STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BEND NURSING AND REHABILITATION	4600 W WASHINGTON AVE SOUTH BEND, IN 46619

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00187945. Complaint IN00187945 - Substantiated. Federal/State deficiencies related to the allegation are cited at F284 and F333. Survey date: December 9, 2015 Facility number: 000246 Provider number: 155355 AIM number: 100275420 Census bed type: SNF/NF: 88 Total: 88 Census payor type: Medicare: 12 Medicaid: 67 Other: 9 Total: 88 Sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 14454 on December 15, 2015.	F 0000	**Thecreation and submission of this plan of correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation.** **Dueto the relative low scope and severity of this survey, the facilityrespectfully requests a desk review in lieu of a post-survey revisit on orafter December 23, 2015.**	

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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F 0284 SS=D Bldg. 00	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. Based on record review and interviews, the facility failed to follow the corporate policy & procedure for discharge to ensure ordered medications were sent home with 1 of 6 residents reviewed for discharge planning. (Resident "C") Finding includes: The record of Resident "C" was reviewed on 12/09/15 at 10:05 a.m. Resident "C" was admitted to the facility on 09/15/15 with diagnoses including, but were not limited to, aftercare of (L) (Left) hip fracture, urinary retention, dementia, diabetes, hypertension, CHF (Congestive Heart Failure), GERD (Gastro Esophageal Reflux Disease), gastric paresis (impaired movement of bowel) and anorexia. The "Discharge/Appointment/Transfer -	F 0284	**F284 – ANTICIPATEDISCHARGE: POST DISCHARGE PLAN**Itis the practice of this provider that residents will discharge from thefacility, as per Physician's order, and that a review of the resident's homecare needs and medications are completed with the resident and family prior todischarge from the facility. **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice:** The facility Director of Nursing spoke with the resident's guardian followingthe event and apologized for the medication error that occurred at the time ofdischarge. Review of resident home careneeds and medications are being completed for all discharges with the residentsand family prior to discharge.	12/23/2015

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	ASC [American Seniors Communities] Home Discharge Instructions", dated 11/25/15 at 1:09 p.m., indicated a printed list of discharge medications and included the time of the last dose, prescription number, and the amount of each medication sent with the resident. The medications and dosages listed included: "...Medications and Treatments. List all current medication and treatment orders... 1. Aspirin [anticoagulant: blood thinner] 81 mg [milligram] take by mouth daily in the morning... 2. Pantoprazole 40 mg, take one table daily in the morning for GERD... 3. Polyethylene glycol powder 17 grams per dose...take by mouth daily in the morning for constipation... 3. [sic] Senna with Docusate sodium 8.6-50 mg take one tablet by mouth daily in the morning for constipation... 4. Toprimate 50 mg, Take one tablet by mouth daily for Hypertension... 5. Olanzapine [antipsychotic] 5 mg, take one tablet by mouth daily before bed... 6. Mitrazapine 7.5 mg, Take one tablet by mouth daily for appetite... 7. Percocet (oxycodone-acetaminophen) 10-325 mg take one tablet by mouth every 6 hours moderate pain...none given... 8. Isosorbide dinitrate (Imdur) 30 mg		**How other residents having the potentialto be affected by the same deficient practice will be identified and whatcorrective action(s) will be taken:** Allresidents have the potential to be affected by this finding. An audit of discharges/transfersfor the last 30 days will be conducted by DNS or designee to ensure accuracy ofDischarge Instructions and accurate completion of patient and family dischargeeducation. Physician ordered Discharge Medications and Instructions willbe checked against facility Discharge Instructions to ensure accuracy. **What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** Anursing in-service to review the Discharge Policy and process will be conductedby the DNS or designee on or before 12/23/2015. Name alerts or identifiers willbe placed in the medication carts and in the charts to identify residents withthe same names and/or are residing close to one another. Resident and family discharge education willbe completed before discharge and verified with return demonstration ofmedication administration, accurate insulin dosing, nebulizer treatments andwound dressing changes if applicable. Allresident Discharges Instructions from the	

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	Take one tablet twice daily...for angina [chest pain]... 9. Tylenol 325 mg Take two tablets 650 mg by mouth as needed for mild pain...." The form was signed as reviewed by Resident C's family member. A confidential interview, conducted on 12/09/15, indicated Resident "C" was discharged home with the medications as listed on the Discharge Instructions as well as medications which belonged to another resident and not prescribed for Resident "C." Information from the interview indicated 6 medications sent with Resident "C" belonged to another resident, Resident "B," and included: Lisinopril 5 mg (hypertension) Plavix 75 mg (anticoagulant) Multivitamin Metoprolol 25 mg (hypertension) Hydrochlorothiazide 25 mg (diuretic) Ferrous Sulfate 325 mg (iron supplement) The interview indicated a family member of Resident "C" had been administering the medications of Resident "B" from punch pack cards (cards which contain individual doses that are punched out to administer), which were labeled with the picture and name of Resident "B," medication name and dosage for Resident		facility will be reviewed and signedoff by 2 Nurses. This will verify thatthe medications being sent home with the resident are the correct medications andare correlated correctly with the Physician ordered Discharge Instructions. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place:**Toensure compliance with this corrective action, the DNS/designee will completethe CQI tool titled, “Discharge Review”. This tool will be completed weekly for 4 weeksfollowed by monthly for 6 months. If threshold of 90% is not met, anaction plan will be developed. Findings will be submitted to the CQICommittee for review and follow up. **By what date the systemic changes willbe completed:** Compliance Date: 12/23/15.	

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	"B," as well as the prescribed medications sent home for Resident "C." The family member was reported to note the error on Saturday, November 28, 2015, and took the resident to the ACF (Acute Care Facility: hospital) Emergency Room for evaluation and treatment. The resident was admitted to the ACF and discharged home on November 30, 2015. The DNS (Director Nursing Services) was interviewed on 12/09/15 at 1:00 p.m. The DNS indicated the facility was unaware of the medications of Resident "B" being sent home with Resident "C" on 11/23/15, until they were notified by the guardian of Resident "C." The DNS indicated medications for residents who receive Medicaid are sent home with those resident's upon discharge. The rooms for Resident B and Resident C were in sequence. Both residents were of the same ethnic background, close to the same age and have the same first name. The facility's investigation indicated the medications were pulled from the medication cart following the following the discharge teaching. The medications for Resident "B" were pulled from her bin, located next to that of Resident "C" in addition to the medications of Resident "C."			

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	The DNS provided, on 12/09/15 at 1:30 p.m., a copy of the current Policy & Procedure, titled "Discharge Planning: 2/2015." The policy indicated: "Policy:...It is the policy of this facility that residents will discharge from the facility, as per physician's order, and that a review of the resident's home care needs and medications are completed with the resident an family prior to discharge from the facility...." This Federal tag relates to Complaint IN00187945. 3.1-36(a)(3)			
F 0333 SS=D Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interviews, the facility failed to ascertain the accuracy of medications sent home with a resident upon discharge for 1 of 7 residents who were reviewed for	F 0333	**F333 – RESIDENTS FREE OFSIGNIFICANT MED ERRORS**Itis the practice of this provider to ensure residents residing in the facilityare free of medication errors and the facility	12/23/2015

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	medication orders. (Resident "C") Finding includes: The record of Resident "C" was reviewed on 120915 at 10:05 a.m. Resident "C" was admitted to the facility on 09/15/15 with diagnoses including, but were not limited to, aftercare of (L) (Left) hip fracture, urinary retention, dementia, diabetes, hypertension, CHF (Congestive Heart Failure), GERD (Gastro Esophageal Reflux Disease), gastric paresis (impaired movement of bowel) and anorexia. The "Discharge/Appointment/Transfer - ASC [American Seniors Communities] Home Discharge Instructions", dated 11/25/15 at 1:09 p.m., indicated a printed list of discharge medications and included the time of the last dose, prescription number, and the amount of each medication sent with the resident. The medications and dosages listed included: "...Medications and Treatments. List all current medication and treatment orders... 1. Aspirin [anticoagulant: blood thinner] 81 mg [milligram] take by mouth daily in the morning... 2. Pantoprazole 40 mg, take one table daily in the morning for GERD...		maintains a medication errorrate of less than 5%. **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice:** The facility Director of Nursing spoke with the resident's guardian followingthe event and apologized for the medication error that occurred at the time ofdischarge. Review of resident home careneeds and medications are being completed for all discharges with the residentsand family prior to discharge. **How other residents having the potentialto be affected by the same deficient practice will be identified and whatcorrective action(s) will be taken:** Allresidents have the potential to be affected by this finding. An audit of discharges/transfersfor the last 30 days will be conducted by DNS or designee to ensure accuracy ofDischarge Instructions and accurate completion of patient and family dischargeeducation. Physician ordered Discharge Medications and Instructions willbe checked against facility Discharge Instructions to ensure accuracy. **What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot**	

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	3. Polyethylene glycol powder 17 grams per dose...take by mouth daily in the morning for constipation... 3. [sic] Senna with Docusate sodium 8.6-50 mg take one tablet by mouth daily in the morning for constipation... 4. Toprimate 50 mg, Take one tablet by mouth daily for Hypertension... 5. Olanzapine [antipsychotic] 5 mg, take one tablet by mouth daily before bed... 6. Mitrazapine 7.5 mg, Take one tablet by mouth daily for appetite... 7. Percocet (oxycodone-acetaminophen) 10-325 mg take one tablet by mouth every 6 hours moderate pain...none given... 8. Isosorbide dinitrate (Imdur) 30 mg Take one tablet twice daily...for angina [chest pain]... 9. Tylenol 325 mg Take two tablets 650 mg by mouth as needed for mild pain...." The form was signed as reviewed by Resident C's family member. A confidential interview, conducted on 12/09/15, indicated Resident "C" was discharged home on 11/25/15, with the medications as listed on the Discharge Instructions as well as medications which belonged to another resident and not prescribed for Resident "C." Information from the interview indicated 6 medications sent with Resident "C"		**recur:** Anursing in-service to review the Discharge Policy and process will be conductedby the DNS or designee on or before 12/23/2015. Name alerts or identifiers will be placed in the medication carts and inthe charts to identify residents with the same names and/or are residing closeto one another. All resident dischargesfrom the facility will be reviewed and signed off by 2 Nurses. This will verify that the medications beingsent home with the resident are the correct medications and are correlatedcorrectly with the Physician ordered Discharge Instructions. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place:**Toensure compliance with this corrective action, the DNS/designee will completethe CQI tool titled, “Discharge Review”. This tool will be completed weekly for 4 weeksfollowed by monthly for 6 months. If threshold of 90% is not met, anaction plan will be developed. Findings will be submitted to the CQICommittee for review and follow up. **By what date the systemic changes willbe completed:** Compliance Date: 12/23/2015	

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	belonged to another resident, Resident "B," and included: Lisinopril 5 mg (hypertension) Plavix 75 mg (anticoagulant) Multivitamin Metoprolol 25 mg (hypertension) Hydrochlorothiazide 25 mg (diuretic) Ferrous Sulfate 325 mg (iron supplement) The interview indicated a family member of Resident "C" had been administering the medications of Resident "B" from punch pack cards (cards which contain individual doses that are punched out to administer), which were labeled with the picture and name of Resident "B," medication name and dosage for Resident "B," as well as the prescribed medications sent home for Resident "C." The family member was reported to note the error on Saturday, November 28, 2015, and took the resident to the ACF (Acute Care Facility: hospital) Emergency Room for evaluation and treatment. Review of information from the ACF indicated: "EMERGENCY DEPARTMENT PHYSICIAN EVALUATION...11/28/15... CHIEF COMPLAINT: Given wrong medicines.			

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	HISTORICAL DATA: Therefore comes to the emergency department because concerned given the wrong medicine on discharged [sic] to nursing home. The patient also has a small amount of abdominal discomfort... DIAGNOSTIC IMPRESSION: This is a very complicated case of 82-year-old woman who was given medicines of another patient for 4 days but it seems to have had no ill effects." Resident "C" was admitted to the ACF and discharged home, on 11/30/15, in stable condition. The DNS (Director Nursing Services) was interviewed on 12/09/15 at 1:00 p.m. The DNS indicated the facility was unaware of the medications of Resident "B" being sent home with Resident "C" on 11/23/15, until they were notified by the guardian of Resident "C." The DNS indicated medications for residents who receive Medicaid are sent home with those resident's upon discharge. The rooms for Resident B and Resident C were in sequence. Both residents were of the same ethnic background, close to the same age and have the same first name. The facility's investigation indicated the medications were pulled from the medication cart following the following the discharge teaching. The medications			

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	for Resident "B" were pulled from her bin, located next to that of Resident "C" in addition to the medications of Resident "C." The DNS provided, on 12/09/15 at 1:30 p.m., the current copy of a Policy & Procedure, titled "Discharge Planning: 2/2015," which indicated: "Policy:...It is the policy of this facility that residents will discharge from the facility, as per physician's order, and that a review of the resident's home care needs and medications are completed with the resident an family prior to discharge from the facility...." This Federal tag relates to Complaint IN00187945. 3.1-48(c)(2)			