STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER HEALTH CARE CENTER	2210 GREENTREE N CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaint IN00384372 and a COVID 19 Infection Control survey. This visit included the Investigation of Residential Complaint IN00387203. Complaint IN00384372 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387203 - Substantiated. State deficiency related to the allegations is cited at F0241. Survey dates: September 1 and 2, 2022 Facility number: 000100 Provider number: 155191 AIM number: 100266130 Census Bed Type: SNF/NF: 61 Residential: 88 Total: 149 Census Payor Type: Medicare: 9 Medicaid: 40 Other: 12 Total: 61 Westminster Health Care Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Nursing Home Complaint IN00384372. Quality review completed on September 8, 2022.	F 0000		

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

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R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00387203. This visit included the Investigation of Nursing Home Complaint IN00384372 and a COVID 19 Infection Control survey. Complaint IN00387203 - Substantiated. State deficiency related to the allegations is cited at R0241. Complaint IN00384372 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 1 and 2, 2022 Facility number: 000100 Residential Census: 88 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on September 8, 2022.	R 0000		
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure a resident (Resident B) received the correct medications for 1 of 3 residents	R 0241	**1. PLAN OF CORRECTION TEXT** This plan of correction is prepared	09/23/2022

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	reviewed for medication administration. Findings include: The clinical record for Resident B was reviewed on 9/1/22 at 11:57 a.m. The diagnoses included, but were not limited to, hypertension, depression, hyperlipidemia, and anxiety. The incident report, dated 8/3/22 at 10:01 p.m., indicated Resident B was given the wrong medications, no injuries were noted, and facility staff would be inserviced/educated medication administration. The clinical note, dated 8/3/22 at 11:09 p.m., indicated LPN (Licensed Practical Nurse) 4 had given Resident B her night time medications. The resident had taken the Melatonin (sleep aid) 10 mg (milligrams), Hydroxyurea (antineoplastic) 500 mg, and Trental (vasodilator) 400 mg before Resident B realized the medications were not hers. The Nurse Practitioner was notified with a new order to monitor the resident's vital signs ever 2 hours for 8 hours and then every shift for 3 days. During an interview on 9/1/22 at 4:10 p.m., LPN 4 indicated she had set up the medications for both Resident B and Resident C. She received a phone call and when she returned to the medication cart, she picked up the wrong cup of medications. Resident B had taken the Hydroxyurea, Trental and Melatonin when the resident reported that she did not think the medications were hers. During an interview on 9/1/22 at 11:53 a.m., the Assisted Living Director indicated medication administration education had not yet been provided to the staff nurses.		and executed because it is required by the provisions of state and federal law. Westminster Health Care Center Assisted Living maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor are they of such character so as to limit its ability to render adequate care. This plan of correction shall operate as Westminster Health Care Center Assisted Living credible allegation of compliance. This plan of correction is not meant to establish a standard of care, contract, obligation or position and Westminster Health Care Center Assisted Living reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. What corrective actions will be accomplished for the residents found to have been affected by the deficient practice: **Resident #B was provided the correct medication starting on 8/3/22 at 11:00pm. The resident was monitored for any negative effects from the provision of the incorrect medication on 8/3/22 at 10:01pm.** **2.** How other resident's having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: **All**	

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	The incident report, dated 8/3/22 at 10:01 p.m., indicated Resident B received the wrong medications. On 9/1/22 at 4:52 p.m., the Assisted Living Director provided a current copy of the document titled "Administering Medications" dated 12/2012. It included, but was not limited to, "Policy Statement...Medications shall be administered in a safe...manner, and as prescribed...Medications must be administered in accordance with orders...Medications ordered for a particular resident may not be administered to another resident...." This State tag relates to Complaint IN00387203		**residents that have an order for a medication could be affected. Nursing staffs that administer medication or observe the resident taking the medication were re- inserviced on the policies and procedures titled "Administering Medication". Nursing staffs that administer medication or observe the resident taking the medication will be in-serviced on these requirements in new hire orientation and annually. An audit was completed to check the medication administration/observation practice by all nursing staff that administer medication. If there is a need for further re-training, this education was provided.** **3.** What measures will be put in place or systemic change will be made to ensure that the deficient practice does not recur: **Nursing staffs that administer medication or observe the resident taking the medication were re- inserviced on the policies and procedures titled "Administering Medication". Nursing staffs that administer medication or observe the resident taking the medication will be in-serviced on these requirements in new hire orientation and annually. An audit was completed to check the medication administration/observation**	

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			practice by all nursing staff that administer medication. If there is a need for further re-training, this education was provided. The Nursing Manager or designee will check the in-service sign-in sheets related to these requirements to ensure compliance. In addition, the Nursing Manager or designee will audit the medication administration practices of six nursing staff members who administer/observe medication monthly to ensure compliance. These audits will occur for a year. Any staff member found not to be in compliance will be re-educated and counseled as necessary with the progressive disciplinary process. **4.** How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: **The audit findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of 4 months @ 100% compliance.** **5.** By what date the systemic changes will be completed: **This will be completed by 9/23/22, except 1 nurse who is currently on vacation. Will be retrained**	

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			and in serviced before returning to work.	