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 02/11/2013

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

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F0000	This visit was for the investigation of Complaint #IN00123756. Complaint #IN00123756-Substantiated. Federal deficiencies related to the allegation are cited at F323. Survey date: February 11, 2013 Facility number: 000086 Provider number: 155170 AIM number: N/A Survey team: Shelley Reed, RN Census bed type: SNF: 59 Residential: 184 Total: 243 Census payor type: Medicare: 21 Other: 222 Total: 243 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F0323 SS=D	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 a resident was provided with an environment that was free from hazards following an elopement for 1 of 3 residents who were reviewed for accidents. (Resident A) Findings include: During an interview on 2/11/13 at 10:00 a.m., the Health Facility Administrator #1 indicated on 2/2/13 at approximately 12 a.m., Resident A was not observed in her room during the 2 hour room check by the staff. She indicated the staff immediately started to search for the resident. She indicated the resident was found almost immediately after the staff began to search for her. She indicated Resident A had exited out door #6, pushing a wheelchair, and was found close to door #5. Resident A was found laying face-down on the ground. She indicated Resident A had no history of exit seeking behaviors prior to 2/2/13.	F0323	**Westminster Village Muncie, Inc. Plan of Correction F-323** ***1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice:*** All security door alarm panels were immediately placed on a two (2) hour check system by Nursing personnel. A form was initiated that indicated Date, Time and Initials of Personnel that were actually checking the system. (See Attachment A). Staff on-site was initially in-serviced on 2/2/2013 by 6:00 a.m. following the alleged deficient practice. The entire Skilled Nursing Unit staff was in-serviced during the following week on each shift as they came in to work to ensure that there would not be a recurrence related to the alleged deficient practice. (See Attachment B). ***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 were re-assessed and their clinical	02/11/2013

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	During an interview on 2/11/13 at 11:50 a.m., Resident A indicated she remembered going outside and not being able to get back inside. She indicated as she was pushing her wheelchair, it fell over and she then fell onto the ground. She indicated she started to crawl towards door #5. She indicated it was freezing outside and she was yelling, but could not be heard. She was not sure how long she was outside, but did not feel like it was very long. During an interview on 2/11/13 at 11:55 a.m., Resident A's daughter indicated maybe the construction workers shut off the alarm to door #6 because they had been working in the area that day. She indicated they have no concerns with the facility and the staff have been very good to her mother. During an interview on 2/11/13 at 1:30 p.m., RN #1 indicated she was the night Charge Nurse for Bristol Hall on 2/1/13. She indicated she was working with 2 CNA's on the night of 2/1/13 when Resident A was found outside of the building. She indicated she was notified by two CNA's on 2/2/13 at approximately 12 a.m. that Resident A was not in her room. She		records were updated to reflect current status for potential elopement risk. This measure is to be routinely completed on Admission, Quarterly and Change of Condition. A complete in-servicing process was initiated with Nursing, Maintenance and Security staff directly related to the security door alarm panels with the newly instituted policy. (See Attachment C). All security door alarm panels were immediately placed on a two (2) hour check system by Nursing personnel. A Monitoring Log was initiated that indicated Date, Time and Initials of Personnel that were actually checking the door alarm system. Staff on-site was initially in-serviced on 2/2/2013 by 6:00 a.m. following the alleged deficient practice. The entire Skilled Nursing Unit staff was in-serviced during the following week on each shift as they came in to work to ensure that there would not be a recurrence related to the alleged deficient practice. These measures were completed to ensure that no other resident was affected by the alleged deficient practice. ***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:*** Increased routine monitoring of security alarm panels was immediately initiated on an every two (2) hour basis	

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	indicated they immediately searched nearby rooms and the resident was not found in another room. She then went to the security board panel and noticed the alarm for door #6 was in the off position. She indicated she then looked out door #6 and found a wheelchair on it's side. Next to the wheelchair, Resident A was found laying on her side, close to door #5. She indicated the resident was alert and shivering. The staff immediately placed the resident in the wheelchair and moved her into her room. They applied warming blankets. She assessed the resident. Vital signs and neurological assessments were completed. RN #1 then called the HFA #1 and was instructed to call 911 to transport Resident A for evaluation and treatment. During an interview on 2/11/13 at 2:30 p.m., Physical Plant Manager #5 indicated he was responsible for security throughout the facility. He indicated the facility had been doing some construction work around door #6 and they had been bringing material in and out of door #6. He indicated the workmen would often turn off the alarm, but turn it back on when they left for the day. He indicated the security staff was to do security checks every 90 minutes on		with a newly instituted policy for actual check and initialing with date and time. This was implemented with Nursing. In addition it should be noted that Maintenance and Security will continue their routine checks. (See Attachment D). The Physical Plant Director will monitor for compliance and report to the QA Committee for a minimum of 6 months or until the renovation phase has been thoroughly completed. Alert stop tape was also applied to every alarmed door on the skilled units for visible awareness of resident safety. This measure was put in place to alert residents as a reminder to not exit alarmed doors. ***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:*** Unit Managers and/or designee will monitor all Security Alarm signature forms completed by Nursing staff on a weekly basis to ensure that the alleged deficient practice does not recur. This review will be presented on a monthly basis to the Quality Assurance Committee. This process will continue for a minimum of six (6) months or until the renovation phase has been thoroughly completed. Any modification of this audit will be addressed through the QA process. The Physical Plant Director will also	

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	every door and panel in the facility. He indicated he spoke to Security Guard #6 who was working on the night of 2/1/13 related to the time when the panel on Bristol Hall was last checked. He indicated Security Guard #6 stated the door monitors indicated "all systems functioning" on each door throughout the facility on the evening of 2/1/13. Physical Plant Manager #5 then asked if Security Guard #6 checked the security panels themselves and Security Guard #6 appeared to have a "blank look" on his face and indicated he had not checked the panels only the door alarms. Physical Plant Manager #5 indicated the last known security panel check was on 2/1/13 between 4-4:40 p.m. according to the security log. During an interview on 2/11/13 at 3:15 p.m., Assistant Physical Plant Manager #7 indicated he received a call at home related to the phones in the facility not working properly. He arrived at the facility after Resident A had been transported to the hospital. He was informed the security alarm to door #6 had been turned off at some point. He indicated he then walked around the facility with Security Guard #6 checking the alarms and doors. He indicated when he spoke to		monitor Maintenance and Security staff for their routine checks for compliance and report to the QA Committee for a minimum of 6 months or until the renovation phase has been thoroughly completed. ***5) All components of the systematic adjustments for notification of changes will be implemented by:*** The facility was secured and a newly instituted policy was initiated, in-serviced and enacted by 6:00 a.m. on 2/2/2013. During the following week a sincere effort was made to strengthen our systems through various measures (i.e. Maintenance, Security and Nursing Management reviews and in-services presented by President, Vice President and Physical Plant Director) to prevent any recurrence of the alleged deficient practice. At the time of the Complaint Survey on 2/11/2013, the facility was operating with all measures fully instituted. As we continue on with additional measures, we have created and assigned additional in-services through SilverChair, titled “Accident Prevention and Management”. (See Attachment E). Based upon the concern of the alleged deficient practice, it should be noted that we are strongly committed to quality resident care and resident safety. All proper regulatory measures were strengthened to prevent	

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	Security Guard #6, the guard indicated he did not check the panel to make sure the alarms were set, only the door alarm panels on the doors were checked. During an interview on 2/11/13 at 4:45 p.m., CNA #3 indicated she was working on Bristol Hall on 2/1/13. She indicated CNA #4 and herself were doing round checks every 2 hours and Resident A was doing well at 8:00 p.m. She indicated they checked on her again around 10:00 p.m. Resident A was watching TV at that time and did not want to change into her pajamas until after she was done watching TV. They checked on her again around 12:00 a.m. and found she was not in her room. They immediately notified the nurse and began a search. She indicated Resident A was found outside of door #6, laying on the ground beside the tipped over wheelchair. She indicated the resident was alert and was quickly moved back inside. She indicated the resident did not have any increased confusion earlier in the evening and had no history of wandering prior to 2/1/13. During an interview on 2/11/13 at 5:00 p.m., CNA #4 indicated she was working on Bristol Hall on 2/1/13.		recurrence of alleged deficient practice. All affected departments responded appropriately, efficiently and with great compassion for the resident and her family. A full disclosure of the alleged deficient practice occurred with the family and resident. All measures as noted in the ISDH narrative were completed to ensure safety and security for the residents we serve.	

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	She indicated CNA #3 and herself checked on Resident A at 8:00 p.m. Resident A was watching TV and declined getting her pajamas on at that time. She indicated they checked on her again at 10:00 p.m., Resident A did use the bathroom, but declined changing into her pajamas at that time. They decided to check on her first at 12:00 a.m. to see if she would like to get ready for bed. She indicated the resident was not in her room so they then reported to the nurse that they could not find Resident A. She indicated rooms close by were checked and they could not find the resident. They then looked outside door #6 and saw a wheelchair laying on it's side and Resident A was laying beside the wheelchair. She was then brought into the facility and wrapped in warm blankets. She indicated the resident indicated she was trying to get to the beauty shop. During record review on 2/11/13 at 1:00 p.m., Resident A was admitted on 1/29/13. Resident A's diagnoses included but were not limited to; diabetes mellitus, hypertension, CVA, Alzheimer's disease and asthma. The Minimum Data Set assessment (MDS), dated 2/3/13, indicated Resident A scored a 8 of 15 for the			

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	Brief Interview Mental Status (BIMS). A score of 8 indicated the resident was moderately impaired at the time of the assessment. An assessment risk for potential elopement was completed on 1/29/13. The assessment indicated Resident A was not an elopement risk at the time of admission. Resident A was unable to ambulate independently without the use of an assistive device. An elopement risk assessment was completed on 2/2/13, indicating Resident A was an elopement risk and a Wander Guard was placed on her left ankle. Review of nursing note, dated 2/2/13, following the elopement, indicated Resident A's hands and face were red from exposure, abrasions to bilateral knees and an small abrasion to her 4th digit knuckle were noted. Vital signs were assessed with the following; temperature 96.5, blood pressure 122/63, oxygen saturation 96%, and respiration 20 per minute. A neurological assessment also indicated they were within normal limits. The physician, HFA, DoN, and POA were notified of elopement and transfer to the local hospital. During review of hospital records on			

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	2/11/13 at 4:30 p.m., Resident A was treated for hypothermia. Resident A also had scratches on her right hand and bilateral knees. Resident A denied any pain, weakness or shortness of breath. On 2/2/13 at 1:47 a.m., Resident A's temperature was 97.0. A Bair Hugger warming blanket was provided to increase her body temperature. Resident A was discharged back to the facility on 2/2/13 at 5:49 a.m. Review of a current facility policy dated 5/313/10 titled "Westminster Village Muncie, Inc. Locating a Missing Resident Policy" which was provided by the HFA #1 on 2/11/13 at 10:55 a.m., indicated the following; "Procedures: Westminster Village Health Center has implemented security procedures to minimize the probability of a Resident leaving the facility and/or grounds. Security measures include 24 hour use of an alarm system for all exit/outside doors and security cameras. All residents upon admittance to the Health Center will have an elopement risk assessment completed." This federal tag relates to Complaint IN000123756.			

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