STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING _____ B. WING _____	03/04/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address a grievance timely for 1 of 3 residents reviewed for property. (Resident 63) Findings include: The clinical record for Resident 63 was reviewed on 2/26/20 at 2:15 p.m. The resident's [DIAGNOSES REDACTED]. An interview was conducted with Family Member 25 on 2/26/20 at 2:33 p.m. She indicated Resident 63 had been missing some clothing for weeks and had not heard anything about them. Family Member 25 does his laundry at home, so clothing should not be sent to the facility's laundry room. Resident 63 was missing 5 shirts and 1 pair of exercise pants. An interview was conducted with Social Services 19 on 2/28/20 at 3:54 p.m. She indicated she did not have a grievance for Resident 63 nor was she aware of any missing clothing. The facility will replace the clothing in 30 days after searching and unable to locate them. During an interview with the Environmental Services (ES) on 2/28/20 at 4:15 p.m., she indicated someone had pinned a grievance form for Resident 63 on the board in the laundry room about 2 weeks ago. Laundry personnel had been looking for the listed missing items. We have not reported back to Family Member 25 about the items, because we were still looking for them. The items will be replaced if unable to find the clothing. Usually, Social Services will have a copy of the grievance and after 30 days of searching for the missing items, staff will turn in a claim to replace them. Most of the time the clothing will turn up. A grievance form dated 12/30/19, was provided by the ES on 2/28/20 at 4:30 p.m. It indicated Family Member 25 had a concern regarding Resident 63 had missing clothing items. The missing items were the following: 6 short sleeve golf shirts, 1 pair of blue jeans, 2 pair of long exercise pants, and 5 white undershirts The grievance form did not have documented staff member taking the complaint nor follow-up response or corrective measures. A grievance policy was provided by the Director of Nursing on 3/2/20 at 2:00 p.m. It indicated .Purpose: To ensure that residents and sponsors have the opportunity to have complaints heard, reviewed, and, when possible, receive resolution and/or appropriate disposition. Responsibility: Executive Director, Administrator, Director of Nursing, Social Service Director and all facility staff. Policy: It is the policy of (name of facility) that residents may, throughout the period of the stay, voice complaints and grievances with respect to treatment and care or concerns of any other nature and recommend changes in policy and services without fear of discrimination, reprisal or interference. Prompt efforts will be made by facility staff to review and resolve, when possible, grievances identified by residents and others, including those involving other residents. Standards: .6. Any facility staff member receiving a concern/suggestion is responsible to report the concern/suggestion to their supervisor and/or Department Manager, the Charge Nurse on duty and to complete a Concern/Suggestion Report. If a resident or family member desires, they may complete the form personally or request a staff member to do so on their behalf. 7. The staff member, depending upon the circumstances, will take immediate interventions to correct the concern, including contacting other departments, visiting with the resident or gathering additional related information. Interventions shall be documented on the form .12. The date resolution was reported to the person who made the initial complaint or to the resident will be documented on the form by staff involved. Individual department managers will be responsible for documenting information on actions. taken. 13. In the event the complaint is not resolved within 5 days, the Executive Director, Administrator or Designee will meet with staff responsible for addressing, and/or resident, to determine reason for delay . 3.1-7(a)(2)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate a reportable incident for 1 of 1 residents reviewed for abuse. (Resident 103) Findings include: The clinical record for Resident 103 was reviewed on 2/27/20 at 3:15 p.m. The resident's [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 103 was cognitively impaired. An incident reported to Indiana State Department Health for Resident 103 indicated .Incident date: 2/15/20 Incident Time: 5:35 p.m .Brief Description: .Resident (103) was ambulating in the dining room with her rollator. Dietary staff was exiting the kitchen the same time resident was walking by. Door hit resident's rollator and she lost her balance .Acute minimally displaced fracture through the left pubic rams . The investigation file for Resident 103 and Dietary Aide (DA) 31 was provided on 2/27/20 at 9:00 a.m. It included the following documentation: incident report, Resident 103's face sheet, x-ray, progress note written by License Practical Nurse (LPN) 30, witnessed fall event, and medication list sent to hospital. The investigation file lacked a written statement from Dietary Aide 31 or Certified Nurse Assistant (CNA) 32. An interview was conducted with LPN 30 on 3/2/20 at 1:45 p.m. She indicated she had not witnessed the incident regarding Resident 103 and Dietary Aide 31. She was told Resident 103 had ambulated with her rollator in the dining room. As DA 31 opened the kitchen door, Resident 103 was standing directly behind the door and hit the resident's rollator causing her to lose her balance and fall. CNA 32 had notified her of the fall. DA 31 was the only staff member in the area at the time of the incident. An interview was conducted with the Administrator on 3/2/20 at 2:15 p.m. She indicated she was under the impression the fall had been witnessed by LPN 30. If an incident was reportable a full investigation should have been conducted. An interview was conducted with DA 31 on 3/3/20 at 4:03 p.m. She indicated after Resident 103 had fallen she went and told CNA 32 who was in the kitchen at the time of the fall. Then LPN 30 was notified. There were a couple of non-interviewable residents in the dining room at the time of the fall. The Abuse policy was provided by the Administrator on 2/26/20 at 1:00 p.m. It indicated .Purpose: To establish guidelines for assuring the residents are free of all abusive acts and to establish guidelines for investigating, resolving and reporting abuse .Policy: It is the policy of (name of facility) to protect residents from all abusive acts and to comply with state and federal laws and regulations for reporting suspected or actual acts .14. An Accident/Incident Report will be initiated by a licensed nurse or other individual who observed/or has first-hand knowledge of an abuse incident. The Director of Health Center Operations, Director of Nursing and Manager of Social Services are responsible for reviewing the report as well as other investigate reports and developing interventions to care for the resident's medical and psychosocial needs. As per policy, the incident will be communicated immediately to the resident's representative and and physician by telephone. All notifications will be documented in the nurse's notes and any assessments completed will be contained in the medical chart .16. The Director of Health Center Operations shall immediately identify and investigate all incidents of suspected resident abuse , neglect, or mistreatment or misappropriation of property where by staff or others. 3.1-28(d)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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.

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Based on observation, interview and record review, the facility failed to ensure activities of daily living (ADLS) were provided to residents that required assistance related to the use of a stand up lift, showers, glasses, and hair blow dryer for 4 of 7 residents reviewed for ADLs. (Resident 23, 53. 73, 88 and 94) Findings include: 1. The clinical record for Resident 88 was reviewed on 2/26/20 at 11:00 a.m. The resident's [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment, dated 1/20/20, indicated Resident 88 was cognitively intact and needed extensive assistance with transfers and toileting. An interview was conducted with Resident 88 on 2/26/20 at 11:15 a.m. She indicated there was only 1 stand up lift, and she had to wait a long time to use it. She liked to lay down after lunch, but there was a long wait time to be assisted to lay down using the stand up lift. 2. An observation was made of Resident 53 and Resident 50 on 2/27/20 at 10:00 a.m. Resident 53 was observed sitting in her wheelchair in her room, and Resident 50 was in her bed. Resident 53 indicated she had been waiting to go the bathroom. She could not be taken, because she had to wait until the stand up lift was available. They only had one stand up lift, and there were other residents that used it too. At that time, Qualified Medication Aide (QMA) 35 was standing outside Resident 53's room and indicated to Resident 53 that Resident 42 was using the stand up lift, and she would be assisted to the bathroom afterwards. Resident 53 indicated I have to go so bad. I'm trying to hold it. Resident 53 then began to yell out to Resident 42 she needed to hurry and get done using the stand up lift. As of 10:16 a.m., Resident 42 yelled out from her room, she had finished, and it was taken down the hall to someone else. Resident 50 indicated Resident 53 had to go through this all the time. As of 10:20 a.m., the stand up lift was brought into Resident 53's room by Certified Nursing Assistant (CNA) 40 to assist the resident to the bathroom. The clinical record for Resident 53 was reviewed on 2/27/20 at 10:00 a.m. The resident's [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment, dated 12/20/19, indicated Resident 53 was cognitively intact and needed extensive assistance with transfers and toileting. An interview was conducted with QMA 35 on 2/27/20 at 10:15 a.m. She indicated the unit had 1 stand up lift and 4 residents that use it. They use to have 2 stand up lifts, but another unit had taken it. She had repeatly requested for a 2nd stand up lift. We need one in the front hall and one in the back hall. We get the backlash of only having one stand up lift by the residents. The residents have to go to the bathroom at the same time after meals, and it always is a waiting game. An interview was conducted with the Unit Coordinator 1 on 2/27/20 at 10:25 a.m. She indicated it had been over a month since the 2nd stand up lift had been removed from the unit. The staff are struggling with getting the residents to the bathrooms with 1 stand up lift. We are suppose to get one, but haven't gotten one yet. A list of all residents that use a stand up lift for transfers on the willow unit was provided by the Administrator on 3/4/20 at 9:34 a.m. There were 4 residents that use the stand up lift. Resident 42, 88, 53 and 104 were on list. 2. A record for Resident 23 was reviewed on 3/4/20 at 1:01 p.m. The resident's [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) assessment, dated 2/28/20, indicated the resident's cognition was intact and and required physical help in part with the assistance of one staff member for bathing. The resident's shower sheets for the months of January and February, 2020 were provided by the Administrator on 3/4/20 at 1 p.m. Resident 23's shower sheets for the following dates could not be located by the facility: 1/7, 1/24, 2/7. 2/14, and 2/28/20 Resident 23 had not received her two showers per week for 5 out of 8 weeks reviewed. An interview with Resident 23 on 2/26/20 at 2:02 p.m., indicated her shower days were Tuesdays and Fridays, but she had not received two showers a week for a while now. An interview with the DON on 3/4/20 at 1:21 p.m., she indicated It is the expectation that residents get two showers a week unless the resident refused a shower. The shower sheets should be filled out each shower day even if the resident refused or had a bed bath. 3. The clinical record for Resident 94 was reviewed on 2/27/20 at 2:00 a.m. The resident's [DIAGNOSES REDACTED]. The vision care plan, dated 9/16/19, indicated Resident 94 had impaired vision and had eye glasses. An intervention was to maintain eye glasses in good condition and keep within reach for use. The Annual MDS assessment, dated 9/18/19; the Quarterly MDS assessment, dated 10/21/19; and the Quarterly MDS assessment, dated 1/21/20; indicated the resident had impaired vision, and no corrective lenses were used for the assessments. The Quarterly MDS assessment, dated 1/21/20, indicated the resident had moderately impaired cognition. An interview and observation was conducted with Resident 94 on 2/27/20 at 2:10 p.m. He indicated he wore glasses, but they were lost, and nothing had been done about it. He was not wearing glasses at this time. There was an empty glasses case on the dresser with Resident 94's name and facility name written on the case. An observation of Resident 94 was made on 2/28/20 at 1:49 p.m. He was sitting in his wheel chair in a circle in the common area of the unit during a word game activity that used a white board. He was not wearing his glasses. The resident was looking down and not looking at the white board. An interview was conducted with UC (Unit Coordinator) 12 on 2/28/20 at 1:54 p.m. She indicated Resident 94 had glasses, but had chose not to wear them sometimes. He was able to put them on and take them off himself, and were either in his room or in the medication cart. An observation of Resident 94's room was made with UC 12 on 2/28/20 at 1:55 p.m. UC 12 picked up the empty glasses case from Resident 94's dresser, then proceeded to look through his drawers, but was unable to locate the glasses. UC 12 then went to the medication cart on the unit. After unlocking the cart, UC 12 looked through several pairs of glasses and retrieved Resident 94's glasses from the cart. The glasses had his last name written on the side. UC 12 walked over to Resident 94 in the common area of the unit and asked him if he wanted to wear his glasses. Resident 94 responded and affirmed he wanted his glasses. After retrieving his glasses from the medication cart, Resident 94 was observed wearing his glasses on the following dates and times: 2/28/20 at 2:16 p.m., 3/2/20 at 11:09 a.m., 3/2/20 at 11:50 a.m., and 3/3/20 at 9:58 a.m. The Hearing and Vision Services policy was provided by the DON (Director of Nursing) on 2/28/20 at 3:20 p.m. It indicated, 5. Employees will assist the resident with the use of any devices or adaptive equipment needed to maintain vision or hearing. 6. Assistive devices to maintain vision include, but are not limited to, glasses, contact lenses, and magnifying lens or other devices that are used by the resident. 4. The clinical record for Resident 73 was reviewed on 2/27/20 at 9:30 a.m. The [DIAGNOSES REDACTED]. The Admission MDS (Minimum Data Set) assessment, dated 1/17/20, indicated an interview for her mental status was not conducted, as she was rarely/never understood. She required extensive assistance of one staff member for personal hygiene and was totally dependent on one staff member for bathing. An observation of Resident 73 and interview with FM (Family Member) 6, was conducted on 2/27/20 at 9:57 a.m. He indicated staff showered the resident the previous day, but they did not blow dry her hair. The CNA (Certified Nursing Assistant) informed him they did not have a blow drier to use, and would come back with a towel to dry her hair, but she never returned, so Family Member 6 retrieved a towel. He would prefer the facility blow dry her hair as a hair drying preference and because he was afraid she would catch a cold with wet hair. An interview was conducted with FM 6 and FM 7, on 3/2/20 at 11:22 a.m. FM 6 indicated he hadn't noticed before her shower on 2/26/20 that the facility hadn't been blow drying her hair. FM 7 indicated she thought the facility was blow drying her hair, before she moved to her current unit. The shower sheet, dated 2/2/20, for Resident 73 was reviewed with UC (Unit Coordinator) 12 on 3/2/20 at 11:37 a.m. The sheet was signed off by UC 12. It indicated she was given a shower by CNA (Certified Nursing assistant) 8 and her hair was washed. An interview was conducted with UC 12 on 3/2/20 at 11:37 a.m. She indicated staff were to ask residents, if they wanted their hair blow dried after receiving a shower. If not, it could be towel dried, then styled as usual. They would especially ask the residents with shorter hair, if they wanted it blow dried, because they knew they got cold. Family would be asked to bring a blow drier in, because there was no community blow drier. Resident 73 did not have a blow drier in the facility and didn't ask, so her hair wasn't blow dried on 1/26/20. If a resident wanted their hair blow dried and had no blow drier, staff could ask the beautician, if the beautician was in the facility. She would have expected CNA 8 to notify her that the resident wanted her hair blow dried after her 2/26/20 shower, so she could contact the family about bringing one in, but CNA 8 did not inform her of this. This was the first she'd heard of it. An interview was conducted with CNA 8 on 3/2/20 at 4:12 p.m. She indicated FM 6 asked for Resident 73's hair to be blow dried on 2/26/20. She informed him she would ask the nurse for a blow drier, but she never asked, because FM 6 informed her he'd just bring one in next time. An interview was conducted with FM 6, FM 7, and UC 12 on 3/2/20 at 11:42 a.m. UC 12 explained to FM 6 and FM 7 that residents needed to have their own personal hair dryers on the unit. FM 7 indicated they would bring one in for her. FM 6 indicated before now, no one, including CNA 8, had ever discussed needing to bring in a hair dryer for her. 3.1-38(b)(2) 3.1-38(b)(3)(B)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Based on interview and record review, the facility failed to ensure the physician was notified of an x-ray result and address a resident's skin condition in a timely manor, to ensure a physician's orders [REDACTED]. (Resident 3, 103, 109 195) Findings include: 1. The clinical record for Resident 103 was reviewed on 2/27/20 at 3:15 p.m. The resident's [DIAGNOSES REDACTED]. An x-ray imaging, dated 2/15/20, indicated the resident had an .acute minimally displaced fracture on left side of pubic bone. The x-ray was signed by imaging staff on 2/16/20 at 12:03 a.m. The fax activity log indicated the staff had received the x-ray imaging results by fax on 2/16/20 at 1:51 a.m. The facility faxed the results to the provider on 2/16/20 at 3:14 a.m. A progress note, dated 2/15/20 at 10:03 p.m., indicated Resident 103 had fallen that evening. The medical provider was notified, and staff received an order for [REDACTED]. and placed in the physician binder. A progress note, dated 2/16/20, indicated nursing staff had spoken to the medical provider at 7:40 a.m., and Resident 103 was to be sent to the emergency room for evaluation and treatment due to a fracture to left pubic bone. An interview was conducted with License Practical Nurse (LPN) 30 on 3/2/20 at 1:45 p.m. She indicated Resident 103 had fallen in the dining room on 2/15/20 at approximately 5:40 p.m. She had notified the provider and received an order for [REDACTED]. 2. The clinical record for Resident 109 was reviewed on 2/26/20 at 10:15 a.m. The resident's [DIAGNOSES REDACTED]. A skin assessment, dated 2/24/20, indicated Resident 109's .skin remains intact with no redness or bruising . A skin assessment, dated 2/29/20, indicated Resident 109 had a new area to left buttocks. A skin assessment, dated 3/2/20, indicated Resident 109 had a stage 2 open area to left inner thigh. The measurements were 2.5 centimeters by length, 2.5 centimeters by width and 0.1 centimeters by depth. The notes indicated .wound bed red/pink. 100% granulation tissue. Well defined wound margins, periwound intact. Resident rates pain 3/10. [MEDICATION NAME] dressing change q (every) 3 days and prn (as needed) for soilage or dislodgement . A physician's orders [REDACTED]. The February 2020 Medication and Treatment Administration (MAR/TAR) for Resident 109 indicated the staff had applied bag balm ointment to peri area every shift as ordered. An interview was conducted with Resident 109 on 2/26/20 at 11:46 a.m. She indicated she had a red welted blister on the inner part of her thigh for about a month that hurts. She had addressed it with the nursing staff and requested the wound team to look at it. No one has came to look it, and she did not feel anyone was addressing the problem. The staff do apply the bag balm ointment to her thighs, but it did not help the blistered area. An interview was conducted with the Director of Nursing on 3/2/20 at 8:15 a.m. She indicated she had the Unit Coordinator assessed Resident 109's skin over the weekend. There was a blister, and she was calling the doctor to address. 3. An observation on 2/26/20 at 11:39 a.m., Resident 3 was sitting in his wheelchair and his legs were not wrapped with ace wraps. An observation on 3/3/20 at 4:04 p.m., the resident was sitting in his wheelchair in the common area and his legs were not wrapped with ace wraps. An observation on 3/4/20 at 9:13 a.m., the resident was sitting in his wheelchair looking out his window and his legs were not wrapped with ace wraps. The resident's clinical record was reviewed on 3/3/20. The [DIAGNOSES REDACTED]. The resident's cognition was severely impaired. A physician's orders [REDACTED]. The resident's Treatment Administration Record (TAR) indicated the following: - On 2/26/20, the ace wraps were applied - On 2/27/20, the ace wraps were not applied - On 3/3/20, the ace wrap was coded as 9 which indicated to see the progress notes, however there was no progress note in the chart regarding the ace wraps that day. - On 3/4/20, the ace wraps were applied An interview with the DON, on 3/4/20, indicated the expectation is for nursing to follow the physician's orders [REDACTED]. 4. The clinical record for Resident 195 was reviewed on 2/26/20 at 2:00 p.m. The resident's [DIAGNOSES REDACTED]. The nurse's note, dated 2/20/20 at 9:37 p.m., indicated Resident was sent to he hospital and family not happy ? however she was sent back around 9:30 p.m. and has new orders for 2.5 mg (milligram) of [MEDICATION NAME] scheduled q (every) 12 hours and cbc in the next 2 days due to her hemoglobin being 7.2. while at the hospital she received [MEDICATION NAME], 50 mg of [MEDICATION NAME] and they placed an 18 inch french catheter and is draining yellow uring (sic.) resident received prn hydro ([MEDICATION NAME]) 7.5 mg along with sleeping pill after return. resident still complaining of pain 6/10 after return. will continue to monitor. The hospital emergency department instructions, dated 2/20/20, indicated to Please have a repeat CBC in next 24 hours to ensure your hemoglobin is stable. The progress note, dated 2/21/20 at 2:12 p.m., progress note indicated Orders - Administration Note Text: CBC one time only for LOW HEMOGLOBIN until 02/21/2020 .not drawn placed in lab book for it to be drawn on Monday. The CBC lab results, dated 2/24/20, was entered into the system/requested on 2/21/20 at 5:07 p.m. the results indicated the resident's hemoglobin was 6.8. A note at the bottom of the results indicated a repeat H/H (hemoglobin/hematocrit or HGB/HCT.) The HGB/HCT lab results, dated 2/25/20, indicated a hemoglobin of 6.9. A note at the bottom of the results indicated a new order was received. The nurse's note, dated 2/25/20 at 1:37 p.m., written by UC (Unit Coordinator) 9, indicated Resident had a critical lab today of HGB 6.9, yesterday HGB was 6.8. (Name of physician) had visited and had ordered this lab to be redrawn today. (Name of nurse practitioner) NP made aware of. The nurse's note, dated 2/25/20 at 4:02 p.m., written by UC 9, indicated Received new orders from (name of NP) due to most recent labs. (family member) made aware of and had reported that resident had been having periodic nosebleeds. Resident made aware of orders. Resident had also been having loose stools. NP made aware of all of the above. An interview was conducted with the DON (Director of Nursing) on 3/4/20 at 2:20 p.m. She indicated the CBC lab was entered into the system on 2/21/20, instead of 2/20/20 when Resident 195 returned from the hospital, likely because it was an agency nurse who readmitted her on 2/20/20. An interview was conducted with UC 9 on 3/4/20 at 1:40 p.m. She indicated if there was an order for [REDACTED]. The current physician's orders [REDACTED]. The Admission of a Resident policy was provided by the DON on 3/4/20 at 2:54 p.m. The policy indicated, Call for any labs or Xrays & make follow up appointments, if applicable. 3.1-37(a)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a sling pad used on a mechanical stand up lift was not defected prior to transferring a resident for 1 of 2 residents reviewed for accidents, (Resident 53) Findings include: The clinical record for Resident 53 was reviewed on 2/27/20 at 10:00 a.m. The resident's [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment, dated 12/20/19, indicated Resident 53 was cognitively intact and needed extensive assistance with transfers and toileting. An Activities of Daily Living (ADL)s care plan, dated 11/19/19 with a revision date of 1/3/20, indicated Resident 53's transfer plan of care was .The resident usually requires mechanical lift or stand up lift and 2 staff to move between surfaces example to bed to wheelchair .Toilet use: The resident usually requires extensive assistance by staff for toileting . A Restorative progress note dated 11/8/19, indicated Resident 53 needed moderate to maximum assistance of 2 staff persons. A progress note dated 12/3/19 at 4:35 p.m., indicated Resident 53 was using the stand up lift, and the pad snapped. The resident had hit her head during the incident and was sent to the emergency room . A pain level score was documented on 12/3/20 at 4:45 p.m. The resident's pain level was a 7 out of 10. An interview was conducted with Resident 53 on 2/27/20 at 9:16 a.m. She indicated in December she had fallen using the stand up lift. The strap had broken while being transferred to the bathroom using the lift. She had hit her head and her back. It was painful, and she was sore afterwards. There was only one staff member in the room at the time of the transfer. An interview was conducted with CNA 35 and the Administrator on 3/3/20 at 4:38 p.m. CNA 35 indicated License Practical Nurse (LPN) 50, and she were transferring Resident 53 to the bathroom. They were at the doorframe of the bathroom when the plastic buckle of the sling had broken. CNA 35 was able to grab Resident 53 and lower her to the floor. The Administrator indicated the root cause of the fall was the plastic buckle of the sling pad had snapped. The plastic piece was defective. During an observation of a stand up lift with Resident 53 on 3/4/20 at 8:30 a.m., CNA 44 and CNA 35 indicated the sling pads for the lifts are inspected by the laundry department. The sling pad used during the transfer was not observed to be defected. An interview was conducted with the Laundry Aide (LA)15 on 3/4/20 at 8:45 a.m. She indicated she does wash the sling pads for the lifts. She inspected the sling pads for soilage, and then places them into the washing machine. Then the pads are dried on low in the dryer. If they are dried to high they could shrink. There are times, depending on the soilage the pads had to be washed more than once. If the pad was observed to be damaged, the pad would be thrown away. 3.1-45(a)
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure daily weights were obtained per physician orders

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WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) [REDACTED]. (Resident 88) Findings include: The clinical record for Resident 88 was reviewed on 3/3/20 at 12:11 p.m. The [DIAGNOSES REDACTED]. A physician's orders [REDACTED].Daily Weight one time a day The Electronic Medication Administration Record [REDACTED]. The EMAR, dated February of 2020, indicated 5 occurrences to where no daily weight was obtained. A care plan for [MEDICAL TREATMENT], revised 8/22/19, indicated the following, .(name of Resident 88) needs [MEDICAL TREATMENT] hemotoneal (sic) r/t (related to) [MEDICAL CONDITION] .Interventions .Monitor VITAL SIGNS per protocol and as needed. Notify MD of significant abnormalities An interview conducted with the Director of Nursing (DON), on 3/4/20 at 2:50 p.m., she indicated she was unsure why Resident 88's weights were not documented on the EMAR or under the vital signs tab in the electronic health record. There should have been documentation as to why the weights were not signed off as completed. A policy titled Weight Policy, undated, was provided by the Director of Nursing on 3/4/20 at 2:25 p.m. The policy indicated the following, .Procedure: .2. Unit Coordinators are responsible for getting monthly or weekly weights and maintaining documentation in PCC (Point Click Care) 3.1-46(a)(1)
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure the appropriate treatment and services were provided to prevent a possible complication of a feeding tube by not flushing the feeding tube after checking for a residual amount. (Resident 54) Findings include: An observation of Licensed Practical Nurse (LPN) 15 checking Resident 54's residual volume, on 3/3/20 at 4:18 p.m., indicated the following: Prior to entering the resident's room, she retrieved her stethoscope from her personal bag, which was in one of the drawers in the nursing station. She then walked into the resident's room, donned gloves, grabbed the syringe which was in an opened, unlabeled plastic bag. The LPN then attached the syringe to gastric tube port and pulled back the syringe until it was full, detached the syringe from the port and placed residual contents into a measured cup. She then repeated the procedure 3 more times until no more gastric contents could be aspirated. The total amount of residual gastric contents was 290 milliliters. She then re-instilled the full 290 milliliters back through the gastric tube. She then capped the gastric tube, rinsed the syringe and measured cup, doffed gloves, and performed hand hygiene prior to leaving the room. LPN 15 did not aspirate the tube for placement, flush Resident 54's gastric tube after re-instilling the residual thus leaving the gastric contents within the tube nor was the plastic bag which contained the syringe labeled with the resident's name or dated. A physician's orders [REDACTED].> (grater) than 60 milliliters, staff were to hold the feeding and administer [MEDICATION NAME]. A physician's orders [REDACTED]. An interview with Director of Nursing (DON) was conducted on 3/3/20. The DON could not answer the question of when checking a resident's residual amount, if the gastric tube should have been flushed after re-instilling the residual. A Gastrostomy or Jejunostomy Feeding procedure provided by the DON on 3/3/20 at 4:49 p.m., indicated, 7. Insert barrel of syringe into tube. Aspirate tube to check for placement and for excess residual. Because amount of residual may affect volume of formula to be given, consult with physician regarding orders for specific resident . Under the Rationale/Amplification for number 7 it stated, b. If there is no excess residual, return gastric contents into the stomach and flush tube first with 30 cc (sic, cubic centimeter) of tap water. Give slowly . In the Guidelines for Cleansing and Storage Syringe section, Wash syringe after each use by flushing thoroughly with tepid water. Store clean syringe in a covered container labeled with resident's name, or in a plastic bag. You may utilize syringe if it can be closed. Replace syringe and storage container every 24 hours or more often if needed. 3.1-44
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely address a resident's pain for 1 of 2 residents reviewed for pain. (Resident 200) Findings include: The clinical record for Resident 200 was reviewed on 2/26/20 at 11:00 a.m. The resident's [DIAGNOSES REDACTED]. The nurse's note, dated 2/26/20 at 8:00 a.m., indicated the Res. (Resident) arrived from (name of hospital) 2/25/20 at 6 pm per ambulance service on stretcher. A/O (alert and oriented,) able to communicate needs. Res. fell at home and has a fx. (fracture) right clavicle. Has a sling to right arm . An interview and observation was conducted with Resident 200 on 2/26/20 at 11:35 a.m. She indicated she hurt everywhere, but mostly her right shoulder. She arrived at the facility at approximately 6:00 p.m. the previous night and was supposed to get a pain pill that night after arriving, but did not receive a pain pill until 9:00 this morning. The physician's orders [REDACTED]. The Controlled Drug Use Record for the above medication indicated the first dose was administered at 9:00 a.m. on 2/26/20. The Weights and Vitals Summary indicated Resident 200's pain level was a 2 on a scale of 1 to 10 on 2/25/20 at 7:12 p.m. An interview was conducted with Resident 200 on 2/28/20 at 3:14 p.m. She indicated she was in so much pain when she admitted to the facility, she didn't know what was going on, but she remembered telling staff her pain was a 10 that first night. An interview was conducted with resident's Family Member 10, on 3/3/20 at 11:48 a.m. He indicated he was present at the facility with his family member was admitted and for several hours on the evening of 2/25/20. The resident was in constant pain that night. An interview was conducted with UC (Unit Coordinator) 9 on 2/28/20 at 3:21 p.m. She indicated, if a resident was in pain and had a PRN pain medication ordered, nursing should ask where the pain was located, the level of the pain, offer the PRN medication, and follow up for effectiveness. If a resident was moaning or it was obvious they were in pain, then nursing could assess that way as well. LPN (Licensed Practical Nurse) 11 was Resident 200's admitting nurse on 2/25/20. An interview was conducted with LPN 11 on 2/28/20 at 3:40 p.m. She indicated she remembered Resident 200 having pain in her shoulder after admission, when she and other nursing staff went into her room to reposition her in bed. She did not offer any pain medication, because her medication orders weren't in the system yet. An observation of Resident 200 was made in the dining room on 2/28/20 at 8:35 a.m. A nurse was present in the dining room. Resident 200 had a grimace on her face, looking down towards her lap. On 2/28/20 at 9:45 a.m., another resident in the dining room informed the nurse in the dining room that Resident 200 was in pain. The nurse then informed Resident 200 that she would get her nurse. On 2/28/20 at 9:50 a.m., a nurse came to the dining room and assisted the resident to the nurses station for pain medication. An interview was conducted with Family Member 10, on 3/3/20 at 11:48 a.m. He indicated the facility couldn't seem to stay ahead of her pain. His family member would tell the aides, but they weren't sure the information was being communicated to the nurses. The Pain Assessment and PRN Medication Administration policy was provided by the DON (Director of Nursing) on 3/2/20 at 10:20 a.m. It indicated, Procedure: 1. Upon knowledge of a resident voicing complaints of pain and/or exhibiting non-verbal signs/symptoms of pain the licensed nurse or QMA (Qualified Medication Aide) shall be notified. 2. If the resident is verbal, the licensed nurse/QMA shall be responsible to inquire as to the location and the intensity of the resident's pain. If the resident is non-verbal he/she should be observed for non-verbal indications of pain (i.e. grimacing, moaning, crying, etc.) 3. The licensed nurse/QMA shall then review the physician's orders [REDACTED]. 3.1-37(a)
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a pharmacist's irregularity report was acted upon in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident 48) Findings include: Resident 48's clinical record was reviewed on 3/3/20 at 1:26 p.m. The resident's [DIAGNOSES REDACTED]., and voice/resonance disorders. The resident was severely cognitively impaired. A physician's orders [REDACTED]. A physician's orders [REDACTED]. A Pharmacist's Medication Regimen Review dated 1/10/20, indicated to, recommend assessing the [MEDICAL CONDITION] PRN (as needed) medications: [REDACTED]. The facility could not provide any information indicating Resident 48's physician had acted upon, provided rationale, or provided a stop date per the pharmacy recommendation as of 3/4/20. An interview with the Director of Nursing (DON) conducted on 3/3/20 indicated a rationale and stop date are needed when responding to the Pharmacist's Medication Regime Reviews. 3.1-25(i)
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prime an insulin pen before administering the

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) dose of insulin for 1 of 5 residents randomly observed for medication administration (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 2/27/2020 at 11:00 a.m. The resident's [DIAGNOSES REDACTED]. On 2/27/2020 at 10:58 a.m., UC (Unit Coordinator) 1 was observed administering insulin to Resident 25. She removed the Basaglar (type of insulin) pen injector from the drawer in the medication cart. She attached the needle to the pen injector. She indicated Resident 25 was to receive 18 units of Basaglar insulin. She dialed the pen injector to read 18 units. She then entered the room and administered the injected the insulin into his abdomen. She did not prime the insulin pen injector prior to dialing the dosage amount. During an interview on 2/27/2020 at 11:15 a.m., UC 1 indicated she did not prime the insulin pen injector prior to use. During an interview on 2/28/2020 at 10:35 a.m., Pharmacist 2 indicated Basaglar pen injectors should be primed with 2 units of insulin prior to each use to assure the accurate dose of insulin is administered to the resident. 3.1-48(c)(2)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to discard 1 resident's expired insulin prior to administration and to ensure medications were not preset for 3 residents that receive medications for 2 of 5 medication carts observed. (Residents 88, 53, 42, and 63) Findings include: 1. An observation of the Willow Commins front medication cart with RN 20, on 3/4/20 at 12:45 p.m., the following was observed: Resident 88 had a basaglar (insulin) pen with an open date of 1/24/20. The RN indicated she works day shift and did not administer Resident 88's evening time insulin so she would not have looked to see the expiration date. A physician's orders [REDACTED].Basaglar KwikPen .Inject 14 unit subcutaneously in the evening The February and March, 2020 Medication Administration Record [REDACTED]. 2. During an observation of the Willow Commins back medication cart with RN 22, on 3/4/20 at 12:35 p.m., 3 medication cups were observed stacked in the narcotic locked compartment. The RN indicated the medications were noon medications that were preset for Resident's 53, 42, and 63. a. A medication cup was identified as Resident 53's [MEDICATION NAME] caplet. A physician's orders [REDACTED]. b. A medication cup was identified as Resident 42's [MEDICATION NAME] and duloxetine capsules. A physician's orders [REDACTED]. A physician's orders [REDACTED]. c. A medication cup was identified as Resident 63's two tablets of accetaminophen. A physician's orders [REDACTED]. On 3/4/20 at 12:36 p.m., RN 22 indicated she usually did not preset her medications for administration An interview conducted with the Director of Nursing (DON), on 3/4/20 at 2:13 p.m., she indicated nurses should not preset medications. The nurses and pharmacy should audit the carts for expired medications. A policy titled Medication Storage, dated 11/17, was provided by the DON on 3/4/20 at 3:23 p.m. The policy indicated the following, .Medications housed on our premises are stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations 3.1-25(b)(5) 3.1-25(o)
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dental services were provided timely, and to coordinate a resident's dental appointment for 4 of 6 residents reviewed for dental services. (Resident 53, 74, 94 and 118) Findings include: 1. The clinical record for Resident 53 was reviewed on 2/27/20 at 10:00 a.m. The resident's [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident 53 was cognitively intact. A dental consent indicated Resident 53's representative signed a consent, on 1/22/20, for dental services. A nursing progress note, dated 1/3/20, indicated Res (Resident 53) informed nurse at 11:20 a.m. that while eating the breakfast casserole this morning she felt something hard in her mouth. She put the pieces aside and continued eating. By the time she thought to look at it closer it was gone. Res thinks it may have been an old filling. Res denies all pain and discomfort. Social services will be notified . A quarterly dental assessment, dated 2/12/20, indicated Resident 53 had natural teeth and no decay. The resident .wishes to see dentist when available, she feels she might of lost a filling in natural upper tooth .SS (Social Services) aware . An interview was conducted with Resident 53 on 2/27/20 at 9:25 a.m. She indicated she needed to see the dentist. She had lost a filling about a month ago and have been waiting to see the dentist. On 2/28/20 at 3:05 p.m., Social Services 25 provided the following past dental visits and the future dental visits. The dental visit, dated 1/23/20, indicated Resident 53 had not been seen. The dental hygienist visit, dated 2/19/20, indicated a hand written note to add Resident 53. The resident had not been seen. The dental hygienist visit, dated 3/3/20, indicated the resident was not on the list to be seen. An interview was conducted with Social Services (SS) 25 on 3/2/20 at 8:56 a.m. She indicated Resident 53 had not been seen. The facility had just changed dentists. She had written the note on 2/19/20 to add Resident 53 on the next visit. An interview was conducted on SS 25 at 3/20/20 at 9:15 a.m. She indicated Resident 53 would be seen on 3/3/20 by the hygienist, and on 3/31/20 to see the dentist. 2. The clinical record for Resident 74 was reviewed on 2/27/20 at 9:00 a.m. The resident's [DIAGNOSES REDACTED]. An Annual MDS Assessment, dated 11/27/19, indicated the resident was cognitively intact. An interview was conducted with Resident 74 on 2/27/20 at 8:57 a.m. She indicated she would like to see the dentist, but she had not seen the dentist in a while. The facility had just changed dentists and she had not seen him yet. A staff dental assessment, dated 11/27/19, indicated Resident 74 had front right lower tooth obvious decay . A staff dental assessment, dated 1/21/20, indicated Resident 74 had front right lower tooth obvious decay A dental treatment consult, dated 12/18/19, indicated an oral exam was conducted. The recommendations were for Resident 74 to have .extract problematic root tips if pt (patient) desires, repair decay if pt desires . An interview was conducted with SS 25 and Social Services Assistant (SSA) on 3/2/20 at 8:56 a.m. SS 25 indicated Resident 74 had not been seen by the dentist, because she did not have a signed consent. Social Services were having trouble reaching Resident 74's family member to sign the consent for dental services. The facility had changed dentist and needed consents to be signed for the new dentist. SSA indicated we have tried to discuss dental services with the family member, but unable to get a response from him. SSA indicated Resident 74 had voiced in the past, she liked for her family member to go over services prior to signing. The next step would be to send a certified letter to the family or we could talk with Resident 74 to see if there was another family member we could reach out too. 3. The clinical record for Resident 118 was reviewed on 3/3/20 at 1:14 p.m. The [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) assessment, dated 2/8/20, indicated the resident was cognitively intact. An interview conducted with Resident 118, on 2/26/20 at 1:48 p.m., she indicated it has been over a year since she had seen the dentist. A form titled Dental Services, dated 11/23/18, indicated the following, .Pt. (patient) complaints of upper denture moving during biting .Recommendations: File PA (term for authorization) for reline upper denture which may improve fit slightly There were no further dental consult forms noted in Resident 118's clinical record. A care plan, revised 8/21/19, indicated the following, .(name of Resident 118) at risk for oral/dental health problems .8/9/19 (name of Resident 118) has upper denture and lower natural teeth .Interventions .Coordinate arrangements for dental care An interview conducted with the Social Service Assistant, on 3/4/20 at 9:27 a.m., indicated Resident 118 was not seen by the dentist in 2019 because the company the provided dental services did not add her to their list. 4. The clinical record for Resident 94 was reviewed on 2/27/20 at 2:00 p.m. The [DIAGNOSES REDACTED]. The Annual MDS assessment, dated 9/18/20, indicated the resident had broken or loosely fitting full or partial dentures. The Quarterly MDS assessment, dated 1/21/20, indicated he had moderately impaired cognition. An interview and observation was conducted with Resident 94 on 2/27/20 at 2:09 p.m. He indicated his dentures did not fit properly, and slid around in his mouth. He had informed staff, but was unsure if anything was done about it. He had dentures in his mouth at this time. The dental care plan, revised 10/2/19, indicated Resident 94 was edentulous. His dentures were loose fitting, and he did not wear them. An intervention was to coordinate arrangements for dental care and transportation as needed. The dental note, dated 1/23/20, indicated on 1/23/20 Attempt #1-pt (patient) was at church. Attempt #2-Pt was getting ready to leave for a doctor's appointment and will be rescheduled per facility. An interview was conducted with UC 12 on 3/3/20 at 2:33 p.m. She indicated, when she confirmed Resident 23's 1/23/20 dermatology appointment, she was unaware of the dental appointment was scheduled for the same day. An interview was conducted with the SSA (Social Services Assistant) on 3/3/20 at 2:25 p.m. She

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F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) indicated she was responsible for scheduling dental appointments on the unit. She tried to coordinate appointments with nursing by emailing the unit coordinators a list of residents who will be seen by dental to avoid any conflicts. She did not recall being notified of Resident 94's dermatology appointment date of 1/23/20. An observation of Resident 94 was made on 3/2/20 at 11:09 a.m. He was not wearing his dentures. An observation and interview was conducted with Resident 94 on 3/2/20 at 11:50 a.m. He was not wearing his dentures and suggested they may be in one of his drawers. Several drawers were observed, but the dentures could not be located. An observation of Resident 94 eating lunch in the dining room was made on 3/3/20 at 1:22 p.m. He was not wearing his dentures. An interview was conducted with UC 9 on 3/3/20 at 1:37 p.m. She indicated she was unsure why Resident 94 did not wear his dentures, but she knew he had a history of [REDACTED].Purpose: To ensure that each resident receives adequate dental services and assure facility staff are providing proper oral hygiene Policy: It is the policy of (name of facility) that each resident will be provided assistance in obtaining routine and emergency dental care. It is further the policy that an agreement will be maintained with a consulting dentist .A licensed nurse and/or the Social Services Director will assist in arranging preventative, restorative and emergency dental services upon need or at the request of the resident and in coordination with the attending physician. 3.1-24(a)(1) 3.1-24(b)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to ensure that food was stored properly and that thermometers were present in a cold bar refrigerator. This had the potential to affect 135 of 135 residents who eat food out of the kitchen. Findings include: On 2/27/2020 at 9:10 a.m., kitchen 1 was observed with the HCD (Health Center Dietician). A rolling bin with storage containers was present under the counter. One of the storage containers was labeled as containing gelatin. The lid was removed and a silver scoop was present inside the container, with the handle of the scoop touching the gelatin. A container, labeled as containing sugar, was opened and a clear measuring cup was present inside the container with the handle touching the sugar. During an interview on 2/27/2020 at 9:20 a.m., the HCD indicated scoops and measuring cups should not be stored inside of the containers, with handles touching the food items. On 2/28/2020 at 11:30 a.m., kitchen 2 was observed with the HCD. The sandwich bar refrigerator was observed. There was no thermometer present in the refrigerator to measure the temperature. During an interview on 2/28/2020 at 11:45 a.m., the KM (Kitchen Manager) 3 indicated that a thermometer should have been present in the sandwich bar refrigerator. On 2/28/2020 at 1:00 p.m., the HCD provided the Monitoring of Cooler/ Freezer Temperature Policy, revised 1/1/2020, which read Policy: It is the policy of this facility to maintain temperatures of coolers and freezers at appropriate temperature to promote food safety. This policy also addresses refrigerated storage. Policy Explanation and Compliance Guidelines .2. Thermometers shall be placed inside each cooler/ freezer and calibrated at least once per week . 410 IAC 7-24-234 In-use utensils; between-use storage Sec. 234. (a) During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored in one (1) of the following ways: (1) Except as specified under subdivision (2), in the food with their handles above the top of the food and the container. (2) In food that is not potentially hazardous with their handles above the top of the food within containers or equipment that can be closed, such as bins of ice, sugar, flour, or cinnamon. (3) On a clean portion of the food preparation table or cooking equipment if both the in-use utensil and food-contact surfaces of food preparation tables or cooking equipment are cleaned and sanitized at a frequency specified under section 296, 297, or 303 of this rule. (4) In running water of sufficient velocity to flush particulates to the drain if used with moist food, such as ice cream or mashed potatoes. (5) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous. (6) In water maintained clean and at a temperature of at least one hundred thirty-five (135) degrees Fahrenheit. (b) For purposes of this section, a violation of subsection (a) is a noncritical item. 3.1-21(i)(3)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to glove use, medical equipment cleaning, hand hygiene, and wound care for 3 of 4 residents reviewed for infection prevention. (Resident 25, 78 and 93) Findings include: 1. The clinical record for Resident 25 was reviewed on 2/27/2020 at 11:00 a.m. The resident's [DIAGNOSES REDACTED]. On 2/27/2020 at 10:58 a.m., UC (Unit Coordinator) 1 was observed administering insulin to Resident 25. She entered Resident 25's room and placed the [MEDICATION NAME] (type of insulin) pen injector on the table next to his bed. She cleansed in abdomen with an alcohol swab, removed the top of the pen injector and administered the medication to him. She wiped the injection area with an alcohol swab. She did not wear gloves prior to administering the injection. She then preformed hand hygiene and left the room. She went to the medication cart and obtained a temporal thermometer. She dropped the temporal thermometer on the floor, picked it up and entered the room. She sat the thermometer on the resident's bedside table and washed her hands. She then obtained Resident 25's temperature, using the temporal thermometer. She did no cleanse the thermometer prior to using it. During an interview on 2/27/2020 at 11:15 a.m., UC 1 indicated she should have worn gloves while administering the insulin injection and that she should have cleansed the temporal thermometer, after it fell of the floor, prior to using it. 2. The clinical record for Resident 78 was reviewed on 2/28/2020 at 8:26 a.m. The resident's [DIAGNOSES REDACTED]. On 2/28/2020 at 8:26 a.m., RN 3 was observed administering medications to Resident 78. She obtained the medications from the medication cart and put them into a medication cup. She indicated that Resident 78 needed to have her medications crushed to aide in swallowing them. She then obtained a plastic sleeve from the medication crushing device. She had difficulty opening the plastic sleeve, she licked her fingers and attempted to open the plastic sleeve with the fingers she had licked. She was able to open the plastic sleeve and put the medications from the medication cup into the plastic sleeve, crushed them, and then emptied them into another medication cup. She mixed the medications with applesauce and administered them to Resident 78. During an interview on 2/28/2020 at 10:25 a.m., the DON (Director of Nursing) indicated RN 3 should not have licked her fingers to assist her in opening the plastic medication sleeve. On 2/27/2020 at 1:32 p.m., the DON provided the Hand Washing/ Hand Hygiene Policy which read Purpose: Hand washing is the single most important measure for preventing the spread of infection .Note: Remember, when a Resident's body is weakened by illness of any kind, even his/her own germs can be a danger to him/her. It is your responsibility to minimize the spread of germs in the nursing facility by keeping the Resident, his/her surroundings, and yourself as clean and free of germs as possible . 3. An observation, on 3/4/20 at 9:32 a.m., of Certified Nursing Assistant (CNA) 13 performed incontinent care on Resident 93. The CNA had washed her hands upon entering the resident's room, donned her gloves, placed towels in tub of warm water, and removed the resident's pillow that was under her right side. She washed the resident's face, moved to lower abdomen and then noticed the resident had a bowel movement so she rolled the resident onto her left side and provided incontinent care. She removed the soiled coccyx dressing and cleansed the area. She then applied a cream around the wound area with the same gloves she had used to perform incontinent care. A cleaning spray was used during the incontinent care and she handled the spray bottle without changing her gloves. She placed the spray bottle on the resident's sheets. Upon completion of care and still wearing the same gloves, she placed a sheet and blanket on the resident and touched the resident's bedside table 3 times. An interview with the Director of Nursing (DON), on 3/4/20 at 11:34 a.m., she indicated the CNA should have changed her gloves after performing incontinent care and used clean gloves to apply cream to a wound site. She should not place soiled items on a resident's bed or touched a resident's bed side table with dirty gloves. Proper hand hygiene should be practiced throughout the facility. On 3/4/20 at 10:11 a.m., an observation was made of Licensed Practical Nurse 14 entering Resident 93's room carrying a cup. LPN 14 asked the resident if she would like some of the shake and when the resident indicated she would. The LPN donned one glove to assist the resident with drinking. LPN 14 then donned another glove and proceeded to apply the resident's pain patches. When she was done, she doffed her gloves and performed hand hygiene. LPN 14 had not performed hand hygiene prior to entering Resident 93's room nor prior to donning gloves. A Complete Bed Bath procedure policy received on 3/4/20, by DON indicated, 31. Conduct handwashing procedure before and after direct resident care. Wear non-sterile disposable gloves in the presence of visible blood, gross contamination or potential exposure, and other protective equipment or clothing as indicated. Wash hands after removing gloves. A glove use policy could not be provided by the facility. The Handwashing/Hand Hygiene policy received on 3/4/20, from DON indicated, Hand hygiene shall be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING _____ B. WING _____	**03/04/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) maintained as per CDC guidance addressing handwashing as well as per guidance addressing alcohol-based hand rubs . The CDC guidance provided by the CDC website indicated, Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. 3.1-18(a) 3.1-18(l)