

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  10/13/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for Investigation of Complaint IN00363762. This visit included a COVID-19 Focused Infection Control Survey. This visit included a Residential COVID-19 Quality Assurance Walk Through.</p> <p>Complaint IN00363762 - Substantiated. Federal/State deficiencies related to the allegations are cited at F623.</p> <p>Survey dates: October 12-13, 2021</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Census Bed Type: SNF/NF: 107 Residential: 71 Total: 178</p> <p>Census Payor Type: Medicare: 14 Medicaid: 65 Other: 28 Total: 107</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 14, 2021</p>	F 0000	<p>October 29, 2021</p> <p>Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204</p> <p>Re: Survey Event ID GBM211</p> <p>Dear Ms. Buroker:</p> <p>Please find attached my Plan of Correction for deficiencies cited during this Infection Control survey event conducted 10/12-13/2021. I am respectfully requesting paper compliance.</p> <p>If you have any questions, please feel free to contact me.</p> <p>Sincerely,</p> <p>Shannon Poole Administrator</p>	
F 0623 SS=D Bldg. 00	<p>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a</p>			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4) (ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c) (1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c) (1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c) (1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> <li>(i) The reason for transfer or discharge;</li> <li>(ii) The effective date of transfer or discharge;</li> <li>(iii) The location to which the resident is transferred or discharged;</li> <li>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</li> <li>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</li> <li>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</li> <li>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</li> </ul> <p>§483.15(c)(6) Changes to the notice.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>Based on record review and interview, the facility failed to ensure the name and email address of the Office of the State Long-Term Care Ombudsman was updated and recipients notified of the change on the Notice of Transfer or Discharge form prior to the discharge for 3 of 3 residents. (Residents B, C, and D)</p> <p>Findings include:</p> <p>1. A Notice of Transfer or Discharge for Resident B could not be located in Resident B's clinical record per ED (Executive Director).</p> <p>An interview with ED was conducted on 10/13/21 at 9:32 a.m. She indicated, the person who discharged Resident B did not make a copy of the Notice of Transfer or Discharge for the clinical record.</p> <p>An interview with Resident B's family member (FM 2) was conducted on 10/13/21 at 10:24 a.m.</p>	F 0623	<p>PROPOSED PLAN OF CORRECTION</p> <p>F623</p> <p>1 – Upon notification of deficient notice, our contact information for our representative of the Office of the State Long-Term Care Ombudsman was immediately updated in our records. (Noted the information had been updated and the Social Services Director did have the corrected information. The notice used for 3 residents was an old form).</p>	10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>They indicated, the name and email address for the State Long-Term Care Ombudsman on the Notice of Transfer and Discharge was of a person who no longer was the Ombudsman. They stated, they found out who was the current Ombudsman by investigating online.</p> <p>An interview was conducted with the State Long Term Care Ombudsman for the facility on 10/12/21 at 12:26 p.m. She indicated, the name and email address of the person listed on Resident B's Notice of Transfer or Discharge form had vacated the position a couple of years ago.</p> <p>2. A Notice of Transfer or Discharge form for Resident C was received on 10/13/21 at 9:32 a.m. from ED. The Notice of Transfer or Discharge was dated 8/19/21 and in the section "Your Local Ombudsman", the name and email address of the local Ombudsman is incorrect and lists the name and email address of the previous Ombudsman who vacated the position a couple of years ago.</p> <p>3. A Notice of Transfer or Discharge form for Resident D was received on 10/13/21 at 9:32 a.m. from ED. The Notice of Transfer or Discharge was dated 9/14/21 and in the section "Your Local Ombudsman", the name and email address of the local Ombudsman is incorrect and lists the name and email address of the previous Ombudsman who vacated the position a couple of years ago.</p> <p>A Transfer and Discharge Policy was received on 10/12/21 at 11:57 a.m. by ED. It indicated, "6. c. Contents of the notice must include:...</p> <p>v. The name, address (mailing and email) and telephone number of the Office of the State</p>		<p>2 – The facility has determined that all residents have the potential to be affected.</p> <p>3 – The Social Services Manager will educate staff who are involved with discharging residents on the importance of the discharge planning packet and the elements that need to be included. An email was also sent to the local Ombudsman requesting notification directly for any changes in contact, address or phone numbers to be sent to our facility.</p> <p>4 - The Social Services Manager will conduct 4 weekly audits of our discharged residents to make sure the proper contact information is included in the discharge packet. The monitoring will continue weekly for 6 weeks and until compliance is maintained.</p> <p>As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring</p>	

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  10/13/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0880 SS=D Bldg. 00	<p>Long-Term Ombudsman...e. If the information in the notice changes prior to effecting the transfer or discharge, the Social Services Director must update the recipients of the notice as soon as practicable once the updated information becomes available."</p> <p>This Federal tag relates to complaint IN00363762.</p> <p>3.1-12(a)(6)(A) 3.1-12(a)(9)(G)</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p>		<p>increased or decreased on the basis of compliance.</p> <p>5 – Corrective action completed by 10/29/2021.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which 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; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 for 1 of 5 residents reviewed for infection control and by not administering a second Mantoux skin test timely. (Residents E and F)</p> <p>Findings include:</p> <p>1. The clinical record for Resident E was reviewed on 10/12/21. Resident E's diagnoses included, but not limited to, Alzheimer's dementia, psychotic disorder with delusions, and major depressive disorder. The clinical record indicated Resident E received a step one Mantoux skin test (Tuberculosis, TB, test) which was read on 6/13/21.</p> <p>A nursing note dated 6/27/21 indicated, "unable[sic] to perform PPD[sic, Purified protein derivative used for TB tests] today as there is no unexpired PPD[sic] solution available. Reported to this RN[sic, Registered Nurse] that this was on order. Will perform when new solution arrives"</p> <p>The clinical record did not indicate the step two Mantoux skin test was administered.</p> <p>An interview with DON (Director of Nursing) was conducted on 10/12/21 at 12:02 p.m. She indicated, Resident E had not received the step 2 TB test within the recommended 1-3 week time period between each TB test.</p> <p>A Tuberculosis Exposure Control Plan was</p>	F 0880	<p>F880</p> <p>1 – Upon notification of deficient infection control practice, identified staff member was immediately in-serviced on proper PPE in the yellow zone. Disciplinary action immediately given. Upon notification of deficient infection control practice, an audit was done for admissions in the last 90 days to ensure proper Mantoux/TB tests were done as Step 1 and Step 2.</p> <p>2 – The facility has determined that all residents have the potential to be affected.</p> <p>3 – The Quality Assurance Nurse and the Director of Nursing will conduct in-service education with staff regarding proper PPE wearing and techniques for donning and doffing, and the process for Step 1 Mantoux placement upon admission and Step 2 within 21 days.</p> <p>4 - The Infection Preventionist, or designee, will do 10 random weekly observations of staff working on different shifts, on random days to ensure PPE is being worn appropriately. The</p>	10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>received on 10/12/21 at 1:58 p.m. from DON. It indicated, "Resident Screening Standards 1. A physician's verification is required upon admission, subsequent to TB testing and annual thereafter that the resident shows no signs of TB in an infectious stage...b. Results of a two-step diagnostic intermediate strength PPD, if not a reactor, shall be completed within three (3) months of admission, or administered as part of the admission process. Admission PPD's [sic] will be administered no later than twenty-four (24) hours after the resident's arrival to the facility. 2. A licensed nurse shall perform an admission assessment for each resident to determine the resident's immunization history, including a documented history of a positive TB skin test. a. Each resident shall have evidence of a two-step Mantoux test to establish baseline data. The second test shall be administered at least one (1) week and no more than three (3) weeks after the first test is the measurement is 0-9 mm[sic, millimeters]"</p> <p>2. The clinical record for Resident F was reviewed on 10/13/21. Resident F's diagnoses included, but not limited to, acute kidney failure, malignant neoplasm of bone (bone cancer), and type II diabetes. Resident F was re-admitted to the facility following a hospital stay on 10/9/21. Resident F's hospital stay was greater than 24 hours, so when she re-admitted back to the facility she was placed in droplet TBP (Transmission-based precaution) for unknown COVID-19 status for a period of 14 days. Resident F's clinical record indicated, she refused the COVID-19 vaccination.</p> <p>An observation was made on 10/13/21 at 1:38 p.m. of RN (Registered Nurse) 3 exiting Resident F's room. RN 3 was not wearing a N95</p>		<p>Director of Nursing or Quality Assurance Nurse will do 5 random weekly audits of new admissions for Mantoux placement and then also audit Step 2 placement. The monitoring will continue weekly for 6 weeks and until compliance is maintained.</p> <p>As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance.</p> <p>5 – Corrective action completed by 10/29/2021.</p> <p>F880 Directed Plan of Correction</p> <p>Failure of one employee to properly wear the correct mask while caring for a resident in the yellow zone.</p> <p>Identify the root cause resulting in the facilities failure:</p> <p>An analysis of contributing factors</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>mask upon exiting the room. She had on a surgical mask instead.</p> <p>An interview with RN 3 was conducted immediately following the observation. She indicated, she had forgot place her N 95 mask on prior to entering Resident F's room.</p> <p>An interview with DON was conducted on 10/13/21 at 1:50 p.m. She indicated, prior to entering a yellow precaution room, staff should don an isolation gown, a N 95 mask, eye protection, and gloves.</p> <p>The CDC's (Centers for Diseases and Control) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes &amp; Long-Term Care Facilities New Admissions and Residents who Leave the Facility last updated on 9/10/21 indicated, "Create a Plan for Managing New Admissions and Readmissions:</p> <ul style="list-style-type: none"> <li>Residents with confirmed SARS-CoV-2 infection who have not met criteria to discontinue Transmission-Based Precautions should be placed in the designated COVID-19 care unit, regardless of vaccination status.</li> <li>In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission."</li> </ul> <p>3.1-18(b) 3.1-18(f)</p>		<p>which lead to identifying the root cause regarding the failure to properly wear PPE was conducted. The internal investigation included:</p> <ul style="list-style-type: none"> <li>Staff identified and were immediately educated one-on-one on the facility policy and proper PPE.</li> <li>Staff member received a final written warning disciplinary action for failure to follow policy.</li> <li>Education given to Admissions Nurse and staff nurses on importance and policy on Mantoux placement at admission and Step 2 within 21 days.</li> <li>Completion of the 5 Whys Worksheet.</li> <li>Education with staff on Green, Yellow, Red STOP signs</li> <li>Education with staff on specifically what PPE is needed.</li> </ul> <p>The analysis concluded that: Staff is exhibiting fatigue in the many guideline changes over the last 18 months. Employee knew better. Continued reinforcement of infection control practices to staff is important. In-services and random PPE observations are needed by Unit Coordinators, management nurses and co-workers. Immediately it was corrected.</p> <p>Corrective Action: Nursing staff were reeducated on proper PPE. Proper signage on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>how to don and doff. PPE are available at each nurse's station and at the entry door to the facility upon reporting for work and checking in while screening. Westminster Village North has a generous supply of PPE.</p> <p>Solutions and Systemic changes and Monitoring that needs to be taken to address the root cause:</p> <ol style="list-style-type: none"> <li>1. On 10/13/2021, re-education was given to specific employee who was found to not follow yellow zone PPE policy.</li> <li>2. On 10/27/2021, re-education was given during a nursing staff meeting for current front line staff to remind them appropriate PPE needed in zones.</li> <li>3. Admissions Nurse was re-educated on placement of Mantoux for Step 1 and placing an order for reading and placement of Step 2 within 21 days. Nursing staff re-educated.</li> <li>4. The DON, IP nurse, and QA/Inservice nurse will continue education. The education will be a part of the orientation for new staff and will be reiterated at our staff meeting in November and December.</li> <li>5. The Infection Preventionist, or designee, will do 10 random weekly observations of staff working on different shifts, on random days to ensure PPE is being worn appropriately. The Director of Nursing or Quality</li> </ol>	

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  10/13/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0886 SS=D Bldg. 00	<p>483.80 (h)(1)-(6) COVID-19 Testing-Residents &amp; Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:</p> <p>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:</p> <ul style="list-style-type: none"> <li>(i) Testing frequency;</li> <li>(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;</li> <li>(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;</li> <li>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;</li> <li>(v) The response time for test results; and</li> <li>(vi) Other factors specified by the Secretary that help identify and prevent the</li> </ul>		Assurance Nurse will do 5 random weekly audits of new admissions for Mantoux placement and then also audit Step 2 placement. The monitoring will continue weekly for 6 weeks and until compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>transmission of COVID-19.</p> <p>§483.80 (h)(2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;</p> <p>§483.80 (h)(3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.</p> <p>§483.80 (h)(4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.</p> <p>§483.80 (h)(5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.</p> <p>§483.80 (h)(6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.</p> <p>Based on record review and interview, the facility failed to ensure unvaccinated staff members completed biweekly COVID-19 testing</p>	F 0886	<p>F886</p> <p>1 – Upon notification of deficient</p>	10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>based on the facility's county level of community transmission for 3 of 5 staff members reviewed for infection control.</p> <p>Findings include:</p> <p>A list of unvaccinated staff was provided on 10/12/21 by ED (Executive Director). The list indicated RN (Registered Nurse) 4, CNA (Certified Nursing Assistant) 5, and DA (Dietary Aide) 6 were staff members who were unvaccinated against COVID-19 and worked in the Healthcare building.</p> <p>1. The COVID-19 testing results for RN 4 were received on 10/12/21 at 3:25 p.m. from IP (Infection Preventionist). The testing results indicated, RN 4 had been tested for COVID-19 on the following dates: 9/30/21 then 10/7/21.</p> <p>RN 4's time sheets were provided on 10/12/21 at 3:25 p.m. by DON (Director of Nursing). RN 4's time sheets indicated, she had worked on the following days: 10/4/21, 10/6/21, and 10/7/21. RN 4 had not been tested for COVID-19 biweekly during the time period between 9/30/21 and 10/7/21.</p> <p>The facility's county level of community transmission during the period of 9/30/21 and 10/7/21 indicated transmission rate for the county was "High".</p> <p>2. The COVID-19 testing results for CNA 5 were received on 10/12/21 at 3:25 p.m. from IP (Infection Preventionist). The testing results indicated, CNA 5 had been tested for COVID-19 on the following dates: 9/10/21, 9/16/21, 9/23/21, 9/30/21, and 10/7/21.</p>		<p>notice, employees found not to have tested for the appropriate times were tested and disciplinary actions were given. Immediately a sign in sheet was created for our testing area. Any employee who has not tested at the end of the testing day will receive a phone call to remind.</p> <p>2 – The facility has determined that all residents have the potential to be affected.</p> <p>3 – The Administrator will in-service staff of the importance of testing according to the policy. Manager were also made aware of staff who are not getting tested regularly.</p> <p>4 - The Infection Preventionist and Department Managers will conduct 10 weekly audits of employees to make sure the proper testing frequency is happening. The monitoring will continue weekly for 6 weeks and until compliance is maintained.</p> <p>As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance.</p> <p>5 – Corrective action completed</p>	

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  10/13/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The facility's county level of community transmission during the period of 9/10/21 to 10/7/21 indicated transmission rate for the county remained at a "High" level each week during the time frame.</p> <p>CNA 5's time sheets were provided on 10/12/21 at 3:25 p.m. by DON (Director of Nursing). CNA 5's time sheets indicated, she worked on the following days: 9/10/21, 9/11/21, 9/12/21, 9/13/21, 9/14/21, 9/15/21, 9/16/21, 9/17/21, 9/18/21, 9/18/21, 9/19/21, 9/20/21, 9/21/21, 9/22/21, 9/23/21, 9/28/21, 9/29/21, 9/30/21, 10/3/21, 10/4/21, 10/5/21, 10/6/21 and 10/7/21. CNA 5 had not been tested for COVID-19 biweekly during the following time periods: 9/10/21 to 9/16/21 9/16/21 to 9/23/21 9/23/21 to 9/30/21 9/30/21 to 10/7/21</p> <p>3. The COVID-19 testing results for DA 6 were received on 10/12/21 at 3:25 p.m. from IP (Infection Preventionist). The testing results indicated, DA 6 had been tested for COVID-19 on 8/12/21. DA 6 has not had any COVID-19 testing completed since that date.</p> <p>DA 6's time sheets were provided on 10/12/21 at 3:25 p.m. by DON (Director of Nursing). DA 6's time sheets indicated, she worked on the following days: 9/9/21, 9/11/21, 9/12/21, 9/14/21, 9/16/21, 9/17/21, 9/20/21, 9/21/21, 9/22/21, 9/23/21, 9/25/21, 9/26/21, 9/28/21, 9/29/21, 9/30/21, 10/4/21, 10/5/21, 10/6/21, and 10/7/21. DNA 6 had not been tested for COVID-19 biweekly during the following time periods: 9/10/21 to 9/16/21 9/16/21 to 9/23/21</p>		by 10/29/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0000  Bldg. 00	<p>9/23/21 to 9/30/21 9/30/21 to 10/7/21</p> <p>The facility's county level of community transmission during the period of 9/10/21 to 10/7/21 indicated transmission rate for the county remained at a "High" level each week during the time frame.</p> <p>An interview with DON was conducted on 10/13/21 at 1 p.m. She indicated, the persons responsible for ensuring unvaccinated staff members complete the routine testing for COVID-19 were herself and IP.</p> <p>A Coronavirus Testing policy was received on 10/12/21 at 12:11 p.m. from ED (Executive Director). It indicated, "Routine Testing of Staff 1. [sic, initials of facility] will utilize their county's COVID positivity rate in the prior week as the trigger for staff testing frequency for those who are not vaccinated." The facility's policy is not in accordance with the current CMS's (Centers for Medicaid and Medicare Services) policy.</p> <p>The CMS's Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, last updated on 9/10/21 indicated, if the county level of transmission was at a "high" level, unvaccinated staff members should be tested for COVID-19 biweekly.</p> <p>This visit was for a Residential COVID-19</p>	R 0000	October 29, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Quality Assurance Walk Through. This visit included an Investigation of Complaint IN00363762, and a COVID-19 Focused Infection Control Survey.</p> <p>Complaint IN00363762 - Substantiated. Federal/State deficiencies related to the allegations are cited at F623.</p> <p>Survey dates: October 12-13, 2021</p> <p>Facility number: 000084</p> <p>Residential Census: 71</p> <p>Westminster Village North was found to be in compliance with 410 IAC 16.2-5 in regard to the Residential COVID-19 Quality Assurance Walk Through.</p> <p>Quality review completed on October 14, 2021</p>		<p>Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204</p> <p>Re: Survey Event ID GBM211</p> <p>Dear Ms. Buroker:</p> <p>Please find attached my Plan of Correction for deficiencies cited during this Infection Control survey event conducted 10/12-13/2021. I am respectfully requesting paper compliance.</p> <p>If you have any questions, please feel free to contact me.</p> <p>Sincerely,</p> <p>Shannon Poole Administrator</p>	