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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 00 B. WING	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES HEALTH CARE CENTER	3301 N CALUMET AVE VALPARAISO, IN 46383

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F0000	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00111937 and IN00112652 completed on 8/2/12. This visit was in conjunction with the Investigation of Complaints IN00115470 and IN00115762. Complaint IN00112652 - corrected. Complaint IN00111937 - not corrected. Survey dates: September 11, 12, 13, 17, and 18, 2012 Facility number: 000176 Provider number: 155277 AIM number: 100288940	F0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Whispering Pines desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on October 8, 2012.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Survey Team: Marcia Mital, RN, TC Sheila Sizemore, RN Census bed type: SNF: 06 SNF/NF: 110 Total: 116 Census Payor type: Medicare: 19 Medicaid: 70 Other: 27 Total: 116 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 9/20/12 by Suzanne Williams, RN			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F0309	F309 It is the policy of this facility to ensure residents are provided the necessary care and services to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. **I. <u>Specific Corrective Actions:</u>** The nurse responsible for the resident's care on the date in question, related to pain, has been counseled/educated regarding standard policy and procedure that should have been followed regarding assessment, treatment, and re-assessment. **II. <u>Identification and correction of others:</u>** All residents have the potential to be affected by assessments not completed per policy and treatment provided for pain. The residents on PRN pain medication were assessed for documentation of assessment and treatment provided as indicated with post assessment after treatment. **III. <u>Systemic Changes:</u>** All nursing staff attended an in-service on August 30 and 31, 2012 which covered	10/08/2012

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	Based on record review and interview, the facility failed to ensure a resident's pain was assessed and treatment provided for pain, which resulted in the resident having unrelieved pain, for 1 of 7 residents reviewed for pain in a total sample of 7. (Resident D) Findings include:		providing care and services to the highest level of well being for each resident and developing comprehensive care plans. All nursing staff will attend another in-service prior to October 8, 2012 to review the same material relating to ensuring residents are provided the necessary care and services to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care; with specific concentration and review of our Pain Assessment and Documentation Policy. **IV. <u>Monitoring:</u>** The unit managers or designee will audit MARs weekly any PRN pain medication given, this will be placed on the PRN Medication Administration Audit. Audits to be submitted to the DNS on Fridays. Audits will be done weekly for three (3) months, then monthly for four (4) months. [Form: PRN Medication Administration Audit]	

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	Resident D's closed record was reviewed on 9/13/12 at 9 a.m. Resident D's diagnoses included, but were not limited to, arthritis, respiratory failure, anemia, and failure to thrive. A significant change MDS (minimum data set) assessment, dated 6/29/12, indicated the resident had severely impaired cognition and had not had any complaints of pain. A Pain assessment, dated 6/22/12, indicated the resident was not having any pain. There was a lack of documentation of any further pain assessments in the residents record. A care plan, dated 8/2/12, indicated "...has potential for pain...Observe for and record any non-verbal signs of pain...Administer medications as ordered...Evaluate effectiveness of pain management interventions. Adjust if ineffective...Receives routine et (and) prn (as needed) pain medications..." The resident's physician's order recapitulation, dated 8/12, indicated the resident received Tylenol 650 milligrams four times a day, at 6 a.m., 12 p.m., 6 p.m., and 12 a.m. The resident also had an order for Tylenol 650 milligrams four times a day as needed for pain.			

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	The nurses' notes indicated: 8/16/12 at 6:45 p.m. "resident's son was in to visit this evening. he asked CNA questions about his father. after speaking c (with) the CNA resident's son approached writer questioning pain meds (medications). Writer informed son he is given Tylenol Q6o (every six hours). resident only s/s (signs and symptoms) of pain when we turn & move him. I told him we notify (physician name) in the am as (another physician name) is on call this evening . He does not want a narcotic given at this time." There was a lack of documentation of an assessment of the resident's pain. 8/16/12 at 7:15 p.m., "resident daughter-in-law called this writer demanding that I call DoN & tell her we are not handling (Resident's name) pain effectively." There was a lack of documentation to indicate the nurse had assessed the resident's pain. 8/16/12 at 7:20 p.m., "writer called on call MD- (name) & told him that resident's daughter in law called demanding we give him something stronger than Tylenol. I explained to the MD on call our pharm's (pharmacy) procedure for narcotics that he would have to call pharm himself for			

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	narcotics. MD response was 'I don't call pharmacys (sic). They will have to call (resident's physician's name) in the a.m.'..." 8/16/12 at 9:45 p.m., "resident's daughter-in-law @ (at) facility requesting writer call MD & get an order for Tylenol 500 (milligrams) ii (two) tabs to equal 1000 q 4o until (resident's physician name) is available in a.m. so writer called on call MD he said okay to give Tylenol 1000 mg (milligrams)..." This was three hours after the son had first notified the nurse the resident was having pain. The resident's MAR (medication administration record), dated 8/12, indicated the resident had received the routine Tylenol at 6 p.m., but had not received any as needed Tylenol. 8/17/12 at 8 a.m., "MD updated this am, N.O. (new order) Received...Norco (narcotic pain medication) 5/325 mg...q 4o/pain..." There was a lack of documentation to indicate the resident's pain had been assessed after receiving the Tylenol 1000 milligrams. During an interview on 9/13/12 at 1:05 p.m., the DoN indicated the resident should not have been in pain when being turned. She indicated it was not okay to			

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	have to wait until the morning to get an order for pain medication. She indicated she would have administered the as needed Tylenol to the resident. The nurse had not called her but had left her a message on her work voice mail. She indicated the nurse had not followed the facility policy. The Medical Director should have been called for pain medication, She indicated the nurses should have completed pain assessment on the resident. She indicated Norco was ordered to be given routinely the next day for the resident's pain. During an interview on 9/13/12 at 3:05 p.m., LPN #2, who took care of the resident on 8/16/12, indicated the resident showed pain when being turned and repositioned. She indicated the resident had facial grimacing. She indicated on a non-verbal pain assessment, his pain level was between a 5 and a 6 on a scale of 1 to 10. She indicated she had gotten the order for the Tylenol 500 milligrams and had given the medication at 10 p.m. She indicated she did not know if the pain medication was effective because she was not there when the resident was turned and repositioned. A facility policy, dated 7/10, titled "Pain Assessment and Documentation Policy", received form the Administrator as			

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	current on 8/17/12 at 8:45 a.m., indicated "...Residents with newly developed pain will be assessed by the licensed nurse utilizing the appropriate pain scale and the MD shall be notified...The pain scale shall be used when PRN (as needed) pain medications are administered and the effect of the pain medication shall be documented on the MAR and or the nurses notes...Pain scales are to be used to determine that the medication given is appropriate for the level of pain the resident is having...1-5 Mild 6-10 Moderate to Severe..." This deficiency was cited on 8/2/12. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint IN00111937. 3.1-37(a)			