

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 12/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Survey.</p> <p>Survey dates: December 1, 2, 3, 4, 8, 9, and 10, 2014</p> <p>Facility number: 000093 Provider number: 155177 AIM number: N/A</p> <p>Survey Team: Bobette Messman, RN-TC Maria Panteleo, RN Rita Mullen, RN Holly Duckworth, RN (December 3, 4, 8, 9 and 10, 2014)</p> <p>Census bed type: SNF: 68 Residential: 34 Total: 102</p> <p>Census payor type: Medicare: 17 Other: 68 Total: 85</p> <p>Residential sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		

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.

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 12/10/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F000278 SS=D	<p>-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on December 12, 2014.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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</p>						

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 12/10/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to accurately complete an Admission Minimum Data Set assessment (MDS) regarding a resident's bladder continence status for 1 of 3 residents review for bladder incontinence (Resident #117).</p> <p>Findings include:</p> <p>The clinical record of Resident #117 was reviewed on 12/3/14 at 2:00 p.m.</p> <p>Diagnoses included, but were not limited to, urinary tract infection and bladder incontinence.</p> <p>A Nursing admission assessment, dated 8/6/14, indicated Resident #117 was incontinent of bladder.</p> <p>A Nursing Fall Risk Assessment dated 8/6/14, indicated the resident's elimination status as incontinent of bladder.</p> <p>A Care Plan, dated 8/6/14, indicated bowel and bladder incontinence.</p>	F000278	<p>On 12/10/14, the Minimum Data Set(MDS) was reviewed for resident #117. Corrective action for resident #117 was not needed due to resident discharge on 11/24/14. On 12/11/14-12/23/14, MDS nurses reviewed section "H" on all resident's MDS for accuracy. This section was completed accurately on all reviewed MDS section"H". The Director of Nursing (DON) provided the MDS nurses with accuracy training on 12/23/14. Five Audits will be performed by the DON or MDS nurse or her designee monthly for accuracy of the bowel and bladder section "H" of the MDS. 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 monthly.</p>	12/23/2014			

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 12/10/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F000371 SS=D	<p>A review of the Care Tracker entries for the month of Aug 2014, indicated the resident was incontinent on 8/9/14 on the 7-3 shift. This was within the monitoring period.</p> <p>An Admission MDS assessment, dated 8/12/14, indicated Resident #117 was always continent of urine.</p> <p>During an interview with the MDS Coordinator, on 12/8/14 at 10:45 a.m., she indicated, "I made an error when I looked at the Care Tracker record."</p> <p>3.1-31(a)</p> <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</p>				

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 12/10/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 kitchens were cleaned regarding the floor and Combo oven in the Main kitchen and the dishwasher in the Village Cafe.</p> <p>Findings include:</p> <p>During the initial tour with the Assistant Dining Director, on 12/1/14 at 9:30 a.m., the following was observed:</p> <ol style="list-style-type: none"> 1. In the Main Kitchen the floor behind the juice dispenser and cola machine had two clear plastic cups, a small straw basket and dark dried liquid on the flooring. 2. The lower right Combo oven had brown dried liquid and debris on the top of the outer casing. 3. The Village Cafe dishwasher had lime build-up on the housing. <p>During an interview with the Assistant Dining Director, on 12/1/14 at 10:00 a.m., she indicated she was not aware of the debris behind the juice and cola dispensers and had not noticed the dried liquid on the Combo oven. She also indicated the dishwasher in the Village</p>	F000371	<p>On 12/1/14, when concerns werevoiced to the Director of Dining Services, the main kitchen floor behind thejuice dispenser and cola machine was immediately cleaned and all debris wasremoved. Additionally, the combo ovenwas cleaned and all debris was removed from the top of the outer casing. On 12/11/14, the Village Café dishwasher wascleaned and all lime build-up was removed. The dining management team immediately viewed areas in the kitchen toensure food was stored, prepared, distributed and served under sanitaryconditions. Appropriate dining staffhave received additional in-service training by the dining management team on cleaningequipment per policy by 12/23/14. Thesethree items will become part of the facility Quality Assurance PerformanceImprovement program and will be monitored by dining management staff daily. Aswell as daily monitoring, the dining management staff will audit the diningareas twice per week and log the findings. The times of the audit will berandom and there will be a minimum of one pre-breakfast audit per month toensure sure all staff is adhering to the policies. Findings of the audit willbe reported to the Quality Assurance Performance</p>	12/23/2014

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 12/10/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
R000000	Cafe was due for de-liming. 3.1-21(i)(2) Westminster Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R000000	Improvement (QAPI) committee and a performance plan will be established based on the findings. The QAPI committee will meet monthly. 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.		