

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  06/03/2016
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NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
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F 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00197728 completed on April , 19, 2016</p> <p>Complaint IN00197728-Not corrected.</p> <p>Survey date: June 3, 2016</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Census bed type: SNF/NF: 124 Total: 124</p> <p>Census payor type: Medicare: 24 Medicaid: 60 Other: 40 Total: 124</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on June 6, 2016</p>	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in the survey report are accurate or reflect accurately the provision of nursing care and service to the Residents at Westminster Village North	

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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F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure each resident identified by the facility for the use of a personal safety alarm (PSA) had one in use as ordered for 1 of 3 residents reviewed for PSA use in a sample of 4. (Resident #G)</p> <p>Findings include:</p> <p>During an observation on 6-3-16 at 11:40 a.m., in her room, Resident #G was not observed to have a PSA on her wheelchair. At this time, two PSA units were observed attached to the upper left hand siderail of Resident #G's bed. In an interview with Resident #G at this time, she indicated she has had a history of falls in the past and the facility utilizes a PSA for her wheelchair.</p> <p>Notification was made immediately to RN #5. RN #5 verified Resident #G was ordered to have a PSA to both the bed and wheelchair. RN #5 was observed to place a PSA to Resident #G's wheelchair</p>	F 0323	<p>The licensed nursing staff will continue to monitor/document the use of personal alarms, as per the current practice. However, subsequent to this citing additional layers of monitoring for the use of personal alarms has been added: 1) going forward, Restorative Nursing staff will monitor alarm use daily; 2) the Quality Assurance Nurse will randomly monitor alarm use on a weekly basis.</p> <p>Nursing staff will be re-educated regarding</p>	06/04/2016

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	<p>at 11:45 a.m.</p> <p>In an interview with CNA #6 on 6-3-16 at 11:47 a.m., she indicated she assisted another staff member in getting Resident #G up that morning. She indicated she observed the resident had two PSA units attached to her bed, "but I don't think she has one for her wheelchair [ordered]... We didn't put one on her. I know they [the facility] went through and got rid of a bunch of alarms not long ago."</p> <p>In an interview with CNA #7 on 6-3-16 at 11:47 a.m., she indicated she was unsure if Resident #G was ordered for the use of a PSA to her wheelchair. CNA #7 was observed to obtain a copy of a CNA assignment sheet, dated 5-10-16. CNA #7 indicated, to the best of her knowledge, this was the most current CNA assignment sheet for the unit. The CNA assignment sheet indicated Resident #G was to have a PSA to both her bed and wheelchair "per nursing measure as well as family request and consent."</p> <p>Resident #G's clinical record was reviewed on 6-3-16 at 11:50 a.m. Her diagnoses included, but were not limited to Alzheimer's disease, anxiety and chronic pain. Her most recent Minimum Data Set assessment, dated 5-23-16,</p>		<p>the importance of the consistent use of C.N.A. Assignment Sheets. Licensed Nurses will ensure that the C.N.A. Assignment sheets are distributed at the beginning of each shift. Random checks for the use of the C.N.A. Assignment Sheets will be conducted by Administrative Staff on a daily basis. The Quality Assurance Nurse will randomly monitor the use of the C.N.A. Assignment sheets on a weekly basis.</p> <p>Monitoring for both the appropriate alarm use and consistent use of the C.N.A. Assignment Sheets will continue for at least the next six months. The findings of the aforementioned reviews will be monitored during the facility's monthly Quality Assurance Meetings for at least the next six months. At the end of six months if 100% compliance achieved the QA Committee may elect to end the monthly review of this topic</p>	

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	<p>indicated she is moderately cognitively impaired, requires extensive assistance for ambulation and transfers. Review of the nursing progress notes from 5-13-16 through 6-3-16, indicated the resident had multiple attempts at self transfers from bed. Her care plans indicated she displayed noncompliance with safety measures and was a fall risk. Review of the June, 2016 recapitulation orders indicated a PSA unit was to be placed to the bed and wheelchair with function of the unit to be checked each shift. In review of the Medication Administration Record (MAR), this was indicated to have been checked off for the day shift on 6-3-16. In an interview with RN #5 on 6-3-16 at 1:30 p.m., she indicated she had signed this as checked/verified after the PSA unit was placed by her prior to noon.</p> <p>This deficiency was cited on 4-19-16. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2016

FORM APPROVED

OMB NO. 0938-0391

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F 9999  Bldg. 00		F 9999	NA	06/04/2016	