STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155177	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE - WEST LAFAYETTE	2741 N SALISBURY ST WEST LAFAYETTE, IN 47906

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 10,11,12,13,14,15 and 19, 2016 Facility number: 000093 Provider number: 155177 AIM number: N/A Census bed type: SNF: 68 Residential: 42 Total: 110 Census payor type: Medicare: 12 Other: 56 Total: 68 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 21662 on January 25, 2016.	F 0000		
F 0371 SS=F	483.35(i) FOOD PROCURE,			

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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Bldg. 00	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, record review and interview, the facility failed to ensure food was covered, labeled and dated in the freezers in 2 of 2 kitchenettes in the facility. This deficient practice had the potential to affect 64 of 64 residents receiving food from the kitchen. Findings include: During the tour of the kitchenettes on 1/10/2016 at 3:00 p.m., with the Dietary Manager, the following observations were made: 1.) The Cafe Dining Area kitchenette was observed to have open, and not dated items: a.) a frozen container of 2 salmon patties was opened and not dated. b.) a frozen package of 4 hamburger patties was opened and not dated. c.) a frozen package of 4 turkey patties was opened and not dated. d.) a frozen package of 9 pizza shells was opened and not dated. e.) 2 frozen ice cream containers were opened and not dated.	F 0371	F371 On 1/10/16, when concerns were voiced to the Director of Dining Services, the open items in the Café kitchenette were immediately removed and discarded. Additionally, the frozen ice cream in the Terrace kitchenette was immediately removed and discarded from the freezer. The dining management team immediately reviewed all areas in the kitchens to ensure food was labeled and dated properly. Appropriate dining staff will receive additional in-service training by the dining management team on the labeling and dating policy by 2/17/16. Labeling and dating audits will be completed by dining management staff weekly. Findings of the audit will be reported to the Quality Assurance Performance Improvement(QAPI) committee and a performance plan will be established based on the findings. The QAPI committee will meet quarterly. Additionally, the Registered Dietician will complete a monthly inspection of all kitchen areas to be reported as part of the Quality Assurance Performance Improvement program.	02/17/2016

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	2.) The Terrace Area kitchenette was observed to have 2 containers of frozen ice cream open and not dated. During an interview on 1/10/2016 at 4:00 p.m., with the Dietary Manager, he indicated that all open items should have been sealed and dated when opened. The policy titled "Labeling and dating items in bulk," dated 8-08, received on 1/14/2016 at 2:45 p.m., from the Administrator, indicated "... items that have been opened will have an opened date on them...." 3.1-21(i)(2)			
F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to provide accurate labeling of medication for 1 of 8 residents observed during medication administration. (Resident #33) Findings include: During an observation of medication administration on 1/14/16 at 1:37 p.m., Resident #33 received 1 Morphine (a narcotic) 15 mg (milligrams) tablet by QMA #1. The MD (Medical Doctor) order written on 1/12/16 at 6:00 a.m., indicated "...give Morphine 15 mg P.O. (by mouth) every 4 hours routine for pain...." The MAR (Medication Administration Record), dated 1/12/16, indicated give Morphine 15 mg P.O. every four hours for chronic pain.	F 0425	F425 On 1/14/16, the medication label for resident #33 was immediately changed to comply with the MD order and the MAR. On 1/14/16, the medication labels were audited for all residents to ensure the labels complied with the MD orders and MAR. All nurses and QMAs will receive additional in-service training on the medication administration policy by 2/17/16. Additionally, five audits will be performed by the DON or her designee monthly for accuracy of the medication labels. Findings of the audit will be reported to the Quality Assurance Performance Improvement (QAPI) committee and a performance plan will be established based on the findings. The QAPI committee will meet quarterly.	02/17/2016

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	The Pharmacy medication label on the card containing the medication for administration indicated give 1 Morphine 15 mg tab every 4 hours PRN (as needed). During an interview on 1/14/16 at 1:50 p.m., with QMA #1, she indicated the Pharmacy medication label was incorrect and should have been updated with a direction change label. The policy titled "Medication Administration" received from the Nurse Educator on 1/15/16 at 9:10 a.m., indicated "...V. Medication Verification and Administration Record Transcribe medication orders to MAR accurately. Confirm that the physician order matches the MAR and medication label. Use "direction change" stickers as appropriate...." 3.1-25(k)(5)			
F 0441 SS=D Bldg. 00	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			

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	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 record review and interview, the facility failed to ensure annual tuberculosis (TB) screening was completed for employees. This deficient practice affected 2 of 5 employees screened for TB. (CNA #1 and Staff Member #2) Findings include: 1. During a record review on 1/14/16 at	F 0441	F441 On 1/12/16, CNA #1 and Staff Member#2 received their first step of their annual TB screening. Additionally, CNA #1 received her second step of her TB screening on 2/2/16 and Staff Member #2 received her second step of her TB screening on 1/22/16. On 1/12/16, an audit was completed for all employees to ensure annual TB screenings were completed. Human Resources staff will receive additional in-service training on	02/17/2016

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	3:00 p.m., CNA #1's employment record indicated the most recent tuberculin skin test was completed on 10/28/14. No tuberculin skin test was completed for 2015. 2. During a record review on 1/14/16 at 3:15 p.m., Staff Member #2's employment record indicated the most recent tuberculin skin test was completed on 10/17/14. No tuberculin skin test was completed for 2015. During an interview with the Administrator on 1/14/2016 at 2:45 p.m., he indicated the annual tuberculin skin tests were overlooked for CNA #1 and Staff Member #2 and not completed for 2015. A review of policy titled "Annual TB Testing", dated February 5, 2001 received on 1/15/2016 at 11:15 a.m., from Medical Records Director, indicated "... 2. Employees hired between April 1 and September 30 will receive their annual TB test in April of each year. Employees hired between October 1 and March 31 will receive their annual TB test in October of each year...." 3.1-18(k)		the annual TB testing policy by 2/17/16. Additionally, five audits will be performed by the HR Director or his designee monthly for accuracy of annual TB screenings. Findings of the audit will be reported to the Quality Assurance Performance Improvement (QAPI) committee and a performance plan will be established based on the findings. The QAPI committee will meet quarterly.	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 42 Sample : 9 Westminster Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000		