

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(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
F0000	<p>This visit was for the Investigation of Complaint IN00101963.</p> <p>Complaint IN00101963 substantiated, Federal/State deficiencies related to the allegations are cited at F157 and F314.</p> <p>Survey dates: January 17,18, 2012</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: SNF: 49 SNF/NF: 63 Residential: 89 Total: 201</p> <p>Census payor type: Medicare: 38 Medicaid: 50 Other: 113 Total: 201</p> <p>Sample: 4</p> <p>These deficiencies also reflect State</p>	F0000		

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:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	findings cited in accordance with 410 IAC 16.2.  Quality review completed 1/23/12 Cathy Emswiler RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(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
F0157 SS=D	<p>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 a resident's physician was promptly notified and appropriate orders received after a reddened area to her coccyx was identified which led to the development of a stage III pressure sore (Resident F) for</p>	F0157	Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in this survey report are accurate or reflect accurately the provision of nursing care and services to the Residents at Westminster Village	02/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2012	
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236			
(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>1 resident of 3 reviewed for pressure sores in a sample of 4.</p> <p>Findings included:</p> <p>1. The record of Resident F was reviewed on 1/18/12 at 9:00 a.m.</p> <p>Diagnoses included, but were not limited to, recent fracture of the left femoral head, atrial fibrillation, gastro-esophageal reflux disease a history of urinary tract infection, and hypothyroidism.</p> <p>An admission Minimum Data Set (MDS) assessment dated 11/10/11 indicated Resident F had no cognitive or communication deficits, and required staff assistance for all activities of daily living.</p> <p>Records indicate Resident F was re-admitted to the facility on 11/26/11.</p> <p>A Nursing Admission Assessment dated 11/26/11 indicated Resident F had no pressure sores on admission to the facility.</p> <p>A "Skin Condition Report" dated 11/26/11 indicated "Appearance: Pink coccyx..."</p> <p>An admission "Nutritional Assessment" dated 12/01/11 includes a hand written note</p>		<p>North.F 157Stictly for purposes of clarification, please note that the surveyor's notation regarding the 12/13/11 Nurses' Note erroneously stated that the wound was noted to be a "Stage III" wound. In actuality, said Nurses' Note denotes the area in question to be a "Stage II".I. One must note that the following interventions were in place for this Resident at the time of admission: low air loss mattress; chair cushion. Additioinally, on 11/28/11, a multivitamin was ordered for the Resident.Also, one must note that the N.P. saw this Resident on 11/28/11 and, under the category of "Skin", only noted the presence of the Resident's left hip incision. Also, the Attending Physician performed an Admission H&amp;P for the Resident on 12/1/11, and only noted the presence of the left hip incision under the category of "Skin".The wound dimentions steadily decreased: 12/13/11 - 2.8 cm x 1.9 cm and of superficial depth; 12/16/11 - 1 cm x .05 cm x 0.1 cm; 12/23/11 - - 0.5 cm x 0.5 cm x 0.1 cm; 12/30/11 - 0.3 cm x 0.2 cm x 0.1 cm.It is important to denote that the area in question was healed as of 1/4/12 and this was further affirmed by the wound care specialist as on the routinely scheduled (weekly) visit on 1/6/12, they, too noted that the area was "resolved". The Resident suffered no long term negative affects secondary to this</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2012	
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236			
(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>"Red Coccyx."</p> <p>During an interview with the Director of Nursing 1/18/12 at 4:20 p.m. she indicated that prior to the identification of Resident F's stage III pressure sore on 12/13/11, there was no indication Resident F's physician had been contacted, no order for Calmoseptine ointment or other preventive treatment had been obtained, and no documentation any preventive treatment had been done following the identification of the pink/reddened areas to her coccyx first noted on 11/26/11.</p> <p>2. A Facility document titled "Wound Protocols" and signed as authorized by the Medical Director on 9/14/06 and indicated by the Director of Nursing to be a current facility policy indicated: "The attending physician must be advised at the first sign of a persistent reddened area and/or an open area of the skin. In an effort to allow prompt treatment of superficial, uncomplicated conditions...the following treatment protocols are to be initiated...Stage I Pressure Ulcer: Gently cleanse the area with soap and water. Pat dry. Apply Calmoseptine Cream. This treatment is to be performed twice daily and as needed..."</p> <p>This federal tag relates to Complaint</p>		<p>wound. II. Subsequent to this finding, and to ensure to identify any resident who could potentially be affected, a Skin Assessment was performed for all of the facility's Residents in an effort to ensure that the physician had been promptly notified and appropriate treatment orders were in place for any observed condition. III. Although the facility had Quality Assurance measures in place at the time of this incident, this oversight was the result of human error. It has been a long standing practice that two nurses conduct the admitting skin assessment and both review the admitting orders for accuracy. The nurses noted the need for Calmoseptine on the skin assessment form; regrettably, they failed to obtain the order. One of the two nurses is no longer employed by the facility. The remaining nurse has been disciplined for this oversight. In view of this oversight, the Quality Assurance measures germane to the admission process have been modified in an effort to prevent future recurrence. Revised criteria dictates the need for both nurses to review the admitting skin assessment with the admitting orders to ensure that any areas identified on the admitting skin assessment have an appropriate, corresponding treatment order in place - to be secured at the time the physician</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2012
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236		
(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	
	IN00101963.  3.1-40(a)(1)		is advised of the admission and admitting orders clarified. In short, the nurses shall be responsible to ensure the resident's physician is promptly notified and appropriate orders received for any persistent reddened or open area identified. Additionally, as part of the Quality Assurance measures germane to admission, the admission orders have undergone a third review by an Administrative Nurse subsequent to admission. The role of the Administrative Nurse in the process has been expanded to also include review of the admitting skin assessment with the admitting orders to ensure that any areas identified on the admitting skin assessment have an appropriate corresponding treatment order in place, which will also serve to dentoe that the physician was advised. Should any discrepancies be noted, the physician will be contacted for clarification. Should there be any evidence of any non-compliance on the part of an employee(s), said employee(s) will be addressed regarding the same. Charge Nurses are responsible. Administrative Nursing Staff will monitor for compliance on scheduled days of work. All nursing Personnel will be provided with additional inservice education regarding the prevention and treatment of wounds, including prompt		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2012
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236		
(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>physician notification and obtaining of appropriate orders should a persistent reddened or open area be observed. Record of weekly skin observations of all residents shall be reviewed by administrative nursing to ensure compliance with prompt physician notification and obtaining necessary orders should a persistent reddened or open area be observed. One must also note that it has been a long standing practice of this facility to utilize an outside consulting group of wound care specialists. This practice shall also continue. A wound care specialist from this group will be providing additional wound care education to all licensed nurses.IV. As a means of quality assurance, continued compliance with the revised Quality Assurance monitoring as described above and concerns identified and/or corrective actions taken in response (if any) shall be reported to the Quality Assurance Committee during quarterly meetings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2012	
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236			
(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			
F0314 SS=G	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to ensure a resident who entered the facility without pressure sores (Resident F) did not develop a pressure sore after admission for 1 resident of 3 reviewed for pressure sores who developed a pressure sore which progressed to a stage III in a sample of 4.</p> <p>Findings included:</p> <p>1. The record of Resident F was reviewed on 1/18/12 at 9:00 a.m.</p> <p>Diagnoses included, but were not limited to, recent fracture of the left femoral head, atrial fibrillation, gastro-esophageal reflux disease a history of urinary tract infection, and hypothyroidism.</p> <p>An admission Minimum Data Set (MDS) assessment dated 11/10/11 indicated Resident F had no cognitive or communication deficits, and required staff assistance for all activities of daily living.</p>	F0314	<p>F 314Strictly for purposes of clarification, please note that the surveyor's notation regarding the 12/13/11 Nurses' Note erroneously states that the wound was noted to be a "Stage III" wound. In actuality, said Nurses' Note denotes the area in question to be a "Stage II".I. One must note that the following interventions were in place for this Resident at the time of admission: low air loss mattress; chair cushion. Additionally, on 11/28/11, a multivitamin was ordered for the Resident. The Resident had a low air loss mattress in place since her admission on 11/26/11. It was explained during the survey process that the Resident had returned to WVN after a brief hospital stay. Upon her return on 11/26/11, she returned to her previous room; the low air loss mattress remained on the Resident's bed - it had never been removed. As a demonstration of the facility's commitment to minimize the risk of skin issues for our Residents, it has been a long standing practice</p>	02/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2012	
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236			
(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>Records indicate Resident F was re-admitted to the facility on 11/26/11.</p> <p>A Nursing Admission Assessment dated 11/26/11 indicated Resident F had no pressure sores on admission to the facility.</p> <p>A "Skin Condition Report" dated 11/26/11 indicated "Appearance: Pink coccyx..."</p> <p>An admission "Nutritional Assessment" dated 12/01/11 includes a hand written note "Red Coccyx."</p> <p>Nurse's notes indicated:</p> <p>12/13/11 9:00 p.m. "While doing res (resident) tx (treatment)...noted that she has develop (sic) open area in coccyx size 2.8 x 1.9 cm (centimeters) superficial stage..."</p> <p>12/17/11 3:00 a.m. "...skin care provided no changes in condition of coccyx area..."</p> <p>1/01/12 7:30 p.m. "...res open area in coccyx healing slow..."</p> <p>A "Skin Condition Report" dated 12/13/11 indicated "Size: 2.8 x 1.9 cm...Appearance: open area coccyx stage III..."</p>		<p>to provide low air loss mattresses to Residents. The use of the low air loss mattress is provided to Residents at no cost; the facility does not bill any entity for the use of these mattresses. The Resident had a prior order in her old chart for the use of the low air loss mattress. Heretofore, the facility has considered the use of the low air loss mattress as a "nursing measure"; thus, not always, have orders been secured for the use of the same - especially since there is no financial interest in the use of the low air loss mattresses. However, in the future, orders shall be secured for the use of a low air loss mattress. Also, one must note that the N.P. saw this Resident on 11/28/11 and, under the category of "Skin", only noted the presence of the Resident's left hip incision. Also, the Attending Physician performed an Admission H&amp;P for the Resident on 12/1/11, and only noted the presence of the left hip incision under the category of "Skin". The wound dimensions steadily decreased: 12/13/11 - 2.8 cm x 1.9 cm and of superficial depth; 12/16/11 - 1 cm x 0.5 cm x 0.1 cm; 12/23/11 - 0.5 cm x 0.5 cm x 0.1 cm; 12/30/11 - 0.3 cm x 0.2 cm x 0.1 cm. It is important to denote that the area in question was healed as of 1/4/12 and this was further affirmed by the wound care specialist as on the routinely scheduled (weekly) visit on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2012	
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>A "Skin Condition Report" dated 12/22/11 indicated "...Appearance: stage III to coccyx..."</p> <p>A "Sunnyside (Resident F's unit) Wound Log Report" Dated 12/16/11 indicated Resident F had a stage III pressure sore to her coccyx, the onset date was 12/13/11, and that the wound was facility acquired.</p> <p>A physician's order date 12/13/11 indicated "Calmoseptine oint (ointment) apply apply (sic) to coccyx (symbol for "and") buttocks Q (every) shift...L.A.L. (low air loss) mattress in bed."</p> <p>A "30 Day Nutritional Assessment" dated 12/21/11 indicated "Skin condition: Stage III coccyx...given new pressure ulcer resident may require add'l (additional) food/fld (fluid) for wound healing. Spoke (symbol for "with") Resident- she is trying to increase pro (protein) foods but wants fortified fds/supps (foods, supplements) to aid in healing..."</p> <p>During an interview on 1/18/12 at 3:00 p.m. the Health Center Food Service Director indicated that dietary interventions, including fortified foods and supplements, had been started immediately following the 12/21/11</p>		<p>1/6/12, they , too noted that the area was "resolved". The Resident suffered no long term negative affects secondary to this wound. II. Subsequent to this finding, and to ensure to identify any resident who could potentially be affected, a Skin Assessment was performed for all of the facility's Residents in an effort to ensure that the physician had been promptly notified and appropriate treatment orders were in place for any observed condition. III. Although the facility had Quality Assurance measures in place at the time of this incident, this oversight was the result of human error. It has been a long standing practice that two nurses conduct the admitting skin assessment and both review the admitting orders for accuracy. The nurses noted the need for Calmoseptine on the skin assessment form; regrettably, they failed to obtain the order. One of the two nurses is no longer employed by the facility. The remaining nurse has been disciplined for this oversight. In view of this oversight, the Quality Assurance measures germaine to the admission process have been modified in an effort to prevent future recurrence. Revised criteria dictates the need for both nurses to review the admitting skin assessment with the admitting orders to ensure that any areas identified on the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>assessment noted above. She also indicated no nutritional assessment or interventions had been implemented between the identification of Resident F's stage III pressure ulcer on 12/13/11 and the assessment done on 12/21/11.</p> <p>During an interview on 1/18/12 at 3:45 the Assistant Director of Nursing indicated Resident F had a low air loss mattress ordered during her previous stay in the facility, and that it remained on her bed when she was readmitted from the hospital on 11/26/11. She also indicated that Resident F's current record contained no order for a low air loss mattress, and no documentation that it had been in use since her readmission.</p> <p>During an interview with the Director of Nursing 1/18/12 at 4:20 p.m. she indicated that prior to the identification of Resident F's stage III pressure sore on 12/13/11, there had been no order for Calmoseptine ointment or other preventive treatment, and no documentation any preventive treatment had been done following the identification of pink/reddened areas to her coccyx on admission.</p> <p>2. A Facility document titled "Wound Protocols" and signed as authorized by the Medical Director on 9/14/06 and indicated</p>		<p>admitting skin assessment have an appropriate, corresponding treatment order in place - to be secured at the time the physician is advised of the admission and admitting orders clarified. In short, the nurses shall be responsible to ensure the resident's physician is promptly notified and appropriate orders received for any persistent reddened or open area identified. Additionally, as part of the Quality Assurance measures germane to admission, the admission orders have undergone a third review by an Administrative nurse subsequent to admission. The role of the Administrative Nurse in this process has been expanded to also include a review of the admitting skin assessment with the admitting orders to ensure that any areas identified on the admitting skin assessment have an appropriate, corresponding treatment order in place, which also serves to denote that the physician was advised. Should any discrepancies be noted, the physician will be contacted for clarification. Should there be any evidence of any non-compliance on the part of an employee(s), said employee(s) will be addressed regarding the same. Charge Nurses are responsible. Administrative Nursing Staff will monitor for compliance on scheduled days of work. All Nursing Personnel will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>by the Director of Nursing to be a current facility policy indicated: "The attending physician must be advised at the first sign of a persistent reddened area and/or an open area of the skin. In an effort to allow prompt treatment of superficial, uncomplicated conditions...the following treatment protocols are to be initiated...Stage 1 Pressure Ulcer: Gently cleanse the area with soap and water. Pat dry. Apply Calmoseptine Cream. This treatment is to be performed twice daily and as needed..."</p> <p>This federal tag relates to Complaint IN00101963.</p> <p>3.1-40(a)(1)</p>		<p>provided with additional inservice education regarding the prevention and treatment of wounds, including prompt physician notification and obtaining of appropriate orders should a persistent reddened or open area be observed. Record of weekly skin observations of all residents shall be reviewed by administrative nursing to ensure compliance with prompt physician notification and obtaining of necessary orders and implementation of appropriate preventative measure, should a persistent reddened or open area be observed. A checklist has been formulated to serve as a guideline to the licensed nurses to ensure that all the necessary steps are taken upon the discovery of a persistent reddened or open area, which denotes the need to notify the Dietary Supervisor. The Nutrition Interventions Protocol for Residents with Pressure Ulcers P&amp;P has been reviewed, revised, and implemented. The completion of the checklist is the responsibility of the nurse at discovery. The Unit Coordinator is responsible to review the completed checklist for completion. One must also note that it has been a long standing practice of this facility to utilize an outside consulting group of wound care specialists. This practice shall also continue. A</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			wound care specialist from this group will be providing additional wound care education to all licensed nurses. The facility shall continue to provide all Residents with a pressure reduction mattress, and shall upgrade to a pressure relief mattress for any Resident for whom the same is warranted. Additionally, the facility will continue to perform Braden Scales as a means to evaluate risk factors. IV. As a means of quality assurance, continued compliance with the revised Quality Assurance monitoring as described above and concerns identified and/or corrective actions taken in response (if any) shall be reported to the Quality Assurance Committee during quarterly meetings.	