STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155135		04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN 47421

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Compliant IN00195396. This visit was in conjunction with the Investigation of Complaint IN00196696. Complaint IN00195396-Substantiated. Federal/State deficiencies related to the allegations are cited at F-224. Survey dates: March 31, April 1, 4, 5, 6, 7, 2016. Facility number: 000060 Provided number: 155135 AIM number: 100266600 Census bed type: SNF/NF: 74 Total: 74 Census Payor type: Medicare: 13 Medicaid: 48 Other: 13 Total: 74 These deficiencies reflect State findings cited in accordance with 410 IAC	F 0000	Westview Nursing and Rehabilitation Center would like to request a Paper Compliance Review **Westview Nursingand Rehabilitation and Rehabilitation is requesting Paper IDR Review.** **Westview Nursing andRehabilitation respectfully request s additional evidentiary information beconsidered to reduce F 278 in severity from a D level to an A level in the2567.**	

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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	16.2-3.1. Q.R. completed by 14466 on April 14, 2016.			
F 0224 SS=D Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of property in that a resident's narcotic medication and narcotic medication count sheets were taken by License Practical Nurse (LPN) #2 for 1 of 1 resident reviewed for abuse. (Resident #91) Findings include: Resident #91's clinical record was reviewed on 4/7/2016 at 1:30 p.m. The resident was admitted on 2/26/2016, and was discharged to the hospital on 3/6/2016. The resident was not in the facility on 3/9/2016, when the narcotics and narcotic count sheets went missing.	F 0224	This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission thatthe deficiency exists or that on was cited correctly. This Plan of Correction is submitted to meet requirements by state and federal law. **F 224 ProhibitMistreatment/Neglect/Misappropriation What correctiveaction will be accomplished for those resident s found to have been affected bythe deficient practice?** Resident #91 did not have any negative outcomes related to the alleged deficient practice. **How other residentshaving the potential to be affected by the same deficient practice will**	04/18/2016

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	March 2016, Physician orders indicated Resident #91's medications included, but were not limited to Norco (a narcotic) 10-325 mg every 6 hours for moderate pain and Xanax (an antianxiety) 0.25 mg twice a day as needed for anxiety. On 4/7/2016 at 11:28 a.m., an interview with Unit Manager (UM) #1 indicated on 3/9/2016, she was flipping through the narcotic book to see who needed narcotics reordered. At that time, she realized the narcotics and narcotic sheets were missing for Resident #91. She looked everywhere for them, because she thought they might have been destroyed by someone. She could not locate them and notified the DON (Director of Nursing) on 3/9/2016 at around 10:00 a.m., that the narcotics and narcotic sheets were missing for Resident #91. During an interview on 4/7/2016 at 2:35 p.m., LPN #1 indicated she counted the narcotics with LPN #2 on 3/8/2016 at 11:00 p.m. The narcotic count was correct and the narcotics and narcotic sheets were there, at that time, for Resident #91. During an interview on 4/7/2016 at 11:04 a.m., the Director of Nursing indicated on 3/9/2016 at approximately 10:00 a.m., she received a call from UM #1 regarding		**beidentified and what corrective actions will be taken?** All residents have the potential to be affected by thedeficient practice. The licensed nursingstaff was immediately re-in-serviced by the DNS and the ADNS on thepolicy/procedure for administering and counting a controlled substance, andmedication storage. An audit was completed on all residents receiving narcotics to ensure the narcotic counts were correct and all narcotics were accounted by Unit Mangers. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** All licensed nursing staff was in-service on thepolicy/procedure for administering a controlled substance, and medicationstorage. The Unit Managers/designee willreview Mars/control log daily to ensure controlled medications are documentedappropriately and all medication is counted correctly. Non-compliance with these practices will result in further education including disciplinary actions. The DNS and/or Designee will review the log weekly. **How will thecorrective actions be maintained to ensure the deficient practice will notrecur?** To ensure compliance, the DNS and/or Designee will bring the log to the	

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	missing narcotics and narcotic sheets for Resident #91. The DON began an investigation at that time. Continued interview on 4/7/2016 at 11:04 a.m., with the DON, indicated on 3/8/2016 at 11:00 p.m., the narcotic count had been completed by LPN #1 and LPN #2 and was accurate for Resident #91. LPN #1 left for the night and LPN #2 worked the 11:00 p.m. to 7:00 a.m., shift alone. On 3/9/2016 at 7:00 a.m., LPN #2 and UM #1 completed a narcotic count, but UM #1 did not notice the narcotics and narcotic sheets were missing for Resident #91. After LPN #2 left for the day, UM #1 was going through the narcotic book to see who needed medications reordered and, at that time, noticed the narcotics and narcotic sheets were missing for Resident #91. After an extensive search for the narcotics and narcotic sheets, the DON was notified on 3/9/2016, time unknown. On 4/7/2016 at 11:55 a.m., the DON provided a copy of the investigation in regard to the missing narcotics and narcotic sheets for Resident #91. The investigation indicated the following: On 3/9/2016, time unknown, the DON was notified by UM #1 that twenty two Norco 10-325 milligram (mg) tablets and		monthly Quality Assurance Meeting for review. The DNS/or Designee will audit the Mars/control log five times a week for four weeks and then once a week for 6 months. Any deficiencies will be corrected on the spot, and the findings of the Quality Assurance check will be documented and submitted in monthly Quality Assurance Meeting until no negative finding achieved for 6 months and ongoing as needed. I am requesting paper compliance	

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	twenty seven Xanax 0.25 mg tablets along with the narcotic count sheets were missing from the locked narcotic box for Resident #91. The DON began an investigation at that time and the police were notified. An officer from police department #1 took statements and opened a case number. All nurses involved were sent for drug screens. On 3/10/2016 at 4:30 p.m., the DON took a statement from LPN #2, in which LPN #2 admitted to taking the medications and the narcotic sheets for Resident #91. On 3/10/2016 at 5:30 p.m., the DON indicated a detective from Police Department #1 notified her that LPN #2 admitted to taking the medication and LPN #2 would be in the nursing facility on Monday to write out a statement. On 3/21/2016 at 12:00 p.m., the DON indicated LPN #2 was terminated from employment due to theft/misappropriation of funds. On 4/7/2016 at 1:47 p.m., the DON provided a copy of the policy "Abuse Prohibition, Reporting, and Investigation" and indicated it was the one currently being used by the facility. The policy indicated, "It is the policy of [corporation name] to protect the			

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	residents from abuse including ... misappropriation of resident property and/or funds ... Misappropriation of Resident Funds or Property-the deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's belongings or money without the resident's consent ... includes any medication dispensed in the name of the resident ... [corporation name] will not permit residents to be subjected to abuse by anyone including employees ...." This Federal tag relates to Complaint IN00195396. 3.1-28(a)			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.			

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	A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on observation, interview, and record review, the facility failed to ensure resident's assessed dental status was accurately documented on the Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for dental status and services. (Resident #3) Findings include: On 4/5/16 at 10:22 a.m., Resident #3 was observed to have broken tooth fragments and was missing multiple teeth.. The resident indicated she did not remember the last time she was seen by a dentist. On 4/7/16 at 10:14 a.m., Resident #3's	F 0278	**F 278 AssessmentAccuracy/Coordination/Certified What corrective action will be accomplished for those residents found to have been affected bythe deficient practice?** Resident #3's MDS assessment that was incorrectly coded was modified to reflect resident's accurate current condition. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. The MDS and/orDesignee will review all resident Oral/Dental Status to ensure the most recent Minimum	05/03/2016

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	clinical record was reviewed. The resident was admitted on 12/24/14. Resident #3's Admission Assessment Form, dated 12/24/14, indicated, " .... Dental: Obvious or likely cavity or broken natural teeth ..." Resident #3's Admission Minimum Data Set (MDS) Assessment, dated 1/2/15, indicated, " .... Oral/Dental Status ... D. Obvious or likely cavity or broken natural teeth." The signature portion of the MDS was signed as complete and accurate. Resident #3's Annual MDS assessment, dated 12/23/15, " .... Oral/Dental Status ... Z. None of the above were present." The signature portion of the MDS was signed as complete and accurate by the Registered Nurse. On 4/7/16 at 2:04 p.m., the MDS coordinator indicated she incorrectly coded the Annual assessment, dated 12/23/15. On 9/3/15 at 2:45 p.m., the Assistant Director of Nursing indicated the facility did not have a policy regarding accurately coding of the MDS assessments. 3.1-31(h)		Data Set Assessment information accurately reflect s each resident's dental status. If an MDS assessment isfound to be inaccurate, it will be modified to include the accurateinformation. This audit will completed by 05.03.2016. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** MDS Coordinator and/or MDS Designee will keep a log of all MDS assessment completed for the next three months, indicating all residents' dental status. The MDS Coordinatorand/or Designee will initial each assessment on the log to indicate accuracy. All MDS assessments will be double-checked for accuracy by the DNS and /or Designee. The Executive Director will review the log weekly and any issues with accuracy will be addressed with the MDS Coordinator. **How will the corrective actions be maintained to ensure the deficient practice will not recur?** To ensure compliance, the MDS Coordinator will bring the log to the monthly Quality Assurance Meeting for review. The MDS Coordinator and/or Designee will audit assessment for accuracy five times a week for four weeks and then once a week for 6 months. Any deficiencies will be corrected on the spot, and the findings of the Quality Assurance check will be	

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			documented and submitted in monthly Quality Assurance Meeting until no negative finding achieved for 6 months and ongoing as needed. I am requesting paper compliance **Westview Nursingand Rehabilitation IDR Informal DisputeResolution for Recertification and Licensure Survey 4-7-16** **Westview Nursingand Rehabilitation is requesting Paper IDR review** Westview Nursing and Rehabilitation respectfully requestsadditional evidentiary information be considered to reduce F 278 in severityfrom a D level to an A level in the 2567. **F 278*(Rev. 70, Issued: 01-07-11, Effective: 10-01-10Implementation: 10-01-10)*** **§483.20(g)Accuracy of Assessment** **Theassessment must accurately reflect the resident's status.** **Intent§483.20(g):** To assurethat each resident receives an accurate assessment by staff that are qualifiedto assess relevant care areas and knowledgeable about the resident's status,needs, strengths, and areas of decline. **InterpretiveGuidelines §483.20(g):** "Theaccuracy of the assessment"	

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			means that the appropriate, qualified healthprofessional correctly documents the resident's medical, functional, andpsychosocial problems and identifies resident strengths to maintain or improvemedical status, functional abilities, and psychosocial status. The initialcomprehensive assessment provides baseline data for ongoing assessment ofresident progress. **The deficient practice statement states:** Based on observation, interview, andrecord review, the facility failed to ensure resident's assessed dental statuswas accurately documented on the Minimum Data Set (MDS) assessment for 1 of 3residents reviewed for dental status and services. (Resident #3). **Evidence to refute the finding:** **State Operations Manual definition of severity:** B. Guidanceon Severity Levels There arefour severity levels. Level 1, no actual harm with potential for minimal harm;Level 2, no actual harm with potential for more than minimal harm that is notimmediate jeopardy; Level 3, actual harm that is not immediate jeopardy; Level4, immediate jeopardy to resident health or safety. These four levels aredefined accordingly: 1. Level 1is a deficiency that has the potential for causing no more than a minornegative impact on	

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			the resident(s). 2. Level 2is noncompliance that results in no more than minimal physical, mental and/orpsychosocial discomfort to the resident and/or has the potential (not yetrealized) to compromise the resident's ability to maintain and/or reach his/herhighest practicable physical, mental and/or psychosocial well-being as definedby an accurate and comprehensive resident assessment, plan of care, andprovision of services. 3. Level 3is noncompliance that results in a negative outcome that has compromised theresident's ability to maintain and/or reach his/her highest practicablephysical, mental and psychosocial well-being as defined by an accurate andcomprehensive resident assessment, plan of care, and provision of services.This does not include a deficient practice that only could or has causedlimited consequence to the resident. 4. Level 4is immediate jeopardy, a situation in which immediate corrective action isnecessary because the facility's noncompliance with one or more requirements ofparticipation has caused, or is likely to cause, serious injury, harm,impairment, or death to a resident receiving care in a facility. (See AppendixQ.)	

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			The deficiency addresses 1 specificresident, resident # 3. The admission assessment form for resident 3dated 12-24-14 correctly identified dental concerns -obvious or likely cavityor broken natural teeth. (Attachment 1). Resident #3 Admission MDS dated 1-2-15identified dental concerns - Obvious or likely cavity or broken natural teeth. Resident #3 had a care plan to addressher teeth developed 1-8-15. (Attachment 2). Resident #3 went to the dentist withher son on 9-30-15. The dentist did not prescribe any new orders. (Attachment3). Resident #3 was seen by the dentist on01-27-16. The dentist did not prescribeany new orders. (Attachment 4). A similar deficiency was written atWhite River Lodge on 1-7-16, which resulted in an A level deficiency. (Attachment5). **Conclusion:** The definition of level 2 scope andseverity - D level “. Level 2 isnoncompliance that results in no more than minimal physical, mental and/orpsychosocial discomfort to the resident and/or has the potential (not yetrealized) to compromise the resident’s ability to maintain and/or reach his/herhighest practicable physical, mental and/or psychosocial well-being as definedby an accurate and comprehensive resident	

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			assessment, plan of care, andprovision of services. The coding onthe MDS is an error which had no impact on the resident. The resident admissionassessment, admission MDS, were accurate. Resident #3 had a care plan for herteeth, and resident saw the dentist in September. Based on the definitions provided inthe state operations manual, this deficiency should be considered a Level 1 deficiency – deficiency thathas the potential for causing no more than a minor negative impact on theresident(s). **Westview Nursing and Rehabilitation Center is requesting thedeficiency be reduced in severity from a D to an A level.** Thank you for your consideration.	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure staff handwashed after coughing and after touching their uniform while placing eye glasses in their pocket and taking the eye	F 0371	This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that the deficiency exists or that on was cited	04/18/2016

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NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DR BEDFORD, IN 47421	

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	glasses out of their pocket to place on their face as indicated by the facility policy and the Center for Disease Control for 7 of 7 residents served a puree diet from the kitchen. Findings include: On 04/07/2016 12:13 a.m., Cook #1 was observed coughing over food while pureeing liver without covering her mouth. Cook #1 was also observed to take her glasses off and place the glasses in her pocket. Cook #1 was then observed to take her glasses out of her pocket and place them on her face. No handwashing was observed. This was done several time. Cook #1 indicated she should have handwashed. The Dietary Manager (DM) was informed of Cook #1's coughing over the food and provided Cook #1 with a face mask. Review of Center for Disease Control at ww.cdc.gov/handwashing/, dated December 16, 2013 indicated, " When should you wash your hands? Before, during, and after preparing food... After blowing your nose, coughing, or sneezing ..." On 4/7/16 the Assistant Director of Nursing (ADON) provided the policy		correctly. This Plan of Correction is submitted to meet requirements by state and federal law. **F 371 Food Procure,Store/Prepare/Serve-Sanitary What correctiveaction will be accomplished for those resident s found to have been affected by the deficient practice?** Cook #1 was immediately re-in-serviced on hand hygiene. All dietary staff was immediately re-in-serviced on hand hygiene. **How other residentshaving the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the deficient practice. The Dietary Managerand/or Designee re-in-serviced all dietary staff to ensure this deficient practice is identified with all dietary staff. The Dietary Manager or Designee will conduct daily audits on proper handwashing during meal services which will be done before, during and after preparing foods. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Dietary Manager and/or Designee do random audit of all meal services to ensure proper handwashing is being done before, during and after preparing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/07/2016
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	"Dietary Personal Hygiene " dated 07/2015, and indicated the policy was the one currently used by the facility. The policy indicated, " 1. Proper handwashing is the most critical aspect of personal hygiene. Dietary employees must wash their hands before they start work and after: ...c. Touching the hair, face, or body, d. Sneezing, coughing, or using a tissue, ...j. Touching anything else that may contaminate hands, ... " 3.1-21(i)(3)		foods. The Executive Director and/or Designee will review the log weekly. **How will the corrective actions be maintained to ensure the deficient practice will not recur?** To ensure compliance, the Dietary Manager and/or Designee will bring the log to the monthly Quality Assurance Meeting for review. The Dietary Manager and/or Designee will audit dietary meal services five times a week for four weeks and then once a week for 6 months. Any deficiencies will be corrected on the spot, and the findings of the Quality Assurance check will be documented and submitted in monthly Quality Assurance Meeting until no negative finding achieved for 6 months and ongoing as needed. I am requesting paper compliance	