

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 12, 13, 14, 15, 2012</p> <p>Facility number: 000100 Provider number: 155191 AIM number: 100266130</p> <p>Survey team: Donna Groan, RN TC Avona Connell, RN Dorothy Navetta, RN (March 14, 15, 2012)</p> <p>Census bed type: SNF/NF: 89 Residential: 94 Total: 183</p> <p>Census payor type: Medicare: 15 Medicaid: 62 Other: 106 Total: 183</p> <p>Sample: 18 Supplemental sample: 01 Residential sample: 07</p> <p>These deficiencies also reflect State</p>	F0000	<p>Completion Date: 4/14/12 Plan of Correction Text: Re: Provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 March 23, 2012 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, IN 46204 Dear Ms. Rhodes, Please find the Form CMS-2567 with the plan of correction for the deficiencies sited during our recertification and Indiana State Licensure survey conducted at Westminster Healthcare Center on March 12th through March 15th 2012. I can be reached at 812-282-9691 ext. 123 if you would have any question or comments regarding the enclosed documents. Sincerely, Floyd Shewmaker Administrator Westminster Healthcare Center Preparation and execution of this plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Healthcare Center ("Facility") is not in substantial compliance with federal requirements of</p>	
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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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	Findings cited in accordance with 410 IAC 16.2. Quality review completed 3/16/12 by Jennie Bartelt, RN.		participation, this response and plan of correction constitute Westminster Healthcare Center allegation of Compliance. Date of Compliance: April 14, 2012		

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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 record review and interview, the facility failed to ensure the physician was notified of the resident's request for no cardiopulmonary resuscitation (CPR) as indicated in the resident's Advance</p>	F0157	Please Consider Paper Compliance for F157Resident #62To Identify Those Resident's Who Have The Potential To Be Affected by The Alleged Practice:On 3/14/12 the physician	04/14/2012			

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	<p>Directive. The deficient practice affected 1 of 18 sampled residents reviewed related to Advance Directives. (Resident #62)</p> <p>Findings include:</p> <p>The clinical record for Resident #62 was reviewed on 3/14/12 at 12:05 p.m. The resident's diagnoses included, but were not limited to, dementia and hypokalemia (low potassium). The resident was admitted to the facility on 3/10/12. The current physician orders, signed and dated 3/12/12, included, but were not limited to "Code Status: Full [cardiopulmonary resuscitation (CPR) to begin when the heart stops]."</p> <p>The Advance Directive, signed and dated 3/12/12 by the Legal Representative, included, but was not limited to: "I would not wish for CPR to be administered and would like a physician to be contacted to request that he/she write an order to this effect." Documentation was lacking of the physician being notified of the residents Advance Directive.</p> <p>In interview with RN #1 on 3/14/12 at 3:00 p.m., she indicated the order should have been clarified with the physician.</p> <p>On 3/15/12 at 10:55 a.m., RN #1 provided</p>		<p>was notified, an order was obtained to change the code status, and documentation was completed in the nurses notes. All resident's medical records were audited by the Social Service Director on 3/14/12 to ensure accuracy of all code status. All were found to be correct. Interventions Implemented to Ensure the Alleged Deficient Practice Does Not Recur: Policy implementation of "Change in Advanced Directive" to be in-serviced 3/29/12 to all licensed nurses The Admissions Director and Social Services Director to be in-serviced on 3/29/12 to provide a signed "Advanced Directive" upon admission to the charge nurse. The Admission's Director or designee to provide the charge nurse a signed "Advanced Directive" pursuant to the "Patient Self Determination Act of 1990 (Public Law 101-508)" upon admission. The Director of Nursing or designee to audit all new admission's medical records for the accuracy of the code status within 24 hours for the next 90 days. Quality Assurance Program Evaluation: The DON or designee shall report at the scheduled Quality Assurance Committee meetings the new admission audit findings. Any revisions needed will be evaluated by the Quality Assurance Committee and the Administrator. Completion Date:</p>		

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	<p>the revised April 3, 2009, policy/procedure for "Physician Notification" which included, but was not limited to: "The purpose of this facility policy is to ensure the prompt notification of the resident, the residents attending physician and the resident's POA (Power of Attorney) of any significant changes in the resident's health status, need to alter treatment or plan of care, the decision to transfer the resident to another room, or a roommate change or the need to discharge the resident from the facility. The resident, resident's attending physician, the POA and the DON [Director of Nursing] must also be notified of any of the changes in the resident's rights...."</p> <p>On 3/15/12 at 11:15 a.m., in interview with the Admissions Coordinator, she indicated she normally gives the Advance Directive to the nurses, but had put this one into the chart without notifying staff.</p> <p>3.1-5(a)(3)</p>		4/14/12				

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F0371 SS=F	<p>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</p> <p>Based on observation and interview, the facility failed to ensure hands were washed and meat for salads was kept at the proper temperature for 1 of 2 dietary observations in the main kitchen. This deficient practice had the potential to affect 88 residents receiving meals from the dietary department, from the 89 facility residents.</p> <p>Findings include:</p> <p>On 03/12/12 between 8:29 a.m. and 11:34 a.m., the following was observed in the main kitchen:</p> <ol style="list-style-type: none"> At 10:10 a.m., Dietary Aide #1, was observed to raise the lid of the trash container with her hand, and dispose of trash in the container. Without washing her hands, she returned to preparing food items. At 11:04 a.m., Dietary Aide #2, was observed to raise the lid of the trash container with her hand, dispose of used 	F0371	<p>Please Consider Paper Compliance for F371 Corrective Action for 88 Residents Affected by the Alleged Deficiency: No residents have been affected by the alleged deficiency. Primary staff were in-service March 12, 2012 immediately upon alleged deficiency. Corrective warning issued to employee. Copies given to surveyors. Copies of orientation and in-service training also made available. Primary staff were interviewed for complaints of GI disturbance. None had been reported. Identify Residents Who Have Potential To Be Affected By Alleged Deficiency and Corrective Action For Those Residents: All residents have potential to be affected by the alleged deficiency. Primary care staff have been interviewed to determine if any wide spread GI disturbance and none have been noted. CDM to in-service staff March 27, 2012 on the importance of hand washing. The in-service will include the policy and procedure for hand washing, policy and procedure for proper preparation and storage of potentially hazardous foods, and</p>	04/14/2012	

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	<p>gloves and without washing her hands, return to mixing dumplings.</p> <p>3. At 11:08 a.m., Dietary Aide #2, was observed to rinse her hands in the salad prep sink, and dry her hands on a cloth towel. The cloth towel was on a cart used to drain clean dish/pan items. She then lifted the lid of the trash container and wiped her hands on the front of her apron, without hand washing.</p> <p>4. At 11:13 a.m., a large plastic container of cubed ham for salad preparation was sitting on the prep counter. In interview at this time, Dietary Employee #3, responsible for salad prep, indicated the ham had been sitting on the counter since 7:30 a.m. The plastic container of ham was not in ice and measured 73 degrees Fahrenheit (F). Dietary Employee #3 indicated the temperature should be 41 degrees F or below.</p> <p>5. At 11:34 a.m., a large trash container by the dish machine was uncovered. The lid was on the floor.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>proper storage of garbage. Corrective Actions Will Be Monitored to Ensure the Alleged Deficient Act Does Not Recur:1. All staff in-service March 27, 2102 regarding handwashing, proper garbage management, and proper food temperatures.2. Staff will be monitored daily to ensure all staff are washing their hands appropriately, properly storing potentially hazardous foods, and utilizing garbage receptacles correctly. The CDM or designee will monitor two (2) employees daily on handwashing for 90 days then randomly after that. Any deviation will be corrected immediately and responsible employee educated. Audit and findings to be reported to the QA team and in monthly meeting.3. CDM and / or designee will be completing daily rounds to ensure all staff are following facility policy and procedure regarding proper garbage handling.4. RD to monitor monthly for compliance and report to CDM, RD, and Administrator.5. Dietary staff will record food temperatures upon removing from refrigerator, during preparation, upon returning to refrigerator, and upon serving. Food temperatures will be recorded on a food temperature sheet and initialed by the employee. This will be monitored daily by the CDM or designee for compliance.Effectiveness of the Plan:Any revisions needed will be</p>				

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			evaluated by the QA team, CDM, RD, and Administrator. Completion Date:4/14/12	

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the clinical record was complete and accurate for 2 of 18 sampled residents reviewed for accuracy of the clinical record. (Residents #62 and #100)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #62 was reviewed on 3/14/12 at 12:05 p.m. The record indicated the resident's diagnoses included, but were not limited to, dementia and hypokalemia (low potassium). The resident was admitted to the facility on 3/10/12. The current physician orders, signed and dated 3/12/12, included, but were not limited to, "Code Status: Full [cardiopulmonary resuscitation (CPR) to begin when the heart stops]."</p>	F0514	<p>Please Consider Paper Compliance for F514Resident #62To Identify Those Resident's Who Have The Potentail To Be Affected by The Alleged Practice:On 3/14/12 the physician was notified, an order obtained to change the code status, and documentation completed in the nurses notes.All resident's medical records were audited by the Social Services Director on 3/14/12 to ensure accuracy of all code status. All were found to be correct.Interventions Implemented to Ensure the Alleged Deficient Practice Does Not Recur:Policy Implementation of "Change in Advanced Directive" to be in-serviced 3/29/12 to all licensed nurses.The Admissions Director and Social Services Director to be in-serviced on 3/29/12 to provide a signed "Advanced Directive" upon admission to the charge</p>	04/14/2012			

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	<p>The Advance Directive signed and dated 3/12/12, by the Legal Representative, included, but was not limited to: "I would not wish for CPR to be administered and would like a physician to be contacted to request that he/she write an order to this effect." Documentation was lacking of a DNR (Do Not Resuscitate) physician's order being obtained.</p> <p>In interview with RN #1 on 3/14/12 at 3:00 p.m., she indicated the order should have been clarified.</p> <p>2. The closed record for Resident #100 was reviewed on 3/14/12 at 9:45 a.m. The resident's diagnoses included, but were not limited to: depression and brain cancer. The resident expired on 12/7/11.</p> <p>Nurses Notes included, but were not limited to:</p> <p>12/7/11 11:00 a.m., "[Name of hospice provider] lpn [Licensed Practical Nurse] here. Pt (patient) resting abed Resp (respirations) shallow 28 -32, mottling to Bil (bilateral) hands/feet & ears. Son, dtr (daughter) here, they have called [named] in who has also called Pt's brother. Update to family that pt will possibly go today. Pt is comfortable @ this time...."</p>		<p>nurse.The Admission's Director or designee to provide the charge nurse a signed "Advanced Directive" pursuant to the "Patient Self Determination Act of 1990 (Public Law 101-508)" upon admissionThe Director of Nursing or designee to audit all new admission's medical records for the accuracy of the code status within 24 hours for the next 90 days.Quality Assurance Program Evaluation:The DON or designee shall report at the scheduled Quality Assurance Committee meetings the new admission audit findings. Any revisions needed will be evaluated by the Quality Assurance Committee Members and the Administrator.Completion Date: 4/14/12Resident #100To Identify Those Resident's Who Have The Potential To Be Affected by The Alleged Practice:The medical record of all resident deaths to be audited by the Medical Records Director the next 90 days to ensure facility policy compliance.Interventions Implemented to Ensure the Alleged Practice Does Not Recur:The facility nurse was counseled related to the lack of documentation per facility policy in the nurses notes.The revised policy "Death of A Resident" to be in-serviced 3/29/12 to all licensed nurses. Quality Assurance Program Evaluation:The DON or designee shall report at the scheduled Quality Assurance Committee meetings the death</p>				

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	<p>12/7/11 2:00 p.m., "[Name of hospice provider] lpn here after being called for pt death...."</p> <p>The Discharge Summary indicated the time of death as 1:35 p.m. on 12/7/11. Nurse's Notes lacked documentation the resident's respirations had ceased.</p> <p>On 3/14/12 at 10:27 a.m., in interview with RN #1, she indicated the nurses notes should have included the time of death and more detail. At 11:55 a.m., RN #1 provided the undated policy/procedure for "Death of a Resident" which included, but was not limited to: "2. All information pertaining to a resident's death must be recorded in the nurses notes.(Example: Date, Time of death...)"</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>		<p>audit findings. Any revisions needed will be evaluated by the Quality Assurance Committee Members and the Administrator. Completion Date:4/14/12</p>		