13 the entire day was not checked or marked it was blank.</p> <p>Further review of the 3/9/13 bladder assessment indicated there had not been any further assessments of the resident's urinary status since the first initial assessment.</p> <p>Review of the CNA Activities of Daily Living (ADL) Tracking form for the month of June 2013 indicated the resident was incontinent between one and two times a day each shift. Further review of the ADL Tracking form indicated there was no incontinence recorded for the resident for the 7-3 shift on 6/16, 6/17, 6/19-6/23, 6/25, 6/26, 6/29, and 6/30/13.</p> <p>Review of Nursing Progress Notes dated 6/4/13 at 1:35 p.m., indicated the resident was incontinent of bowel and bladder. Further review of Nursing Progress Notes dated 9/3/13</p>			

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	<p>indicated the resident was occasionally incontinent of bladder.</p> <p>Review of the current 3/2010 Incontinence Management Program provided the Nurse Consultant indicated complete admission nursing assessments including the Incontinence Assessment and proceed with a Three Day Voiding Pattern Diary if indicated. The Assessment Process indicated to identify residents already experiencing some level of incontinence or were at risk of developing urinary incontinence. To complete an accurate and thorough assessment of facts. The Procedure was for the Unit Supervisor to review the tool and voiding patterns at the end of the three day period and make determination regarding appropriate incontinence management protocol. The supervising nurse was responsible for instructing the staff and updating the nursing assistant assignments and resident care records so staff will provide appropriate and safe assistance, as well as document the continent and incontinent episodes with the toileting program.</p> <p>Interview with the Assistant Director of Nursing (ADoN) on 9/9/13 at 9:27</p>				

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	<p>a.m., indicated the bladder assessments were to be completed every quarter by the Unit Manager. She further indicated there should have been a care plan for urinary incontinence if the resident had a decline. The ADoN indicated if a resident had a decline in urinary function another urinary assessment should have been completed as well as a three day bladder voiding pattern.</p> <p>Interview with CNA #3 on 9/9/13 at 9:34 a.m. indicated the resident was usually up when she came to work. She further indicated she toilets the resident at least three times a day after the meals, but if the resident indicated she had to go before the meal than she would do it then. The CNA indicated the resident was usually incontinent at least one to two times during her shift.</p> <p>Interview with LPN #4 on 9/9/13 at 10:00 a.m., she indicated the Unit Manager was responsible for updating the bladder assessments and they should be done every three months.</p> <p>Interview with the MDS Coordinator on 9/9/13 at 10:35 a.m., indicated the resident did trigger for a care plan to</p>			

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	<p>be done on the admission assessment. She further indicated a care plan was not completed for the admission assessment or for the quarterly assessment. The MDS Coordinator indicated if there was a decline in urinary status a new bladder assessment was to completed as well as a three day voiding pattern.</p> <p>3.1-41(a)(2)</p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interviews the facility failed to ensure the hot water temperatures in the resident's rooms were between 100 and 120 degrees Fahrenheit for 1 of 3 Units. (The Rehab Unit) This had the potential to effect 17 residents who resided on the Rehab Unit.</p> <p>Findings include:</p> <p>1. On 9/04/13 at 10:24 a.m. the hot water was hot to touch in room 160. At that time, a temperature of the hot water was obtained in which it was 126 degrees Fahrenheit.</p> <p>On 9/04/13 at 10:33 a.m., the hot water was hot to touch in room 156. , At that time, a temperature of the hot water was obtained in which it was 126 degrees Fahrenheit.</p> <p>On 9/04/13 at 11:08 a.m., the hot water was hot to touch in room 154. At that time, a temperature of the hot water was obtained in which it was 126 degrees Fahrenheit.</p>	F000323	<p>F323 1. With regards to elevated water temperatures in rooms 160, 156, and 154, facility staff were immediately instructed to postpone all showers until further instructed. Extra cleaning wipes were distributed to the units to provide adequate care. Environmental director immediately contacted outside contractor and mixing valve was repaired. With respect to residents on rehab unit, no injuries noted. 2. All residents on the rehab unit had the potential to be affected 3. Facility staff will be in-serviced by the environmental director and/or maintenance staff on increased observation of elevated water temperatures and the importance of immediately ceasing use of water and making contact to environmental supervisor to ensure water temperature is safe. 4. Random audits of water temperatures will be completed by the environmental director and/or environmental staff 1 time a week on each shift for 4 weeks then 1 time a week completed on random shift. Results of findings will be reported to the Quality Assurance Committee consisting</p>	10/10/2013

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383		
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	<p>On 9/4/13 at 11:23 a.m., the Environmental Supervisor obtained a hot water temperature from room 154 in which she obtained a reading of 126 also.</p> <p>On 9/4/13 at 2:05 p.m., Interview with the Environmental Supervisor indicated she had called out the repair service and they were looking into the problem.</p> <p>On 9/4/13 at 3:07 p.m., the water temperatures in the above mentioned rooms were now below 120 degrees Fahrenheit.</p> <p>On 9/9/13 at 2:00 p.m., During the Environmental Tour the hot water temperature in the above mentioned rooms were 109 degrees Fahrenheit.</p> <p>Interview with the Environmental Supervisor on 9/9/13 at 2:00 p.m., indicated there was mixing valve problem and now it had been fixed.</p> <p>3.1-19(r)(1) 3.1-19(r)(2)</p>		<p>of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date:10/10/13</p>		

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a resident's medication regimen was free from unnecessary medications related to lack of monitoring a resident on stool softeners for constipation for 1 of 3 residents reviewed for unnecessary medications of the 5 who met the criteria for unnecessary medications. (Resident B)</p> <p>Resident B's record was reviewed on</p>	F000329	F329 1. With respect to resident B, constipation care plan was initiated 9/12/13. Routine bowel movements have been documented. 2. All residents have the potential to be affected by this citation. All residents treatment records were reviewed to ensure regular bowel movements were occurring and bowel protocol were be being initiated as necessary. No negative outcomes noted. 3. Nursing staff will be re-educated by Director of nursing and/or nursing supervisory staff on	10/10/2013			

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	<p>9/10/13 at 8:50 a.m. The resident's diagnoses included, but were not limited to, dementia, Alzheimer's, constipation, and depression.</p> <p>Review of the Medication Administration Record (MAR) dated 8/13 indicated the resident had a Phycsian's Order for Docusate Sodium (constipation medication) 100 mg (milligrams) by mouth twice a day. The MAR further indicated the resident did not have a bowel moment dated 8/21/13 thru 8/25/13 and had not received any additional treatment for constipation as indicated by the facility bowel protocol.</p> <p>Review of the Care Plan indicated there was no evidence of any documentation for constipation.</p> <p>Interview with the LPN #4 at 9:01 a.m., indicated the resident has had constipation in last 30 days, she also indicated the facility has a bowel protocol which states, if the resident has not had a bowel moment within three days administer Milk of Magnesia (MOM) 30 ml (milliliters) orally and if no results in 24 hours then administer a Bisacodyl Suppository rectally. She also reviewed the MAR dated 8/13 and</p>		<p>bowel protocol including assessing and observing for need to implement protocol determined by bowel pattern documented in the Treatment Record. 4. Random audits of three resident's bowel pattern documented in the treatment records will be conducted 3 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date:10/10/13</p>	

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	<p>indicated the resident had five days of constipation with no prn medication given.</p> <p>During an interview with the ADoN at 9:10 a.m., indicated the facility has a bowel movement protocol which states, if the resident has not had a bowel moment within three days administer Milk of Magnesia (MOM) 30 ml (milliliters) orally once daily prn (as needed) and if no results in 24 hours then administer a Bisacodyl Suppository rectally prn, if no results after 24 hour then administer 133 ml enema rectally once daily prn.</p> <p>Interview with the ADoN at 11:05 a.m., indicated the resident did not have a care plan for constipation due to the constipation not being identified as a problem.</p> <p>3.1-48(a)(6)</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to serve food under sanitary conditions related to using gloved hands to serve dinner rolls, uncovered fruit cups and bread for 2 of 6 dining rooms. (The Rehab and Maple Dining Rooms)</p> <p>Findings include:</p> <p>1. On 9/3/13 at 12:02 p.m. there were two dietary aides standing behind the steam table in the Rehab Dining Room. Both Dietary Employees were observed to be preparing the resident's plates with food from the steam table. Dieatry Aide #1 was observed to be wearing gloves to both of her hands. She was picking up the utensils, plates, lids, and other containers with both of her gloved hands. The Dieatry Aide did not change her gloves during this time. Dietary Aide #1 was then observed picking up the dinner rolls and placing them on the resident's plates with her gloved hands. She did</p>	F000371	<p>F371 1. With regards to Dietary Aide #1, reeducated by Dietary Manager regarding infection control/glove utilization. Dietary aide #2 no longer employed with facility. 2. All residents had the potential to be affected by this citation. 3. All dietary staff will be in-serviced on proper glove use, serving method, and tray line setup with sufficient utensils readily available for meal service, and proper transportation of food by Dietary manager and/or dietary supervision team on or before alleged date certain of 10/10/13. 4. Dietary manager and/or dietary supervisory team will audit infection control/glove utilization and proper transportation of food items and all proper serving utensils available during random meal services times, 3 times a week for 4 weeks, then 2 times a week for 2 weeks and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity</p>	10/10/2013			

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	<p>this for the entire meal and did not change her gloves or use utensils to pick up the dinner rolls.</p> <p>Continued observation indicated Dieatary Aide #2 was also wearing gloves to both of her hands. Dietary Aide #2 was also observed at the steam table placing dinner rolls on the resident's plates with her gloved hands after she had been touching the pans, plates, and the utensils.</p> <p>Interview with Dietary Aide #1 on 9/3/13 at 12:25 p.m., indicated she normally serves breakfast but today she was serving lunch at the steam table. She further indicated she had a pair of tongs, but could not find them during the meal service to serve the dinner rolls.</p> <p>Interview with Dietary Aide #2 at that time, indicated today was her first day on the job.</p> <p>Review of the current and undated Handwashing and Glove Use Policy provided by the Dieatary Food Manager indicated gloves must be changed as often as hands needs to be washed. Important to remember that gloves can often give a false sense of security and can carry germs same as our hands.</p>		<p>Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved.</p>	

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	<p>Interview with the Dietary Food Manager on 9/6/13 at 10:00 a.m., indicated the Dietary Aides should not have used their gloved hands to pick up any type of food after touching other items. She further indicated she discourages her staff to wear gloves while serving the meals from the steam tables.</p> <p>2. On 9/3/13 at 11:27 a.m., there were 20 fruit cups observed on the dining room counter and a half loaf of wheat bread was noted to be sitting on top of the refrigerator unclosed. At that time, there was no plastic wrap noted to be covering the fruit. At 12:05 p.m., the staff began serving the uncovered fruit cups to the residents.</p> <p>On 9/9/13 at 11:18 a.m., interview with Dietary Aide #3, indicated when food is transported to the dining rooms it was place on a tray and covered with plastic wrap.</p> <p>3.1-21(i)(3)</p>			
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F000412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, record review and interview, the facility failed to provide necessary services for a resident related to obtaining a dental consult for 1 of 1 residents reviewed for dental services. (Resident #16)</p> <p>Findings include:</p> <p>During an observation on 9/3/13 at 3:37 p.m., Resident #16 was observed to have small, dark, discolored bottom teeth. The resident would frequently put her hand up to her mouth. She denied pain to her mouth.</p> <p>The resident's record was reviewed on 9/5/13 at 9:51 a.m. The resident was originally admitted to the facility on 7/11/07. Diagnoses included, but were not limited to, Szichophrenia, anxiety, and dementia. A Minimum</p>	F000412	F4121.With respect to resident #16, social service arranged a dentalconsult to be completed on 9/30/13. Resident referred to Speech therapy on 9/25/13 to ensure appropriatediet is ordered. Pain assessmentcompleted by nursing staff which indicated no pain on 9/20/13.2.All residents have the potential to be affected by thiscitation.3.Licensed nursing staff will be educated by Director ofnursing and/or nursing supervisory staff on assessment of dental changes withregards to possible pain and weight loss and referral to dentist and/or speechtherapy as deemed necessary. Educationwill also include importance on accurate reflection of resident's currentdental status in the care plan and any weight loss secondary to dental statuswill be followed in Nutrition at Risk weekly meetings.4.Director of Nursing and/or Nursing	10/10/2013

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	<p>Data Set quarterly assessment dated 7/16/13 indicated the resident's BIMS (Brief Interview for Mental Status) score was 8, indicating mild cognitive impairment.</p> <p>A care plan dated 4/11/13 indicated the problem of nutritional risk related to chewing difficulties and teeth in poor condition. Approaches included a mechanical soft diet, to monitor and record weight, and monitor and document food consumption.</p> <p>A care plan dated 7/16/13 indicated a problem that the resident had some natural tooth loss. Approaches included to obtain a dental consult as needed and to provide assistance with oral care.</p> <p>The September 2013 Physician Order Statement indicated, under miscellaneous orders, that the resident could be seen by a dentist.</p> <p>There was no documentation in the resident's record that she had seen a dentist.</p> <p>The resident's weight record was reviewed. There was a 15 pound weight loss in the past four months. The Physician was notified of weight loss on 8/2/13, there were no new</p>		<p>Supervisory staff will audit residents identified by the MDS to have dental changes/concerns 3 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Director, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date: 10/10/13</p>		

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	<p>orders.</p> <p>5/4/13- 212 pounds</p> <p>6/1/13 -208 pounds</p> <p>7/1/13- 208 pounds</p> <p>8/2/13- 200 pounds</p> <p>9/1/13 -197 pounds</p> <p>Interview with the Social Service Director on 9/5/13 at 12:48 p.m., indicated the resident had not been seen by a dentist since admission to the facility. She further indicated she was going to contact the family and attempt to schedule an appointment.</p> <p>Interview with the Activity Director (former Social Service Employee) on 9/5/13 at 1:15 p.m. indicated the care plan indicated the resident would be seen by a dentist as needed. She explained need was determined if the resident exhibited symptoms related to eating difficulties such as chewing problems, pain or weight loss. She further indicated the resident should have been seen by the house dentist, but was unable to produce documentation that the resident had been seen by the house dentist.</p> <p>3.1-24(a)(1)</p>				

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F000425 SS=E	<p>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. Based on observation, record review, and interview, the facility failed to ensure multi dose vials were not used past the expiration date for 3 of 6 medication rooms observed. (The Maple, Rehab, and Pines North medication rooms)</p> <p>Findings include:</p> <p>1. On 9/10/13 at 9:03 a.m. in the Maple medication room there was one multi dose vial of Humalog Insulin opened with the date opened of 7/7/13. Continued observation indicated there was one multi dose</p>	F000425	<p>F425 1. With regards to multi-dose vials on Rehab, Maple, and Pines north medication rooms, the medications were immediately labeled if appropriate and/or discarded and new vial was obtained and accurately marked with necessary information. 2. All residents had the potential to be affected by this citation. All multi-dose vials in facility were audited to ensure proper dating on vial. Changes to vials and medications reordered as necessary. No negative outcomes were noted. 3. Licensed nursing staff will be in-serviced by Director of Nursing and/or nursing supervisory team</p>	10/10/2013	

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	<p>vial of Lantus Insulin opened with no date noted.</p> <p>Interview with the Timber Unit Manager at the time, indicated the vials of Insulin are only good for 28 days and should be labeled when they were opened.</p> <p>2. On 9/10/13 9:16 a.m. on the Rehab Unit, there was one multi dose vial of Tuberculin opened with no date noted.</p> <p>Interview with the Rehab Unit Manager at the time, indicated the vial of Tuberculin should have been labeled with a date when it was opened.</p> <p>3. On 9/10/13 9:30 a.m. on the Pines North Unit there was one multi dose vial of Novolin Insulin opened with the date of 7/25/13. Further observation indicated there was one multi dose vial of Lantus Insulin with the date opened of 8/6/13.</p> <p>Review of the current 7/1/2010 Preparation of Medication Administration Policy: Vials and Ampules of injectable medications indicated "The date opened and the initials of the first person to use the vial are recorded on multi dose vials</p>		<p>regarding proper procedure for dating opened multi-dose vials of medications by alleged compliance date of 10/10/13. 4. Director of Nursing and/or Nursing Supervisory staff will audit multi-dose vials for adequate labeling on each unit 3 times a week for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date: 10/10/13</p>				

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	<p>on the accessory label affixed for that purpose. Medications in multi dose vials may be used for 30 days if inspection reveals no problems during that time...."</p> <p>Interview with the Director of Nursing on 9/10/13 at 10:38 a.m., indicated the vials of Insulin and Tuberculin should have been labeled with a date opened when they were first opened and none of them should have been used past the expiration date.</p> <p>3.1-25(o)</p>			

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F000441 SS=E	<p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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>Based on observation, record review and interview, the facility failed to</p>	F000441	F441 1. With regards to Activity Aide #1, education was	10/10/2013			

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	<p>ensure hand washing was completed by staff after picking utensils off of the floor for 1 resident who was eating in the Linden dining room, cleaning of glucometers and disposing of lancets into the garbage can for 2 of 3 residents observed for glucometers, and hand washing after glove removal for 2 of 6 residents observed during medication pass. This had the potential to affect the 13 residents who ate in the Linden dining room. (Resident #159, #19, and #40) The facility also failed to ensure contact precautions were followed based on the facility policy for 1 of 1 residents who were positive for the clostridium difficile antigen on the Maple unit. (Resident #28)</p> <p>Findings include:</p> <p>1. On 9/3/13 at 12:04 p.m., in the Linden dining room, Activity Aide #1 was assisting Resident #159 with her meal. A spoon fell from the resident's wheelchair and landed on the floor. The Activity Aide proceeded to bend over and pick up the spoon. The Activity Aide placed the spoon in the container for dirty utensils. The Activity Aide then proceeded to assist the resident with her meal. The Activity Aide did not wash her hands nor use an alcohol based gel.</p>		<p>conducted on 9/26/13 regarding hand washing policy by activity director. With regards to Resident #28, gowns were stocked in regards to specified contact precautions. With regards to LPN #2, education was completed on 9/27/13 by nursing supervisor regarding infection control, glucometer disinfecting, and sharps policies. With regards to LPN #1, education was conducted on 9/27/13 by nursing supervisory regarding disinfection of glucometer. With respect to resident #159, 19, 40, and #28 no ill affect noted. 2. All residents had the potential to be affected by this citation. 3. Facility staff will be in-serviced regarding infection control policy which includes hand washing and isolation precautions by director of nursing and/or nursing supervisory staff. Licensed and certified nursing staff will be educated on glucometer cleaning and sharps disposal policy by director of nursing and/or nursing supervisory staff. 4. Director of Nursing and/or Nursing Supervisory staff will audit hand washing, glucometer disinfecting, lancet disposal, and isolation precautions 1 time a week on all shifts for 4 weeks then 1 time a week for two months and/or until 100% compliance obtained. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of</p>				

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	<p>Interview with the Assistant Director of Nursing (ADoN) on 9/5/13 at 1:15 p.m., indicated anytime a staff member picks something up from the floor, they should wash their hands.</p> <p>Review of the facility "Handwashing" policy provided by the ADoN on 9/5/13 at 1:25 p.m., and identified as current, indicated the following: "Appropriate hand washing will be performed at the following times, but not limited to, before and after all patient/resident care activities. The following are examples of patient/resident care activities: before touching, preparing, or serving food."</p> <p>2. On 9/5/13 at 1:00 p.m., an orange contact precaution sign was posted on Resident #28's door frame. Two red trash cans were observed inside the resident's bathroom. Trash can liners and gloves were located in the resident's room but no gowns. The contact precaution sign indicated gowns were indicated if soiling was likely.</p> <p>Interview with the Assistant Director of Nursing (ADoN) on 9/5/13 at 1:10 p.m., indicated gowns were encouraged if the resident had c-diff (clostridium difficile) or MRSA</p>		<p>Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Director, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date:10/10/13</p>	

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	<p>(methicillin resistant staphylococcus aureas) in the urine. Continued interview with the ADoN at 1:40 p.m., indicated the resident was positive for the c-diff antigen but was not having loose stools. She indicated the resident's stools needed to be re-cultured to see if the contact precautions could be discontinued. She indicated the resident to be incontinent at times and there were no gowns in the resident's room and there should have been. She indicated the Timbre Unit Manager was going to get some gowns and place them in the resident's room.</p> <p>Review of the Contact Precautions policy provided by the ADoN on 9/5/13 at 1:25 p.m., and identified as current, indicated "clostridium difficile" was an infection or condition requiring contact precautions.</p> <p>3. On 9/6/13 at 6:08 a.m. LPN #2 was observed preparing to do a glucometer (a machine used to obtain blood from a resident) for Resident #40. At that time, she applied clean gloves to both of her hands while standing at the medication cart. She walked into the resident's room with her gloved hands, the lancet, the strip, and glucometer machine. She then wiped the resident's finger with an alcohol pad and pricked the</p>			

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	<p>resident's finger with the lancet. She then squeezed the resident's finger but could not obtain enough blood. She then walked out of the resident's room and into the hall to get another lancet. At that time, she was still wearing the same gloves and did not remove them before leaving. LPN #2 then came back into the room with another lancet, wiped another finger with the alcohol pad and obtained the blood by using the strip. The LPN then removed her gloves from her hands and placed them into a ball with both lancets, the alcohol pads, and the strip in the glove and placed the rolled gloves into trash can on the side of the cart. She then picked up her pen and signed out the glucometer and performed other documentation. During this time, she had not washed her hands after glove removal and after leaving the resident's room.</p> <p>The LPN then placed clean gloves on her hands and wiped the glucometer off with an alcohol pad. Interview with LPN #2 at that time, indicated she used the alcohol wipe to clean the glucometer when the big containers of wipes were unavailable. She then removed her gloves and threw them away into the garbage can and used alcohol gel to clean her hands.</p>			

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	<p>At 6:19 a.m. on 9/6/13 LPN #2 was going to do another glucometer reading using the same glucometer. She applied clean gloves while standing at the medication cart. She then walked into the Resident #19's room and used an alcohol pad to wipe the resident's finger. She then pricked the finger with the lancet and obtained the blood and placed it on the strip into the glucometer. The LPN then removed her gloves and rolled them up into a ball. At that time, she had placed the lancet, the strip and alcohol pad into the ball of rolled gloves and threw them away into the garbage can on the side of the cart. The LPN again did not throw the lancet into the sharps container located on the side of the medication cart.</p> <p>Interview with the LPN at that time, indicated it was ok to place the lancets into the garbage cans and not into the sharps container. The LPN further indicated she was not aware of the facility's policy regarding cleaning and disinfecting the glucometer. She indicated she had never heard of waiting two minutes for the glucometer to dry. The LPN indicated she did not remove her gloves before leaving the resident's</p>						

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	<p>room to get another lancet.</p> <p>Review of the current and undated hand hygiene policy indicated Handwashing may also be used for routinely decontaminating hands in the following clinical situations: Glove and Hand Hygiene: Remove gloves promptly after use, before touching non contaminated items and environmental surfaces, and before caring for another patient.</p> <p>Review of the current and undated Sharps and Needles policy which was provided by the Director of Nursing on 9/6/13 at 10:15 a.m., indicated to contain all sharps and needles immediately after use in a leak proof container that was appropriately labeled.</p> <p>Interview with the Director of Nursing on 9/6/13 at 8:45 a.m., indicated the nurse should have removed her gloves before leaving the room, after she had completed the glucometer.</p> <p>4. On 9/7/13 at 7:54 a.m., LPN #1 was observed cleaning a glucometer after he had just performed an accucheck for Resident #40. The LPN used a wipe called a Sani-cloth. He was observed to wipe down the machine and threw the wipe into the</p>				

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	<p>garbage. The LPN did not wrap the Sani-cloth around the glucometer and wait for a full two minutes.</p> <p>Interview with LPN #1 at that time, indicated he had thought the procedure for the glucometer cleaning was to wipe down the machine with the Sani cloth wipe and let dry for a minute. He was unaware the Sani-cloth had to be wrapped around the glucometer for two minutes.</p> <p>Review of the current 1/12 Disinfection of glucometer meter policy, provided by the Director of Nursing indicated after every use of a glucometer or PT/INR meter the meter must be thoroughly cleaned with 1:10 bleach wipe. Then, the meter was not to be used for two minutes until it was dry.</p> <p>Interview with the Director of Nursing on 9/6/13 at 8:45 a.m., indicated all sharps and needles were to be placed into the sharps container after use. She further indicated the glucometer should be not used for two minutes and should be wrapped in the Sani-cloth after use.</p> <p>3.1-18(b)(1) 3.1-18(l)</p>				

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F000465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to ensure the resident's environment was clean and in good repair related to marred walls, marred door frames, dirty wheelchairs, and torn wallpaper for 2 of 3 units. (The Timber and Pines units) This had the potential to effect 95 residents of the 112 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. On 9/9/13 at 2:00 p.m., the following was observed during the Environmental Tour on the Timber Unit:</p> <p>A. In room 260 the bathroom door frame and the bottom of the door was marred and scratched. There were two residents who resided in the room.</p> <p>B. In room 272 the wallpaper was torn and walls were marred behind the dresser of bed one. Further observation at that time indicated the wheelchair located next to the bed had a large amount of dried food</p>	F000465	<p>F4651.A. Room 260: mars andscratches to the bathroom door frame and bottom of the door were repaired on9/23/13 by Maintenance staff.B. Room 272: wallpaperC. Room 208: deepclean was completed by housekeeping staff on 9/23/12 to include elimination ofthe large accumulation of dust on fan blades and screen.D. Room 269: thelarge amount of chipped paint behind the bed and in corners will be repaired bythe Maintenance staff on or prior to alleged compliance date of 10/10/13.E. Room 271: thechipped paint behind bed two and wall paper torn will be repaired byMaintenance staff on or prior to alleged compliance date of 10/10/13.F. Room 213: thetrack on the closet door was replaced by Maintenance staff on 9/23/13.G. Room 32, the marson the bathroom walls, door, and door frame will be repaired by the Maintenancestaff by alleged compliance date of 10/10/13.H. Room 34: the paintpeeling off of the wall by the heating and air conditioning unit will berepaired by Maintenance staff on/before alleged compliance date of 10/10/13.I. Room 29: bathroomwalls marred with black</p>	10/10/2013

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	<p>and/or beverage spillage noted on the brakes and wheels along with crumbs noted in the chair. There were two residents who resided in the room.</p> <p>C. In room 208 there was a large accumulation of dust on the fan blades and screen. There was one resident who resided in the room.</p> <p>D. In room 269 there was a large amount of chipped paint behind the bed and in the corners. There were two residents who resided in the room.</p> <p>E. In room 271 there was chipped paint behind bed two and the wall paper was torn. There was one resident who resided in the room.</p> <p>F. In room 213 the closet door was off the track. There were two residents who resided in the room.</p> <p>2. On 9/9/13 at 2:15 p.m., during the Environmental Tour the following was observed on the Pines Unit:</p> <p>A. In room 32 the bathroom walls and doors were marred. The door frame to the bathroom was also marred. There was one resident who resided in the room.</p>		<p>scuff marks on the bottom of the door and frame will be completed by Maintenance staff on or prior to alleged compliance date of 10/10/13. Residents residing in the above mentioned areas, no illaffect noted. 2. All residents have the potential to be affected by the alleged citation. 3. Maintenance staff will be inserved by Administrator or designee regarding facility rounds, timely completion of work orders, and preventative maintenance schedule throughout facility. This will be completed on or prior to alleged compliance date of 10/10/13. 4. Maintenance Director and/or Maintenance staff will complete random facility room checks to identify repairs needed and address any and all issues noted promptly 3 times a weekly. Findings and repairs completed given to facility Administrator weekly. Results of findings will be reported to the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Social Services Director, Activity Directory, Maintenance Director, Environmental, Dietary Manager and Medical Director. The findings will be discussed for 3 months or until 100% compliance is achieved. 5. Alleged Compliance Date: 10/10/13.</p>		

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	<p>B. In room 34 the paint was peeling off of the wall by the heating and air conditioning unit. There were two residents who resided in this room.</p> <p>C. In room 29 the bathroom walls were marred with black scuff marks noted on the bottom of the door and frame.</p> <p>Interview with the Environmental Supervisor on 9/9/13 at 2:30 p.m., indicated all the above was in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>			

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify non-compliance of the facility's Quality Assessment and Assurance protocol related to lack of identifying concerns related to infection control, proper disposal of lancets, cleaning glucometers, urinary incontinence, dignity, and assessments.</p> <p>Findings include:</p>	F000520	F5201.The facility must maintain a Quality Assessment and Assurance committee consisting of the Director of Nursing, Medical Director, and at least 3 other members of the facility staff. This facility does have a committee which meets the required attendees. The facility Quality Assurance Committee meets monthly to discuss identified quality deficiencies. 2. All Residents have the potential to be affected by this citation. 3. An in service will be	10/10/2013

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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN 46383			
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	<p>Interview with the Assistant Director of Nursing (ADoN) on 9/10/13 at 11:35 a.m. indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Administrator, the Director of Nursing, Social Service, Dietary, Activities, and Nursing as well as the Medical Director. The ADoN indicated at the time, dignity was not discussed in any Quality Assurance Meetings related to calling resident's sweetie, honey, baby ect.... She further indicated they had not discussed or identified as being a problem the names written on the back of the resident's wheelchairs. She further indicated there had been no action plan or system put into place to identify the problem of Dignity.</p> <p>Interview with the Timber Unit Manager on 9/5/13 at 8:30 a.m., indicated the residents were to be called by their first name and not by "sweetheart" and "honey". She further indicated all the resident's have their names on the chairs so they can identify the chairs and who they belong to.</p> <p>On 9/10/13 at 11:35 a.m., interview with ADoN indicated infection control related to the disposal of lancets and</p>		<p>conducted by the Administrator and/or designee to review Quality Assurance Policy and citations received on this annual survey to the Quality Assurance Committee. This committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, CarePlan Coordinator, Social Services Director, Activity Director, Maintenance Director, Environmental, Dietary Manager and Medical Director. In addition, identified quality deficiencies will be discussed and the Plan of Correction to allege compliance on or prior to alleged compliance date of 10/10/13.4. All random audits completed for cited deficiencies will be presented to the Quality Assurance Committee to ensure routine compliance. Any concerns noted will be addressed by the committee and changes will be made to the Plan of Correction if deficiencies continue.5. Alleged Compliance Date: 10/10/13</p>				

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	<p>glucometer cleaning had not been identified as a problem in any Quality Assurance Meetings. She further indicated there had been no action plan or system put into place to identify the problem of Infection Control.</p> <p>Interview with the LPN on 9/6/13 at 6:08 a.m., indicated it was ok to place the lancets into the garbage cans and not into the sharps container. The LPN further indicated she was not aware of the facility's policy regarding cleaning and disinfecting the glucometer. She indicated she had never heard of waiting two minutes for the glucometer to dry. The LPN indicated she did not remove her gloves before leaving the resident's room to get another lancet.</p> <p>Interview with LPN #1 at that time, indicated he had thought the procedure for the glucometer cleaning was to wipe down the machine with the Sani cloth wipe and let dry for a minute. He was unaware the Sani-cloth had to be wrapped around the glucometer for two minutes.</p> <p>Review of the current and undated hand hygiene policy indicated Handwashing may also be used for routinely decontaminating hands in</p>			

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	<p>the following clinical situations: Glove and Hand Hygiene: Remove gloves promptly after use, before touching non contaminated items and environmental surfaces, and before caring for another patient.</p> <p>Review of the current and undated Sharps and Needles policy which was provided by the Director of Nursing (DoN) on 9/6/13 at 10:15 a.m., indicated to contain all sharps and needles immediately after use in a leak proof container that was appropriately labeled.</p> <p>Interview with the DoN on 9/6/13 at 8:45 a.m., indicated the nurse should have removed her gloves before leaving the room, after she had completed the glucometer.</p> <p>On 9/10/13 at 11:35 a.m., interview with ADoN indicated urinary incontinence had not been identified as a problem in any Quality Assurance Meetings. She further indicated there had been no action plan or system put into place to identify the problem of Urinary Incontinence and Assessments.</p> <p>Interview with LPN #4 on 9/9/13 at 10:00 a.m., she indicated the Unit Manager was responsible for</p>						

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	<p>updating the bladder assessments and they should be done every three months.</p> <p>Interview with the MDS Coordinator on 9/9/13 at 10:35 a.m., indicated the resident did trigger for a care plan to be done on the admission assessment. She further indicated a care plan was not completed for the admission assessment or for the quarterly assessment. The MDS Coordinator indicated if there was a decline in urinary status a new bladder assessment was to be completed as well as a three day voiding pattern.</p> <p>3.1-52(b)(2)</p>			