

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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 survey was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: August 14, 15, 18, 19, 20 and 21, 2014</p> <p>Facility number: 000086 Provider number: 155170 AIM number: n/a</p> <p>Survey team: Ginger McNamee, RN Karen Lewis, RN Tina Smith-Staats, RN Toni Maley, BSW</p> <p>Census bed type: SNF: 56 Residential: 180 Total: 236</p> <p>Census payor type: Medicare: 19 Other: 217 Total: 236</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	See Attachments.	
---------	---	---------	------------------	--

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: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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
F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to identify a potential resident for 1 of 1 residents reviewed for restraints. (Resident #55)</p> <p>Findings include:</p> <p>During an observation on 8/19/14 at 7:40 a.m., Resident #55 was observed sitting in her wheelchair with a seatbelt alarm in place.</p> <p>During an interview on 8/19/14 at 2:11 p.m., Physical Therapist #1 indicated the seatbelt alarm for Resident #55 was not a therapy recommendation.</p> <p>During an observation on 8/20/14 at 6:58 a.m., Resident #55 was observed sitting in her wheelchair with a seatbelt alarm in place.</p> <p>During an observation on 8/20/14 at 7:56</p>	F000221	<p>Westminster Village Muncie, Inc. Plan of Correction ISDH Survey 2014 F221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>1) What corrective actions (s) will be accomplished for those Residents found to have been affected by the alleged deficient practice: Resident #55: Seatbelt alarm for Resident #55 has been discontinued upon record review. Resident's care plan has been reviewed and updated.</p> <p>2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions (s) will be taken: All Residents within the skilled facility have been reviewed. Currently there are no Residents with seatbelt alarms in use within the facility.</p> <p>3) What measures will be put into place or what systemic changes will be made to</p>	09/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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>a.m., LPN #2 and CNA #3 asked Resident #55 to release her seatbelt alarm. Resident #55 would not release her seatbelt alarm. Staff attempted to cue resident verbally and physically but Resident #55 would not release seatbelt alarm.</p> <p>The clinical record for Resident #55 was reviewed on 8/18/14 at 8:13 a.m. Diagnoses for Resident #55 included, but were not limited to, dementia with behaviors, depression, anxiety, and mood disorder.</p> <p>Resident #55 had a care plan for the problem of falls. An intervention for this problem was "Seat belt alarm" effective 7/14/14.</p> <p>The clinical record lacked a physician order, assessment, and monitoring for the seatbelt alarm.</p> <p>During an interview on 8/20/14 at 9:35 a.m., additional information related to Resident #55's seatbelt alarm was requested of the Abbey Unit Manager.</p> <p>During an interview on 8/20/14 at 1:23 p.m., the Abbey Unit Manager indicated she did not have an physician order, assessment, or monitoring of Resident #55's seatbelt alarm. She indicated they</p>		<p><i>ensure that the alleged deficient practice does not recur:</i> Seatbelt belt alarms deemed as a safety measure will be assessed by a licensed nurse every shift and documented in the residents clinical record. 4) <u>How the corrective actions (s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:</u> The Nurse Manager and/or Designee will monitor seatbelt alarm use to ensure that proper use and documentation has occurred on a monthly basis for 9 months. The Quality Assurance Committee will review the results on a monthly basis and modify the monitoring system as necessary to maintain compliance. 5) <i>All components of the systematic adjustments for notification of changes will be implemented by:</i> September 20th, 2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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>did not consider the seatbelt alarm a restraint since the resident could self release the seatbelt alarm.</p> <p>Review of the current facility policy, dated 2006, titled "Restraint Devices, Physical", provided by the Health Facility Administrator #2 on 8/20/14 at 12:42 p.m., included, but was not limited to, the following:</p> <p>"...PHYSICAL RESTRAINTS are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.... ...PROCEDURE 1. Assess resident's need for restraint device use. 2. Obtain informed consent for restraint device use. 3. Obtain physician's order for restraint device. 4. Develop or review resident care plan for type of restraint device... ...DOCUMENTATION GUIDELINES... ...Assessment for restraint device use.... ...Monitoring resident...."</p> <p>3.1-3(w)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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			
F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who received their meals in the assisted dining area were served meals in a manner to preserve their dignity regarding lengthy meal waits. This deficient practice impacted 6 of 13 residents reviewed for dignified dining (Resident #63, #110, #88, #26, #61 and #36).</p> <p>Findings include:</p> <p>During an 8/14/14, 11:45 a.m. to 12:34 p.m., observation of the assisted dining area in the Victoria Dining Room, 6 of 13 residents who ate in the assisted dining area waited from 23 to 45 minutes to be served their meals. The 6 residents included Residents #88, #36, #110, #26 and #63. Although some of the residents were offered drinks, not all were. No activity, manipulative device or visual stimulation was offered during this wait. The residents simply sat at the table</p>	F000241	<p>Westminster Village Muncie, Inc. Plan of Correction ISDH Survey 2014 F 241 DIGNITY AND RESPECT OF INDIVIDUALITY 1) What corrective actions (s) will be accomplished for those Residents found to have been affected by the alleged deficient practice: Resident #63: Clinical records in regards to Diagnoses have been reviewed and have been found to be accurate and up to date. The MDS and Care Plan have been reviewed for assistance in: decision making; mobility; ADL's, and have been found to be accurate and up to date. Resident #110: Clinical records in regards to Diagnoses have been reviewed and have been found to be accurate and up to date. The MDS and Care Plan have been reviewed for assistance in: decision making; mobility; ADL's, and have been found to be accurate and up to date. Resident #88: Clinical records in regards to Diagnoses have been reviewed and have</p>	09/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>awaiting their meal.</p> <p>During a 8/19/14, 11:30 a.m. to 12:40 p.m., observation of the assisted dining area in the Victoria Dining Room, 13 residents who ate in the assisted dining area waited from 23 to 59 minutes to be served their meals. The 13 residents included but were not limited to Residents #88, #55, #36, #56, #49, #110, #26, #61, #63, #40, #59, #6 and #117. Although some of the 13 residents were offered drinks, not all were. No activity, manipulative device or visual stimulation was offered during this wait. The residents simply sat at the table awaiting their meal.</p> <p>1. Resident #63's record was reviewed on 8/18/14 at 8:45 a.m. Resident #63's current diagnoses included, but were not limited to, depression, vascular dementia with depressed moods and anxiety.</p> <p>Resident #63 had a current, 7/20/14, quarterly, Minimum Data Set (MDS) assessment which indicated she needed assistance for decision making, required extensive assistance for eating and locomotion both on and off the unit.</p> <p>Resident #63 had a current, 4/27/14, care plan problem regarding nutritional risk. An approach to this problem was to</p>		<p>been found to be accurate and up to date. The MDS and Care Plan have been reviewed for assistance in: decision making; mobility; ADL's, and have been found to be accurate and up to date. Resident #26: Clinical records in regards to Diagnoses have been reviewed and have been found to be accurate and up to date. The MDS and Care Plan have been reviewed for assistance in: decision making; mobility; ADL's, and have been found to be accurate and up to date. Resident #61: Clinical records in regards to Diagnoses have been reviewed and have been found to be accurate and up to date. The MDS and Care Plan have been reviewed for assistance in: decision making; mobility; ADL's, and have been found to be accurate and up to date. Resident #36: Clinical records in regards to Diagnoses have been reviewed and have been found to be accurate and up to date. The MDS and Care Plan have been reviewed for assistance in: decision making; mobility; ADL's, and have been found to be accurate and up to date. In-servicing of Dietary staff will occur and will include but not be limited to: time-management promotion strategies including focus of timely meal service. In-servicing of Nursing staff will occur and will include but not be limited to: time-management</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>encourage food and fluid intake.</p> <p>During a lunch meal observation on 8/19/14, Resident #63 was escorted into the dining room by facility staff and assisted to sit at the dining table at 11:55 a.m. She was not served her meal until 12:30 p.m. (35 minutes).</p> <p>2. Resident #110's record was reviewed on 8/20/14 at 3:20 p.m. Resident #110's current diagnoses included, but were not limited to, macular degeneration, memory loss and congestive heart failure. Resident #110 began receiving hospice services on 8/13/14.</p> <p>Resident #110 had a current, 8/8/14, change in therapy, Minimum Data Set (MDS) assessment which indicated she needed assistance for decision making, required extensive assistance for eating and locomotion both on and off the unit.</p> <p>Resident #110 had a current, 6/23/14, care plan need regarding requiring assistance with ADLs. An approach to this problem was to assist with eating.</p> <p>During a lunch meal observation on 8/19/14, Resident #110 was escorted into the dining room by facility staff and assisted to sit at the dining table at 11:54</p>		<p>promotion strategies including focus of timely meal service. A Dietary leader will be present during peak meal service times. A designated nursing staff member will be present upon opening of dining room. Dining room seating will be arranged according to the arrival of the residents, filling each table/area until they are full. Meal Cards/Menus will be pulled and submitted as residents arrive and are seated in the dining room. One table/area will be designated for the residents that only require cueing and supervision. Residents that express a desire to sit in a specific location will be seated according to their preference. Nursing staff will be in-serviced to notify the on-call nurse manager if they are experiencing an extended wait time for food service; the on-call nurse manager will notify the Dietary Leader if an extended wait time is being observed so that corrective actions can be implemented. 2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions (s) will be taken: The MDS and Care Plan have been reviewed for all Residents within the skilled facility for Residents deemed needing assistance in: decision making; mobility and ADL's. In-servicing of Dietary staff will occur and will</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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>a.m. Resident #110 was served a hot drink while awaiting her meal. From 12:12 p.m. to 12:20 p.m. Resident #110 slept with her chin to her chest. She was not served her meal until 12:35 p.m. (41 minutes).</p> <p>3. Resident #88's record was reviewed on 8/20/14 at 3:10 p.m. Resident #88's current diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus and depression.</p> <p>Resident #88 had a current, 6/15/14, admission, Minimum Data Set (MDS) assessment which indicated he needed assistance for decision making, required extensive assistance for locomotion both on and off the unit and cueing and set up assistance when eating.</p> <p>Resident #88 had a current, 6/18/14, care plan problem regarding needing assistance with activities of daily living. An approach to this problem was to assist with eating and drinking as needed.</p> <p>During a lunch meal observation on 8/19/14, Resident #88 was escorted into the dining room by facility staff and assisted to sit at the dining table at 11:37 a.m. Resident #88 was served a hot drink while awaiting his meal. He was not served his meal until 12:35 p.m. (59</p>		<p>include but not be limited to: time-management promotion strategies including focus of timely meal service. In-servicing of Nursing staff will occur and will include but not be limited to: time-management promotion strategies including focus of timely meal service. A Dietary leader will be present during peak meal service times. A designated nursing staff member will be present upon opening of dining room. Dining room seating will be arranged according to the arrival of the residents, filling each table/area until they are full. Meal Cards/Menus will be pulled and submitted as residents arrive and are seated in the dining room. One table/area will be designated for the residents that only require cueing and supervision. Residents that express a desire to sit in a specific location will be seated according to their preference. Nursing staff will be in-serviced to notify the on-call nurse manager if they are experiencing an extended wait time for food service; the on-call nurse manager will notify the Dietary Leader if an extended wait time is being observed so that corrective actions can be implemented. 3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: In-servicing of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>minutes).</p> <p>4. Resident #26's record was reviewed on 8/20/14 at 3:00 p.m. Resident #26's current diagnoses included, but were not limited to, malaise/fatigue, congestive hear failure, end stage renal disease and depression.</p> <p>Resident #26 had a current, 6/15/14, admission, Minimum Data Set (M.D.S.) assessment which indicated she required extensive assistance for locomotion both on and off the unit and set up for eating.</p> <p>Resident #26 had a current care plan problem regarding requiring assistance with activities of daily living. An approach to the problem was to assist with eating as needed.</p> <p>During a lunch meal observation on 8/19/14, Resident #26 was escorted into the dining room by facility staff and assisted to sit at the dining table at 11:35 a.m. Resident #26 was served a hot coco while awaiting her meal. Resident #26 had periods of time when she fell asleep and jerked awake while awaiting her meal. At 12:10 p.m. (35 minutes after entering the dining room), Resident #26 fell asleep an dropped her cooled hot coco on herself. She was taken to her room to change clothes and then chose to</p>		<p>Dietary staff will occur; and will include but not be limited to: time-management promotion strategies including focus of timely meal service.</p> <p>In-servicing of Nursing staff will occur: and will include but not be limited to: time-management promotion strategies including focus of timely meal service. A Dietary Leader will be present during peak meal service times.</p> <p>A designated nursing staff member will be present upon opening of dining room. Dining room seating will be arranged according to the arrival of the residents, filling each table/area until they are full. Meal Cards/Menus will be pulled and submitted as residents arrive and are seated in the dining room. One table/area will be designated for the residents that only require cueing and supervision.</p> <p>Residents that express a desire to sit in a specific location will be seated according to their preference. Nursing staff will be in-serviced to notify the on-call nurse manager if they are experiencing an extended wait time for food service; the on-call nurse manager will notify the Dietary Leader if an extended wait time is being observed so that corrective actions can be implemented. 4) How the corrective actions (s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>eat in her room.</p> <p>5. Resident #61's clinical record was reviewed on 8/18/14 at 8:39 a.m. The residents diagnoses included, but were not limited to, debility, Alzheimer's disease, dementia with behavioral disturbance, senile dementia with depressive disorders, psychological visual disturbances, psychotic disorder with hallucinations, paranoid state, explosive personality disorder, anxiety state, acute reaction to stress and protein-calorie malnutrition.</p> <p>Resident #61 had a 7/13/14, annual Minimum Data Set assessment. The assessment indicated the resident had severe cognitive impairment and required the extensive assistance of one person for eating and locomotion on and off the unit.</p> <p>The resident had a care plan review on 7/23/14. The resident had a problem of requiring assist with activities of daily living related to impaired mobility and impaired cognition related to cognition. An intervention for this problem was to assist with transfers and mobility and the intake of meals as needed.</p> <p>Resident #61 had a care plan problem of nutritionally at risk as evidenced by dementia with cognitive loss, and oral</p>		<p>assurance program will be put into place: The Nurse Manager and /or Designee will report weekly any untimely meal service to the Quality Assurance Nurse for 3 months, then will adjust accordingly for the following 6 months. The Dietary Manager and/or Designee will perform a meal service time monitoring 3 times weekly at varying meal times and days for 3 months, then will be adjusted accordingly for the following 6 months. The Quality Assurance Committee will review the results on a monthly basis and modify the monitoring system as necessary to maintain compliance. 5) All components of the systematic adjustments for notification of changes will be implemented by: September 20th, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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>intake of less than 75% of meals and needs assistance at times. Some approaches for this problem included, but were not limited to, provide set up to extensive assist with meals as required. Resident may become distracted/agitated while eating, serve meals in quiet environment as needed.</p> <p>During a lunch meal observation on 8/19/14, Resident #61 was escorted into the dining room by facility staff and assisted to sit at the dining table at 11:55 a.m. As she sat at the dining room table, she cried, called out, or moved restlessly. She was not served her meal until 12:35 p.m. (40 minutes).</p> <p>6. Resident #36's clinical record was reviewed on 8/18/14 at 12:08 p.m. Resident #36's current diagnoses included but were not limited to anemia, atrial fibrillation, senile dementia with depressive features, mood disorder, anxiety, hypertension, congestive heart failure, osteoporosis and hypopotassium.</p> <p>Resident #36's Significant Change MDS, dated 6/15/14, indicated Resident #36's cognition skills of daily decision making were severely impaired and required extensive assistance for eating.</p> <p>Resident #36's, 3/25/14, current care plan for activities of daily living indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>Resident #36 should have been provided assistance with eating as the resident required.</p> <p>During an observation on 8/19/14 at 11:31 a.m., Resident #36 arrived in the Victoria Dining Room at 11:40 a.m. and was assisted to one of the assist tables. Resident #36 received the meal at 12:35 p.m. During the fifty-five minutes it took for Resident #36's meal arrive, Resident #36 was provided no stimulation such as conversation or activity.</p> <p>7. During an 8/20/14, 10:20 a.m., interview, the Food Services Supervisor indicated lunch was served in the Victoria Dining Room form 11:30 a.m. to 1:00 p.m. Residents should be served in the order they arrive unless they need assistance to dine. If they needed assistance to eat, the resident was served when the staff member was available to assist.</p> <p>During an 8/20/14, 5:15 p.m., interview, the Director of Nursing indicated a 20 to 59 minute wait for meals was not acceptable and the facility had the goal to serve the meals quickly after the resident arrived in the dining room.</p> <p>On 8/20/14 at 1:07 p.m., the Social Service Director provided a copy of the,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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			
F000242 SS=D	<p>June 1997, current, " Resident Rights", which addressed a resident's right to dignity as follows: "Dignity A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review, the facility failed to honor resident choices/preferences regarding when they would like to wake up in the morning for 3 of 3 residents observed to be awake before 6:00 a.m. (Resident #5, #56, and #2)</p> <p>Findings include:</p> <p>1. During an interview on 8/14/14 at 2:36 p.m., Resident #5, who was deemed reliable during the stage 1 survey process,</p>	F000242	<p>Westminster Village Muncie, Inc.</p> <p>Plan of Correction</p> <p>ISDH Survey 2014</p> <p>F 242 SELF-DETERMINATION-RIGHT</p>	09/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>indicated the facility staff wake him up each morning at 4:30 a.m. He indicated he would like to get up around 6:30 a.m. or 7:00 a.m. He indicated the staff take him down to the TV lounge but he doesn't want to watch TV</p> <p>During an observation on 8/20/14 at 5:36 a.m., Resident #5 was dressed, sitting in his wheelchair in the TV lounge with his head forward and his eyes closed. Resident slept until 7:41 a.m., having been awakened two times (once when staff spoke to him and once when staff administered his medications.)</p> <p>The clinical record for Resident #5 was reviewed on 8/20/14 at 2:13 p.m. Diagnoses for Resident #5 included, but were not limited to, depression, anxiety, and pain.</p> <p>Resident #5 had a 4/27/14, significant change Minimum Data Set assessment (MDS) which indicated the resident was cognitively intact.</p> <p>Resident #5 had a careplan problem of "Sleep Pattern Disturbances." One of the interventions for this problem was to observe naps during the day and encourage daytime activity, effective 10/30/12.</p>		<p>TO MAKE CHOICES</p> <p>1) What corrective actions (s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:</p> <p>Resident #5: Clinical records in regards to: Diagnoses; Care Plan and MDS have been reviewed and revised as needed; and have been found to be accurate and up to date.</p> <p>Resident #56: Clinical records in regards to: Diagnoses; Care Plan and MDS have been reviewed and revised as needed; and have been found to be accurate and up to date.</p> <p>Resident #2: Clinical records in regards to: Diagnoses; Care Plan and MDS have been reviewed and revised as needed; and have been found to be accurate and up to date.</p> <p>A Preferences For Living form has been developed to assist in addressing resident's</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>The clinical record lacked any assessment or documentation of the resident's choice/preference for getting up in the morning.</p> <p>2. During a family interview on 8/15/14 at 1:42 p.m., the wife of Resident #56 indicated staff got her husband up at 5:00 a.m. She indicated she did not know why they got him up that early.</p> <p>During an observation on 8/20/14 at 6:04 a.m., Resident #56 was brought to the TV lounge in his wheelchair. He was dressed for the day.</p> <p>During an observation on 8/20/14 at 7:47 a.m., Resident #56 was removed from the TV lounge by staff to go to dining room.</p> <p>The clinical record for Resident #56 was reviewed on 8/19/14 at 1:05 p.m. Diagnoses for Resident #56 included, but were not limited to, Alzheimer's disease, depression, and hemiplegia affecting non-dominant side.</p> <p>Resident #56 had a 5/18/14, quarterly MDS which indicated the resident had severe cognitive impairment.</p> <p>The clinical record lacked any assessment or documentation of the resident's choice/preference for getting up in the</p>		<p>likes/dislikes and preferences. This form will be utilized upon admission and will be completed and signed by the resident and/or resident representative and nurse/designee. The preferences will be taken into consideration when initiating CNA assignment for care. (See Attachment A)</p> <p>2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions (s) will be taken:</p> <p>The MDS and Care Plan have been reviewed and revised as needed for Residents within the skilled facility and have been found to be accurate and up to date.</p> <p>A Preferences For Living form has been developed to assist in addressing resident's likes/dislikes and preferences. This form will be utilized upon admission and will be completed and signed by the resident and/or resident representative and nurse/designee. The preferences will be taken into consideration</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>morning.</p> <p>3. During an observation on 8/20/14 at 5:40 a.m., Resident #2 was brought to the TV lounge in her wheelchair. She was dressed for the day.</p> <p>During an observation on 8/20/14 at 7:52 a.m., Resident #2 was removed from the hall by staff to go and get coffee in the dining room.</p> <p>The clinical record for Resident #2 was reviewed on 8/20/14 at 2:58 p.m. Diagnoses for Resident #2 included, but were not limited to, dementia with behaviors, diabetes, edema, and debility.</p> <p>Resident #2 had a 5/4/14, significant change MDS which indicated the resident had severe cognitive impairment.</p> <p>The clinical record lacked any assessment or documentation of the resident's choice/preference for getting up in the morning.</p> <p>4. During an interview on 8/20/14 at 5:42 a.m., CNA #6 and CNA #7 indicated Resident #5 was the first resident they got up in the morning. They indicated there were 7 residents they got up between 5:00 a.m. and 6:00 a.m. CNA #6 indicated if the resident did not</p>		<p>when initiating CNA assignment for care.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:</p> <p>A Preferences for Living form has been developed to assist in addressing resident's likes/dislikes and preferences. This form will be utilized on admission and will be filled out and signed by the resident and/or resident representative and nurse/designee. The preferences will be taken into consideration when initiating CNA assignment for care.</p> <p>4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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>want to get up at 5:00 a.m., they returned to ask the resident again before 5:30 a.m. CNA #6 indicated the residents were always ready to get up by 5:30 a.m. One of the residents requested to be up at 6:00 a.m., so she was the last resident they assisted. Both CNAs indicated they regularly work 6:00 p.m. to 6:00 a.m. on Abbey court.</p> <p>5. During an observation on 8/21/14 at 6:45 a.m., Resident #5, #56 and #2 were dressed and sitting in their wheelchairs in the TV lounge. Each resident's eyes were closed.</p> <p>6. During an interview on 8/20/14 at 10:20 a.m., the Food Service Supervisor indicated breakfast was served in the Victoria dining room between 7:30 a.m. to 9:00 a.m.</p> <p>During an interview on 8/20/14 at 9:35 a.m., additional information related to resident choices/preferences was requested of the Abbey Unit Manager. She indicated she would check with the social services and activities directors also.</p> <p>During an interview on 8/20/14 at 11:10 a.m., the Activities Director indicated she asked the Minimum Data Set (MDS) assessment questions of the residents.</p>		<p>into place:</p> <p>The Nurse Manager and/or Designee will ensure the form is completed upon admission and placed in medical record. Unit Managers will monitor all admissions monthly for 9 months and report findings monthly to the Quality Assurance Committee.</p> <p>The Quality Assurance Committee will review the results monthly and modify the monitoring system as necessary to maintain compliance.</p> <p>5) All components of the systematic adjustments for notification of changes will be implemented by: September 20th, 2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>She indicated these questions do not include preference for getting up in the morning only preference for going to bed.</p> <p>During an interview on 8/20/14 at 11:19 a.m., the Social Services Director indicated they did not do any additional resident choice/preference questions than the MDS questions.</p> <p>During an interview on 8/20/14 at 1:23 p.m., the Abbey Unit Manager indicated they had no policy related to resident choices or preferences. She also indicated she had no other choice/preference documentation to provide.</p> <p>7. On 8/20/14 at 1:07 p.m., the Social Service Director provided a copy of the, current, June 1997, "Resident Rights", which addressed a resident's right for self-determination and participation as follows: "Self-determination and participation The resident has the right to-</p> <ul style="list-style-type: none"> a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; b) Interact with members of the community both inside and outside the facility; and c) Make choices about aspects of his or her life in the facility that is significant to 						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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
F000250 SS=D	<p>the resident."</p> <p>3.1-3(u)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and, the facility failed to develop and implement a behavior monitoring and management plan for residents who had a diagnoses of anxiety and displaced symptoms which required the use of psychoactive medication for 3 of 5 residents reviewed for psychoactive medication use (Residents #63, #121 and #98)</p> <p>Findings include:</p> <p>1. Resident #63's record was reviewed on 8/18/14 at 8:45 a.m. Resident #63's current diagnoses included, but were not limited to, depression, vascular dementia with depressed moods and anxiety. Resident #63 had a current, 7/26/14, physician's order for trazadone 25 mg- two times a day to treat depression and</p>	F000250	<p>Westminster Village Muncie, Inc.</p> <p>Plan of Correction</p> <p>ISDH Survey 2014</p> <p>F 250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICES</p> <p>1) <i>What corrective actions (s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:</i></p>	09/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>anxiety.</p> <p>Resident #63 had a current, 7/20/14, quarterly, Minimum Data Set (MDS) assessment which indicated she needed assistance for decision making and displayed behaviors of verbal abuse or aggression and negative behaviors towards others.</p> <p>Resident #63 lacked a plan of care to address restlessness with personalized individual approaches to reduce or prevent the behavior.</p> <p>Review of Resident #63's "Behavior/Interventions Monthly Flow Record" (a check box record form) for July 2014 and August 1-18, 2014 indicated Resident #63 had behaviors of "yelling out" or "restlessness" on the following dates: August 4, 7,9,11,12,13,14 and 15, 2014 July 5, 6, 20, 21, 23, 24, 25, 26 and 27, 2014.</p> <p>The clinical record lacked a description of the behavior that occurred, event that proceeded the behaviors, time of day, location, individual present or any possible precipitating factors. The record lacked the information needed to evaluate or assess the event for possible precipitating factors in order to develop a</p>		<p>Resident #63: Clinical records have been reviewed for Diagnoses, medication orders, MDS, Care Plan and Behaviors/Interventions Monthly Flow Record; and have been revised as needed, and have been found to be accurate and up to date.</p> <p>Resident #121: Clinical records have been reviewed for Diagnoses, medication orders, MDS, Care Plan; and have been revised as needed, and have been found to be accurate and up to date. Resident was discharged August 27th, 2014.</p> <p>Resident #98: Clinical records have been reviewed for Diagnoses, medication orders, MDS, Care Plan and Behaviors/Interventions Monthly Flow Record; and have been revised as needed, and have been found to be accurate and up to date.</p> <p>2) How other Residents having the potential to be affected by the same alleged deficient practice will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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>plan to reduce or eliminate future distressful episodes.</p> <p>2. Resident #121's record was reviewed on 8/18/14 at 1:00 p.m. Resident #121's current diagnoses included, but were not limited to, macular degeneration, anxiety and chronic pain. Resident #121 had a current, 7/29/14, physician's order for Alprazolam 0.25 mg- two times daily for anxiety.</p> <p>Resident #121's lacked a care plan to address behavioral symptoms associated with anxiety.</p> <p>Review of Resident #121's "Behavior/Interventions Monthly Flow Record" (a check box record form) for July 17-31, 2014 and August 1-18, 2014 indicated resident #121 had behaviors of "anxiety" or "restlessness" on the following dates: July 28 and 30, 2014 August 1, 9,11,12 and 13, 2013.</p> <p>The clinical record lacked a description of the behavior that occurred, event that proceeded the behaviors, time of day, location, individual present or any possible precipitating factors. The record lacked the information needed to evaluate or assess the event for possible precipitating factors in order to develop a</p>		<p>identified and what corrective actions (s) will be taken:</p> <p>Clinical records for Residents within the skilled facility have been reviewed for: Diagnoses, medication orders, MDS, Care Plan and Behaviors/Interventions Monthly Flow Record; have been revised as needed; and have been found to be accurate and up to date.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:</p> <p>Nurse Managers will initiate Interim Care Plans for residents within 5 days of admission for residents with medication orders for mood or behavior.</p> <p>Resident Behavior/Intervention Monthly Flow Record will be revised to include resident specific interventions.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>plan to reduce or eliminate future distressful episodes.</p> <p>3. During an 8/18/14, 2:50 p.m., interview, the Bristol Unit Manager indicated the facility had no documentation of precipitating factor, date, location and such for any of the behavioral flow sheet events listed for Residents #61 and 121. She indicated the system did not have a place to document a narrative of the behavioral event and events would need to be documented in the clinical record. She indicated the current system did not provide information about precipitating factors for evaluation or assessment to prevent or reduce future episodes of distress.</p> <p>4. Resident #98's clinical record was reviewed on 8/18/14 at 8:11 a.m. Resident #98 had current diagnoses which included but were not limited to dementia, mood disorder, anxiety delusional disorder and Parkinson's disease. Resident #98's medication orders included carbidopa levodopa for paralysis agitans, mirtazapine for mood disorder, seroquel for delusional disorder and alprazolam for anxiety.</p> <p>Resident #98's clinical record provided care plans for psychotropic drug use: at risk for side effects and mood state: depression. The clinical record lacked</p>		<p>Nurses will be in-serviced on appropriate documentation on the Resident Behavior/Intervention Monthly Flow Record in conjunction with the Interdisciplinary Behavior Observation Form that is within the Electric Health Record. (See Attachment B)</p> <p>Resident specific interventions will be noted within the CNA assignment behavior section, to assist staff with direction on management of mood/behaviors.</p> <p>A Behavior Monitoring and Management Policy will be initiated.</p> <p>Risk Committee will continue to meet monthly and will continue to monitor and re-evaluate the Behavior Monitoring Program.</p> <p>4) How the corrective actions (s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>any care plan for anxiety.</p> <p>The Behavior /Intervention Monthly Flow Record for May, June and July 2014 indicated Resident #98 displayed behaviors on the following dates without a description of how anxiety was displayed, event location, or precipitating factors to allow for an evaluation and assessment of the event in order to develop a plan to reduce or eliminate future episodes of anxiety: May 21, 24, and 29. June 11, 25 and 29. July 1, 2, 3, 4, 5, 6 and 9.</p> <p>5. During an 8/20/14, 1:07 p.m., interview, the Social Service Director indicated the behavior flow record was used for both residents who displayed behavioral symptoms and/or used psychoactive medication. She additionally indicated the form had check marks and no narrative information. She indicated the form alone did not allow for an evaluation or assessment of precipitating factions in order to develop a plan to reduce or eliminate distressful behaviors in the future. She also indicated the facility did not have a behavior monitoring and management policy or program.</p> <p>3.1-34(a)</p>		<p>assurance program will be put into place:</p> <p>Social Services will monitor and revise the Care Plan to be resident specific.</p> <p>MDS nurses will monitor the Care Plan to ensure that they are resident specific monthly for 9 months; and report findings monthly to the Quality Assurance Committee.</p> <p>The Quality Assurance Committee will review the results monthly and modify the monitoring system as necessary to maintain compliance.</p> <p>5) All components of the systematic adjustments for notification of changes will be implemented by: September 20th, 2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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		
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to develop care plans to address target behaviors being treated by psychoactive medications for 2 of 5 residents reviewed for the development of care plans and the use of psychoactive medications (Residents #98 and #121).</p> <p>Findings include:</p> <p>1. Resident #98's clinical record was reviewed on 8/18/14 at 8:11 a.m. Resident #98's current diagnoses</p>	F000279	<p>Westminster Village Muncie, Inc.</p> <p>Plan of Correction</p> <p>ISDH Survey 2014</p> <p>F 279 DEVELOP COMPREHENSIVE CARE PLANS</p>		09/20/2014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>included, but were not limited to, dementia, mood disorder, anxiety, delusional disorder and Parkinson's disease. Resident #98's current, 7/3/14, medication orders included carbidopa levodopa for paralysis agitans, mirtazapine for mood disorder, seroquel for delusional disorder and alprazolam for anxiety.</p> <p>Resident #98's clinical record lacked any care plan for anxiety.</p> <p>"The Behavior /Intervention Monthly Flow Record" for May, June and July 2014 indicated Resident #98 displayed behaviors on the following dates: May 21, 24,and 29. June 11, 25 and 29. July 1, 2, 3, 4, 5, 6 and 9, 2014. The flow record lacked a description of how anxiety is displayed, event location or precipitating factors to allow for an evaluation and assessment of the event in order to develop a plan to reduce or eliminate future episodes of anxiety:</p> <p>During and interview on 8/20/14 at 9:545 a.m., Bristol Unit Manager indicated the resident did not have a care plan for anxiety.</p> <p>2. Resident #121's record was reviewed on 8/18/14 at 1:00 p.m. Resident #121's current diagnoses included, but were not limited to, macular degeneration, anxiety</p>		<p>1) What corrective actions (s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:</p> <p>Resident #98: Clinical records have been reviewed for Diagnoses, medication orders, MDS, Care Plan and Behaviors/Interventions Monthly Flow Record; and have been revised as needed, and have been found to be accurate and up to date.</p> <p>Resident #121: Clinical records have been reviewed for Diagnoses, medication orders, MDS, and Care Plan have been revised as needed, and have been found to be accurate and up to date. Resident was discharged August 27th, 2014.</p> <p>2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions (s) will be taken:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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>and chronic pain. Resident #121 had a current, 7/29/14, physician's order for Alprazolam 0.25 mg (an anti-anxiety medication)- two times daily for anxiety.</p> <p>Resident #121 lacked a care plan to address behavioral symptoms associated with anxiety.</p> <p>Review of Resident #121's "Behavior/Interventions Monthly Flow Record" (a check box record form) for July 17-31, 2014 and August 1-18, 2014 indicated resident #121 had behaviors of "anxiety" or "restlessness" on the following dates: July 28 and 30, 2014 August 1, 9,11,12 and 13, 2013.</p> <p>During an 8/18/14, 2:50 p.m., interview, the Bristol Unit Manager indicated the facility did not have a care plan to address medical/behavioral symptoms associated with anti anxiety use for Resident #121.</p> <p>3.1-35(a)</p>		<p>Clinical records for Residents with a diagnosis of Anxiety within the skilled facility have been reviewed for: Diagnoses, medication orders, MDS, Care Plan and Behaviors/Interventions Monthly Flow Record; have been revised as needed; and have been found to be accurate and up to date.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:</p> <p>Nurse Managers will initiate an interim mood and/or behavior Care Plan for residents within 5 days of admission; for residents with medication orders for mood and/or behavior.</p> <p>Social Services will individualize the Care Plan to meet the needs of the resident.</p> <p>The MDS nurse will monitor to make sure the Care Plan is in place and complete.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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>Risk Committee will monitor/discuss mood and/or behavior Care Plans and ensure resident specific interventions; and Risk Committee will report to Quality Assurance Committee monthly.</p> <p>4) How the corrective actions (s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>The MDS nurse will monitor Care Plans for completeness monthly for 9 months to ensure Resident needs are being met.</p> <p>The Quality Assurance Committee will review the results on a monthly basis and modify the monitoring system as necessary to maintain compliance.</p> <p>5) All components of the systematic adjustments for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: August 14,15,18,19, 20, 21, 2014</p> <p>Facility number: 000086 Provider number: 155170 AIM number: n/a</p> <p>Survey team: Ginger McNamee, RN, TC Karen Lewis, RN Tina Smith Staats, RN Toni Maley, BSW</p> <p>Census bed type: SNF: 56 Residential: 180 Total: 236</p> <p>Census payor type: Medicare: 19 Medicaid: n/a Other: 217</p>	R000000	<p>notification of changes will be implemented by: September 20th, 2014.</p> <p>See Attachments.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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			
R000217	<p>Total: 236</p> <p>Residential sample: 10</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>involved in identification and documentation of the services to be provided.</p> <p>This Residential Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop a signed, dated, plan of service with the resident and or their representative. This effected 9 of 10 residents reviewed for service plans (Residents #s R1, R3, R4, R5, R6, R7, R8, R9 and R10).</p> <p>Findings include:</p> <p>1. Resident #R1's clinical record was reviewed on 8/21/14 at 10:00 a.m. Resident #R1's current diagnoses included but were not limited to dementia, anxiety, hypertension and diabetes.</p> <p>Resident #R1's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative.</p> <p>2. Resident #R3's clinical record was reviewed on 8/21/14 at 1:56 p.m. Resident #R3's current diagnoses included, but were not limited to, edema, insomnia, anxiety, rectal prolapse and osteoarthritis.</p>	R000217	<p>Westminster Village Muncie, Inc.</p> <p>Plan of Correction</p> <p>ISDH Survey 2014</p> <p>Residential Services</p> <p>R217 – Evaluations/Services</p> <p>1) What corrective action(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:</p> <p>R #1 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p> <p>R #3 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p>	09/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304
--	--

(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>Resident #R3's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative</p> <p>3. Resident #R4's clinical record was reviewed on 8/21/14 at 2:00 p.m. Resident #R4's current diagnoses included, but were not limited, to hypertension, dementia, hypothyroidism, anxiety and pain.</p> <p>Resident #R4's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative</p> <p>4. Resident #R5's clinical record was reviewed on 8/21/14 at 2:35 p.m. Resident #R5's current diagnoses included, but were not limited to, depression and restless leg syndrome.</p> <p>Resident #R5's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative.</p> <p>5. Resident #R6's clinical record was reviewed on 8/21/14 at 2:50 p.m. Resident #R6's current diagnoses included, but were not limited to, hypertension, asthma, diabetes and senile dementia.</p>		<p>R #4 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p> <p>R#5 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p> <p>R#6 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p> <p>R#7 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p> <p>R#8 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p> <p>R#9 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304			
(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>Resident #R6's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative.</p> <p>6. Resident #R7's clinical record was reviewed on 8/21/14 at 2:55 p.m. Resident #R7's current diagnoses included, but were not limited to, hypothyroidism, insomnia, hypertension and depressive disorder.</p> <p>Resident #R7's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative.</p> <p>7. Resident #R8's clinical record was reviewed on 8/21/14 at 3:18 p.m. Resident #R8's current diagnoses included, but were not limited to, debility, diabetes, hypertension, osteoarthritis and heart disease.</p> <p>Resident #R8's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative</p> <p>8. Resident #R9's clinical record was reviewed on 8/21/14 at p.m. Resident #R9's current diagnoses included, but were not limited to, Pick's disease</p>		<p>R#10 Clinical record, including diagnoses, has been reviewed and includes a signed service plan.</p> <p>2) How other Residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken:</p> <p>Clinical records for all residents in residential areas have been reviewed. All records contain a signed service plan.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:</p> <p>The facility has been completing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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>dementia, hypertension, hypothyroidism and diabetes.</p> <p>Resident #R9's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative</p> <p>9. Resident #R10's clinical record was reviewed on 8/21/14 at 2:00 p.m. Resident #R10's current diagnoses included, but were not limited to diabetes, congestive heart failure, depressive disorder and polyneuropathy.</p> <p>Resident #R10's clinical record lacked a service plan developed with the resident or their representative and signed by the resident or their representative</p> <p>10. During a 8/21/14, 3:00 p.m., interview, the Director of Nursing indicated the facility did not have nursing service plans which were developed with the resident and/or family and signed by the resident or family.</p>		<p>Service Plans upon admission to residential areas. However, upon research, the policy had not been uniformly implemented. During survey, staff misunderstood the information request, and was unable to provide at the requested time, the information that was already in place per policy.</p> <p>Service Plans are completed on newly admitted residents in residential areas. This process will continue for future admissions.</p> <p>Service Plans will be reviewed, signed and dated by the resident and/or their representative; and the designee nurse with each 6 month evaluation.</p> <p>Service Plans will be initiated/updated upon: admission and change of services based on resident needs.</p> <p>Signed Service Plans will be maintained within the resident's health record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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>4) How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>The Nurse Manager and/or Designee will monitor for completed, signed service plans, based on; admissions, change of services, and 6 month evaluations; and report to Quality Assurance monthly for 9 months.</p> <p>The Quality Assurance Committee will review the results monthly and modify the monitoring system as necessary to maintain compliance.</p> <p>5) All components of the systematic adjustments for notification of changes will be implemented by: September 20th, 2014.</p>		