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	03/06/2024

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00428784 and IN00428793. Complaint IN00428784 - No deficiencies related to the allegations are cited. Complaint IN00428793 - Federal/state deficiencies related to the allegations are cited at F726. Survey dates: March 5 and 6, 2024. Facility number: 000086 Provider number: 155170 AIM number: 30067850 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 17 Medicaid: 5 Other: 37 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 11, 2024.	F 0000	The submission of this Plan of Correction 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. We respectfully request a paper compliance review. We wish to thank you for your understanding and cooperation with the investigation of this self reported complaint. Compliance is Effective: 4/5/2024	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Huser	Health Operations Administrator	03/21/2024

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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	maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on observation, interview and record review, the facility failed to ensure employees were trained in and knowledgeable of the facility elopement policy and protocol, resulting in a cognitively impaired resident being unsupervised outdoors for 17 minutes (QMA 16). Findings include: Resident B's clinical record was reviewed on 3/5/24 at 10:23 a.m. Diagnoses included unspecified dementia, unspecified severity,	F 0726	F-726 Competent Nursing Staff: 1. The deficient practice was found to be an isolated deficiency. The female resident that presented with cognitive impairment exited the facility through door #6, although did not leave the premise, and did not sustain any injuries. This female resident was transitioned with ease to a local facility with a secured memory	04/05/2024

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	without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Her physician orders included check placement of the wanderguard to her left ankle twice daily and check motion sensor for placement by her door and to make sure it was on and worked properly. An admission Minimum Data Set (MDS) assessment, dated 1/10/24, indicated she was severely cognitively impaired. She had a current care plan for psychosocial well-being, as she had the potential to exhibit wandering and exit seeking behaviors (1/12/24). Her interventions included document in the progress notes the intensity, duration or frequency of behavior, complete a behavior event when she wandered/exit sought (1/12/24), provide redirection or distraction to minimize frequency of behavior, identify pattern of behavior and behavior triggers (1/12/24), wanderguard in place and staff to check for placement each shift (1/12/24), and when she began to wander, provide comfort measures for basic needs (pain, hunger, toileting, too hot/cold, etc.) (1/12/24). A nurses note, dated 2/17/24 at 6:45 p.m., indicated at 6:11 p.m., the door 6 alarm on the Bristol Unit sounded at the same time the wanderguard system alerted at the nurses station. Per QMA 16, she saw the door 6 alarm alerting and switched it off. The alert light was still on, but the sound was turned off. She saw Resident B's name on the monitor of the wanderguard system. She went to Resident B's room and did not see her in there, then she went to the Bristol Unit's entrance and looked down the halls for Resident B. She asked the nurse on the Abbey Unit if she had seen Resident B and was told no.		care unit. 2. Our interdisciplinary team identified all residents that present as a potential elopement risk. All identified residents have the potential to be affected. Elopement binders have been created. These binders have been placed on each unit, as well as, the front desk to easily identify a resident with the potential to exit the facility. Those residents that wear a wanderguard device receive twice daily checks assuring that the devices are functioning properly, and the devices are properly placed on the resident and/or their wheelchair. 3. In diligent effort to ensure all employees are properly trained in and knowledgeable of the facility elopement policy and protocol, our Assistant Physical Plant Manager/Designee will in-service all current staff members on the wanderguard alarm system and security system. This education will be ongoing. When a new employee is hired, our Assistant Physical Plant Manager/Designee will train all new hires on both the wanderguard alarm system and security system as part of their mandatory orientation process. Routine, random elopement drills will be conducted to assess for opportunities of improvement.	

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	The Unit Manager met QMA 16 in the hallway by the health center dining room and asked her about Resident B and what had happened. QMA 16 told her that she said she had heard the alarm but was not able to locate Resident B. The Unit Manager told her that Resident B was outside, but was inside now, and she was walking back with staff to the Bristol unit. From 6:20 p.m. to 6:23 p.m., a facility nurse was driving in front of the building and saw a person that could had possibly been a resident walking on the east side of the building by the Coopervista side doors. As he drove up closer to the building, he saw the resident fall to her knees in the snow. He was able to help her to her feet and assist her inside the Coopervista doors. At 6:28 p.m. the Devon Unit wanderguard alarm sounded as staff walked Resident B back to the Bristol Unit. Fifteen minute checks and one on one observations for Resident B were started at 6:45 p.m. There was a 17-minute difference between the door 6 alarm sounding and her being assisted back to the Bristol Unit. During an interview with QMA 16, on 3/5/24 at 2:21 p.m., she indicated prior to the elopement, she assisted Resident B to the bathroom and gave her medications. Resident B sat on her bed playing with a babydoll. The QMA heard a noise and went to another resident's room. She then heard an alarm going off and went to the wanderguard system monitor and saw Resident B's name across the monitor screen. She went to the Abby Unit, and they had not seen Resident B. She headed towards the Coopervista Unit, but didn't go all the way to the unit because she didn't think she could had gotten that far. She went back to the Bristol Unit and the alarm was still going off and still indicated Resident B's name. She headed back towards Coopervista Unit, and she met the Unit Manager in the hallway. The Unit Manager told		4. HFA/HOA/DON/Designee will assure all current employees have received training on both the wanderguard system and security system, as well as, ensuring all new employees moving forward receive the proper training. Will assure completion and follow through weekly x4 weeks as orientation of new employees takes place weekly. Will monitor this process for 9 months and all results will be taken to QA. Corrective action for any concerns identified will be initiated as appropriate. 5. Date of compliance: 4/5/2024	

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	her to go back to the Bristol Unit. QMA 16 didn't know the exit doors opened. She thought that was why the keypad was located on the wall at the exit doors. She had not really been educated on what to do when there was an elopement or who to call. Resident B was an "exit seeker", and they kept her with staff, in the lounge, or occupied with activities. She was the only staff on the unit due to shift change and waiting for a CNA to come from another unit. During an observation of door 6, accompanied by the Bristol Unit Manager on 3/5/24 at 3:28 p.m., she had a wanderguard unit in her hand. As she approached the door, the keypad on the wall to the left of the door began to make a chirping sound and the small red light flashed. She opened door 6 and an alarm began to sound. At the back corner of the nurses station, there was a monitor for the wanderguard system with a map of the Bristol Unit on the screen. The wanderguard system was making a chiming sound and the door alarm was sounding, and she silenced the door alarm. The wanderguard monitor screen had a red dot on it where the wanderguard alarm was triggered and at the top of the screen showed the name of whom the wanderguard belonged to. During an interview with CNA 21, on 3/6/24 at 9:14 a.m., she indicated if a resident's wanderguard was alarming, she would go find and see where the resident was or where the alarm was going off at. She wouldn't know who was eloping, but she could find if any residents were going off the unit. She pointed towards the wanderguard monitor, but looked at the other CNA that was present during the interview for guidance. The other CNA then explained how the wanderguard system worked.			

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	During an interview with Housekeeper 18, on 3/6/24 at 1:51 p.m., she indicated she didn't know what to do if a resident eloped and she would need to ask her supervisor. At 2:20 p.m., she indicated she would alert the nurse and the front desk. During a review of the video footage (without audio) from the camera located at the Bristol Unit nurses station, on 3/6/24 at 2:25 p.m., with the Maintenance Director, the DON and Administrator 2 present, the Maintenance Director indicated the times to the video footage were not the same as the video footage from the Coopervista camera due to being on different Digital Video Recorders (DVRs). At 6:24 p.m., Resident B walked into the camera view from the vicinity of her room, passed the nurses station, and walked to the hall with door 6. At 6:25 p.m., QMA 16 walked from a medication cart located beyond the nurses station (opposite the hall of Resident B's room), towards Resident B's room and then to the nurses station. She walked towards the back corner of the nurses station where the wanderguard monitor system and the door alarm panel were located. (The wanderguard monitor and the door alarm panel were out of the camera view.) She walked out of the nurses station and towards Resident B's room. At 6:28 p.m., QMA 16 walked back into the nurses station to the back corner and back out of the nurses station towards Resident B's room. At 6:32 p.m., QMA 16 came into the camera view and walked towards the exit door 3, located in the lounge area across from the nurses station, then walked towards the nurses station and then to her cart at 6:33 p.m. At 6:35 p.m., QMA 16 walked towards the nurses station then towards exit door 5, then exit door 4 (located beyond her medication cart, at the end of the hallway). At 6:36 p.m., QMA 16			

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	walked into the nurses station towards the back corner, then walked towards the hall where resident eloped from. At 6:37 p.m., RN 7 walked into the camera view, and QMA 16 came back into the camera view and walked in the direction of Resident B's room. At 6:38 p.m. QMA 16 walked towards her cart, and RN 7 walked in the direction of the hall from where Resident B eloped from. During an interview, after reviewing the video footage with Administrator 2 and the DON, with the Maintenance Director present, on 3/6/24 at 2:50 p.m., the DON indicated QMA 16 acknowledged Resident B was missing and Administrator 2 indicated QMA 16 knew what she was doing, but there was opportunity for education. During an interview with RN 7, on 3/6/24 at 3:06 p.m., she indicated she was alerted by the door alarm on Coopervista Unit where she was working. A family member opened the door for both the Resident B and the nurse who had found her outside back into the building. RN 7 took the wanderguard off Resident B to test it to make sure it was working properly. She checked it at the doors of the Devon Unit, then she went to the Bristol Unit. As she went onto the Bristol Unit, she was unable to find staff. The wanderguard system alarm and the door alarm were sounding simultaneously. She was not sure what door she exited from, because the Velcro stop signs to the exit doors were in place. In her opinion, QMA 16 didn't know the difference between the sounds of the door alarm and the wanderguard system alarm. QMA 16 was the only one on the Bristol Unit at the time of the incident, the CNA had already left, and the CNA from the Coopervista Unit was to replace the Bristol Unit CNA. Normally, the CNA was to wait until their replacement arrived on the			

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	unit before they were to leave. A current facility policy, titled "ELOPEMENT/MISSING RESIDENT POLICY AND PROCEDURE PROGRAM FOR SKILLED FACILTY," dated 10/1/13, and provided by the DON, on 3/5/24 at 2:19 p.m., indicated the following: "...IN THE EVENT OF A MISSSING RESIDENT...1. With occurrence of a Missing Resident/Elopement a call will be placed to the Front Desk to initiate an all call "FREE BIRD" over the intercom. 2. All areas/rooms checked will have a "Yellow Door Tag" placed to verify that area is cleared...3. An organized facility and grounds search will be initiated by all available staff including Maintenance and Security. The Front Desk and Administrator will be notified...." This citation relates to complaint IN00428793. 3.1-14(i)			