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	05/28/2024

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 21, 22, 23, 24, and 28, 2024 Facility number: 000086 Provider number: 155170 AIM number: 30067850 Census Bed Type: SNF/NF: 56 Residential: 139 Total: 195 Census Payor Type: Medicare: 11 Medicaid: 5 Private: 40 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 6, 2024.	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:** **June 21, 2024** **Mary Jo Crutcher, HFA** **President and Administrator** **June 20, 2024** **Date**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Jo Crutcher	HFA, President	06/20/2024

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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	instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to provide safe and secure storage of medications for 17 of 17 residents on the Bristol Unit and to label a multi-use medication vial with an open date for 1 of 4 residents reviewed for medication storage. (Resident 14) During an observation on 5/22/24 at 2:31 p.m., a medication cart was unattended and unlocked in a common area of the unit. At 2:34 p.m., RN 5 approached the cart and confirmed the cart was unlocked. RN 5 indicated it should be locked and contained medications for the residents on the unit only. During a medication administration observation for Resident 14, on 5/23/24 at 9:58 a.m., QMA 6	F 0761	F-761 Label/Store Drugs and Biologicals 1 Based upon observation on 5/22/24, the medication cart that was unattended and unlocked for 3 minutes by the RN on duty, was immediately locked. Also, upon medication administration observation, the open vial of prescription eye drops that were observed without an open date, however should have had a date were discarded and reordered at facility expense. 2 All other medication carts were checked to assure proper locking mechanisms in place, and	06/21/2024

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	indicated an open vial of prescription eye drops, Latanoprost 0.005% solution (for glaucoma), did not have an open date on it, but should be dated. She was unsure which types of prescription eyedrops were supposed to be dated upon opening. A current facility policy titled "LTC Facility's Pharmacy Services and Procedures Manual," revised on 7/21/22, was provided by the Health Operations Administrator on 5/28/24 at 12:01 p.m. The manual, under "General Storage Procedures - 3.3", indicated the following: "...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." The same policy, under the heading "Ophthalmic Solutions Storage Parameters", indicated the following: "Eye medication bottles/tubes with accelerated expiration dates must be dated/initialed upon opening. Follow manufacturer instructions, or facility policy. (e.g., Latanoprost - 42 days)...." 3.1-25(k)(6) 3.1-25(m)		also checked to assure all eye drops requiring a date opened were accurately dated. 3 All nursing staff that administer medications from a medication cart will be in-serviced on both the regulatory guidance on keeping all drugs and biologicals in locked compartments that are inaccessible by residents and visitors, as well as, the regulatory guidance on dating eye medications bottles/tubes with accelerated expiration dates assuring they are dated and initialed upon opening. 4 Unit Managers, DON, and/or designee along with our Pharmacy Consultant will complete daily audits for 2 weeks during random times/shifts to assure medication carts are kept locked, then every week for 4 weeks, and then monthly for 9 months. Medication carts will also be checked weekly for 4 weeks, then monthly for 9 months by our Unit Managers, DON, or designee to assure all eye drops requiring a date opened and initialed have been completed. Our pharmacy consultant will also check monthly during routine visits. Any area of noted concern will be reported during our monthly QA meeting, and agreed upon correction will be carried forward. 5 Date of compliance: June 21, 2024	

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F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

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	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to implement the facility's pneumococcal vaccines policy utilizing the Centers for Disease Control and Prevention (CDC) guidelines and failed to offer appropriate pneumococcal vaccinations for 1 of 5 residents reviewed for vaccinations. (Resident 49) Findings include: The clinical record for Resident 49 was reviewed on 5/22/24 at 2:39 p.m. Diagnosis included hypertensive heart disease with heart failure, unspecified chronic atrial fibrillation, and type 2 diabetes mellitus. Resident 49 was over 65 years of age. Resident 49's current vaccination record indicated she received the Pneumococcal Conjugate vaccine (PCV) 13 on 3/18/15 and the Pneumococcal Polysaccharide vaccine (PPSV) 23 on 5/22/18.	F 0883	F-883 Influenza and Pneumococcal Immunizations 1 Based upon record review resident #49's current vaccination record was once again reviewed by our RN Unit Manager. She did offer resident #49 the PCV 20 vaccine according to CDC guidance. 2 All other resident's vaccination statuses were audited, and the PVC 20 was offered to those residents that were eligible per the CDC guidance. 3 With any new admission, vaccination status will be reviewed when completing a new admission audit. If eligible per CDC guidance the PCV 20 will be offered to new admitting residents. 4 Unit Managers, DON, and/or designee will monitor this process	06/21/2024

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	The clinical record lacked indication of any other offered pneumococcal vaccinations. During an interview, on 5/28/24 at 10:10 a.m., RN 3 indicated she only utilized the Children and Hoosiers Immunization Registry Program (CHIRP) for all new residents. The CHIRP website contained the recorded vaccinations of residents and at the top of the document was a section to forecast upcoming and/or missed vaccinations. She indicated she was not aware Resident 49 was to have been offered the PCV 20 vaccine according to CDC guidance. Review of the current online CDC Pneumococcal vaccination guidelines, retrieved from www.cdc.gov/vaccines/vpd/pneumo/index.html on 5/29/24 at 11:56 a.m., indicated the following: "... Adults 65 years or older have the option to get PCV 20 if they have already received PCV 13 (but not PCV 15 or PCV 20) at any age AND PPSV 23 at or after the age of 65 years old..." A facility policy, provided by the Health Operations Administrator on 5/28/24 at 12:02 p.m., titled "Pneumococcal Vaccine (Series)" and implemented on 11/6/23, indicated the following: "Policy: It is our policy to offer residents and staff immunizations against pneumococcal disease in accordance with the current CDC guidelines and recommendations.... 6. The type of pneumococcal vaccine (PCV 15, PCV 20, or PPSV 23) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations...." 3.1-13(a)		with each new admission for 4 weeks, then monthly for 9 months. Any area of concern noted will be reported during our monthly QA meeting, and agreed upon correction will be carried forward. 5 Date of Compliance: June 21, 2024	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 21, 22, 23, 24, and 28, 2024 Facility number: 000086 Residential Census: 139 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 6, 2024.	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:** **June 21, 2024** **Mary Jo Crutcher, HFA** **President and Administrator** **June 20, 2024** **Date**	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and			

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	services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure 24 hour coverage of a staff member with first aid and cardiopulmonary resuscitation (CPR) certification. Findings include: Employee schedules, provided by the Health Operations Administrator, on 5/24/24 at 1:30 p.m., were reviewed and indicated the following: On 5/13/24, there were 21 hours of First Aide coverage and 3 hours missing of First Aid coverage from 6:30 a.m.- 8:00 a.m. and 4:30 p.m.- 6:00 p.m. On 5/14/24, there were 19 hours of First Aide coverage and 5 hours missing of First Aid coverage from 6:30 a.m.- 8:00 a.m. and 7:30 p.m.- 10:00 p.m.	R 0117	R-117 Personnel- Deficiency 1 Based upon record review and interview on the scheduled days requested the facility failed to ensure 24 hour coverage of a staff member with both first aid and CPR certification. 2 Our Clinical Education Coordinator and/or designee will complete an audit of all staff members to determine exactly whom needs first aid/CPR training. 3 Our Clinical Education Coordinator and/or designee will conduct in person, face-to-face first aid and CPR training to ensure all completed and at least one first aide/CPR staff member will be available on all shifts. This training will also be an expectation	06/21/2024

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	On 5/15/24, there were 22.5 hours of First Aide coverage and 1.5 hours missing of First Aid coverage from 6:30 a.m.- 8:00 a.m. On 5/16/24, there were 21 hours of First Aide coverage and 3 hours missing of First Aid coverage from 6:30 a.m.- 8:00 a.m. and 4:30 p.m.- 6:00 p.m. On 5/17/24, there were 15 hours of First Aide coverage and 9 hours missing of First Aid coverage from 11:00 p.m.- 8:00 a.m. On 5/18/24, the schedule lacked an employee certified in First Aid for the 24 hour period. During an interview, on 5/24/24 at 3:30 p.m., LPN 4 indicated all the certifications for First Aid had been provided. A facility policy, dated 11/19/22, provided by the Health Operations Administrator, on 5/28/24 at 1:27 p.m., titled, "Cardiopulmonary Resuscitation (CPR)" indicated the following: "...3. At least one CPR and First Aide certified staff member will be available on all shifts."		with any new employee. 4 Any concerns regarding the first aid/CPR training process will be reported during our monthly QA meeting. Agreed upon corrections will be carried forward. 5 Date of compliance: June 21, 2024	