

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 12/05/2013
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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 the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 9/10/13.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00135685 completed on 9/10/13.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00138441, IN00138616, and IN00139026.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00137664 completed on 10/17/13.</p> <p>Survey dates: December 3, 4 and 5, 2013</p> <p>Facility number: 000176 Provider number: 155277 Aim number: 100288940</p> <p>Survey team: Yolanda Love, RN, TC Cynthia Stramel, RN Lara Richards, RN</p> <p>Census bed type:</p>	F000000		
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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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F000282 SS=D	<p>SNF/NF: 102 Total: 102</p> <p>Census Payor type: Medicare: 15 Medicaid: 70 Other: 17 Total: 102</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 11, 2013, by Janelyn Kulik, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure the plan of care was followed related to activities for a dependant resident, for 1 of 1 residents reviewed for activities. (Resident #B)</p>	F000282	Resident #B had her activity care plan clarified to reflect needs. As an added point of initiative, all resident care plans pertaining to activities and recreation were clarified and daily notes and trackers updated to reflect current level of functioning, as well as needs and preferences. The activity director has received	12/20/2013			

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	<p>Findings include:</p> <p>The record for Resident #B was reviewed on 12/3/13 at 2:05 p.m. The Minimum Data Set (MDS) quarterly assessment dated 8/17/13 indicated the resident had a diagnosis of traumatic brain injury. The resident was functionally dependant for bed mobility, transfers and activities of daily living (ADL's). A cognitive assessment was not able to be done because the resident was rarely/never understood.</p> <p>An activity care plan dated 3/19/13 indicated the problem, "Resident spends a lot of time in bed. Mother marks off calendar of programs she would like her up for and list is hung by her bed each month..." Approaches included, "Place list of programs family wants her up for each day at the head of her bed. Include her in musical programs, movies, special events..."</p> <p>Interview with a family member of Resident #B on 12/5/13 at 1:00 p.m., indicated she did not think the staff was getting the resident up for activities very often. She further indicated they were not providing a calendar or hanging up lists of</p>		<p>education on care planning and activity execution. Care plans will be reviewed, as needed and with change in condition, as well as along with the care plan schedule. All updated care plans will be submitted to the quality assurance committee for review and processing. Ongoing monitoring will be conducted for 90 days to ensure compliance. The activity director was responsible for this completion.</p>		

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	<p>activities to attend, "...for months."</p> <p>There was not a list of activities or programs at the head of her bed or in her room during observations on 12/3/13 at 12:45 p.m., 12/4/13 at 8:45 a.m., or 12/5/13 at 9:40 a.m.</p> <p>The Individual Resident Daily Activities logs for November and December 2013 were reviewed. The log indicated the resident was taken to church on 11/3 and 11/17 and was taken to live entertainment on 11/6 and 11/19.</p> <p>Interview with Activity Director on 12/5/13 at 10:00 a.m., indicated she was not aware of a calendar or list of activities the family wanted the resident to attend. She checked the resident's room at that time and confirmed there was not a list of activities posted in her room. She indicated the above listed events were the only activities the resident was taken to in November.</p> <p>Interview with Activity Aide #1 on 12/5/13 at 11:00 a. m., she explained the activities she provided for the resident in her room. She was unable to say how often the resident was taken to activities outside her room; she indicated the</p>			

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F000323 SS=D	<p>resident had been up on her birthday in the common area on November 12.</p> <p>This deficiency was cited on September 10, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p> <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 record review and interview, the facility failed to ensure each resident was free from accidents related to the improper use of a Hoyer lift (transferring assistive device) resulting in a fall with injury for 1 of 3 residents reviewed for falls. (Resident #D)</p> <p>Findings include:</p> <p>The record for Resident #D was reviewed on 12/3/13 at 2:29 a.m. Diagnoses included, but were not limited to, intracranial hemorrhage,</p>			F000323	<p>Resident #D had been clinically checked at the time of the incident and receives ongoing care. No chronic injury noted. Clinical personnel have been trained on the facility policy on Hoyer Lift transfers and the director of personnel has now added the didactic portion of this training to a monthly calendar for the next 90 days. All new personnel will received didactic training, as well as hands on skills checks upon hire. To ensure compliance there will be three transfers monitored per week for two weeks. All audits will be submitted to the quality</p>		12/20/2013

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	<p>aphasia, chronic pain, and osteoporosis.</p> <p>A Nursing Progress Note dated 11/19/13 at 5:10 a.m., indicated the resident was found in her wheelchair tipped all the way back, the Hoyer was also tipped over sideways so that the top bar of the Hoyer was directly beneath the resident's head. The resident indicated she did not have any pain, however, she did hit her head and pointed out a small bruise measuring 2.8 x 1.8 cm (centimeters), purplish-blue in color. Further review of the progress note indicated the CNA stated she used the Hoyer to lower the resident in the chair and the chair tipped backward.</p> <p>Interview with CNA #1 on 12/4/13 at 8:59 a.m., indicated Hoyer use was individualized and was based on how much weight a resident was able to bear. She also indicated Resident # D was a two person transfer assist.</p> <p>An Incident Report dated 11/19/13 indicated nursing staff was called into the resident's room. The resident was in her wheelchair with her wheelchair tipped all the way backward. The Hoyer was also</p>		<p>assurance committee for review and processing. The director of nursing and/or designee shall be responsible for compliance. Monitoring will be ongoing two times per week (by audit) for the next six months or until compliance of 100% is achieved.</p>	

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	<p>tipped over sideways so that the top bar of the Hoyer was directly beneath the resident's head. The resident indicated she did not have any pain, however, she did hit her head and pointed out a small bruise measuring 2.8 x 1.8 cm (centimeters), purplish-blue in color. Further review of the Incident Report indicated, "Staff re-educated about the proper use of Hoyer lifts, ALWAYS using two personnel."</p> <p>Interview with the Pines Unit Manager on 12/4/13 at 9:49 a.m., indicated all nursing staff were trained on the proper use of the Hoyer during new hire orientation. She also indicated there should always be two staff operating the Hoyer.</p> <p>Interview with CNA #2 on 12/4/13 at 2:25 p.m., indicated she was trained during new hire orientation on the proper use of the Hoyer. She also indicated there should be a spotter (assistant) present.</p> <p>Interview with the Director of Personnel on 12/4/13 at 2:50 p.m., indicated upon hire CNA's sign off on the Job Description form that they will use and operate Hoyer lifts. She also provided the New Hire</p>			

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	<p>Check List which indicated they would be trained on two person lifts, in which she demonstrates the proper use to them. She also stated there should always be two personnel operating a Hoyer.</p> <p>A policy for Transferring A Resident Using the Hoyer Lift was reviewed on 12/4/13 at 10:26 a.m. The policy indicated, "All residents will be transferred safely with no injury to the resident or staff member. Residents who are totally dependent for lifting or to heavy to be lifted will be transferred using the Hoyer Lift with two staff assist to perform the transfer."</p> <p>This deficiency was cited on September 10, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(2)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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>	F000441	While the facility disputes the validity of this allegation, Resident	12/20/2013

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	<p>Based on observation, record review and interview, the facility failed to ensure infection control measures were followed related to a suction canister not being changed or dated for 1 out of 3 residents reviewed who required suctioning. (Resident #C)</p> <p>Findings include:</p> <p>The record for Resident #C was reviewed on 12/4/13 at 9:30 a.m. A Minimum Data Set quarterly assessment dated 11/1/13 indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating no cognitive</p>		<p>#C had his canister changed immediately as the date was not noted. The new canister was dated immediately. All other residents with suction machines had the potential to be affected by this deficient practice and therefore all canisters were checked for compliance. The director of nursing and/or designee will conduct an audit three times per week for two weeks to ensure compliance. All audits will be submitted to the quality assurance committee for review and processing. Monitoring for compliance (through audit) will be conducted two times per week for the next six months or until 100% compliance is achieved.</p>		

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	<p>impairment. The resident's diagnoses included, but were not limited to, quadriplegia.</p> <p>An observation of the resident in his bed was made on 12/5/13 at 3:00 p.m. The suctioning unit on the bedside table was approximately half full with liquid, there was no date on the canister to indicate when it had been changed. The resident did not know when the canister had been changed.</p> <p>The December 2013 Medication Administration Record (MAR) was reviewed on 12/5/13 at 2:30 p.m. The MAR indicated the aerosol tubing should be changed on Sunday midnight shift. It was documented as being changed on 12/1/13. There was no order for changing the canister on the suction unit in the MAR.</p> <p>Interview with LPN #1 at that time, indicated the canisters were changed on Sundays with the aerosol tubing. Interview with the Unit Manager at that time indicated she did not know when canisters were to be changed. LPN #1 indicated there should be an order for the when the canister is to be changed on the MAR.</p>						

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	<p>A policy for Nasopharyngeal Suctioning was reviewed with the ADON and identified as current on 12/5/13 at 3:15 p.m. The policy indicated, "5. All medivac suction canister inner linings and tubing shall be changed every 24 hours." Interview with the ADON at that time indicated the canister should be changed and dated every 24 hours. This deficiency was cited on September 10, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(a)</p>			