

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  11/24/2015
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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 Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00184713.</p> <p>Complaint IN00184713- Substantiated. Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Survey dates: November 17, 18, 19, 20, 23, &amp; 24, 2015.</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Census bed type: SNF/NF: 133 Residential: 76 Total: 209</p> <p>Census payor type: Medicare: 31 Medicaid: 64 Other: 38 Total: 133</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</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 this survey report are accurate or reflect accurately the provision of nursing care and service to the Residents at Westminster Village North.	
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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 0226 SS=D Bldg. 00	<p>Quality review completed by 30576 on December 2, 2015</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to provide a staff member annual abuse in-service training for 1 of 10 employee personal files reviewed. (CNA #30)</p> <p>Findings include:</p> <p>The Employee Records form and 10 employee personnel files were reviewed on 11/24/15 at 3:30 p.m. The record indicated certified nursing assistant (CNA #30) start date was 2/3/11.</p> <p>The personnel file for CNA #30 did not include annual abuse in-service training.</p> <p>A work scheduled was provided by the Administrator on 11/24/15 at 4:00 p.m. The Administrator at this time indicated CNA #30 was an as needed staff member</p>	F 0226	<p>F 226</p> <p>1. It is facility policy that all employees upon hire and annually thereafter, receive in-service training for Prevention of abuse, neglect, punishment and seclusion. C.N.A. #30 received this annual training on 11/26/15.</p> <p>2. All employees have completed their annual in-service for Prevention of abuse, neglect punishment and seclusion. A 100% audit of all employee files was conducted to ensure annual required training completed.</p> <p>3. Annual Abuse training for all staff completed. Quality Assurance Manager will update calendar to reflect timely completion of required trainings. Monthly audits of required in-services will be completed by Quality Assurance Manager for compliance.</p> <p>4. The Quality Assurance Manager will present the results of</p>	12/22/2015

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F 0282 SS=D Bldg. 00	<p>until 12/2014. CNA #30's work status was changed in December to full time. She indicated a staff member was consider full time if the staff member works 30 hours or greater. The work scheduled indicated CNA #30 has worked 2,122 hours from December 2014 until present.</p> <p>An abuse policy was provided by the Administrator on 11/23/15 at 2:07 p.m. It indicated the following:..."Purpose: To establish guidelines for assuring the residents are free of all abusive acts and to establish guidelines for investigating, resolving and reporting abuse...Standards: 1. All organization staff will be trained during initial orientation and during annual inservice regarding prevention of abuse, neglect, punishment and seclusion and their responsibilities to report suspected abuse as well as conduct their particular service to residents in a manner which assures protection from intentional or unintentional abuse..."</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's</p>		audits at facility's monthly Quality Assurance meetings for 6months. At the end of 6 months,the QA team may choose to cease the monthly audits, if the audits revealed compliance is evident	

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	<p>written plan of care.</p> <p>Based on interview and record review, the facility failed to perform weekly skin assessments, per policy, for 1 of 1 resident reviewed for skin conditions. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 11/23/15 at 2:00 p.m. The diagnoses for Resident #B included, but were not limited to, dementia and left hip fracture. Resident #B resided at the facility from 8/21/15 to 10/31/15.</p> <p>An interview was conducted with Resident #B's Family Member #10, on 11/23/15 at 2:27 p.m. She indicated the facility was unaware how her mother obtained some of her bruises. She indicated she recalled her mother having one on her ankle one day, and no one knew anything about it.</p> <p>An interview was conducted with the DoN (Director Of Nursing) on 11/20/15 at 10:35 a.m. She indicated the only documentation of weekly skin assessments were in the facility database.</p> <p>The 8/21/15 admission skin assessment for Resident #B indicated she had a left shoulder bruise, a left hip incision with 9</p>	F 0282	<p>F282 RE: RESIDENT B 1 Resident B has been discharged from the facility. Thus, there is no corrective action that can be made at this time regarding this particular Resident. 2 Let the record show that there was a multiplicity of reasons why this particular Resident had a propensity for bruising: advanced age; female gender; adult failure to thrive with a history of weight loss; peripheral vascular disease; anemia. Also, the Resident's medication regime includes the concurrent use of all of the following medications—all of which are known to have the potential to create a propensity for bruising: A.S.A.; Plavix; Aricept; Norco; Tylenol. Without any specific details, the facility can substantiate the allegation by Family Member #10 regarding her observation of a bruise on the ankle of Resident B <b>".....on day, and no one knew anything about it"</b>. It is also of paramount importance to note that at no time did Family Member #10 engage in conversation with Administrative staff regarding the area of alleged bruising: no allegation of inappropriate care or treatment relative was ever voiced to Administrative staff germane to this matter. 3. Subsequent to this finding, all Skin Assessments have been reviewed for timeliness. Additional monitoring systems</p>	12/22/2015

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	<p>staples, 2 left hip incisions with 4 staples each, a green bruise on her left knee, 3 right lower extremity abrasions, 3 right upper extremity bruises, and an area on her posterior palm.</p> <p>Subsequent skin assessments were conducted on the following dates and documented in the clinical record as follows:</p> <p>9/6/15 - multiple bruises to right arm, left top of hand, left wrist, and left upper arm</p> <p>9/12/15 - "No new areas observed." There was no mention of the bruising referenced in the 9/6/15 skin assessment.</p> <p>9/20/15 - boil/cyst to upper-mid vertebrae</p> <p>9/27/15 - Area to back remains. No measurements indicated.</p> <p>9/28/15 - bruising to right lower inner leg and left lower leg. No indication of upper-mid vertebrae boil/cyst.</p> <p>10/12/15 - "No new areas observed or reported."</p> <p>10/25/15 - "No new areas observed or reported."</p> <p>10/27/15 - "No new areas observed or</p>		<p>have been put into place as follows: Unit Coordinators will perform a documented review or the status of Skin Assessments for their respective units each day that they are on duty. If Skin Assessments are noted to be untimely, a Skin Assessment will be completed at the time of discovery. The individual responsible for the untimely assessment will be addressed accordingly. The Unit Coordinators are responsible. The Quality Assurance will monitor for compliance by the Unit Coordinators. Additionally, the Quality Assurance Nurse will complete an independent weekly review (documented) as an additional Quality Assurance measure to minimize the risk of any future Skin Assessments being missed. 4. The Quality Assurance Nurse will forward evidence of her weekly review to the Administrator. Additionally, the monitoring of the results of these weekly reviews will be discussed during the facility's Quality Assurance Meetings for the next 6 months. At the end of the 6 month period, the Committee may opt to cease review of said monitoring during the Quality Assurance Meetings if compliance is evident.</p>	

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	<p>reported."</p> <p>An interview was conducted with Unit Manager #8 on 11/24/15 at 1:50 p.m. She indicated Resident #B had weekly skin assessments performed and documented in the clinical record. The skin assessments in the clinical record for Resident #B were reviewed with Unit Manager #8 at this time. Unit Manager #8 acknowledged the lack of documented weekly skin assessments between the 8/21/15 admission skin assessment and the 9/6/15 skin assessment, between the 9/28/15 and 10/12/15 skin assessments, and between the 10/12/15 and 10/25/15 skin assessments. Unit Manager #8 indicated the documented 9/28/15 skin assessment was probably a typo on the date, and was probably conducted a week later, indicating a weekly skin assessment was performed between the 9/27/15 and 10/12/15 skin assessments.</p> <p>CNA (Certified Nursing Assistant) Skin Observations forms were provided by Unit Manager #8 on 11/24/15 at 2:40 p.m. for the following dates: 8/31/15, 9/7/15, 10/1/15, 10/8/15, 10/15/15, and 10/19/15. All of the forms were signed by a nurse. During an interview with the ADoN (Assistant Director of Nursing) on 11/24/15 at 2:53 p.m., she indicated the CNA Skin Observation forms prove</p>			

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F 0323 SS=G Bldg. 00	<p>bathing of Resident #B, but since the CNA did not mark any areas on the skin diagrams on the forms, the nurses who signed the forms would not have actually looked at Resident #B's skin.</p> <p>The Skin Condition And Pressure Ulcer Assessment Policy was provided by the Administrator on 11/24/15 at 4:34 p.m. It indicated, "Pressure Sores and other skin problems will be measured at least weekly preferably on the day shift by a licensed nurse and recorded in cm on the Skin Report Form....The Unit Manager or designee is responsible for completing the Weekly Skin Report each week."</p> <p>This federal tag relates to Complaint #IN00184713.</p> <p>3.1-35 (g)(2)</p> <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 interview and record review, the facility failed to ensure precautionary safety measures were taken while undressing a nonweight bearing resident sitting in a wheel chair. This resulted in an urgent transfer from a wheel chair to</p>	F 0323	<p><b>F323 Let the record show that the facility hadself-reported this incident to ISDH at the time of the occurrence. 1. REGARDING RESIDENT #18 Obviously, there are no specific corrective measures thatcan be</b></p>	12/22/2015

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	<p>the bed resulting in a femoral fracture to 1 of 3 residents reviewed for accidents. (Resident #116)</p> <p>Findings include:</p> <p>The clinical record for Resident #116 was reviewed on 11/24/15 at 9:00 a.m. The diagnoses for Resident #116 included, but were not limited to: osteoarthritis, left femur fracture, scoliosis, Parkinson's disease and stroke. Resident #116 was a 2 person assist for bed mobility, a 2 person assist for transfers, and 1 person assist for dressing according to a minimum data set assessment, dated, 8-9-15.</p> <p>A care plan initiated on 5/27/14 and revised on 8/8/15, indicated Resident #116 was to be transferred by (brand name of mechanical lift). The goal for Resident #116 was to have safe transfers for mobility. Resident #116's interventions included, but were not limited to, a 2 person transfer using a (brand name of mechanical lift), and the staff was to monitor Resident #116's limbs during transfers to avoid injury.</p> <p>An interview was conducted with Resident #116's daughter on 11/18/15 at 2:29 p.m. She indicated Resident #116 had broken her left leg in the facility in August. Resident #116 begun to slip out</p>		<p>initiated at this time for Resident #18. REGARDING C.N.A. #22 This employee was disciplined subsequent to this event, the employee willingly submitted to a drug test which was negative. There has been no evidence to suggest that this employee's intent was to cause harm to the Resident. To the contrary, this employee's intent was to prevent this Resident from falling to the floor when she began to slide forward from the chair. The sole intent of the employee's interaction with the Resident at this time was to assist the Resident to doff her clothing, to the extent possible, prior to summoning a second staff member to assist with the <b>actual transfer of the Resident</b>. The most recent MDS for the Resident, germaneto the time of the incident, noted in Section G; Item G (Dressing), that the Resident required "<b>one person assistance</b>" with this ADL. 2. Subsequent to this citing, nursing personnel will be provided with inservice education regarding the Appropriate action to be taken to attempt to abort a fall, as per policy. In so doing, the facility's goal is to ensure that the staff has the knowledge of the steps to take to <b>ensure that precautionary safety measures are taken</b>. In other words, staff will be instructed to use their body, to the</p>	

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	<p>of the wheelchair while certified nursing assistant (CNA) #22 was undressing her. CNA #22 transferred Resident #116 from the wheel chair to the bed to avoid her falling on the floor. Resident #116 indicated she had banged her leg during the transfer. Resident #116 now wears an immobilizer on her leg and has to keep it on at all times for several weeks. She indicated she feels Resident #116 has declined, since this incident.</p> <p>A progress note dated, 8/8/15 at 10:43 p.m., indicated "CNA came and got writer from hallway. CNA states she was undressing resident, when resident began sliding out of her wheelchair. CNA pivoted resident into her bed. Resident states LLE (left lower extremity) and L (left) hip hurt. No visible bruising/tears. Minimal swelling to left knee. Complaints of pain upon movement. PRN (as needed) Tylenol given. New orders per (name of physician office) for stat (immediately) x-ray to lle (left lower extremity), left hip. Son made aware of incident and new order. Resident resting in bed with eyes closed."</p> <p>A progress note dated, 8/9/15 at 2:37 a.m., indicated radiology report received, and Resident #116 had fractured distal femur of the left leg. Resident #116 was sent to emergency room for evaluation</p>		<p>extent possible, to break the Resident's fall while gently assisting the Resident to the floor. 3. During morning rounds, the IDT (including a member of the Therapy staff) will review all incident reports in an effort to ensure that staff members have initiated the appropriate technique to abort a fall, as per policy. The Quality Assurance Nurse will address any deficient practices noted with the staff member in question. 4. Furthermore, the Quality Assurance Nurse will provide the Quality Assurance Committee with the results of her findings during the facility's Quality Assurance Meetings, for at least 6 months. At the end of the aforementioned 6 month period, the Committee may opt to discontinue the review of this data during the monthly Quality Assurance Meetings if compliance is evident. The Quality Assurance Nurse is responsible. The Administrator will monitor.</p>	

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	<p>and treatment per physician order.</p> <p>The 8/9/15 hospital records for Resident #116 indicated, "...presents to ED (emergency department) via EMS (emergency medical services) from ECF (extended care facility) L (left) leg pain s/p (post) fall while getting into bed from wheelchair on 8/8/15 at approx 2000 (8:00 p.m.)....Per nurse ECF described injury LLe (left lower extremity) getting twisted in process of transfer. She doesn't ambulate baseline....Clinical impression 1. Closed fracture of shaft of left femur unspecified fracture morphology, initial encounter.</p> <p>An interview was conducted on 11/23/15 at 11:20 a.m. RN #15 indicated she was Resident #116's nurse on the night when Resident #116 had broken her leg. She indicated CNA #22 had been undressing Resident #116 and had to make a quick decision when Resident #116 began slipping out from the wheel chair. CNA #22 picked up Resident #116 and transferred her to the bed to prevent the resident from falling on the floor. She indicated Resident #116 was a 2 person assist with a (brand name of mechanical lift), because she did not bear weight on her lower extremities. Resident #116's legs did not pivot with CNA #22 during the transfer.</p>			

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	<p>An interview was conducted with the DoN on 11/23/15 at 2:00 p.m. She indicated Resident #116 was cognitively intact, at that time. Resident #116 indicated she had bumped her leg on the bed during the transfer. This was the conclusion to how the fracture on the leg occurred.</p> <p>An incident report was provided by the Director of Nursing (DoN) on 11/23/15 at 2:40 p.m. It indicated the DoN conducted an interview on 8/11/15 with RN #15 regarding Resident #116's incident. RN#15 indicated CNA #22 advised her that Resident #22 had started to slide out of her wheel chair, and she had prevented the resident from sliding to the floor by catching the resident and pivoted her into the bed. CNA #22 indicated Resident #116 had indicated at that time she had bumped her leg, and it was hurting.</p> <p>A statement from CNA #22, dated 8/10/15, indicated Resident #116 was sitting in her wheelchair. CNA #22 indicated as she had begun to remove Resident #116's shirt she was not sitting all the way back in her chair. As the shirt was removed, Resident #116 leaned forward to facilitate removal of the shirt. In doing so, Resident #116 began to slide</p>			

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	<p>out of her wheel chair. CNA #22 indicated she moved the wheel chair closer to the bed and placed her knee between the resident's legs. She grabbed Resident #116 and pivoted her onto the bed. At that time, Resident #116 indicated her leg hit the bed, and it was hurting. There was no other staff members in the room during this time. CNA #22 indicated she wanted to get the resident ready for bed as much as she could before getting another staff member to assist in the transfer.</p> <p>An interview was conducted with CNA #22 on 11/24/15 at 1:29 p.m. She indicated she was removing Resident #116's shirt and leaned the resident forward to pull her shirt up in the back when Resident #116 began to scoot out of the wheel chair. CNA #22 indicated at that time, she panicked and made a sudden decision to brace Resident #116 from falling with her own legs and transferred her from the wheel chair to the bed. CNA #22 can not recall if the wheel chair was locked, and she can not determine if pulling Resident #116 back up in the chair would have been safer. She has asked herself that question many times, but the decision to transfer Resident #116 was a sudden decision out of panic. She indicated it is easier to undress Resident #116 in the wheel chair</p>			

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	<p>versus in the bed when Resident #116 has a long sleeved shirt on. CNA #22 indicated if she could do it all over again she would first not panic and scream for help since the door was closed.</p> <p>An interview was conducted with CNA #28 on 11/24/15 at 1:45 p.m. She indicated she never undresses and dresses residents in the wheelchair. CNA #28 indicated if a resident requires a (brand name of mechanical lift) for transfers it was easier to dress him or her in the bed, because you have to roll the resident back and forth to either place or remove the (brand name of mechanical lift). pad underneath him or her.</p> <p>An interview was conducted with CNA #29 on 11/24/15 at 1:55 p.m. She indicated she only dresses and undresses residents in the bed, because it is easier and safer versus the wheel chair. CNA #29 indicated if a resident needs the (brand name of mechanical lift). for assistance in transfers it was easier, because of the placement and removal of the pad to dress or undress the resident in the bed.</p> <p>An interview was conducted with the DoN on 11/24/15 at 3:07 p.m. She indicated if a resident was being dressed or undressed in a wheel chair, and was</p>			

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F 0329 SS=D Bldg. 00	<p>unable to assist the staff, it would be more appropriate if there was assistance of 2 staff members.</p> <p>An interview was conducted with Unit Manager #2 on 11/23/15 at 11:05 a.m., during a wound dressing observation. She indicated Resident #116 has to wear the immobilizer on her left leg at all times, and that Resident #116 yells out in pain just by touching her.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue</p>			

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	<p>these drugs.</p> <p>Based on interview and record review, the facility failed to ensure Physician's Orders were followed for insulin administration and the facility also failed to ensure a resident whom does not receive insulin, was not administered insulin for 2 of 6 residents reviewed for unnecessary medications (Resident #152 &amp; #159)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #152 was reviewed on 11/23/15 at 10:30 a.m. The diagnosis for Resident #152 included, but was not limited to diabetes mellitus, according to the November 2015 Physician's Orders.</p> <p>The November 2015 Physician's Orders indicated the following orders: Check blood sugar four times daily before meals and at bedtime. The order was initiated on 11/18/14. Administer the following sliding scale of Humalog 100 units/milliliter, three times a day with meals-150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, and 401-450= 12 units. This order was initiated on 6/25/15.</p> <p>The Diabetic Monitoring Flowsheet for</p>	F 0329	<p>F329 REGARDING RESIDENT #152</p> <p>1. At the time of discovery, the attending physician for Resident #152 was advised. The attending physician indicated that the Resident had suffered no negative outcomes subsequent to this finding. The attending physician issued new orders to discontinue the performance of the Accuchecks four (4) times per day. A new order was issued for the Accuchecks to be performed three (3) times daily, in conjunction with the previously ordered sliding scale insulin dosage. The nurses involved in this incident were given additional in-service education.</p> <p>2. At the time of discovery, all Diabetic Flow Sheets in the facility were reviewed by the Quality Assurance Nurse and no discrepancies were noted.</p> <p>REGARDING RESIDENT # 159</p> <p><b>Let the record show that the facility self-reported this matter to ISDH at the time of discovery.</b> The Resident suffered no negative outcomes as a result of this matter. The nurse responsible was disciplined and given additional in-service education. As with any such incident, both the attending physician and the Resident's Responsible Party were advised of the incident at the time of the occurrence.</p> <p>3. Subsequent to this citing, the following interventions have</p>	12/22/2015

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	<p>November indicated the following: 11/3/15 at 9 p.m.-blood sugar of 232 and 4 units were administered, 11/12/15 at 9 p.m.-blood sugar of 288 and 6 units were administered, 11/13/15 at 9 p.m.-blood sugar of 246 and 4 units were administered, &amp; 11/19/15 at 9 p.m.-blood sugar of 220 and 4 units were administered.</p> <p>No further documentation was located in the clinical record regarding why the insulin was administered on the above dates.</p> <p>During an interview with LPN #1, on 11/23/15 at 11:49 a.m., LPN #1 indicated Resident #152 had blood sugar testing four times a day and sliding scale insulin was to be only administered, as needed, three times a day with meals.</p> <p>On 11/23/15, at 12:09 p.m., Unit Coordinator/RN #2 indicated if there was an exception to the orders written above, there would be documentation in the clinical record.</p> <p>At 9:10 a.m., on 11/24/15, the Administrator indicated the facility was unable to locate any further information on why the insulin was administered. The Administrator further indicated the facility had the above Physician's Orders</p>		<p>been initiated: 1. The PharmacyConsultant provided in-service education to the licensed nurses and Q.M.A.'s regarding medication administration and the prevention of medication errors. The printed materials provided by the PharmacyConsultant for this in-service presentation have been added to the Orientation CheckList for all newly hired licensed Nurses and Q.M.A.'s. The Quality Assurance Nurse is responsible. The D.O.N. will monitor. 2. Random medpass observations are being conducted with the licensed nurses and Q.M.A.'s. thispractice shall continue as an ongoing quality assurance measure for the next 6 months. Any individual demonstrating deficient practices in this area will receive additional 1:1 instruction. The Quality Assurance Nurse is responsible. The D.O.N. will monitor. 3. The diabeticflow sheets will undergo a documented review by the Unit Coordinators on a daily basis (on their scheduled days of work) to ensure the accuracy there-in. Any irregularities noted will be addressedwith the individual responsible and reported to the D.O.N. The Unit Coordinators are responsible and the D.O.N. will monitor. 4. The QualityAssurance Nurse will perform a documented review of</p>	

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	<p>changed the previous day.</p> <p>A Diabetes Care Plan, dated 11/14/14, indicated the following intervention, "...Diabetes medication as ordered by the doctor..."</p> <p>2. The clinical record for Resident #159 was reviewed on 11/24/15 at 10:30 a.m. The diagnoses for Resident #159 included, but were not limited to, Alzheimer's disease, depression, and abdominal aortic aneurysm without rupture, according to the clinical record.</p> <p>A Late Entry Progress Note, dated 10/16/15 at 6 p.m., indicated, "...[name of Resident #159] is alert, oriented to self and his family, usual self. At 5:30 pm [sic] he received Levermir 18 units SQ, [subcutaneous] and Novolog 14 units SQ. Immediately realized my mistake, and checked his (name brand of blood glucose monitor), which was 185, other VS WNL [vital signs within normal limits]. Reported this information to [Physician's Office] N.O.s [new orders] received and noted. Reported all this information to his son, [name of son]. He said he would like to notified of any changes with his father. Assured him I would." The note was created on 10/17/2015 7:14 p.m.</p>		<p>the Diabetic Flow Sheets on a weekly basis as an additional quality assurance measure. The D.O.N. will monitor. 5. A brief skills test will be administered to all licensed nurse applicants as a part of the Pre-employment screening process. Said test will assist give insight into the applicant's knowledge basis regarding the administration of insulin. Applicants who perform poorly on this test will not be considered for employment. The Director of Nursing is responsible. The Administrator will monitor.</p> <p>4. The Quality Assurance Nurse will discuss the status of interventions #1 - #4 above during the facility's monthly QA meetings. This practice shall continue for the next 6 months. At the end of the 6 mnth period, the Committee may opt to discontinue discussion of this topic during the monthly QA meetings if compliance is evident</p>	

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	<p>An Incident Report, dated 10/17/15, indicated, "Nurse [Name of RN #3] gave [name of Resident #159] the insulin at 5:30 p.m. on 10/16/15 that was prescribed for [name of Resident #201]. [Name of Resident #159] received Novolog 14 units and Levemir 18 units. [Name of Resident #159] has no order for insulin....Physician notified of medication error to [Name of Resident #159]. New orders received. Check resident's sugar every 4 hours. Call report if sugar lower than 100 times [sic] 24 hours. Family notified...."</p> <p>A Progress Note, dated 10/17/15 at 1:30 a.m., indicated, "Resting quietly, easily awoke, mood pleasant and cooperative. (name brand of blood glucose monitor) was 67, VS WNL. [Physician's Office] notified, she consulted [name of nurse practioner], [name of nurse practioner] stated to try another peanut butter and jelly sandwich, if not offer a protein drink. [name of Resident #159] did not care for the sandwich, he said, but did drink a [name of meal supplement]. [Physician's Office] had said to just continue the regimen we were doing for the remainder of the 24 hour period. Called [name of son] and gave him an update on his father. Thanked me for calling him, and staying on top of this in a timely manner. Safety measures in</p>			

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F 0441 SS=D Bldg. 00	<p>place."</p> <p>During an interview with the Director of Nursing (DoN), on 11/24/15 at 10:29 a.m., the DoN indicated she was unsure if RN #3 performed the "5 Rights" of medication administration (the right patient, the right drug, the right dose, the right route, and the right time), prior to the insulin administration noted above. The DoN further indicated RN #3 alluded to the fact that since both residents (Resident #159 and Resident #201) were in close proximity, was probably how the incorrect insulin administration occurred. During an interview with the Director of Nursing (DoN), on 11/24/15 at 1:15 p.m., the DoN indicated nursing was expected to follow Physician's Orders as written.</p> <p>3.1-48(a)(4)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>			

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	<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure a coagulation machine was cleaned/disinfected as recommended by manufacturer's instructions for 1 of 1 random observations. (Resident #70)</p> <p>Findings include:  During an observation with RN #4, on 11/24/15 at 9:30 a.m., RN #4 obtained a blood sample from Resident #70 and placed the sample in the coagulation machine (machine used to test blood</p>	F 0441	F441 1.At the time of discovery,the surveyor queried the staff to determine if any of the facility's Residents were known to have been positive for any blood borne pathogen: none of the facility's Residents were known to be positive for any type of blood borne pathogen. As noted by the survey citing, the Quality Assurance Nurse took immediate action in response to the surveyor's observations. 2 The policy andprocedure was reviewed and modified at the time. Immediate in-service education began with thelicensed	12/22/2015

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	<p>clotting times). After the measurement was taken, RN #4 took the machine to the medication cart. RN #4 proceeded to clean the coagulation machine with an alcohol for 30 seconds and set the machine on the medication cart. The machine rapidly dried within 15 seconds. RN #4 was not observed taking the blue tab off of the testing strip area, to clean under the tab.</p> <p>During an interview with RN #4, on 11/24/15 at 9:32 a.m., RN #4 indicated the coagulation machine was for the whole unit. RN #4 further indicated she was instructed to clean the machine with alcohol and let dry for 10 minutes. RN #4 also indicated she did not know that the machine was supposed to cleaned with a wipe for greater than 1 minute.</p> <p>On 11/24/15 at 10:16 a.m., the QA (quality assurance) nurse indicated the facility was provided instruction by a representative to use an alcohol wipe and then let the machine dry for 10 minutes. During a review of the manufacturer's instructions with the QA nurse, the QA nurse indicated the facility policy needed to be revised on cleaning the coagulation machine to reflect the manufacturer's instructions. The QA nurse also indicated she will contact the coagulation machine representative for further</p>		<p>nursing staff regarding the appropriate techniques for cleaning the coagulation machine. Laminated cardshave been made with the modified instructions and are maintained with the machines. 3 Additionally, random (documented) observations of staff use of the machine are underway to ensure adherence to the current procedure. Said observations will be conducted by the Quality Assurance Nurse and/or her designee. The Quality Assurance Nurse will monitor. 4 The Quality Assurance Nurse will review the results of said staff observations during the facility's monthly Quality Assurance Meeting. This practice shall continue for the next 6 months . At the end of the 6 month period, the Committee may opt to discontinue monthly review of this subject matter if compliance is evident.</p>	

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	<p>clarification.</p> <p>The [name of manufacturer/coagulation machine] instructions, dated 2013, were located in the packaging/bag of the coagulation machine. The instructions indicated, "...Caution: There is a potential risk of infection. Medical staff and other persons using the [name of coagulation machine] to perform tests on more than one patient must be aware that any object coming into contact with human blood is a potential source of infection....Cleaning/Disinfecting the Exterior It is important to follow the procedures below to clean and disinfect the meter....Use only the following items for cleaning/disinfecting the [name of coagulation machine] housing for a contact time of [symbol for greater than] 1 minute: -70% isopropyl alcohol -10% sodium hypochlorite solution.... Cleaning /Disinfecting the Test Strip Guide -Use only 70 % isopropyl alcohol or 10% bleach solution to clean the [name of coagulation machine]....1. Open the Cover...2. Clean/Disinfect the Test Strip Guide Hold the meter upright with the test strip guide facing down. Clean the easily accessible areas with a cotton swab. Ensure the swab is only damp, not wet. Apply cleaning agent for contact</p>			
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	<p>time of [symbol for greater than] 1 minute....3. Allow to dry with the cover off allow the test strip guide to dry for at least 10 minutes before re-attaching the test strip guide cover and testing again. 4. Close the cover...."</p> <p>A revised copy of the Policy and Procedure Use of [name of coagulation machine] (PT/INR Monitoring), dated 9/11/15 with a revised date of 11/24/15, was received from the QA nurse. It indicated, " ...NOTE: [symbol for greater than] 1 minute alcohol test strip area. The exterior of the machine is to be cleaned with an alcohol wipe after each test. Let dry for 10 minutes between uses..."</p> <p>During an interview with RN #6, on 11/24/15 at 1:50 p.m., RN #6 indicated he wipes the machine and lets it dry for 10 minutes. RN #6 further indicated he does not clean the test strip slot, nor did he even know it opens.</p> <p>On 11/24/15 at 3:21 p.m., LPN #7 indicated she wipes the coagulation machine for 20 seconds on the front of the machine and 20 seconds on the back of the machine. LPN #7 further indicated she does not pull the test strip cover off to clean in the test strip area.</p> <p>3.1-18(a)</p>			

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F 0456 SS=D Bldg. 00	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure a resident's wheel chair was in proper working condition for 1 of 1 resident reviewed for satisfactory ambulation equipment. (Resident #181)</p> <p>Findings include:</p> <p>The clinical record for Resident #181 was reviewed on 11/18/15 at 10:00 a.m. The diagnoses for Resident #181 included, but were not limited to, dementia.</p> <p>An observation of Resident #181 in her wheel chair was made on 11/18/15 at 10:14 a.m. Her left antirollback (a safety brake for use on a wheel chair, specifically for the purpose of preventing the wheel chair from rolling rearward when the occupant attempts to exit or enter the wheelchair) was not positioned over the left wheel. Resident #181's wheel chair had no anti-tippers (devices attached to the frame of the wheel chair to prevent the wheel chair from tipping over and injuring the user).</p>	F 0456	<p>F456</p> <p>1. It is the intent of Westminster Village North to have all Resident wheelchairs in a good condition to ensure Resident safety. The wheelchair for Resident #181 has been repaired. Per video surveillance, the employee that was deficient in reporting repairs needed has been identified. She has been re-inserviced on Customer Service. This was completed on 12/2/2015.</p> <p>2. The Maintenance Department has completed an audit of all wheelchairs in the facility to ensure Resident safety and repairs completed as identified.</p> <p>3. The Maintenance Department has added monthly audits of all wheelchairs. Any wheelchairs identified for repaired if facility owned. Wheelchairs owned privately will be contacted by Social Service Director and/or Administrator to receive approval for repairs. Once obtained, the Maintenance Department will complete repairs.</p> <p>4. The Director of Plant Operations will present the results of audits at facility's monthly Quality Assurance meetings for 6</p>	12/22/2015

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	<p>An observation of Resident #181's wheel chair was made on 11/23/15 at 3:25 p.m. The left antirollback was not positioned over the left wheel.</p> <p>An observation of Resident #181's wheel chair was made on 11/24/15 at 10:29 a.m. The left antirollback was not positioned over the left wheel.</p> <p>An observation of Resident #181's wheel chair was made with QMA (Qualified Medication Aide) #9 on 11/24/15 at 10:31 a.m. QMA #9 indicated the maintenance department was responsible for ensuring residents' ambulation equipment was in good repair. QMA #9 fiddled with Resident #181's left antirollback bar, and indicated she'd put in a work order.</p> <p>An interview was conducted with the Director of Plant Operations on 11/24/15 at 2:46 p.m. He indicated residents' wheel chairs were checked "all the time" for functionality by his technicians as part of their rounds. He indicated there were no logs completed to verify wheel chair functionality checks. He indicated his department would be made aware if a resident's wheel chair was in need of repair if a staff member or resident reported it, or it was seen on his</p>		<p>months. At the end of 6 months, the QA team may choose to cease the monthly audits, if the audits revealed compliance is evident</p>	

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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 9999  Bldg. 00	<p>technician's rounds. On 11/24/15 at 3:11 p.m., the Director of Plant Operations indicated he did not have any work orders for Resident #181's wheel chair. He indicated he just went to look at Resident #181's wheel chair, and verified the left antirollback bar was loose. He indicated Resident #181 was in her wheel chair at the time of his observation.</p> <p>An interview was conducted with the Rehabilitation Manager on 11/24/15 at 3:17 p.m. She indicated the therapy department checked wheel chairs periodically, but the last time they checked Resident #181's wheel chair was in February, 2015. She provided Resident #181's 2/3/15 Health Center Therapy Items Assessment on 11/24/15 at 3:21 p.m. It indicated Resident #181's wheel chair was in good condition, but needed a left brake cushion. The assessment did not reference the left antirollback bar.</p> <p>3.1-19(bb)</p>	F 9999	1. It is facility policy that all employees upon hire and annually thereafter, receive in-service training for Prevention	12/22/2015
	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program			

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	<p>planned in advance for all personnel. This training shall include, but not be limited to, the following:</p> <ol style="list-style-type: none"> <li>(1) Residents' rights.</li> <li>(2) Prevention and control of infection.</li> <li>(3) Fire prevention.</li> <li>(4) Safety and accident prevention.</li> <li>(5) Needs of specialized populations served.</li> <li>(6) Care of cognitively impaired residents.</li> </ol> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide a staff member annual resident rights, and dementia in-service training for 1 of 10 employee personal files reviewed. (CNA #30)</p> <p>Findings include:</p> <p>The Employee Records form and 10</p>		<p>of abuse, neglect, punishment and seclusion. C.N.A. #30 received this annual training on 11/26/15.</p> <p>2.All employees have completed their annual in-service for Prevention of abuse, neglect punishment andseclusion. A 100% audit of all employee files wasconducted to ensure annual required training completed.</p> <p>3.Annual Abuse training for all staffcompleted. Quality Assurance Manager will update calendar to reflect timely completion of required trainings. Monthly audits of required in-services will be completed by Quality Assurance Manager for compliance.</p> <p>4.The Quality Assurance Manager will present the results of audits at facility's monthly Quality Assurance meetings for 6 months. At the end of 6 months,the QA team may choose to cease the monthly audits, if the audits revealed compliance is evident</p>	

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R 0000  Bldg. 00	<p>employee personnel files were reviewed on 11/24/15 at 3:30 p.m. The record indicated certified nursing assistant (CNA #30) start date was 2/3/11.</p> <p>The personnel file for CNA #30 did not include annual resident rights and dementia in-service training.</p> <p>An interview was conducted with QA #5 on 11/24/15 at 3:45 p.m. She indicated she is unable to locate any annual resident rights and dementia in-service training for CNA #30 since her start date of 2/2011.</p> <p>A work scheduled was provided by the Administrator on 11/24/15 at 4:00 p.m. The Administrator at this time indicated CNA #30 was an as needed staff member until 12/2014. CNA #30's work status was changed in December to full time. She indicated a staff member is consider full time if the staff member works 30 hours or greater. The work scheduled indicated CNA #30 has worked 2,122 hours from December 2014 until present.</p> <p>3.1-28(a)</p> <p>These deficiencies reflect State findings</p>	R 0000	Submission of this plan of	

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R 0297 Bldg. 00	<p>cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired insulin was discarded before administration. This had the potential to affect 1 of 3 residents who received insulin from the first floor Sycamore refrigerator. (Resident #1025)</p> <p>Findings include:</p> <p>During an observation of the First Floor Sycamore refrigerator with LPN #15, on 11/24/15 at 12:00 p.m., a box with a vial of Novolog 100 units/milliliter was noted with an open date of 10/20/15. The insulin was for Resident #1025</p> <p>During an interview with LPN #15, on</p>	R 0297	<p>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 service to the Residents at Westminster Village North.</p> <p>R297 1 The expired insulin was identified and discarded on 11/24/15 2 An audit was completed on all refrigerators in the Licensed Residential facility No other expired medications were found 3 Administrative Nurse will complete weekly audits x 6 months. 4 Results of weekly audits will be presented at Facility QA meetings At the end of 6months audits will cease if compliance is evident</p>	12/22/2015

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	<p>11/24/15 at 12:05 p.m., LPN #15 indicated the above Novolog was opened on 10/20/15 according to the box. LPN #15 further indicated she thought insulin expired 28 days after it was opened. LPN #15 also indicated no other vials of Novolog were noted for Resident #1025 in the refrigerator, so the Novolog observed was the insulin that was being administered to Resident #1025.</p> <p>The November Medication Administration Record (MAR) for Resident #1025 indicated Resident #1025 received Novolog three times a day on the following dates: 11/19/15, 11/20/15, 11/21/15, 11/22/15, 11/23/15. The MAR also indicated Resident #1025 received Novolog on 11/24/15 at 6 a.m.</p> <p>A review of a document titled Labeling of Medication, no date, was received from Assistant Director of Nursing, on 11/24/15 at 3:45 p.m. The document indicated, "...Novolog...Once opened, refrigerated or not product must be used within 28 days...."</p>			