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	06/29/2018

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: June 25. 26. 27. 28, and 29, 2018 Facility number: 000089 Provider number: 155170 Census Bed Type: SNF: 62 Residential: 161 Total: 223 Census Payor Type: Medicare: 20 Other: 203 Total: 223 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 6, 2018.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

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

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation and record review, the facility failed to promote dignity during resident dining for 1 of 3 resident observations of dining. (Resident 27) Findings include: During dining room observation on 6/25/18 at 11:38 a.m., CNA 1 was talking to Resident 27 at the	F 0550	**Tag Cited: F-550** **§483.10(a)(1)(2)(b)(1)(2)– Resident Rights/Exercise of Rights** **Issue Cited:** **"Promoting and Maintaining Residents' Dignity during Mealtimes"** 1.Immediate action(s) taken for	07/29/2018

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	dining room table, she stated to the resident "stop hitting me" and " why do you have to be so mean." There was another resident and a family member at the dining table. The record for Resident 27 was reviewed on 6/27/18 at 11:16 a.m., Diagnoses for the resident included but were not limited to, Alzheimer's disease, vascular dementia with behavioral disturbance, and psychotic disorder with hallucinations. The resident had a 4/29/18, quarterly Minimum Data Set (MDS) assessment, which indicated the resident had severe cognitive impairment. During an interview on 6/28/18 at 3:20 p.m., the Director of Nursing indicated the statements made during the dining room observation were inappropriate. Review of the current facility policy, undated, titled "Feeding the Resident" provided by the Director of Nursing on 6/29/18 at 8:27 a.m., included, but was not limited to, "PURPOSE: To assist the resident with feeding as necessary. PROCEDURE:... ...7. Do not discuss unpleasant subjects while the resident is eating..." Review of the current facility policy, undated, titled "Residents' Rights" provided by the Director of Nursing on 6/29/18 at 8:27 a.m., included, but was not limited to, "PURPOSE:....		the resident(s) found to have been affected include: The CNA involved was in-serviced on the proper procedures for maintaining resident dignity during mealtimes. 1.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents requiring feeding assistance at meal times have the potential to be affected. **1.Actions taken/systems put into place to reduce the risk of future occurrence include:** Nursing personnel involved in providing feeding assistance to residents have been in-serviced on the proper procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. Resident Rights education has been provided to all nursing personnel. A “Validation Checklist” will be completed for each individual whose duties involve feeding assistance to determine if he/she was performing the procedure correctly. Findings will be reviewed with each individual and corrective action will be provided as needed. **1.How the corrective action(s) will be monitored to ensure the practice will not recur:** The Nurse Manager, or designee, will conduct random observations of staff during mealtimes ---- to ensure staff are promoting and	

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	...IV. Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality..." 3.1-3(a)		maintaining resident dignity during mealtimes in accordance with our facility's practice guidelines and regulatory requirements. Observation reports and validation checklists will be reviewed monthly by the Quality Assurance Committee. All components of the systematic adjustments for Resident Rights/Exercise of Rights will be implemented by July 29th, 2018.	
F 0623 SS=D Bldg. 00	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 resident, the facility must- (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. (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 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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			

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	discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (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; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email			

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	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 (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. §483.15(c)(6) Changes to the notice. 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. §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). Based on interview and record review, the facility failed to notify the Ombudsman of transfer to a hospital for 1 of 1 residents reviewed. (Resident 25)	F 0623	**Tag Cited: 623** **Notice Requirements Before Transfer/Discharge**	07/29/2018

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	Findings include: The record for Resident 25 was reviewed on 6/26/18 at 8:53 a.m., diagnoses for the resident included, but were not limited to, Alzheimer's disease, depression, and weight loss. The record review lacked information regarding Ombudsman notification for the following hospital transfers: Resident discharged to the hospital on 3/3/18, returned to the facility 3/9/18. Resident discharged to the hospital on 4/24/18, returned to the facility 4/30/18. Resident discharged to the hospital on 5/11/18, returned to the facility 6/1/18. During an interview on 6/28/18 at 3:13 p.m., Social Service LSW 2 indicated she had never notified the Ombudsman of any type of transfers. During an interview on 6/28/18 at 3:13 p.m., the Director of Nursing indicated she was not aware of anyone notifying the Ombudsman of transfers. During an interview on 6/28/18 at 3:22 p.m., the Social Service LSW 1 indicated she had never heard of the Ombudsman needing notified of any type of transfers. During an interview on 6/28/18 at 3:35 p.m., the Director of Nursing indicated there was not policy regarding Notification to the Ombudsman. 3.1-12(a)(6)(iv)		**Issue Cited:** **483.15(c)(3)-(6)(8)** **1.Immediate action(s) taken for the resident(s) found to have been affected include:** The facility recognizes that all residents who are discharged or transferred from the facility may be affected. On 7/11/18, several members of the management team, including the local Ombudsman, met to discuss the expectation and/or requirements of notification of the Ombudsman of discharges and transfers. **2.Identification of other residents having the potential to be affected was accomplished by:** After review of previous discharges and transfers, the facility acknowledges that all residents who have been, or may be discharged or transferred from the facility have the potential to be affected. **3.Actions taken/systems put into place to reduce the risk of future occurrence include:** An Ombudsman Discharge and Transfer report was created, and found to be inclusive of all residents discharged or transferred from the facility. Social Services, or designee, will notify the local Ombudsman within the first week following the previous month to capture all residents. Staff involved in discharging and transfers will be educated on the	

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			new process. Social Services will maintain the data that ensures that the local Ombudsman has been notified. **4.How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing, or designee, will monitor on a monthly basis, that the local Ombudsman is being notified of all transfers and discharges; and that the appropriate records of such is maintained. This plan of correction will be reviewed/monitored/updated in the monthly Quality Assurance meeting for 9 months. **5.All components of the systematic adjustments for Notice Requirements Before Transfer/Discharge will be implemented by: July 29th, 2018.**	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services			

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	staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to revise a careplan with fall interventions that were identified in a post fall investigation by the interdisciplinary team for 1 of 5 residents reviewed for falls (Resident 52). Findings include: During an observation, on 6/25/18 at 2:37 p.m., Resident 52's bed was not in a low position. She was in bed resting. During an observation, on 6/26/18 at 11:46 a.m., her bed was not in a low position. She was in bed resting. The clinical record for Resident 52 was reviewed on 6/28/18 at 11:16 a.m.. Her diagnoses included, but were not limited to: weakness, dementia, Parkinson's disease, delusions, anxiety and psychosis. A 14 day MDS (minimum data set) assessment, dated 6/8/18, indicated she had mild cognitive	F 0657	**Tag Cited: F-657** **§483.21(b)(2)(i)-(iii) Care Plan Timing and Revision** **Issue Cited:** **Care Plan Timing and Revision** 1.Immediate action(s) taken for the resident(s) found to have been affected include: After review of the resident's record; per documentation at time of survey, the electronic health record did indeed include a resolved intervention for "low bed" and to "monitor more frequently" for this resident. A low bed had been attempted, and monitor more frequently (which was not measureable and too subjective); both were found not to be appropriate for this resident, hence the resolution of those particular interventions. 1.Identification of other residents	07/29/2018

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	impairment. She required extensive assistance for bed mobility, transfers, walking, personal hygiene and dressing. A fall risk assessment, dated 6/21/18, indicated she was a high risk for falls. A fall investigation report, dated 4/21/18, indicated she was found sitting on the floor next to her bed. She was found to have an abrasion to her knee. The intervention for this fall was to have her bed in a low position and monitor more frequently. A fall investigation report, dated 4/28/18, indicated she was found on the floor in her room with no injuries noted. The intervention for this fall was to check on her more frequently. A care plan, dated 7/3/17, indicated she was at risk for falls. Interventions included, but were not limited to: assist with toilet use (5/25/18), cordless sensor pad (6/25/18), bed/chair alarm when not in lounge (6/26/18), remind resident to use call light for assistance (5/25/18) and gripper socks when in the bathroom (6/18/18). The care plan lacked the interventions of keeping her bed in the low position and monitor more frequently. During an interview with QMA (Qualified Medication Assistant) 20, on 6/28/18 at 2:03 p.m., she indicated the resident was encouraged to ask for help prior to getting up, but she was non compliant. She indicated there was no scheduled checks for the resident but they checked on her "often". There was no current intervention of a low bed. Her husband stayed with her a lot of the time and helped her, but he was not in the best shape either.		having the potential to be affected was accomplished by: Although the facility can provide documentation of interventions, having been resolved, at time of survey-All residents of the facility have the potential to be affected. The facility makes every attempt to implement appropriate interventions related to the safety and well-being of the residents we serve. **1.Actions taken/systems put into place to reduce the risk of future occurrence include:** Education has been provided regarding care plan interventions. Although the facility can provide documentation of interventions, having been resolved, at time of survey: as noted above- The existing policy regarding Care Plan Revisions has been reviewed to reinforce our position related to this subject. The Nurse Manager or designee will audit care plan interventions related to falls, after each occurrence, to verify that the intervention is indeed active in the care plan. **1.How the corrective action(s) will be monitored to ensure the practice will not recur:** The Nurse Manager or designee will audit care plan interventions related to falls, after each occurrence, to verify that the	

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	During an interview with the DON (Director of Nursing), on 6/29/18 at 9:13 a.m., she indicated she did not know why the low bed fall prevention intervention was not added initiated on the care plan. A current policy titled "fall policy and procedure program" was provided by the DON, on 6/29/18 at 11:20 a.m. This policy indicated, "...A prevention approach will be taken in order to promote the safety and well being of each resident...the interdisciplinary team will promote communication and monitor the outcomes of the program...PURPOSE: the purpose of the fall program is to:...2. Initiate preventive approaches...3. provide interventions...4. provide education to resident and staff...5. monitor and evaluate outcomes....". 3.1-35(a)		intervention is indeed active in the care plan. This plan of correction will be reviewed/monitored/updated in the monthly Quality Assurance Meeting for 9 months. 1.All components of the systematic adjustments for Care Plan Timing and Revision will be implemented by July 29th, 2018.	
F 0689 SS=D 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 to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent falls for 1 of 5 residents reviewed for falls (Resident 52). Findings include:	F 0689	**Tag Cited: F-689** **§483.25(d)(1)(2) – Accidents and Supervision** **Issue Cited:** **"Resident environment remains as free from accidents/hazards as possible"**	07/29/2018

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	During an observation, on 6/25/18 at 2:37 p.m., Resident 52's bed was not in a low position. She was in bed resting. During an observation, on 6/26/18 at 11:46 a.m., her bed was not in a low position. She was in bed resting. During a continuous observation, on 6/29/18 at 8:02 a.m., the nurse's station on Abbey Court was unattended. The call light for Resident 52 was alarming. At 8:09 a.m., LPN (Licensed Practical Nurse) 21 answered her call light. The resident needed to use the restroom and asked when breakfast was. At this time LPN 21 assisted the resident to the bathroom. The censor pad on the resident's bed alarmed at the nurse's station which indicated she was out of bed. The nurse's station was still unattended. This alarm sounded only at the nurse's station. At 8:14 a.m., the alarm at the nurse's station continued to alert that the resident was out of bed and the nurse's station remained unattended and the alarm sounding. At 8:18 a.m., the alarm at the nurse's station continued to alert that the resident was out of bed and the nurse's station remained unattended and the alarm sounding. The clinical record for Resident 52 was reviewed, on 6/28/18 at 11:16 a.m.. Her diagnoses included, but were not limited to: weakness, dementia, Parkinson's disease, delusions, anxiety and psychosis. A 14 day MDS (minimum data set) assessment,		1.Immediate action(s) taken for the resident(s) found to have been affected include: Use of the sensor alarm for the resident affected has been reviewed. The use of the alarm assists in maintaining dignity while also alerting staff to the resident's movement in providing safety. However, resident care/assistance will always take precedence over silencing an alarm. The only observation noted in the survey process involved nursing present with the resident providing hands on care and was unable to silence the sensor alarm (which must be silenced at the nursing station). The nursing staff will be alert to the sounding sensor, and monitor/assist the resident as needed. However, during the survey process, it should be noted that the resident's needs were being addressed by the nurse on the unit. Additional staff members assigned to the unit were providing care to other residents. Resident care was, and will continue to be, the first priority. 1.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with a fall risk have the potential to be affected.	

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	dated 6/8/18, indicated she had mild cognitive impairment. She required extensive assistance for bed mobility, transfers, walking, personal hygiene and dressing. A care plan, dated 7/3/17, indicated she was at risk for falls. Interventions included, but were not limited to: assist with toilet use (5/25/18), cordless sensor pad on bed (6/25/18), bed/chair alarm when not in lounge (6/26/18), remind resident to use call light for assistance (5/25/18) and gripper socks when in the bathroom (6/18/18). A fall risk assessment, dated 6/21/18, indicated she was a high risk for falls. A fall investigation report, dated 2/21/18, indicated the resident was being assisted to the bathroom by a family member (husband) and fell in the bathroom with no injuries noted. The intervention for this fall was to educate the family (husband) to ask for assistance with resident transfers. A fall investigation report, dated 4/8/18, indicated she was found on the floor in her room by a staff member with no injuries noted. The resident indicated she was cleaning her room. The intervention for this fall was to remind her that housekeeping is responsible for cleaning her room. A fall investigation report, dated 4/20/18, indicated a family member found her on the floor in the bathroom with no injuries noted. The intervention for this fall was to have the resident sit in the lounge when not visiting with family. A fall investigation report, dated 4/21/18, indicated she was found sitting on the floor next		**1.Actions taken/systems put into place to reduce the risk of future occurrence include:** Although the facility provided hands on nursing care at the appropriate time: Nursing personnel have been educated on the sensory alarm for the resident affected. The Fall Care Plan for the affected resident has been reviewed. Therapy will be consulted for the least restrictive interventions to assist in the safety of the resident. **2.How the corrective action(s) will be monitored to ensure the practice will not reoccur:** The Nurse Manager or designee will conduct random audits of staff response to the sensory alarm. Interventions for Fall Care Plans will be continue to be adjusted as needed to meet the resident's needs. This audit will be reviewed monthly in the Risk Committee meeting. In good faith, the facility is putting forth effort to ensure that interventions are appropriate so that all resident's safety needs are met by the facility. The plan of correction will be reviewed/monitored/updated monthly in the Quality Assurance meeting for 9 months. **3.All components of the**	

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	155170	A. BUILDING 00 B. WING	06/29/2018

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	to her bed. She was found to have an abrasion to her knee. The intervention for this fall was to have her bed in a low position and monitor more frequently. This intervention was not noted on the care plan. A fall investigation report, dated 4/28/18, indicated she was found on the floor in her room with no injuries noted. The intervention for this fall was to check on her more frequently. A fall investigation report, dated 5/10/18, indicated she was found on floor in the lounge area with no injuries noted. The intervention for this fall was to schedule an appointment with neurology. A fall investigation report, dated 5/12/18, indicated she was found on the floor in her room with no injuries noted. The intervention for this fall was toileting. A fall investigation report, dated 5/13/18, indicated she was found on the floor in her room. The intervention for this fall was for the resident to sit with a family member (spouse) for 30 minutes. A fall investigation report, dated 5/18/18, indicated she was found on the floor in her room with no injuries noted. She indicated her bed was too high off the ground. The intervention for this fall was to change the call light button to a touch call pad. A fall investigation report, dated 6/12/18, indicated she was found in the hallway with no injuries noted. The intervention for this fall was staff informed her to use the call light before she got out of bed.		**systematic adjustments for accidents/supervision will be implemented by July 29th, 2018.**	

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A fall investigation report, dated 6/15/18, indicated she fell in the bathroom with staff present. No injuries were noted. The interventions for this fall was for the resident to wear gripper socks when in bathroom.

A fall investigation report, dated 6/20/18, indicated she fell in the bathroom when getting transfer assistance by a family member. No injuries were noted. The intervention for this fall was to educate family to call for assistance when transferring the resident.

During an interview with QMA (Qualified Medication Assistant) 20, on 6/28/18 at 2:03 p.m., she indicated the resident was encouraged to ask for help prior to getting up, but she was non compliant. She indicated there was no scheduled checks for the resident but they checked on her "often". Her husband stayed with her a lot of the time and helped her, but he was not in the best shape either. The standard bed alarm that sounded in the resident room when she was up made her very agitated so the facility implemented a censor pad that only sounded at the nurses station to alert them if she got up attended.

During an interview with LPN 21, on 6/29/18 at 8:19 a.m., she indicated the censor pad only alerted at the nurses station. No staff member came into the resident's room to address the alarm, she acknowledged the nurse's station was unattended. She indicated it was a concern that the alarm was sounding at the nurses station and it wasn't addressed for the continuous observation. She indicated this was not best practice for resident safety.

During an interview with the DON (Director of

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	Nursing) 6/29/18 at 9:13 a.m. she indicated if the alarm was sounding and the nurses station was unattended then this was not an effective intervention. The intervention needed to be reviewed because it was not adequate supervision for the resident. A current policy titled "fall policy and procedure program" was provided by the DON, on 6/29/18 at 11:20 a.m. This policy indicated, "...A prevention approach will be taken in order to promote the safety and well being of each resident...the interdisciplinary team will promote communication and monitor the outcomes of the program...PURPOSE: the purpose of the fall program is to:...2. Initiate preventive approaches...3. provide interventions...4. provide education to resident and staff...5. monitor and evaluate outcomes....". 3.1-45(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used			

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	psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to attempt a gradual dose reduction for 1 of 5 residents reviewed for unnecessary medications (Resident 52). Findings include: The clinical record for Resident 52 was reviewed,	F 0758	**Tag Cited: F-758** **§483.45(c)(3)(e)(1)-(5)** **Issue Cited:** **Free from Unnecessary Psychotropic Meds/PRN Use** 1.Immediate action(s) taken for the resident(s) found to have been affected include:	07/29/2018

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	on 6/28/18 at 10:30 a.m. Her diagnoses included, but were not limited to: anemia, dementia, Parkinson's disease, hallucinations, delusions, psychosis and anxiety. A 14 day MDS(minimum data set) assessment, dated 6/8/18, indicated she had mild cognitive impairment. She required the use of anti-anxiety and antidepressant medications. A care plan, dated 3/23/16, indicated she had the potential for adverse drug reaction due to the use of psychotropic medications. Interventions included, but were not limited to: evaluate for dose reductions, follow up with psych as needed, monitor for changes in behaviors and observe for signs of decline in function. A physician order, dated 6/20/17, indicated she was to receive Sertraline (anti-depressant)100 milligrams daily for depression. A Pharmacy progress note, dated 12/27/17, indicated to see the report for noted irregularities in the medication regimen review. The clinical record lacked the report for review. A Pharmacy progress note, dated 1/31/18, indicated to see the report for noted irregularities in the medication regimen review. The clinical record lacked the report for review. A Pharmacy progress note, dated 3/27/18, indicated to see report for noted irregularities. The consultation report, dated 3/27/18, indicated a recommendation to consider a gradual dose reduction of the Sertraline 100 milligrams. This report lacked a physician signature or an indication of acceptance or declination of recommendation.		The resident's file was reviewed. The resident did/and is receiving care and services from the facility, the physician, and through consultant pharmacy medication reviews. Although the gradual dose reduction form for acceptance or declination was not signed by the physician, the resident received consultant psychiatric services which correlated with the Pharmacy gradual dose reduction recommendations as evidenced by signed physician progress notes from the psychiatrist. No observations were noted or evidenced in our written survey report. 1.Identification of other residents having the potential to be affected was accomplished by: All residents who receive gradual dose reduction reviews have the potential to be affected by this practice. Please note, that per Quarterly Review from Pharmacy Services, our facility is one of the lowest antipsychotic use facilities in the state. **1.Actions taken/systems put into place to reduce the risk of future occurrence include:** The gradual dose reduction recommendation forms will be distributed to the resident's physician by a select nursing staff member, or designee. That staff	

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	A Pharmacy progress note, dated 5/31/18, indicated to see the report for noted irregularities. The consultation report, dated 5/31/18, indicated a recommendation to consider a gradual dose reduction of the Sertraline 100 milligrams. The Physician declined this recommendation and indicated the resident had chronic depression and required longer term treatment. Behavior flow sheets from June 2017 to February 2018 were reviewed, on 6/28/18 at 1:32 p.m. Behaviors that were charted included: restlessness, self reported anxiety and paranoid delusions. These behavior logs lacked any depressive behaviors. During an interview with the DON (Director of Nursing), on 6/28/18 at 1:14 p.m. , she indicated no GDR (gradual dose reduction) had been attempted on this resident's Sertraline. She had no further information to provide for review for a GDR being clinically contraindicated by the physician. On 6/29/18 at 9:01 a.m., the DON provided a current policy titled "Medication Regimen Review". This policy indicated, "...Procedure:...7. The facility should encourage physician act upon the recommendations....". 3.1-48(b)		member will verify receipt of and return of a signed gradual dose reduction recommendation form and will input an order if warranted and upload the signed form into the electronic health record. **1.How the corrective action(s) will be monitored to ensure the practice will not recur:** This process will be audited monthly to verify specifically signed receipt of gradual dose reduction recommendation forms. 1.All components of the systematic adjustments for Free from Unnecessary Psychotropic Meds/PRN Use will be implemented by July 29th, 2018.	
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,			

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	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; (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			

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	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, the facility failed to ensure completion of routine vaccinations for 3 of 5 residents reviewed for pneumococcal vaccinations (Residents 5, 17, and 28). Findings include: During vaccination record review on 6/28/18 at 2:19 p.m., the following was indicated: a. Resident 5's clinical record indicated a pneumococcal vaccine was administered on 6/25/15, it did not indicate what type of vaccination was administered (PCV 13 (pneumococcal conjugate vaccine) or PPSV 23 (pneumococcal polysaccharide vaccine)). There is no evidence of follow up offering the other needed pneumococcal vaccination to fulfill the CDC (Centers for Disease Control and Prevention) guidelines. b. Resident 17's clinical record indicated a pneumococcal vaccine was administered on 10/6/16, it did not indicate what type of vaccination was administered (PCV 13 or PPSV 23). There was no evidence of follow up offering the other needed pneumococcal vaccination to fulfill the CDC guidelines. c. Resident 28's clinical record indicated the	F 0883	**Tag Cited: F-883** **§483.80(d)(1)(2) – Influenza and Pneumococcal Immunizations** **Issue Cited:** **Non-Completion of Routine Vaccinations** 1.Immediate action(s) taken for the resident(s) found to have been affected include: Upon review: Regarding Resident 5, the type of vaccination was not located on the immunization record, but was available in the medication administration record. The resident will be vaccinated, upon consent/education to do so; and in accordance with CDC recommendations/guidelines. Upon review: There is no Identifier for a Resident 17. Unable to address a plan of correction d/t number 17 does not exist on Sample List Provided to the Facility. Upon review: Regarding Resident 28, the resident will be vaccinated, upon consent/education to do so; and in accordance with CDC recommendations/guidelines.	07/29/2018

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	pneumococcal vaccination was "refused" on 2/6/15 because the resident was "up to date" on the pneumococcal vaccination. The clinical record did not indicate what pneumococcal vaccine was given or when it was given to this resident. There was no evidence of follow up offering the other needed pneumococcal vaccination to fulfill the CDC guidelines. The Immunization Policy given by the DON on 6/25/18 at the entrance conference did not specify guidelines for pneumococcal vaccinations. During an interview with the Director of Nursing (DON) on 6/29/18 at 8:15 a.m;, she indicated the pneumococcal vaccine was not necessarily a requirement for each resident, it just depended on the resident and the doctor's orders. Review of CDC "Adult Protect Yourself with Pneumococcal Vaccines", dated 9/11/17, indicated the CDC recommends two pneumococcal vaccines for all adults 65 years or older. You should receive a dose of pneumococcal conjugate (PCV13) first, followed by a dose of pneumococcal polysaccharide (PPSV23), at least one year later. 3.1-13(a)		2.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. All residents will be reviewed for; and vaccinated upon need/consent/education to do so; for Pneumococcal Vaccinations in accordance with CDC recommendations/guidelines. **1.Actions taken/systems put into place to reduce the risk of future occurrence include:** Education has been provided to all nursing personnel addressing policies and procedures, regulations and facility expectations related to Pneumococcal Immunizations. A new Policy related to Pneumococcal Vaccine Series has been implemented. **1.How the corrective action(s) will be monitored to ensure the practice will not recur:** The Nurse Manager or designee will review all medical records on the respective unit(s) to assure the vaccination/education of new admission residents are in accordance with CDC recommendations/guidelines. All appropriate orders will be placed in the electronic health record to ensure compliance with vaccinations and follow-through. Reviews will be conducted on all	

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			new admissions monthly for 9 months to ensure compliance. This plan of correction will be reviewed/monitored/updated in the monthly Quality Assurance meeting. 1.All components of the systematic adjustments for Influenza and Pneumococcal Immunizations will be implemented by: July 29th, 2018.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: June 25, 26, 27, 28, and 29, 2018 Facility number: 000086 Residential Census: 161 WestMinster Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed July 6, 2018.	R 0000		