

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  12/11/2012
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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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F0000	<p>This visit was for the Investigation of Complaint IN00119203 and Complaint IN00120571.</p> <p>Complaint IN00119203 substantiated, federal/state deficiencies related to the allegations are cited at F157.</p> <p>Complaint IN00120571 substantiated, federal/state deficiencies related to the allegations are cited at F465.</p> <p>This survey was in conjunction with the Post Survey Revisit [PSR] to Complaint IN00118753 completed on 11/01/2012.</p> <p>Survey dates: December 6, 7, &amp; 11, 2012</p> <p>Facility number: 00139 Provider number: 155234 AIM number: 100266410</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 51 Total: 51</p> <p>Census payor type: Medicare: 5 Medicaid: 39</p>	F0000	<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.</p> <p>Due to the low scope and severity of the survey findings, please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction.</p> <p>The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me.</p> <p>Respectfully,</p> <p>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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	<p>Other: 7 Total: 51</p> <p>Sample: 8</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 12/11/2012 by Brenda Nunan, RN.</p>				

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F0157 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> <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 interview and record review, the facility failed to inform the physician and the resident's legal representative of missed doses of anticonvulsant medications for 1 of 3</p>	F0157	<p>1. Resident #A was not harmed. The resident's physician and responsible party were notified. Resident #A had laboratory tests completed which indicated he had therapeutic levels of his</p>	12/17/2012	

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	<p>residents reviewed for medication administration in a sample of 8 [Resident A].</p> <p>Findings include:</p> <p>1. Resident A's clinical record review on 12/07/12 at 9:05 a.m. indicated the resident had diagnoses which included, but were not limited to, seizure disorder, history of thalamic intracranial bleed, cerebrovascular disease, mental retardation, fracture of right femur, and flexion contractures.</p> <p>The Physician's Orders, dated 12/2012 indicated Resident A was prescribed 3 anticonvulsants (seizure medications) which included Vimpat 200 mg by mouth twice daily, Tegretol 100/mg/5 ml (milliliters),give 20 ml (400 mg) by mouth 3 times daily, and Kepra XL 1500 mg (milligrams) by mouth twice daily.</p> <p>Review of the Medication Administration Record [MAR] for September 2012 indicated Resident A did not receive Kepra XL 500 mg (milligrams) 3 tablets on 09/06/12 at 5 p.m. Vimpat 200 mg was not given at 8:00 p.m. on 09/14/12, 09/26/12, and 09/28/12. Tegretol was not given at 10 p.m. on 09/26/12.</p>		<p>anti-seizure medication and he did not exhibit seizure activity. 2. All residents have the potential to be affected. All 24hour report sheets, nurses' notes, and medication administration records were checked to ensure the physician was notified as appropriate for any changes in condition, including missed doses of medication (i.e., medication errors). 3. As a means to ensure ongoing compliance with physician and family notification, all nurses were in-serviced on the facility's policy on physician and family notification, (please see attachment A), which included missed doses of medication administration, resulting in medication error. Staff were informed non-compliance would result in disciplinary action and potential termination. 4. As a means to ensure ongoing compliance with physician and family notification, the DON or designee will review the 24 hour report sheets, nurses notes, and medication administration records five days weekly for one month, then three days weekly on going to ensure the physician and family are notified per the facility policy, (please see attachment B). Findings and any re-education and/or disciplinary action will be reported to the Quality Assurance Committee during quarterly meetings, and interventions revised accordingly, if warranted.</p>		

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	<p>Review of the November 2012 MAR indicated Resident A did not receive the 5 p.m. dose of Keppra XR 500 mg 3 tablets on 11/05/12 and 11/14/12. Vimpat 200 mg was not given at 8 p.m. on 11/05/12, 11/09/12, and 11/28/12 at 8 p.m. as ordered. The record indicated Resident A did not receive Tegretol 20 ml at 6 a.m. and 10 p.m. on 11/28/12.</p> <p>Review of Nursing Progress Notes, dated 09/29/12, 10/01/12, and 10/02/12, indicated calls were made to the neurologist and Power of Attorney [POA] to inform them of missed doses of medications in September 2012. The record did not indicate the physician and POA were notified of missed doses of medications in November 2012.</p> <p>During an interview on 12/11/12 at 1:45 p.m., the Assistant Director of Nursing [ADON] indicated she placed "sticky notes" indicating the missed medications on the MARs during an audit. She indicated the audit was shredded by a medical records staff.</p> <p>During an interview on 12/11/12 at 3 p.m. the ADON indicated one of her nurses who is no longer here had "...made a lot of errors..." and was</p>			

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	<p>terminated.</p> <p>During an interview on 12/11/12 at 3:20 p.m., LPN #5, indicated she had not administered a dosage of Vimpat. She indicated she did not remember the date the medication was omitted.</p> <p>Interview on 12/11/12 at 3:27 p.m. with LPN #2, indicated Keppra was not available for more than 1 day.</p> <p>Interview on 12/11/12 at 3:35 p.m. with LPN #4, indicated she did not administer a dose of Vimpat. She indicated the medication was locked in the narcotics box.</p> <p>An undated facility policy on Medication Administration Policy and Procedures indicated, "...PURPOSE: To administer medications according to the guideline set forth by the State and Federal Regulations..." The procedure indicated, "...Medication administration will be recorded on the MAR or TAR after given...."</p> <p>A facility policy, dated 01/06 and titled, "Physician &amp; Family Notification Procedure," indicated, "PURPOSE: To keep the physician, resident and family apprised of all condition changes...." The procedure "via telephone," indicated, "...Telephone</p>				

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	<p>notification is required for all emergencies or all condition changes that require an immediate response...Notify the physician of any change in condition that may or may not warrant a change in the treatment plan...Document the information reported to the physician in the nurse's notes including the time and date of notification. Be thorough and explicit...Notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan...."</p> <p>This federal tag is related to Complaint IN00119203.</p> <p>3.1-5(a)(1)</p>			

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F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure maintenance services were provided to repair/replace a light fixture in the dietary office which produced sparks when turned on for 1 of 1 lighting fixtures observed in the dietary office, failed to ensure an employee break room door locked was repaired for 1 of 1 employee break room door locks observed for functioning, and failed to clean 1 of 2 electric wheelchairs observed for cleanliness [Resident E].</p> <p>Findings include:</p> <p>1. Observation was made of a lighting fixture in the dietary office with the Administrator present on 12/11/12 at 10:55 a.m. When the Administrator turned the light fixture on, sparks flew out from the west side of the light fixture. The light did not produce light. Once the fixture was turned on, the fixture had an odor of something burning.</p> <p>During an interview, at the time of the observed spark, the Administrator stated the light had been out of</p>	F0465	<p>1. The light fixture was repaired. The lock on the break room door was replaced. All wheel chairs were checked and cleaned, as indicated. 2. All residents have the potential to be affected. The facility's wheel chair cleaning schedule was updated. Environmental rounds were completed throughout the facility and maintenance request forms completed as indicated. The maintenance request forms will be addressed in order of highest priority first. 3. As a means to ensure ongoing compliance with equipment cleaning and repairs, all staff were in-serviced on cleaning schedules and maintenance request form completion, (please see attachment C). When a maintenance issue is noted, staff are to complete a maintenance request from and turn it in to the Administrator. The Administrator will then place the maintenance request forms in order of priority and ensure those of highest priority are addressed first. 4. As a means of quality assurance with equipment repair/cleaning the Administrator or designee will monitor all maintenance request forms through completion to ensure timely results. Additionally,</p>	12/17/2012
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	<p>service "for a couple of weeks."</p> <p>2. During an observation on 12/11/12 at 11:03 a.m., the employee break room door lock was not functioning. The Administrator indicated a plan to repair/replace the lock after a maintenance supervisor began work on 12/17/2012. The Administrator indicated residents' room trays were collected after supper and the dirty trays were stored in the employee break room overnight.</p> <p>3. Observation of Resident E's electric wheelchair was made on 12/11/12 at 11:20 a.m. The wheel chair was dirty with debris of dust, dirt, and dried spills/food. Resident E could not remember the last time he asked to have his wheelchair cleaned.</p> <p>During an interview on 12/11/12 at 11:45 a.m. CNA #3 indicated she used a putty knife to scrape the debris from Resident E's wheelchair.</p> <p>This federal tag is related to Complaint IN00120571.</p> <p>3.1-19(f)</p>		<p>the Administrator will complete environmental rounds five days weekly for one month, then weekly, thereafter ongoing to ensure proper equipment repair/cleaning, (please see attachment D). The Administrator or designee will review any findings and subsequent corrective action taken with the Quality Assurance Committee during the quarterly meetings, and interventions revised accordingly, if warranted.</p>		

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

PRINTED: 01/10/2013

FORM APPROVED

OMB NO. 0938-0391

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