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 01/30/2014
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00140377, IN00141766, and IN00141541. Complaint IN00140377-Substantiated. No deficiencies related to the allegation. Complaint IN00141766-Substantiated. No deficiencies related to the allegation. Complaint IN00141541-Substantiated. No deficiencies related to the allegation. Survey dates: January 22, 23, 24, 29, and 30 2014. Facility number: 000246 Provider number: 155355 AIM number: 100275420 Survey Team: Julie Baumgartner, RN TC Shauna Carlson, RN Sharon Ewing, RN Shelly Miller-Vice, RN (1/22, 1/24, 1/29, 1/30, 2014) Pamela Williams, RN (1/29, 1/30, 2014) Census bed type:	F000000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after March 1, 2014.	

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

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	SNF/NF: 94 Total: 94 Census payor type: Medicare: 14 Medicaid: 66 Other: 14 Total: 94 These deficiencies also reflect state finding cited in accordance with 410 IAC 16.2. Quality review completed on February 4, 2014, by Brenda Meredith, R.N.			

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F000157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the resident's physician of a blood sugar that was outside of blood sugar monitoring parameters for 1 of	F000157	F157 – Notify of Changes (Injury/Decline/Room, etc)It is the practice of this provider to promptly notify the resident, consult with resident's physician, notify resident's legal	03/01/2014

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	5 residents who met the criteria for unnecessary medications. (Resident # 98) Findings include: On 1/29/14 at 2:21 P.M., review of the clinical record for Resident # 98 indicated diagnosis including but not limited to, kidney disease, diabetes mellitus with peripheral circulation disorder, osteomyelitis, bilateral above knee amputation, tobacco disorder, neuropathy, peripheral vascular disease, reflux, hemochromatosis, hyperlipidemia, constipation, osteoarthritis, hypertension, depression, and osteoporosis. A physicians order written on 11/20/13 indicated, "Novolog [a medication used to lower blood sugar] 100/ML[milliters] In Inject Sub-Q [a route of injection into the subcutaneous level of the skin] per sliding scale: Before Meals and Bedtime., 150-199 = 2 units., 200-249 = 4 units., 250-299 = 6 units., 300-349 =8 units., 350-399 = 10 units., Notify MD if BS[blood sugar level] is < [below]100 or > [above] 350." Review of Resident # 98's capillary		representative or interested family when there is a significant condition change in the resident's physical, mental or psychosocial status and/or the need to alter treatment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #98 – physician has been informed of this resident's blood sugar results for the month of December, January and through current date. The resident has experienced no negative outcome as a result of this finding.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:Any resident with orders for accuchecks have the potential to be affected by this finding. An audit will be conducted by the Nurse Management Team to review all residents with orders for accuchecks. This audit will ensure that all residents have physician call orders for accucheck results and that any residents with results outside the ordered parameters have been reported to the physician. Notification to the physician (and family if appropriate) will occur immediately for any accucheck results noted to be outside the ordered monitoring parameters. What measures will be put into place or what systemic changes will be made to ensure that the	

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	blood glucose monitoring tool and progress notes indicated lack of physician notification for blood sugar levels that were not within the parameters of physician directed notification. The following were indicated: 12/2/13 at 11:00 A.M., blood glucose documented 72. Physician notification not documented. 12/7/13 at 8:00 A.M., blood glucose documented 75. Physician notification not documented. 12/10/13 at 4:00 P.M., blood glucose documented 79. Physician notification not documented. 12/14/13 at 11:00 A.M., blood glucose documented 86. Physician notification not documented. 12/17/13 at 11:30 A.M., blood glucose documented 78. Physician notification not documented. 12/23/13 at 7:30 A.M., blood glucose documented 73. Physician notification not documented. 12/26/13 at 11:30 A.M., blood glucose documented 62. Physician notification not documented. 12/27/13 at 12:00 P.M., blood glucose documented 92. Physician notification not documented. 12/28/13 at 8:00 P.M., blood glucose documented 390. Physician notification not documented. 1/2/14 at 12:00 P.M., blood glucose		deficient practice does not recur:A nursing in-service will be conducted by the DNS/designee on or before 3/1/14. This in-service will include review of the facility policy titled, “Blood Glucose Monitoring”. This in-service will especially emphasize the policy regarding prompt notification to physicians for any accucheck results outside the ordered monitoring parameters. Continued compliance with prompt notification of accucheck results outside the ordered parameters will be monitored through daily review of Blood Glucose Flow Records by the DNS/designee during the clinical meeting. In addition, the DNS/Nurse Management Team will review the Blood Glucose Flow Records on the weekends and holidays to ensure ongoing compliance with prompt physician notification. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Tool titled, “Labs/Diagnostics” daily for 30 day followed by 1x/wk for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what	

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	documented 65. Physician notification not documented. 1/2/14 at 12:20 P.M., blood glucose documented 98. Physician notification not documented. 1/7/14 at 11:30 A.M., blood glucose documented 76. Physician notification not documented. 1/8/14 at 12:00 P.M., blood glucose documented 98. Physician notification not documented. 1/8/14 at 4:15 P.M., blood glucose documented 50. Physician notification not documented. 1/9/14 at 12:15 P.M., blood glucose documented 85. Physician notification not documented. 1/10/14 at 12:00 P.M., blood glucose documented 64. Physician notification not documented. 1/12/14 at 12:00 P.M., blood glucose documented 83. Physician notification not documented. 1/13/14 at 4:00 P.M., blood glucose documented 75. Physician notification not documented. 1/14/14 at 4:30 P.M., blood glucose documented 78. Physician notification not documented. 1/15/14 at 5:00 P.M., blood glucose documented 99. Physician notification not documented. 1/19/14 at 7:00 A.M., blood glucose documented 73. Physician notification not documented.		date the systemic changes will be completed:Compliance Date: 3/1/14.	

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	1/20/14 at 12:15 P.M., blood glucose documented 94. Physician notification not documented. 1/20/14 at 4:00 P.M., blood glucose documented 85. Physician notification not documented. 1/23/14 at 7:00 A.M., blood glucose documented 95. Physician notification not documented. 1/23/14 at 5:00 P.M., blood glucose documented 84. Physician notification not documented. 1/24/14 at 7:00 A.M., blood glucose documented 77. Physician notification not documented. 1/27/14 at 7:00 A.M., blood glucose documented 84. Physician notification not documented. 1/27/14 at 12:00 P.M., blood glucose documented 73. Physician notification not documented. On 1/29/14 at 3:07 P.M., interview with Director of Nurses indicated physician notification would be in the progress notes. On 1/29/14 at 3:30 P.M., review of the Subcutaneous-Injection skills validation procedure, received from the Director of Nurses, indicated "...Verify resident, physician orders and drug allergies...." On 1/29/14 at 3:25 P.M., review of			

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	Resident #98's diabetes careplan indicated "... Problem: At risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and diagnosis of diabetes mellitus. (11/09/2012) Noncompliant with diet family and friends bring him in food....Approach:...medications as ordered...monitor blood sugars as ordered...." 3.1-5(a)(3)			
F000247 SS=A	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based upon interview and record review, the facility failed to provide notification of a change in roommate. This affected 2 out of 20 resident's reviewed for notification of change in roommate. (Resident #124 and Resident # 87)	F000247	F247 – Right to Notice Before Room/Roommate ChangeIt is the practice of this provider that a resident has the right to receive notice before the resident's room or roommate in the facility is changed. What corrective action(s) will be accomplished for	03/01/2014

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	Findings include: On 1/24/14 at 10:51 A.M., interview with Resident #124 indicated she was not notified of a change in her roommate. She indicated, " she woke up and saw her (new roommate) and said " Good Morning." On 1/24/14 at 11:09 A.M., interview with Resident #87 indicated she was not notified of a change in her roommate. She indicated they (the facility staff) brought her in here (her room) and said here you are. On 1/29/14 at 1:57 P.M., interview with Employee #1 and Employee #2 indicated, we notify the resident that they will be getting a roommate but we have not been documenting it. Employee #1 indicated it was something they were working on. On 1/29/14 at 2:00 P.M., record review for Resident #124 indicated no notification of a change in roommate that occurred on 12/4/13. On 1/29/14 at 2:08 P.M., record review for Resident# 87 indicated no notification of a change in roommate		those residents found to have been affected by the deficient practice:Resident #124 – resident and family is aware of the change in roommate and has verbalized their satisfaction with their current room assignment. This resident experienced no negative outcome related to this finding.Resident #87 –resident and family is aware of the change in roommate and has verbalized their satisfaction with their current room assignment. This resident experienced no negative outcome related to this finding. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents experiencing a room or roommate change have the potential to be affected by this finding. A facility audit will be completed by SSD/designee. This audit will ensure all residents and/or legal representative have been given proper and timely notification related to room or roommate changes. Any errors or omissions noted during this audit will be clarified and/or corrected immediately. Room changes and roommate changes will be communicated to all responsible staff during daily meetings. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The ED/DNS/designee will be responsible for	

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	that occurred on 1/17/14. On 1/29/14 at 2:10 P.M., review of the Intra-Facility Transfers policy, received from Social Worker #1 on 1/29/14 at 2:08 P.M. indicated "... the receiving roommate and /or legal representative will be notified of the new roommate prior to the move. This notification will be documented in the medical record...." 3.1-3(v)(2)		re-educating and in-servicing the SSD and other responsible staff members regarding the Intra-Facility Transfer Policy. This in-service will also include review of the facility practice related to notification and documentation for the receiving roommate and/or legal representative prior to the move. This in-servicing will be completed on or before 3/1/14. Room changes and roommate changes will be communicated to all responsible staff during daily meetings. The documentation related to room and roommate changes will be reviewed and verified during daily meetings IDT team/Manager on Duty for weekends. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The ED/SSD/designee will be responsible for completing the CQI Audit Tool titled, “Social Service Documentation” weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.By what date the systemic changes will be completed: Compliance Date: 3/1/14.	

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F000441 SS=C	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interviews and record reviews, the facility did not support a	F000441	F441 – Infection Control, Prevent Spread, LinensIt is the practice of	03/01/2014

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	consistency in the policy and procedure for daily surveying for potential house infections. This potentially affected 94 of 94 residents in the facility. Findings included: On 1/29/14 at 10:00 a.m., an interview was conducted with the Clinical Staff Coordinator identified as the Infection Control Manager indicating the current daily surveillance system for processing in-house infections was to, "...(we) use the daily surveillance log to keep my own personal notes on from the morning manager ... I don't keep these, I shred them at the end of the day...." On 1/29/14 at 10:15 a.m., an interview was conducted with the Director of Nursing (DON) indicating the facility used a computer program upon identifying daily in-house infections and the, "...daily surveillance log isn't used...." On 1/29/14 at 10:20 a.m., a record review was conducted of a policy/ procedure titled, "Surveillance System" provided by the DON indicating,"Policy. The facility shall have surveillance system that		this provider to 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:There was no specifically identified resident found to have been affected by this finding. A surveillance record has been initiated and is being updated daily.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be affected by this finding. A facility audited will be completed by the DNS/CEC/designee to identify any resident with an active infection and/or who has been identified as being at risk for an infection or the spread of infections. The daily Surveillance Log will be updated and used daily to identify actual or potential infections. This will provide ongoing tracking to rule out an infection, the development of a new/recurrent infection and/or spread of infection. Any noted trends or identified concerns noted during the development of this Surveillance Log will be addressed and/or corrected immediately. What measures	

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	investigates, controls and prevents infections. Purpose: To conduct surveillance activities that will identify infections and prevent the spread of infections... Documents/ Records: identify and use consistent definitions, terminology, forms and logs when tracking and reporting infections. The tools include: Daily Surveillance Log used daily to identify actual or potential infections. The tools include: Daily Surveillance Log- used daily to identify actual or potential infections...Note: Daily is defined as 5-7 times per week. Monitor: Provide ongoing tracking to rule out an infection, the development of a new/ recurrent infections, and/or spread of infections. Daily Surveillance Investigation Log:..." On 1/29/14 at 2:00 p.m., a record review was conducted of the 3-ring white binder titled,"Infectious Control 2013." A Daily Surveillance Log was noted for the months of July and August of 2013 only. No further logs for the remainder months were available for review. On 1/29/14 at 2:30 p.m., an interview was conducted with the Clinical Staff Coordinator indicating,"...no, we don't use the		will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:A mandatory nursing in-service will be conducted on or before 3/1/14. The DNS/CEC/designee will be responsible for conducting this in-service. This in-service will include review of the facility policy and procedure related to Infection Control. This in-service will include review of the procedure related to daily Surveillance Log updates and ongoing tracking to rule out an infection, the development of a new/recurrent infection and/or spread of infection. The use of the Surveillance Log will be kept as a record of tracking for infections per the facility policy. The DNS/CEC/designee will be responsible for keeping the daily Surveillance Log current and updated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:To ensure ongoing compliance with this corrective action, the DNS/CEC/designee will be responsible for completion of the CQI Audit tool titled, “Infection Control Review” daily for 1 month and 1x/week for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.By what	

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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
	surveillance daily log, we use the computer program 'activity event summary report.' It was indicated the policy/ procedure for consistency in daily surveying for infections was not the same as what was actually being done. 3.1-18(b)(1)(A)		date the systemic changes will be completed:Compliance Date: 3/1/14.	