

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  05/27/2014
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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 Investigation of Complaints IN00148588 and IN00149735.</p> <p>This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint IN00148588- Substantiated. No deficiencies related to the allegations are cited</p> <p>Complaint IN00149735- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F329.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: May 22, 23, and 27, 2014</p> <p>Facility number: 000176 Provider number: 155277 AIM number: 100288940</p> <p>Survey team: Regina Sanders RN, TC Caityln Doyle, RN Heather Hite, RN Jennifer Redlin, RN (May 22 and 27, 2014) Julie Fegusson, RN (May 23 and 27, 2014)</p>	F000000	<p><b>This Plan ofCorrection constitutes the written allegation of compliance for thedeficiencies cited. However, submissionof this Plan of Correction is not an admission that a deficiency exists or thatone was cited correctly. This Plan ofCorrection is submitted to meet the requirements established by State andFederal law. Whispering Pines requeststhat this Plan of Correction is considered the facility's Allegation ofCompliance is effective June 26, 2014.</b></p>	

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

TITLE

(X6) DATE

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

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	<p>Yolanda Love, RN (May 27, 2014) Janet Adams, RN (May 22, 2014)</p> <p>Census bed type: SNF: 19 NF: 52 SNF/NF: 23 NCC: 5 Total: 99</p> <p>Census payor type: Medicare: 19 Medicaid: 52 Other: 28 Total: 99</p> <p>Sample: 9 Supplemental sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 30, 2014, 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>			

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	<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 physicians' timely, related to a PT/INR (laboratory test for blood clotting) and a change in condition where the resident requested the Physician be notified, for 2 of 7 residents reviewed for medications in a total sample of 9 (Residents #D and #K).</p> <p>Findings include:</p> <p>1. The record for Resident #D was reviewed on 5/22/14 at 9:25 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation (irregular heart rhythm), pacemaker, hypertension, coronary artery disease, and congestive heart failure.</p> <p>A Physician's Order, dated 04/08/14, indicated an order for a PT/INR on 04/21/14.</p> <p>The PT/INR results, dated 04/21/14 indicated the resident's PT was 39.7 (normal 9.1-12.5) and INR was 3.6 (normal 2-3.5). The lab results indicated the facility was made aware of the results on 04/21/14 at 11:28 a.m.</p> <p>The notation on the PT/INR results</p>	F000157	<p><b>F157 Notification of Changes (Injury/Decline/Room, etc.) RESIDENTS FOUND TO BE AFFECTED:</b></p> <p>The staff of the facility makes every effort to ensure that the facility immediately informs the resident, family member, the attending physician and/or legal representative when a change of condition, medication availability and/or lab results.</p> <p>Resident #D lab results will be faxed to her cardiologist along with her attending physician.</p> <p>Resident #K received 10 days of ABT and has been sent to the hospital for low hemoglobin on 6-2-14.</p> <p>Resident #B returned from the hospital with no Coumadin orders.</p> <p>Resident #C has been measured for new Ted Hose and when delivered the order will be added to the TAR.</p> <p><b>OTHER RESIDENTS POTENTIALLY AFFECTED:</b></p> <p>All residents have the potential to be affected due to the facility not notifying the physician of change of condition, medication availability and/or lab results reported timely.</p> <p><b>SYSTEMIC MEASURES/CORRECTIVE ACTION:</b></p> <p>The staff has been re-instructed on notification of physician, family, resident and/or responsible party on change of condition, new</p>	06/26/2014

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	<p>indicated the Physician was not notified of the results until 04/22/14 at 10:39 a.m. (23 hours later)</p> <p>During an interview with Pines Unit Manager on 5/22/14 at 10:00 a.m., she indicated the labs which were drawn in the early morning usually have the results come back fairly quickly that day and the Nursing staff were to notify the Physician when the results were available. The Nurse should have notified the Physician on 04/21/14 and not waited until 04/22/14 to notify the Physician of the PT/INR results.</p> <p>During an interview on 05/23/14 at 3:10 p.m., the Pines Unit Manager indicated the resident's Primary Care Physician was the Physician notified of the PT/INR results, not the Physician who had been ordering the Coumadin.</p> <p>2. During an interview on 05/23/14 at 9 a.m., Resident #K indicated he had been in the hospital recently for pneumonia and on 05/21/14 he started to have a productive cough. He indicated he had reported his concern to the Pines Unit Manager on 05/21/14 around 10 a.m. and asked her to call his Physician. He indicated at 3 p.m. he asked the Pines Unit Manager what the Physician had said and was told by the Pines Unit</p>		<p><b>orders, weights, lab reports, treatment changes, room moves, discharge and or/transfers with appropriate paperwork.</b></p> <p><b>This citation has occurred several times and we will have discussions with staff regarding the importance of notification.</b></p> <p><b>QUALITY ASSURANCE/MONITORING:</b></p> <p><b>The Director of Nursing or designee will audit all resident record documentation for change of condition, treatment changes, lab orders, transfer/or discharges, room moves and/or roommate change three times per week or four weeks, then two times per week for four weeks and once weekly thereafter. The results of the audits will be forwarded to the QA Committee for review. This will be an on-going audit.</b></p> <p><b>DATE OF COMPLIANCE: June 26, 2014</b></p>	

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	<p>Manager she had not notified the Physician yet because she had been busy.</p> <p>Resident #K's record was reviewed on 05/27/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, history of pneumonia and chronic obstructive lung disease.</p> <p>The Annual Minimum Data Set Assessment, dated 02/20/14, indicated the resident's cognition was intact.</p> <p>A faxed information form to the Physician, dated 05/21/14 at 4 p.m. (six hours after the resident had requested the Physician be notified), indicated the Resident's Physician had been notified of the productive cough.</p> <p>A Physician's Order, dated 05/21/14 at 6:10 p.m., indicated an order for a chest x-ray.</p> <p>A Physician's Order, dated 05/21/14 at 7 p.m., indicated an order for Levaquin 500 milligrams (mg) daily for 10 days.</p> <p>During an interview on 05/27/14 at 11 a.m., the Pines Unit Manager indicated Resident #K had spoken to her on the morning of 05/21/14.</p> <p>During an interview on 05/27/14 at 11:15</p>			

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	<p>a.m., the Pines Unit Manager indicated the Resident's Physician had not been notified until 4 p.m. She indicated she had passed the information on to the Day Shift Nurse and was not sure why the Physician had not been notified.</p> <p>An undated policy, titled, "Policy and procedure for Laboratory Services", received from the Interim DoN on 05/22/14 at 2:05 p.m., indicated, "...Each Unit Manager or designee will be responsible to ensure that all labs are completed timely and the physician is notified of lab result in a timely manner."</p> <p>A facility policy, dated 03/10, and received from the Administrative Consultant as current, titled, "Physician Notification For Change In Condition Policy", indicated, "...The resident's primary physician or designated alternate will be notified immediately of any change in the resident's physical or mental condition..."</p> <p>This Federal Tag relates to Complaint IN00149735.</p> <p>3.1-5(a)(2)</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 follow Physician's orders, related to an antibiotic and support hose (TEDS), for 2 of 7 residents reviewed for medications in a total sample of 9 (Resident #C and #K).</p> <p>Findings include:</p> <p>1. During an interview on 05/23/14 at 9</p>	F000282	<p><b>F 282 ServicesBy Qualified Persons/Per Care Plan:</b></p> <p><b>RESIDENTS FOUND TO BE AFFECTED:</b></p> <p><b>The staff of the facility makes every effort to follow physician orders related to antibiotic therapy and support hose (TED).</b></p> <p><b>Resident #C has been measured for new Ted Hose and when delivered, the order will be placed on the TAR.</b></p> <p><b>Resident #K has received 10 days for</b></p>	06/26/2014

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	<p>a.m., Resident #K indicated he had been in the hospital recently for pneumonia and on 05/21/14 he started to have a productive cough. He indicated he had reported his concern to the Pines Unit Manager on 05/21/14 around 10 a.m. and asked her to call his Physician. He indicated his Physician had ordered an antibiotic on 05/21/14 but he had not received the antibiotic (Levaquin) until 05/22/14 at 10:45 a.m. because the medication had not been ordered timely with the pharmacy.</p> <p>Resident #K's record was reviewed on 05/27/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, history of pneumonia and chronic obstructive lung disease.</p> <p>The Annual Minimum Data Set Assessment, dated 02/20/14, indicated the resident's cognition was intact.</p> <p>The Hospital Discharge Summary, dated 05/07/14, indicated the resident's diagnoses included, but were not limited to, acute exacerbation of chronic obstructive pulmonary disease.</p> <p>A chest x-ray, dated 05/02/14, indicated the resident had an increasing small left pleural effusion.</p>		<p><b>ABT and is currently in the hospital for low hemoglobin.</b></p> <p><b>OTHER RESIDENTS POTENTIALLY AFFECTED:</b></p> <p>All residents have the potential to be affected. Thenursing staff have been in-serviced on the use of the EDK (pixes) and theability to order meds during and in the late afternoon/evening/weekendsdaily. The care plan and CNA care cardfor Resident #C has been updated. Whenthe TED hose comes in, the order will be added to the TAR sheet.</p> <p><b>SYSTEMIC MEASURES/CORRECTIVE ACTION:</b></p> <p>The nursing staff hasbeen in-serviced on following physician's orders. The Pharmacy will be in-servicing the nurseson June 12, 2014 on how to use the EDK (Pixes), ordering medication late in theafternoon and on weekends, re-filling of the Pixies so residents can have theirnewly ordered medication timely. Careplans will be updated as needed</p> <p><b>QUALITY ASSURANCE/MONITORING:</b></p> <p>The Director of Nursing or designee will auditall new antibiotic orders for timeliness of the medication administration(receipt of new order). We will reviewof all orders at the morning nursing meeting. The audit will be conducted daily for two months, then twice weekly fortwo months, then weekly for six months. The</p>	

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	<p>A faxed information form to the Physician, dated 05/21/14 at 4 p.m., indicated the Resident's Physician had been notified of the productive cough.</p> <p>A Physician's Order, dated 05/21/14 at 7 p.m., indicated an order for Levaquin 500 milligrams (mg) daily for 10 days.</p> <p>The Medication Administration Record (MAR), dated 05/14, indicated the first dose of Levaquin was administered at 7 a.m. on 05/22/14.</p> <p>A Nurses' Progress Note, dated 05/21/14 at 11:47 p.m., indicated, "...Levaquin...Resident will begin dose at 7 a.m. 05/22/14. Medication was not received with tonight's pharmacy order and it was passed on in report that it will need to be pulled from the EDK (Emergency Drug Kit) in the morning..."</p> <p>During an interview with the Pharmacist on 05/27/14 at 9:50 a.m., he indicated if the medication was not available in the EDK, they should call the Pharmacy and it would have been immediately delivered. He indicated Levaquin is available in the Pixes (machine which emergency medications are retrieved from) and if not in the Pixes, it would be available in the EDK refill box.</p>		<p><b>results will be forwarded to the QA Committee and this will be anon-going audit.</b></p> <p><b>DATE OF COMPLETION: June 26, 2014</b></p>				

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F000329 SS=J	<p>During an interview on 05/27/14 at 10:10 a.m., the Interim Director of Nursing indicated there was Levaquin in the Pixes refill box. She indicated the Nurse also could have called the Pharmacy to have the medication delivered.</p> <p>During an interview on 05/27/14 at 11 a.m., the Pines Unit Manager indicated she did not know why the Nurse did not get the medication from the EDK or why the Pharmacy was not notified.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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>			

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	<p>Based on record review and interview, the facility failed to monitor a PT (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) for a resident who was receiving Coumadin and Lovenox (blood thinners), which resulted in the resident having a critically high PT and INR. The resident was admitted into the hospital with a diagnosis of suprathereapeutic INR secondary to Coumadin overdose. This affected 2 of 3 residents who received Coumadin in a sample of 9. (Residents # B and #D).</p> <p>The immediate jeopardy began on 05/12/14 when the facility failed to monitor a PT/INR on a resident receiving Coumadin and Lovenox as ordered by Resident #B's Physician and was identified on 05/22/14. The Administrator, Administrative Consultant, and the Interim Director of Nursing were notified of the immediate jeopardy at 1:18 p.m. on 05/22/14. The immediate jeopardy was removed on 05/23/14, but noncompliance remained at the lower scope and severity level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p>	F000329	<p><b>F 329 Drug Regimen is Free From Unnecessary Drugs</b></p> <p><b>RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b></p> <p>The facility make every effort to follow physician orders and keep the residents free from unnecessary drugs.</p> <p>Resident #B has returned from the hospital and no longer receives Coumadin.</p> <p>Resident #D - will have all lab results faxed to cardiologist along with her attending physician.</p> <p><b>OTHER RESIDENTS POTENTIALLY AFFECTED:</b></p> <p>All residents have the potential to be affected. A wholehouse anti-coagulate audit was completed. The nursing staff have been in-serviced on following physician orders and new policies, procedures and lab policy on 5-22-14 along with a new Coumadin/anti-coagulate dosing protocol and the accompanying flow sheet. The nurses have been re-educated along with any agency nurses working in the facility. Another in-service will include correctly writing physician orders, transcribing them correctly to the MAR, monthly re-writes, review of the lab procedure for draws and physician notification and the new PT/INR policy. Our training will require return demonstration of order writing, transcription and</p>	06/26/2014

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	<p>1. Resident #B's record was reviewed on 05/22/14 at 8:45 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and history of lower extremity deep vein thrombosis (blood clots).</p> <p>A Physician's Order, dated 05/09/14, indicated an order for Coumadin (blood thinner) 10 mg (milligrams), one daily, and to repeat a PT/INR on Monday 05/12/14 and to discontinue the Lovenox (blood thinner) when the PT/INR is greater than 2 (normal 2.0-3.5).</p> <p>The Medication Administration Record (MAR), dated 05/14, indicated the resident was to have a PT/INR on 05/12/14 and to discontinue the Lovenox if the PT/INR was greater than 2.</p> <p>The MAR lacked documentation to indicate the PT/INR had been completed on 05/12/14 as ordered. The MAR indicated the resident continued to receive Coumadin 10 mg daily and Lovenox 50 mg daily as ordered from 05/12/14 through 05/20/14.</p> <p>A Nurses' Note, dated 05/20/14 at 5:32 p.m., indicated the resident had a scant amount of blood tinted stool and the Physician was notified and ordered an</p>		<p><b>notification.</b></p> <p><b>SYSTEMIC MEASURES/CORRECTIVE ACTION:</b> The nurses have been in-serviced on following physician orders and new policies, procedures, Coumadin flow sheets, Coumadin/anti coagulate dosing protocol and new lab policy. An audit tool will be completed by the unit manager weekly for those residents on anti-coagulation therapy. All agency nurses have been trained on the new procedures and any future agency nurses will be trained prior to beginning work.</p> <p><b>QUALITY ASSURANCE/MONITORING:</b> The Director of Nursing or designee is audit conducting PT/INR audits daily for four weeks and then three times weekly for four weeks, twice weekly for three months and weekly for three months. Results will be brought to the QA Committee. This will be an on-going audit.</p> <p><b>DATE OF COMPLETION:</b> June 26, 2014</p>	

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  05/27/2014
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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>immediate PT/INR. The note indicated the facility completed the PT/INR at the facility and the result was "HI".</p> <p>The meter instruction book, received from the Timbre Unit Manager on 05/22/14 at 11 a.m., indicated a "HI" indicated the test result was above the control range. The booklet indicated the "HI" range for the INR was over 3.1.</p> <p>A Nurses' Note, dated 05/20/14 at 10 p.m., indicated the resident had been transferred to the hospital Emergency Room for an evaluation and was admitted into the hospital.</p> <p>The Hospital History and Physical, dated 05/20/14, indicated the resident was admitted into the hospital due to supratherapeutic INR secondary to Coumadin overdose. The laboratory testing indicated the resident's bowel movement was positive for blood, PT was 29.7 (normal 9.1-12.5) and the INR was &gt; (more than) 8.4.</p> <p>During an interview on 05/22/14 at 8:35 a.m. the Pines Unit Manager indicated the PT/INR on 05/12/14 had not been completed. She indicated the facility realized the PT/INR was not completed on 05/20/14 when the resident had blood tinged bowel movement.</p>			

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	<p>During an interview on 05/22/14 at 9:25 a.m., the Pines Unit Manager indicated she was not sure why the PT/INR was not completed. She indicated she had not spoke with the Nurse who had received the order from the Physician. She indicated she called the Lab and they indicated they did not have the order for the PT/INR.</p> <p>During an interview on 05/22/14 at 10:20 a.m., the Interim Director of Nursing (DoN) indicated the Nurses' should have followed up on the PT/INR. She indicated once the Physician orders a lab, the Nurse was to write the order and send a requisition to the Laboratory company. She indicated the facility only used the meter they have in the facility for emergency testing. She indicated the facility had no system in place to ensure labs were completed as ordered, prior to 05/20/14.</p> <p>During an interview on 05/22/14 at 2:45 p.m., the Interim DoN indicated she had found the requisition to the lab for the PT/INR to be drawn on 05/12/14.</p> <p>Review of the requisition, indicated the lab was notified on 05/12/14 at 12:32 a.m. for the PT/INR to be drawn on 05/12/14.</p>			

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	Interview with the Timbre Unit Manager, on 05/22/14 at 3 p.m., indicated the lab will not hold orders and the lab order has to be faxed to them on midnight shift on the day of the lab draw.				