

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155177	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2023
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP COD 2741 N SALISBURY ST WEST LAFAYETTE, IN 47906
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00407001.</p> <p>Complaint IN00407001 - Federal/State deficiencies related to the allegations are cited at F600.</p> <p>Survey dates: April 26 and 27, 2023</p> <p>Facility number: 000093 Provider number: 155177 AIM number: 201271750</p> <p>Census bed type: SNF: 8 SNF/NF: 61 Residential: 37 Total: 106</p> <p>Census payor type: Medicare: 8 Medicaid: 1 Other: 60 Total: 69</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review was completed on May 9, 2023.</p>	F 0000	<p>This plan of correction is to serve as Westminster Village West Lafayette's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Westminster Village West Lafayette or the management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Our plan of correction is prepared and executed as a means to improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
F 0600 SS=D Bldg. 00	<p>483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Benjamin Blankenship	Health Facility Administrator	05/18/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 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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	<p>freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was free from abuse when a staff member did not follow the facility's abuse policy or the employee handbook for use of a phone in a work area and a second staff member did not follow the facility's abuse policy and report abuse for 1 of 1 resident reviewed for abuse through the use of phone technology. (Resident B)</p> <p>Findings include:</p> <p>A concern was received by email from former Staff Member 13 indicating a photo of a resident was sent to her from a former co-worker. She was not a current employee, but since she had worked at the facility in the past, she knew who the resident in the photo was and wanted to report the incident to the Indiana Department of Health. The concern indicated the resident in the photo was laying on the floor in a soiled gown, her sheets from her bed were sitting in the trash can and her bed was not made. There was no wheelchair by her bed. The photo was taken of an exposed resident laying on the floor and was sent to people.</p> <p>The photo of the resident was observed. The resident was laying on her left side between her bed and the wall in front of her nightstand, with her back to the camera. The back of her gown was</p>	F 0600	<p>It is the practice of Westminster Village West Lafayette to ensure residents are free from abuse and to follow the facility's abuse policy as well as the employee handbook for use of a phone in a work area.</p> <p>I. Resident B had no negative consequences from the alleged deficient practice. CNA 6 is no longer employed by Westminster Village West Lafayette. CNA 7 is on medical leave and will not be permitted to continue employment at Westminster Village West Lafayette at termination of leave.</p> <p>II. The community realizes all residents have the potential to be affected. Interviews of residents conducted for compliance or concerns with abuse, resident rights and usage of cell phones in resident areas.</p> <p>III. The Cell Phone Usage Policy, Federal Resident Rights and the Abuse and Neglect Policy has been reviewed and found to</p>	06/01/2023
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	<p>open exposing her back and her brief. Her gown was laying under her left arm and had a brown substance on it. She was barefooted.</p> <p>The record for Resident B was reviewed on 4/27/23 at 11:45 a.m. Diagnoses included, but were not limited to, type 1 diabetes mellitus, osteoarthritis, hyperkalemia, cerebral ischemia, major depressive disorder, Alzheimer's Disease, chronic kidney disease, persistent mood disorder, and anxiety disorder.</p> <p>An Interdisciplinary Note, dated 4/23/23 at 1:04 p.m., indicated Resident B was found on the floor by her bed on her left side. She was assisted up by three staff members with a gait belt. She had originally refused to get up earlier in the morning and staff went to her room to check if she was ready to get up for lunch when they found her laying on the floor. She received a skin tear to her left forearm measuring 2.5 cm (centimeters) by 1.7 cm.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 4/18/23, indicated Resident B's BIMS (Brief Interview for Mental Status) was scored at a 10 out of 15, which indicated she was moderately cognitively impaired. She required extensive assist of two person for bed mobility, transfers, dressing, and toilet use.</p> <p>Resident B had a care plan, which addressed the problem she had impaired cognition related to her diagnosis of dementia. Interventions included, but were not limited to, maintain daily schedule which she could depend on for increased comfort and familiarity. Started 8/9/21.</p> <p>Resident B had a care plan, which addressed the problem she was at risk for decreased activities of</p>		<p>meet clinical standards. The Employee Handbook has also been reviewed and found to meet standards.</p> <p>Education provided to all Health Center Staff on the above policies and employee handbook including dignity, resident rights, elder justice act, crimes against residents, unauthorized photographs and investigation of potential abuse.</p> <p>IV. The Director of Nursing and Social Services Coordinators or designee(s) will: Interview three (3) random staff members and three (3) random residents for compliance or concerns with abuse, resident rights and usage of cell phones in resident areas, daily, Monday through Friday, for 4 weeks, twice weekly for 3 months, weekly for 3 months, then monthly for a total duration of 12 months.</p> <p>Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for</p>	

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	<p>daily living abilities due to her cognitive impairment. She required assistance with bed mobility, transfers, toileting, eating, and other ADL's secondary to her diagnoses of type 1 diabetes mellitus with diabetic neuropathy, anxiety, Alzheimer's disease with dementia, osteoarthritis, venous insufficiency, pain in lower leg and right radial and ulna fractures. Interventions included, but were not limited to, provide privacy and dignity. Started 8/3/21.</p> <p>During an interview, on 4/26/23 at 11:02 a.m., the DON (Director of Nursing) was shown the photo of the resident laying on the floor, and she indicated she could identify the resident by the lamp sitting on her table. She was unaware the photo had been taken or which employee could have taken it. Resident B had a fall, on April 23, 2023, so she thought the picture was taken on that day.</p> <p>During an interview, on 4/26/23 at 11:57 a.m., RN 3 indicated Resident B refused to get out of bed or eat breakfast the morning of 4/23/23. She was found on the floor on 4/23/23 at 11:15 a.m., when two CNAs went into her room to check if she was ready to get up for the day.</p> <p>During an interview, on 4/26/23 at 12:41 p.m., CNA 6 indicated she and CNA 8 found Resident B on the floor on 4/23/23 at approximately 11:15 a.m., when they went into her room to see if she was ready to get up for the day. When CNA 8 went to get the Hoyer lift, she snapped the picture of Resident B laying on the floor and sent it to CNA 7 privately as a message via Snapchat (a social media communication application). When asked why she took the photo of Resident B, she indicated she was having a bad day. One of her favorite residents passed away, everyone left their</p>		<p>review.</p> <p>V. The facility will be in and remain in compliance by: June 1, 2023.</p>	
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	<p>work for her to do, and then Resident B fell. She took the picture to send to CNA 7, not as a malice intent, but to vent to her how her day was going. She did not think CNA 7 would share the picture with anyone else.</p> <p>During a phone interview, on 4/26/23 at 2:11 p.m., Former Staff Member 13 indicated CNA 7 sent the photo of Resident B to her. She knew the picture was a form of abuse, so she emailed the office of Indiana State Department of Health and reported it.</p> <p>During a phone interview, on 4/26/23 at 2:21 p.m., CNA 7 indicated CNA 6 sent her a picture of Resident B laying on the floor by the texting feature of Snapchat, after she asked how Resident B was doing. She had been off work on FMLA (Family Medical Leave of Absence) and wondered how some of the residents were doing while she was off work. She sent the picture of Resident B laying on the floor to Former Staff Member 13 who had been asking how Resident B was doing.</p> <p>A current policy, titled "Cell Phone Usage," dated as revised 09/2008 and provided by the DON on 4/26/23 at 2:30 p.m., indicated "...Procedure...unless properly authorized, employees will refrain from the use of any form of personal electronic communication device during normal work hours. These devices should be turned off during work hours and stored in a secure place such as a locker. Authorization from the supervisor must be obtained before an employee may carry a personal electronic communication device on their person on the work site. These devices may be used during breaks or when employees are at lunch. They must be used in employee break areas and not used in work areas, public hallways or resident</p>			

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	<p>common areas. Employees whose electronic communication devices are camera-enabled are restricted from using these devices anywhere in the building or on the company property at anytime. Further, employees who are found to have used these camera-enabled features will be subject to progressive discipline...."</p> <p>A current policy, titled "Federal Resident Rights," dated 11/28/2016 and provided by the DON on 4/26/23 at 2:30 p.m., indicated "...A facility must treat each resident with respect and dignity and care for each resident in a manner and in an 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...Respect and dignity. The resident has a right to be treated with respect and dignity...."</p> <p>A current policy, titled "Abuse and Neglect," dated with a revision date of February 2021 and provided by the DON on 4/26/23 at 2:30 p.m., indicated "Purpose...To ensure that each resident is free of...material exploitation. To ensure employees are monitored for signs or symptoms of stress that could lead to abuse and neglect...Policy...The safety and welfare of the residents entrusted to our care shall be maintained at all times. Definitions: Abuse-is the willfully [sic] infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...MENTAL ABUSE includes, but is not</p>			

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	<p>limited to, humiliation, harassment, and threats of punishment or deprivation. The procedures for reporting and documenting mental abuse are the same as reporting physical abuse...TRAINING: Employees are monitored for signs or symptoms of stress that could lead to abuse/neglect such as: physical, i.e. headaches, chronic fatigue, nail biting, tense Emotional, i.e. anger, hostility, apathy, crying, irritability, depression, repeatedly speak of "working short" Intellectual, i.e. indecisive, preoccupied, forgetfulness, poor communication skills Social, i.e. withdrawn from others, criticism of others, dominating, stress in personal life, Spiritual, i.e. low self-esteem, lack of lack of commitment to values. The following strategies are encouraged when employees display signs or symptoms of stress such as: Remove yourself from the situation (if the resident is safe), Ask co-worker for assistance, count to ten and take deep, slow breaths, repeat a favorite saying or song in your mind, Schedule time off, and seek outside assistance. All information regarding employees, residents, and their families is confidential and is not to be discussed either inside or outside of the facility...REPORTING: 1. Any suspicion of abuse/neglect must be reported to the Charge Nurse, Administrator and Director of Nursing Services...."</p> <p>A current policy, titled "Employee Handbook," dated as revised 2021 and provided by the DON on 4/26/23 at 2:30 p.m., indicated "...Employee Use of Cell Phones...Employees are encouraged to use cell phones on personal break times or meal periods and encouraged to store phones in employee lockers. The "use" of cell phones includes but is not limited to: phone calls, texting, Internet, etc. Employees are not permitted to use cell phones while providing any service or care for residents or families, Employees should avoid the</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2023
FORM APPROVED
OMB NO. 0938-039

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	<p>use personal or company cell phones in public view including but not limited to lobbies, corridors, dining rooms, etc...Blogging and Electronic Disclosure of Confidential Information...You may not take or post photos of Westminster Village and/or coworker, client, and/or community resident without the express written permission of Westminster Village, the coworker, client and/or community resident. You may not post personal information about the Company, coworkers, clients and/or community, residents, including general addresses or locations any information which would be construed by the coworker, client and/or community resident to be personal or an invasion of their privacy...."</p> <p>This Federal tag relates to Complaint IN00407001.</p> <p>3.1-27(a)(1) 3.1-28(c)</p>			