

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155234	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/27/2013
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NAME OF PROVIDER OR SUPPLIER  WESTRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802
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F000000	<p>This visit was for the Investigation of Complaint IN00124882.</p> <p>Complaint IN00124882 Substantiated, federal/state deficiencies related to the allegations are cited at F225, F314, and F323.</p> <p>Unrelated deficiency cited at F441.</p> <p>Survey dates: February 25, 26, &amp; 27, 2013</p> <p>Facility number: 000139 Provider number: 155234 AIM number: 100266410</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 50 Total: 50</p> <p>Census payor type: Medicare: 7 Medicaid: 37 Other: 6 Total: 50</p> <p>Sample: 6 Expanded sample: 2</p> <p>These deficiencies also reflect state</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending February 27, 2013.</p> <p>Respectfully, Tracy Dewey Administrator</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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	findings in accordance with 410 IAC 16.2.  Quality Review completed on 03/04/2013 by Brenda Nunan, RN.				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a pressure ulcer did not develop and failed to implement timely interventions to promote healing of the pressure ulcer for 1 of 3 sampled residents reviewed for pressure ulcers [Resident C].</p> <p>Findings include:</p> <p>Resident C was observed, on 02/27/13 at 8:57 a.m., during treatment to her right outer ankle pressure area. The pressure area was observed to be black in color and measured by the Assistant Director of Nursing [ADON] to be 1 centimeter [cm] by 0.8 cm and depth 0.1 cm.</p> <p>Resident C's clinical record was reviewed, on 02/25/13 at 11:30 a.m., and indicated the resident had</p>	F000314	<p>1. Resident C was affected. The resident's diagnosis list includes Peripheral Arterial Disease and Peripheral Neuropathy thus is at risk for open areas. The facility did assess and document the residents risk for pressure ulcers prior to the area developing via the Braden Scale. There were preventative measures in place as to prevent pressure areas before the area occurred as well, which included; pressure relieving devices to her chairs, preventative cream, and a daily multivitamin.2. All residents with pressure areas or are at risk for pressure areas have the potential to be affected. All residents will have a head to toe skin assessment completed. All residents with problem skin areas will be reviewed to ensure appropriate interventions are in place and documented. Nurses were in-serviced on skin management including pressure ulcer treatment and prevention.</p>	03/08/2013			

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	<p>diagnoses which included, but were not limited to, blindness, retinal detachment, glaucoma, anemia, osteoporosis, coronary artery disease, peripheral neuropathy, ataxia, degenerative joint disease, congestive heart failure, dysphagia, atrial fibrillation, difficulty walking, pulmonary artery disease, and aortic and mitrial valve regurgitation.</p> <p>The Admission Nursing Assessment, dated 01/12/13, indicated no open areas.</p> <p>Resident C's Braden Scale For Predicting Pressure Sore Risk, dated 01/15/13, indicated a score of "18" which meant the resident was at risk for pressure sores.</p> <p>Resident C's admission Minimum Data Set [MDS] assessment, dated 01/22/13, indicated the resident was not at risk for pressure ulcers. The most recent quarterly MDS assessment dated 02/18/13, indicated the resident was at risk for pressure ulcers and had a pressure ulcer which measured 0.8 centimeters [cm] x [times] 0.6 cm x 0.1 cm.</p> <p>A Medicare Charting Sheet, dated 01/26/13, indicated, "...Area found on res [resident] right outer ankle. Red</p>		<p>All CNA's will be in-serviced on interventions to prevent and treat pressure ulcers. 3. As a measure to ensure ongoing compliance each resident will have a Braden Scale completed upon admission, then weekly for 4 weeks, then at least quarterly to assess pressure ulcer risk. Additionally, a head to toe skin assessment will be completed on all residents weekly and as needed. If any new areas are noted the resident's responsible party and physician will be notified and a treatment order will be requested. The noted problem skin areas are measured on a weekly basis. The status of all pressure ulcers will be reviewed weekly in SWAT meeting and if no improvement is noted after 2 weeks or the area is worse, a change in the treatment regimen will be requested. The Treatment Administration Records will be reviewed five days a week for 30 days, then weekly for 30 days, then monthly ongoing to ensure treatments are initiated timely and completed as ordered. All residents with orders for dressings will be observed to ensure dressings are changed as ordered five times a week for 30 days, then weekly for 30 days, then monthly ongoing. All residents with pressure areas will be observed to ensure proper positioning to include all shifts five times weekly for 30 days, then weekly for 30 days, then monthly ongoing, (see attachment H). 4.</p>				

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	<p>blackened, unstageable d/t [due to] black area...."</p> <p>Review of Resident C's "PRESSURE ULCER FLOWSHEETS", dated 01/26/13, indicated the resident had an unstageable right outer ankle ulcer with a wound bed which was black/brown [eschar] in color with red colored surrounding edges. On 01/26/13, the wound measured 0.8 cm x 0.6 cm x 0.1 cm. Measurements stayed the same on 01/31/13, 02/07/13, and 02/15/13. The wound enlarged in size on 02/22/13 and measured 1 cm x 1.2 cm x 0.1 cm.</p> <p>Weekly Skin Assessments, dated 01/18/13, 01/26/13, and 02/05/13, completed by nursing staff indicated, "...Head to toe skin assessment completed &amp; no skin alterations noted..."</p> <p>CNA Skin Assessment sheets, dated 01/18/13 and 01/25/13, indicated no areas of concern.</p> <p>Nutritional Progress Notes, dated 02/07/13, indicated a pressure area to ankle. The dietary recommendations were for Vitamin C 250 milligrams [mg] twice a day, superceral at breakfast, and 4 ounce [oz.] shake at</p>		<p>As a quality measure, the DON or designee will review any findings and subsequent corrective action in the quarterly Quality Assurance meeting. Addendum: <i>How will facility ensure dietary recommendations are implemented timely?</i> Dietary recommendations will be provided to the DON or designee by the Registered Dietician. The appropriate physicians will be notified of said recommendations. The DON or designee will review dietary recommendations in the Department Head morning meeting following receipt to ensure the appropriate physicians have been notified of said recommendations. Dietary recommendations will then continue to be reviewed daily in the Department Head meeting until they have been addressed by the physician. Additional physician contact will be made as indicated to ensure dietary recommendations are addressed timely. Additionally, all dietary recommendations will be reviewed in the weekly SWAT (skin weight assessment team) meeting to ensure all dietary recommendations have been addressed by the physician. This will ensure dietary recommendations are addressed and implemented timely. <i>Were staff in-serviced in regard to implementation of dietary recommendations?</i> The in-servicing on interventions to</p>				

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	<p>2 p.m.</p> <p>Review of Physician Telephone Orders, dated 02/15/13, indicated an order for "Add supercereal with breakfast, Vitamin C 250 mg BID [twice a day], 4 oz. mighty shake at 1400 [2 p.m.]." It took 8 days to get the recommendations from the dietary onto orders.</p> <p>Interview with the Dietary Manager, on 02/27/13 at 11:07 a.m., indicated it usually takes a day or 2 to get recommendations from dietary to orders, unless it is an emergency, and the facility can get it done the same day.</p> <p>Interview with the Director of Nursing [DON], on 02/27/13 at 12:45 p.m., indicated if there is a hold up on getting dietary recommendations ordered, it was usually the physician not back respond to the facility's request. If orders are not back in a week, the DON indicated staff would try to reach the physician again in regards to orders. The DON indicated their goal was always to get orders within a week as the resident was reviewed in a weekly meeting. The facility failed to ensure nutritional interventions were implemented timely.</p>		<p>reduce the risk of pressure ulcer development and management included implementing dietary recommendations. The nurses were instructed to notify the physician immediately upon receipt of dietary recommendations. Following physician notification, the DON or designee will review the dietary recommendations in the Department Head meeting following receipt to ensure the appropriate physicians have been notified of recommendations. Dietary recommendations will then continue to be reviewed daily in the Department Head meeting until they have been addressed by the physician. Additional physician contact will be made as indicated to ensure dietary recommendations are addressed by the physician timely. Additionally, all dietary recommendations will be reviewed in the weekly SWAT (skin weight assessment team) meeting to ensure all dietary recommendations have been addressed by the physician.</p>		

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	<p>Resident C had 2 care plans for Pressure Ulcer Risk, one dated 01/15/13 and one dated 01/26/13. The care plans indicated interventions which included, but were not limited to, head to toe skin assessment at least weekly by a licensed nurse, staff to observe skin condition while providing care, notify the charge nurse of any skin problems for further assessment and possible MD [Medical Doctor] and responsible party notification, pressure redirecting cushion to chair, pressure redirecting mattress to bed, encourage and assist resident with turning and repositioning at least every two hours and as needed, apply preventative topical medication as ordered, monitor labs as ordered, encourage food and fluid intake as diet permits, and refer to dietician as indicated. The facility lacked documentation of an evaluation for pressure risk until after the resident developed an unstageable pressure ulcer.</p> <p>This federal finding is related to Complaint IN00124882.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>						

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F000323 SS=G	<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, interview and record review, the facility failed to ensure interventions to prevent a fall with injury for a resident who was noncompliant with fall prevention alarms for 1 of 3 sampled residents reviewed for falls [Resident B].</p> <p>Findings include:</p> <p>Resident B's record review on 02/25/13 at 12:55 p.m., indicated the resident had diagnoses which included, but were not limited to, dementia, cerebrovascular accident, gastro-intestinal bleed, anemia, hypertension, prostate cancer, peptic ulcer disease, muscle weakness, dysphagia, radiation proctitis, and hypothyroidism.</p> <p>Resident B's most recent admission Minimum Data Set [MDS] assessment, dated 12/12/12, indicated Resident B was moderately cognitively impaired, had poor decision making skills, and needed cues/supervision regarding tasks of</p>	F000323	Page 11 of the 2567 states "the facility failed to ensure interventions to prevent a fall with injury for a resident who was noncompliant with fall prevention alarms for 1 of 3 sampled residents reviewed for falls." It is true the x-ray results dated 2/15/13 indicated a sub acute complete displaced sub capital left hip fracture of Resident B; however, one must take into consideration the diligent and consistent interventions implemented by the facility to prevent a fall with injury for a resident who was known to be noncompliant. 1. Resident B exhibited poor safety awareness and had interventions in place to reduce the risk for injury related to falls. Additionally, new interventions were implemented each time a fall occurred to help reduce the risk for injury related to falls. The resident had exhibited noncompliant behavior in all aspects of his care, thus was being monitored ongoing every fifteen minutes. 2. All residents at risk for falls have the potential to be affected. All residents at risk for falls will be reviewed to ensure interventions	03/08/2013			

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	<p>daily life, and wandered at significant risk of getting to a potentially dangerous place daily. The resident needed supervision to limited assistance of one person with mobility. The MDS assessment indicated the resident had no impairment with range of motion and used a wheelchair.</p> <p>Medicare Charting, dated 12/04/12, indicated, "... Res [Resident] noted per therapy being unsafe c [with] ambulation. Res noted being unsteady when stands et [and] has blood levels that are low which will cause dizziness...."</p> <p>Resident B's most recent Fall Risk Assessment, dated 01/26/13 indicated the resident was at risk for falls due to history of falls, confusion, weakness, unsteady gait, non-compliance issues, and history of pacing without regard of need for rest.</p> <p>Resident B's clinical record indicated numerous falls. The following indicates the fall dates: 01/04/13 - unwitnessed fall, ambulating in the hall and fell, wheelchair alarm not on, resident non-compliant and was ambulating without assist; resident very lethargic, had been up all night and half the</p>		<p>are in place as appropriate to reduce the risk for injury related to falls. All nursing staff were in-serviced on the facility's policy on incidents and accidents, interventions to help reduce fall risk, and reporting guidelines.3. As a measure to ensure ongoing compliance the DON or designee will be contacted when a fall occurs to ensure an appropriate intervention, addressing the root cause of the fall, is implemented immediately. The Administrator will be notified immediately if the incident meets reporting guidelines. A post fall investigation will be completed after each fall to identify any trends, potential causes and address appropriate interventions. All incidents will then be reviewed in the morning meeting to ensure all disciplines are aware of the incident and interventions. The assignment sheet and care plan will be updated to include new interventions. Additionally, the Nurse Consultant will review incidents on a weekly basis ongoing to ensure appropriate interventions are implemented addressing the root cause. 4. As a quality measure, the DON or designee will review any findings and subsequent corrective action in the quarterly Quality Assurance meeting.</p>				

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	<p>day before. New intervention -assist to lay down during the day/evening</p> <p>01/09/13 - unwitnessed fall, resident transferred himself, had been incontinent, - placed sensor alarm/floor mat at bedside</p> <p>01/16/13 - unwitnessed fall, resident tripped from moving to one wheelchair to another which was in his room - removed other wheelchair</p> <p>01/17/13 - unwitnessed fall, resident transferred himself out of wheelchair to ambulate, resident had removed alarm, - applied auto lock brakes to wheelchair, 15 minute checks, monitor closely, and x-ray to head.</p> <p>01/21/13 - attempted to sit down in chair at nurse's station, resident missed judged distance, lost balance and sat on bottom - ensure chairs in lobby have arms on them and offer assistance when noticeably tired</p> <p>01/21/13 - unwitnessed fall, ambulating, states he tripped over rug, no rug, - assist resident with attending activities of choice</p> <p>02/07/13 - unwitnessed fall, resident indicated he was going fishing - landing strips beside bed</p> <p>02/14/13 - unwitnessed fall, ambulating in hall - placed on 15 minute checks, checked every 2 hours for incontinence often, and assistance to bathroom</p> <p>02/15/13 - unwitnessed fall, resident</p>				

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	<p>was in bed prior, had removed alarm, resident lost balance attempting to dress self - staff will now assist, stand by assist, resident with dressing.</p> <p>Nurse's Notes, dated 02/15/13 at 7:45 a.m., indicated CNA #1 found resident lying on his left side on the floor in his room. The notes indicated the resident complained of pain in the left groin area. The physician was notified and x-rays were ordered.</p> <p>The x-ray results, dated 02/15/13, indicated a subacute complete displaced subcapital left hip fracture and the resident was sent to the hospital that evening.</p> <p>Post Fall Investigation, dated 02/15/13, indicated the resident was trying to dress self for breakfast, lost balance and fell. The report indicated the resident had removed the bed alarm.</p> <p>Interview with LPN #2, on 02/27/13 at 11:08 a.m., indicated she mostly witnessed Resident B during meals in the dining room. LPN #2 indicated the resident was very difficult to keep in a chair, propelled his wheelchair throughout the dining room and wouldn't remain in the dining room for long.</p>			

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	<p>Interview with CNA #1, on 02/27/13 at 11:15 a.m., indicated she saw the resident sitting in his wheelchair inside the doorway of his room when she picked up breakfast trays and when she returned she found him on the floor. CNA #1 indicated the fall was unwitnessed and the resident did not complain of pain right away and kept saying, "Get me up off the floor." CNA #1 indicated the resident was assessed by the nurse and he was put back into his wheelchair and it was later he complained of pain in his left groin area.</p> <p>Interview with LPN #3, on 02/27/13 at 11:58 a.m., indicated Resident B wandered a lot, was confused, combative, and at other times, was calm and able to sit with other residents at the nurse's station and carry on a conversation.</p> <p>Interview with the Director of Nursing [DoN] and the Administrator on 02/27/2013 at 12:45 p.m. indicated Resident B was non-compliant with alarms and removed/disconnected his alarms and folded them at the end of his bed.</p> <p>Review of the facility's "FALL MANAGEMENT PROCEDURE",</p>						

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	<p>dated 02/2005, indicated, "...PURPOSE: To assess all residents for risk factors that may contribute to falling. To provide planned interventions identified by the team, as appropriate, for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible. PROCEDURE: 1. Complete the fall risk assessment and care plan upon admission, readmission, quarterly and with significant change in status. 2. The interdisciplinary health care plan team will review the risk factors and determine if further assessment is needed. 3. The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls and/or injuries related to falls. 4. Update the plan of care each time there is a change in intervention and communicate to staff..."</p> <p>This federal finding is related to Complaint IN00124882.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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, interview, and record review, the facility failed to</p>	F000441	1. Resident C was affected. The nurse was immediately	03/08/2013			

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	<p>ensure infection control in regard to hand washing for 1 of 3 sampled residents and 2 expanded sampled residents reviewed for infection control during wound care [Resident C].</p> <p>Findings include:</p> <p>Resident C was observed during a dressing change to her right outer ankle, on 02/27/13 at 8:57 a.m. The Assistant Director of Nursing [ADON] washed her hands before the dressing change. The ADON donned gloves and removed the soiled dressing, cleaned the wound area with normal saline gauze, measured the wound, applied santyl and covered the wound with an optifoam dressing. The ADON gathered the trash, removed her soiled gloves, applied the resident's sock and house shoe and directed the resident to the bathroom. The ADON bagged the soiled linens, then opened the resident's door, touching the door knob with her contaminated hands.</p> <p>Review of the facility's undated policy for "HANDWASHING PROCEDURE", indicated, "POLICY: To provide protection for resident and staff when performing direct care procedure. To ensure that hands remain clean so as</p>		<p>re-educated on the facility's Handwashing policy.2. All residents have the potential to be affected. All nursing staff were in-serviced on the facility's policy on Handwashing. Additionally, all nurses will be in-serviced on the facility's policy on changing a clean dressing. The facility policy for Clean Dressing Change was reviewed with no revisions made.3. As a measure to ensure ongoing compliance the DON or designee will complete Dressing change/Treatment procedure observations to ensure handwashing and dressing changes are completed per the facility policy three times weekly for one month, then weekly for one month, then monthly ongoing, (see attachment I).4. As a quality measure, the DON or designee will review any findings and subsequent corrective action in the quarterly Quality Assurance meeting.</p>		

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	<p>to assist in maintenance of a clean environment and assist in the prevention of and the transmission of disease and infection...SPECIFIC TIMES HANDS MUST BE WASHED: ...Before and after direct resident contact...Before and after using the restroom...Before and after cleaning any surface area...."</p> <p>Review of the facility's policy for "CLEAN DRESSING CHANGE PROCEDURE", dated 09/2005, indicated, "PURPOSE: To protect open wounds from contamination, to absorb drainage, and to promote healing...PROCEDURE: ...Wash hands thoroughly...Apply gloves...Remove soiled dressings and discard in plastic bag, including gloves...Apply clean gloves and cleanse wound...Discard gloves...Apply clean gloves, apply medication...apply dressing ...."</p> <p>Interview with the Director of Nursing [DON] and Regional nurse, on 02/27/13 at 12:45 p.m., indicated the facility policy does not indicate handwashing each time gloves are donned during the dressing change. .</p> <p>3.1-18(l)</p>				