

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  11/01/2012
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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 IN00118753.</p> <p>Complaint IN00118753-Substantiated. Federal/state deficiencies related to the allegation are cited at F 323.</p> <p>Survey date: November 1, 2012</p> <p>Facility number: 000139 Provider number: 155234 AIM number: 100266410</p> <p>Survey team: Laura Brashear, RN -TC</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census Payor type: Medicare: 6 Medicaid: 36 Other: 5 Total: 47</p> <p>Sample: 15</p> <p>This deficiency reflects state finding cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on November</p>	F0000	<p>Please find enclosed the plan of correction for the survey on November 1, 2012. Please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me. Respectfully, Sally Robertson 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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	2, 2012 by Bev Faulkner,RN			

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F0323 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 adequate supervision or use of assistive devices to prevent accidents for 2 of 9 residents reviewed for falls in a sample of 15. This deficient practice resulted in Resident B sustaining fractures and Resident A a hematoma.</p> <p>Findings include:</p> <p>1. During initial tour on 11/1/12 at 10:30 a.m., with LPN #3, Resident B was observed in bed with a Foley catheter. The LPN indicated the resident had returned from the hospital the previous evening. The LPN indicated the resident sustained a fractured leg from a manual transfer in the facility.</p> <p>Resident B's clinical record was reviewed on 11/1/12 at 11:40 a.m. A nursing note, dated 10/25/12 at 7:20 a.m., was noted of "Called to res [resident] room et [and] res was sitting beside bed with legs underneath her. CNA was attempting to transfer res to w/c [wheelchair] from bed.</p>	F0323	<p>1. I. Upon return from hospitalization, the careplan and assignment sheet of Resident be was reviewed to ensure accuracy in number of caregivers for transfer, and the same communicated to caregivers. II. As all residents could be affected, all assignment sheets and careplans have been reviewed to ensure accuracy as to number of caregivers necessary for transfers. III. As a means to ensure ongoing compliance with adequate assistance/supervision for transfers, shift to shift inservice was conducted to confirm knowledge of compliance with the number of caregivers as per assignment sheet and careplan for transfers. Staff informed non-compliance would result in disciplinary action and potential termination. IV. As a means of quality assurance, interviews were conducted with caregivers following the aforementioned inservice to confirm compliance with the assignment sheet and careplan in regard to number of caregivers required for resident transfer. Random observations of transfers will be conducted on all shifts by</p>	11/16/2012			

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	<p>...When legs brought out from underneath her (L) [left] leg was noted to have outward rotation et [and] res c/o [complained of] pain. ...MD called order received to send to ER [emergency room]."</p> <p>A report of the incident, provided by the Administrator on 11/1/12 at 11:25 a.m., included, but was not limited to "[name] CNA was transferring [Resident B's name] from the bed to the resident's wheelchair. The caregiver was utilizing a gait belt and the resident was wearing tennis shoes for non-skid footwear. CNA could not execute the transfer prior to the resident's legs buckling under her. The CNA lowered the resident to the floor. ...Type of injury/injuries: Fractured left tibia and fractured left fibula. ..."</p> <p>Further investigation of the incident included in the report included, but was not limited to, "[CNA's name] was helping [resident's name] to get dressed. The CNA assisted the resident with her pants, brief, socks &amp; [and] shoes while the resident sat on the bed. From the edge of the bed, the resident then stood up by herself. The CNA held on to the resident's gait belt while she pulled the resident's brief and pants the rest of the way up. The CNA then assisted the resident to sit back down on the bed. The</p>		<p>the Director of Nursing/Designee at least five times per week for one month, and weekly thereafter, ongoing. Observations and any resulting re-education and/or disciplinary action will be reported to the Quality Assurance Committee during quarterly meetings, and interventions revised accordingly, if warranted. 2. I. The careplan and assignment sheet of Resident A has been reviewed for accuracy of interventions to be in use. Additionally, observations have been conducted to confirm consistent use of interventions to prevent accidents/falls. II. As all residents could be affected, all assignment sheets and careplans have been reviewed to identify and to ensure accuracy as to devices in place with purpose to prevent accidents/falls. All devices have been inspected to ensure that they remain in working order. III. As a means to ensure ongoing compliance with use of devices to prevent accidents, staff has received re-education, including use of devices, engagement (i.e., ensuring the device is turned "on") and placement of control/device out of the reach of the resident to ensure the resident cannot disengage the device. IV. As a means of quality assurance, random observations of devices in use will be conducted on all shifts by the Director of Nursing/Designee at</p>		

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	<p>CNA rechecked the gait belt to ensure it was still in place appropriately. The CNA then asked the resident to stand again so that the CNA could assist to transfer the resident to the wheelchair. As the resident stood, the resident grabbed the wheelchair that was positioned beside the bed, and did a turn. The resident stated she heard her leg 'pop.' The CNA had hold of the gait belt on the resident and felt the resident lowering herself to the floor. ... Type of Injury/injuries: Spiral fracture of the left distal tibia with lateral displacement of the distal fragment and an oblique nondisplaced fracture of the proximal fibula. Preventive measures taken: Post fall investigation was conducted and revealed the ADL [Activities of Daily Living] documentation/grid and staff interviews confirmed one caregiver transfer of this resident the majority of the time, with only a few episodes when two caregivers were necessary."</p> <p>An "Inservice Record," provided by the Administrator on 11/1/12 at 12:45 p.m., was noted of the CNA receiving 1 to 1 training to always use correct number of assist with all transfers. always use gait belt. Wait for help! Ask for help! Always have the resident's safety in mind. Notify charge nurse or DON/ADON [Assistant Director of Nursing] if other</p>		<p>least five times per week for one month, and weekly thereafter, ongoing. Observations and any resulting 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>staff refuse to assist with transfers. Look at CNA assignment sheet prior to transfer.</p> <p>The CNA assignment sheet, dated 10/26/12, provided by the ADON on 11/1/12 at 11:20 a.m. included, but was not limited to, transfers X 2. LPN #3 was interviewed on 11/1/12 at 12:30 p.m., the LPN indicated the resident always required assistance of two for transfers. The LPN indicated the other CNA working on the unit was in a resident's room, feeding the resident.</p> <p>Resident B's Minimum Data Set [MDS] assessment, dated 9/11/12, reviewed on 11/1/12 at 11:40 a.m., had coded the resident with no cognitive impairment. Required extensive assistance of two for transfers. Assistance of one for ambulation in the room. Only able to stabilize balance with staff assistance.</p> <p>A Physical Therapy Evaluation, dated 9/4/12, provided by the DON on 11/1/12 at 12:45 p.m., included, but was not limited to decreased mobility, pain to both knees and left hip. The assessment indicated the resident required assistance of one for sit to stand, and assistance of two for transfers. The assessment indicated the resident was currently demonstrating decline in transfers, balance, safety awareness, physical</p>				

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	<p>functioning, strength, and gait.</p> <p>A plan of Care that addressed "ADL Assist Required" dated 8/21/12 and 10/25/12 addressed the problem of the resident requires up to extensive assistance to total assistance of two in performing ADL's due to decrease in mood, said yes to little pleasure/interest in doing things, feeling down depressed, feeling tired/having little energy having poor appetite half or more of the previous 14 days of assessment period. [8/7/12.]</p> <p>The DON was interviewed on 11/1/12 at 2:25 p.m. The DON indicated therapy had reported assistance of one for sit to stand was appropriate, but required assistance of two for surface to surface transfers.</p> <p>2. During initial tour on 11/1/12 which began at 10:30 a.m., with LPN #3, Resident A was identified as having had falls. The resident was out of the facility for an appointment.</p> <p>The DON was interviewed on 11/1/12 at 2:25 p.m. The DON indicated Resident B had a fall on 10/20/12 at 3:30 a.m. The resident was found on the floor in the bathroom. The DON indicated the resident had transferred self from the bed to wheelchair and gone into the bathroom.</p>			

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	<p>The DON indicated a pressure pad alarm was in place on the resident's bed but was not turned on. The DON indicated she did not know why the alarm was not on.</p> <p>During the interview, the DON indicated the resident had a fall on 10/24/12 at 9:00 a.m. The resident was on the floor beside the bed and the pressure pad alarm on the bed had not sounded. The DON indicated when the alarm was pushed on it sounded and was replaced. The DON indicated she did not know why it had not sounded.</p> <p>During the same interview, the DON indicated the resident fell on 10/30/12 at 9:55 a.m. The resident was seated in the wheelchair in the hallway. A staff person was near by heard a thud looked up and found the resident on the floor. The resident sustained a "goose egg" on the head. The resident was on Coumadin [blood thinner medication] and was taken to the hospital for a CT scan. The DON indicated the resident had a hematoma from the fall. The DON indicated she did not know if an alarm had been in place or sounded at the time of the fall.</p> <p>On 11/1/12 at 3:00 p.m., the resident was observed in her room. The resident was asleep in a personal recliner. A pressure pad alarm was observed under the resident. The wire to the alarm was</p>				

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	<p>draped over the arm of the chair and the alarm box was lying on the floor beside the resident. A pressure pad alarm was observed on the resident's bed. The alarm box was hanging on a cable under the bed rail towards the head of the resident's bed, and would have been within reach of the resident when in bed. At 3:45 p.m., with the ADON the alarm was again observed. The telephone type cord from the pressure pad to the alarm box was observed not to be connected. The cord was also observed to be wrapped around part of the side rail on the resident's bed which was in the down position.</p> <p>The resident's clinical record was reviewed on 11/1/12 at 4:00 p.m., A Minimum Data Set [MDS] assessment, dated 9/5/12, coded the resident with short and long term memory impairment, severely impaired cognition. The assessment coded the resident as requiring extensive assistance of two for bed mobility and transfers, and ambulation in the room. Balance unsteady without staff assistance.</p> <p>A plan of care, dated 8/28/12 and 9/15/12, addressed the problem of resident required use of safety alarm sensor alarm in chair and bed due to high fall risk. Interventions included, but were not limited to, place alarm appropriately per</p>						

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	<p>manufacturer's instructions. Observe for signs of low battery and replace as needed, notify the charge nurse of attempts to remove the device check replacement and function every shift.</p> <p>Manufacturer's directions for the type of alarms utilized for the resident, [Deluxe Bed and Chair Sentry Fall Monitoring Systems User Instructions] provided by the ADON on 11/1/12 at 4:05 p.m., included, but was not limited to, "How to Use the Deluxe Sentry Monitors" 2. Attach the Sentry monitor to a wheelchair, chair or bed using the attached metal clip. Other mounting options include an optional bracket extender and a chair strap for large side chairs. 4. Place the UMP pad on the chair or bed so that the bulk of the patient's weight (buttocks area) will be resting on it. Plug the end of the pad cable into the PAD jack on the bottom of the monitor. For added safety from accidental pulls on the cord, route the cable through the strain relief slot on the bottom of the monitor. NOTE: If the UMP pad is disconnected from the PAD jack while in operating mode, the alarm will be activated. Under the section titled "Caution" information was noted to make sure the monitor is held securely to the bed or chair and that the bracket mount is secure. Documentation was noted on the</p>			

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	<p>Medication Administration Record of the alarms being checked daily.</p> <p>This Federal tag relates to Complaint IN00118753</p> <p>3.1-45(a)(2)</p>				