STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155170	A. BUILDING 00 B. WING	02/10/2023

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WESTMINSTER VILLAGE MUNCIE INC	5801 W BETHEL AVE MUNCIE, IN 47304

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 6, 7, 8, 9 and 10, 2023 Facility number: 000086 Provider number: 155170 Census Bed Type: SNF/NF: 57 Residential: 137 Total: 194 Census Payor Type: Medicare: 16 Medicaid: 1 Other: 40 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 15, 2023.	F 0000	**The submission of this Plan of Correction (HCFA-2567) does not constitute an admission by Westminster Village Muncie, Inc. of any fact or conclusion set forth in the Statement of Deficiencies. This Plan of Correction is being submitted because it is required by law.** **Furthermore, we request that this Plan of Correction serve as our credible allegation of compliance.** **Compliance is effective:** **March 13, 2023** **Mary Jo Crutcher, HFA** **President and Administrator** **March 13, 2023** **Date**	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Jo Crutcher	HFA, President	03/01/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			

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	Based on record review and interview, the facility failed to complete a baseline care plan for 1 of 1 residents reviewed for accidents. (Resident 13) Findings include: The clinical record for Resident 13 was reviewed on 2/8/23 at 10:14 a.m. Diagnoses included, but were not limited to, history of falling, osteoarthritis, and major depressive disorder. The resident admitted to the facility on 1/5/23 from an acute care hospital. An admission Minimum Data Set (MDS) assessment, dated 1/12/23, indicated the resident had moderate cognitive impairment, was not steady, and only able to stabilize herself with assistance from staff when moving from seated to standing and during transfer, and required extensive assist of two staff for transfer and toileting. The resident had fallen in the last month, prior to her admission to the facility. The clinical record lacked a baseline health care plan. A comprehensive care plan was completed on 1/12/23 at 1:09 p.m. On 1/11/23, the resident had a fall from her recliner. During an interview, on 2/10/23 at 8:58 a.m., the Unit Manager indicated the baseline care plan was not created in a timely manner, and staff were to develop the baseline care plan on admission. A current facility policy, dated 11/19/21, titled, "Baseline Care Plan," provided for the Assistant Director of Nursing on 2/10/23 at 3:32 p.m., indicated the following:	F 0655	***F655 – Comprehensive Person-Centered Care Planning*** ***1. The deficient practice was unable to be completed for resident #13 as the baseline care plan was not completed within 48 hours.*** ***2. Our Unit Manager reviewed all baseline care plans for recent new admissions on 2/9/23 and no other residents were effected.*** ***3. Our ADON will educate all nurse management staff regarding the development of a person centered baseline care plan for each resident to include initial goals based upon MD orders, therapy services, Social Services and PASRR when applicable within 48 hours of admission. This education will also be included in the orientation of any new nurse.*** ***4. ADON/Designee will assure completed and accurate daily x4 weeks, twice weekly x2 weeks, then weekly x2 weeks. Results will be forwarded monthly to QA x9 months. Corrective action for trends or on- going concerns will be initiated as appropriate.*** ***5. Date of Compliance: 3/13/23***	03/13/2023

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	"...Policy: The facility will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care...Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. be developed within 48 hours of resident's admission...." 3.1-30(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to obtain daily weights per physician's order for 2 of 3 resident reviewed for edema (Residents 15 and 52), and failed to notify the physician of weight gain per physician's ordered parameters for 3 of 3 resident's reviewed for edema. (Residents 15, 52 and 157) Findings include: 1. Resident 15's clinical record was reviewed on 2/9/23 at 11:06 a.m. Diagnoses included, but were not limited to, congestive heart failure (CHF) and diabetes mellitus. An admission minimum data set (MDS) assessment, dated 1/10/23, indicated the resident	F 0684	***F684- Quality of Care*** ***1. Medical Director was notified for weights out of parameter regarding weight gain for residents #15, #52, and #157. No new orders. 2 residents have since discharged and 1 changed to biweekly weights.*** ***2. ADON and Unit Managers reviewed all residents with orders for daily weights, including the diagnosis of CHF for MD notification of any weight out of order parameters.*** ***3. ADON/Designee will inservice nurse management regarding following MD orders***	03/13/2023

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	was cognitively intact, had no verbal or physical behaviors and no rejection of care. A baseline health care plan, dated 1/3/23, included a condition of CHF with a goal including no edema and an intervention of daily weights. A current physician's order, dated 1/4/23, indicated the resident was to be weighed daily for 30 days and to notify the physician of a gain of two pounds in 24 hours or four pounds in a week due to a diagnoses of CHF. A review of the resident's clinical records for weights, for January and February of 2023, indicated the following: a. The record lacked weights for 1/2/23, 1/4/23, 1/6/23, and 1/9/23. b. The record indicated a 5.2 pound weight gain for the week of 1/3/23 to 1/10/23 and lacked physician notification. c. The record indicated a 5.8 pound weight gain for the week of 1/5/23 to 1/12/23 and lacked physician notification. d. The record indicated a 2.8 pound weight gain on 2/4/23 in one day and lacked physician notification. During an interview, on 2/10/23 at 10:53 a.m., the Unit Manager indicated the physician had not been notified of resident's weight gain, per physician's order. 2. Resident 52's clinical record was reviewed on 2/9/23 at 9:01 a.m. Diagnoses included, but were not limited to, pulmonary edema, CHF, and presence of a implanted cardiac defibrillator. An admission MDS assessment, dated 1/8/23,		***of daily weights and physician notification.*** ***4. ADON/Designee will assure completion and follow through daily x4 weeks, twice a week x2 weeks, then weekly x2 weeks. Results will be forwarded monthly to QA x9 months. Corrective action for trends or on-going concerns will be initiated as appropriate.*** ***5. Date of Compliance: 3/13/23***	

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	indicated the resident had moderate cognitive impairment, had no verbal or physical behaviors, and no rejection of care. A health care plan, dated 1/29/23, indicated the resident was at risk for cardiac dysfunction, and included an intervention to obtain weights as ordered, and to notify the physician of significant changes. A current physician's order, dated 1/29/23, indicated the resident was to be weighed daily for 30 days and to notify the physician of a gain of two pounds in 24 hours or four pounds in a week. A review of the resident's clinical records for weights for February 2023, indicated the following: a. The record lacked weights on 1/4/23 and 1/6/23. b. The record indicated a 5.2 pound weight gain for the week of 1/3/23 to 1/20/23 and lacked physician notification. During an interview, on 2/10/23 at 10:28 a.m., the Assistant Director of Nursing (ADON) indicated the physician should have been notified of the weight gain on 1/10/23 per physician's order. 3. Resident 157's clinical record was reviewed on 2/07/23 at 2:08 p.m. Diagnosis included, but were not limited to, diabetes mellitus, atrial fibrillation, and stage three chronic kidney disease. An admission MDS assessment, dated 2/5/23, indicated the resident was cognitively intact, had no verbal or physical behaviors, and no rejection of care. A health care plan, dated 1/29/23, included			

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	resident was a risk for cardiac dysfunction, and included an intervention to obtain weights as ordered and to notify the physician of significant changes. A current physician's order, dated 1/29/23, indicated the resident was to be weighed daily for 30 days and to notify the physician of a gain of two pounds in 24 hours or four pounds in a week. A review of the resident's clinical records for weights, for February of 2023, indicated a 2.8 pound gain on 2/4/23 in one day. During an interview, on 2/10/23 at 10:57 a.m., the Unit Manager indicated the physician had not been notified regarding the resident's weight gain per physician order. A current facility policy, dated 11/19/22, titled, "Following Medication-Physician Orders/Vital Sign Parameters," and provided by the ADON on 2/10/23 at 1:21 p.m., indicated the following: "...Procedures:...R. Notification of Physician/Prescriber...2....abnormal test results, vital signs...." 3.1-37(a)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents, who were at risk for falls, had interventions in place in accordance with their care plan for 4 of 8 residents reviewed for fall prevention. (Residents 16, 38, 41 & 42) Findings include: 1. Resident 16's clinical record was reviewed on 2/7/23 at 1:05 p.m. Current diagnoses included dementia, hypertension, depression and chronic obstructive pulmonary disease. The resident had a current,8/12/22, physician's orders for a bed pad alarm, a low bed,a single blue mat on the floor beside the bed, and wheel chair anti- tippers. A current, 12/31/22, care plan problem indicated the resident was at risk for falls. Interventions included, chair alarm & bed pad alarm in place, check proper placement and functioning (attempt to place alarm boxes out of resident reach so she does not take them apart 3/17), and anti-tippers on wheelchair. A 1/22/23,quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, used a wheelchair for mobility, could only stabilize her balance with the support of another person, and used a bed alarm daily. A 1/20/23 fall risk assessment indicated the resident was at risk for falls. Factors contributing to the identified risk included, intermittent confusion, poor recall, and poor safety awareness. During the following observations, the resident did not have fall prevention devices in place:	F 0689	***F689-Free of Accident Hazards/Supervision/Devices*** ***1. For residents #16, #38, #41 and #42 physician orders were clarified, interventions were put in place and care plans were updated appropriately. Visual rounds were completed to ensure proper interventions were in place per physicians order.*** ***2. All residents with assistive devices to prevent accidents have the potential to be affected. Visual audits of each unit took place by our ADON and Unit Managers to assure correct devices were in place. ADON and Unit Managers also audited current resident's with assistive devices to prevent accidents have correct physician orders in place and care plans were updated.*** ***3. All current residents utilizing assistive devices to prevent accidents were reviewed by our ADON/Designee. Systemic review included ensuring physician orders are correct, care plans were updated, and visual rounding.*** ***4. ADON/Designee will assure audits are completed daily x4 weeks, twice a week x2 weeks, then weekly x2 weeks. Inservicing will take place with our nursing staff. Results will be forwarded monthly to QA x9***	03/13/2023

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	On 2/6/23 at 9:48 a.m., the resident was in the lounge, seated in her wheel chair. The wheel chair did not have anti-tippers in place. On 2/7/23 at 9:16 a.m., the resident was seated in a wheelchair in the lounge, The wheelchair lacked anti-tippers. On 2/8/23 at 2:22 p.m., the resident was in her room seated in a personal recliner. No alarm was in place on the recliner. On 2/8/23 at 11:43 a.m., the resident was in the lounge, seated at a table in her wheelchair. The chair did not have anti-tippers. On 2/9/23 at 9:59 a.m., the resident was seated in her room in a personal recliner. There was no alarm in place. A clip alarm was observed attached to the empty wheelchair. During an observation and interview, with the Assistant Director of Nursing (ADON) and the Health Operations Administrator on 2/8/23 at 2:29 p.m., the ADON indicated the resident did not have a personal alarm on while she was sitting in her personal recliner. During an interview, on 2/08/23 at 2:36 p.m., the ADON indicated the resident did have current 8/12/22 orders for both bed and chair alarms. Additionally, care plans and orders should match. The facility would need to review care plans and orders and seek clarification. During an interview, on 2/8/22 at 2:38 p.m., the Health Operations Administrator indicated the resident's wheelchair had just been observed and was lacking anti-tipper devices, in conflict with		***months. Corrective actions for trends or on-going concerns will be initiated as appropriate.*** ***5. Date of Compliance: 3/13/23***	

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	her orders and care plan. 2. Resident 38's clinical record was reviewed on 2/7/23 at 1:09 p.m. Current diagnoses included Alzheimer's disease, hypertension, and atrial fibrillation. The resident had a current, 5/24/22, order for a low bed, bed pad alarm, and pull tab alarm while in the bed or chair. A current, 3/1/22, care plan problem indicated the resident was at risk for falls. Interventions included pressure pad alarm in bed, clip alarm on bed and chair, and bed in the lowest position. A 1/08/23, quarterly, MDS assessment indicated the resident was moderately cognitively impaired, used a wheelchair for mobility, could only stabilize her balance with the support of another person, and used a bed and chair alarm daily. An 11/14/22 fall risk assessment indicated the resident was at risk for falls. Factors contributing to the identified risk included, intermittent confusion, poor recall, and poor safety awareness During the following observations, the resident did not have fall prevention devices in place: On 2/8/23 at 2:19 p.m., the resident was in a recliner chair in the lounge. There was no alarm clipped to the resident in the recliner. An alarm was attached to the resident's wheelchair, which was a few feet away from the resident. During an observation and interview, on 2/8/23 at 2:25 p.m., the ADON indicated the resident did not have an alarm attached while in the recliner in the lounge. An alarm should have been moved from his wheelchair and placed on the recliner.			

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	During an interview, on 2/8/23 at 2:39 p.m., the ADON indicated the resident had an order for an alarm to be applied while he was in a chair. 3. Resident 41's clinical record was reviewed on 2/07/23 at 1:11 p.m. Current diagnoses included a history of traumatic hemorrhage of cerebrum, a history of fracture of neck, and dementia. A current, 3/27/22, care plan problem indicated the resident was at risk for falls. Interventions included a low bed, double blue mats to the floor beside the bed, and clip alarm to the bed and chair. A 12/11/22, annual, MDS assessment indicated the resident was severely cognitively impaired, used a wheelchair for mobility, could only stabilize her balance with the support of another person, and used a bed and chair alarm daily. A, 12/22/22, fall risk assessment indicated the resident was at risk for falls. Factors contributing to the identified risk included, intermittent confusion, poor recall, and poor safety awareness. During the following observations, the resident did not have fall prevention devices in place: On 2/7/23 at 1:37 p.m., the resident was in bed in his room. There was no mat of any kind on the floor by the bed. On 2/7/23 at 2:22 p.m., the resident was in bed in his room. There was no mat on the floor. On 2/8/23 at 2:21 p.m., the resident was in bed. There was no mat on the floor and no alarm present on the bed.			

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	During an observation and interview, on 2/08/23 at 2:27 p.m., the ADON indicated there was no mat or alarm in place while the resident was in bed. The ADON indicated the care plan should reflect the resident's current needs. During an interview, on 2/08/23 at 2:40 p.m., the ADON indicated the alarm and mat had been discontinued on 1/25/23. The care plan should indicate the current safety devices needed by the resident. 4. Resident 42's clinical record was reviewed on 2/7/23 at 1:06 p.m. Current diagnoses included dementia, chronic kidney disease, hemiplegia, and hypertension. The resident had a current, 9/2/22, order for a high-backed wheelchair with a left half-lap tray and a pummel cushion to assist with positioning and comfort related to hemiplegia. A current, 5/1/22, care plan problem indicated the resident was at risk for falls. Interventions included use appropriate assistance device and level of assistance as recommended: high back wheelchair, pummel cushion in chair, and two assist for transfers. A 10/30/22, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, used a wheelchair for mobility, and could only stabilize her balance with the support of another person. An 11/14/22 fall risk assessment indicated the resident was at risk for falls. Factors contributing to the identified risk included, intermittent confusion, poor recall, and poor safety awareness. During the following observations, the resident did not have fall prevention devices in place:			

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	On 2/6/23 at 9:47 a.m., the resident was in the lounge in a wheelchair. The wheelchair did not have a lap tray or pummel cushion. On 2/7/23 at 9:15 a.m., the resident was in the lounge in a wheelchair. It did not have a lap tray or pummel cushion. On 2/8/23 at 9:20 a.m., the resident was in the lounge in a wheelchair. It did not have a lap tray or pummel cushion. On 2/8/23 at 10:05 a.m., the resident was in the activity room in a wheelchair. It did not have a lap tray or pummel cushion. During an observation and interview, on 2/8/23 at 2:42 p.m., the ADON indicated the resident was using a chair without a half lap tray or a pummel cushion. During an interview, on 2/9/23 at 9:45 a.m., the ADON indicated the resident had therapy and hospice services, and should have had orders and a care plan for a modified low Broda chair. The current care plan and orders were incorrect. A current, 11/19/22, facility policy titled "Fall Prevention Program", provided by the Health Operations Administrator on 2/10/23 at 11:35 a.m., indicated the following: "...b. Implement interventions from Low/Moderate Risk Protocols. c. Provide interventions that address unique risk factors... d. Provide additional interventions as directed by the resident's assessment, including but not limited to: ...i. Assistive devices			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155170	A. BUILDING 00 B. WING	02/10/2023

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

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	...v. Low bed... 8.b. The plan of care will be revised as needed...." 3.1-45(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: February 6, 7, 8, 9 and 10, 2023. Facility number: 000086 Residential Census: 137 Westminster Village Muncie, Inc was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed February 15, 2023.	R 0000	**The submission of this Plan of Correction (HCFA-2567) does not constitute an admission by Westminster Village Muncie, Inc. of any fact or conclusion set forth in the Statement of Deficiencies. This Plan of Correction is being submitted because it is required by law.** **Furthermore, we request that this Plan of Correction serve as our credible allegation of compliance.** **Compliance is effective:** **March 13, 2023** **Mary Jo Crutcher, HFA** **President and Administrator** **March 13, 2023** **Date**	