

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2014
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NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of complaint #IN00150427.</p> <p>Complaint number IN00150427 substantiated. Federal/State deficiencies related to the allegation are cited at F-314.</p> <p>Survey Dates: June 12, 13, 16, 17, 18 and 19, 2014.</p> <p>Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530</p> <p>Survey Team: Mary Weyls RN TC Kewanna Gordon RN Lora Brettnacher RN June 16, 17, 18 and 19, 2014 Laura Brashear RN June 13, 2014 Brenda Marshall RN June 13, 2014</p> <p>Census Bed Type: SNF/NF: 107 Total: 107</p> <p>Census Payor Type: Medicare: 31 Medicaid: 36</p>	F000000	<p>This plan of correction is submitted under Federal and State Regulations and status applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan of correction does not constitute agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitutes deficiency, or that the scope and severity of any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance. Westside Village Health Center respectfully requests paper compliance for this survey.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000242 SS=E	<p>Other: 40 Total: 107</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2- 3.1</p> <p>Quality review completed June 27, 2014 by Brenda Marshall, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents were assessed for and given a choice regarding their preferences of frequency of bathing/showers for 3 of 3 residents reviewed who met the criteria for choices (Residents #53, #73, and #224).</p> <p>Findings include:</p> <p>1. During an interview on 6/13/2014 at 10:08 A.M., Resident #53 indicated the facility had not inquired of her what her</p>	F000242	Residents #53, #73, and #224 were interviewed to determine if their schedule for shower and/or bath were satisfactory. Other residents in the facility were interviewed to determine if their schedule for shower and/or bath were satisfactory. Any residents identified as wanting to change the frequency, time or style of bathing were adjusted accordingly. In the future new admits will be interviewed to determine their choice of time, frequency, and style of bathing that they prefer within 72 hours of admission by Social Services	07/18/2014

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	<p>preference was for frequency of showers. She indicated the facility had a schedule and she received two showers a week.</p> <p>Resident #53's record was reviewed on 6/19/14 at 10:50 A.M. An annual Minimum Data Assessment Tool (MDS) dated 12/11/14, indicated Resident #53 was cognitively intact with a Brief Mental Interview Status (BIMS) score of 15 out of 15 and making choices regarding bathing was very important to her. The record lacked documentation Resident #53 had been assessed for shower frequency preference.</p> <p>2. During an interview on 6/13/2014 at 10:11 A.M., Resident #73 indicated the facility had not inquired of her what her preference was for frequency of showers. She indicated the facility had a "set schedule" and she received showers twice a week.</p> <p>Resident #73's record was reviewed on 6/19/14 at 10:50 A.M. An annual Minimum Data Assessment Tool (MDS) dated 04/09/14, indicated Resident #73 was cognitively intact with a Brief Mental Interview Status (BIMS) score of 15 out of 15 and making choices regarding bathing was very important to her. The record lacked documentation Resident #73 had been assessed for</p>		<p>Director or designee. Residents will be interviewed during their routine care plan meeting to determine if their preference has changed. New admits will be audited to determine if they were interviewed on choice within a week following admission for 6 months to determine compliance by the Administrator or designee. Results of audits will be reviewed by the Quality Assurance Committee on a monthly basis for follow up and to determine if any further intervention is needed.</p>	

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	<p>shower frequency preference.</p> <p>3. During an interview on 6/13/2014 at 1:50 P.M., Resident #224 indicated the facility had not inquired what her preference was regarding frequency of showers. She indicated the facility had a "set schedule" and she received showers on Tuesdays.</p> <p>Resident #224's record was reviewed on 6/19/14 at 9:20 A.M. An annual Minimum Data Assessment Tool (MDS) dated 04/28/14, indicated Resident #224 was cognitively intact with a Brief Mental Interview Status (BIMS) score of 15 out of 15, and making choices regarding bathing was very important to her. The record lacked documentation Resident #224 had been assessed for shower frequency preference.</p> <p>During interview with the Executive Director on, 6/19/14 at 12:14 p.m., a policy was requested regarding residents choices and he was unable to provide this information.</p> <p>During an interview on 6/19/14 at 9:35 A.M., the Director of Nursing (DON) indicated the facility did not currently inquire of residents what their preferences were for shower frequency.</p>			

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F000247 SS=D	<p>3.1-3(u)(3)</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on interview and record review the facility failed to ensure a resident was given notice of a new roommate prior to the roommate moving into her room. This deficient practice affected 1 of 22 residents reviewed for roommate change/room change notice (Resident #28).</p> <p>Findings include:</p> <p>During an interview on 6/13/14 at 10:24 A.M., Resident #28 indicated she received a roommate and had not been given notice prior to the roommate moving into her room.</p> <p>Resident #28's record was reviewed on 6/19/2014. An Admission Minimum Data Set Assessment Tool (MDS) dated 4/29/14, indicated Resident #28 was cognitively intact with a Brief Interview Mental Status Score (BIMS) of 15 out of 15. Resident #28's record lacked documentation which indicated she had been notified of a new roommate.</p>	F000247	Resident #28 was interviewed to assure that the roommate residing with her was appropriate. Residents that received new roommates in the past 30 days will be interviewed to assure their roommates are appropriate. In the event that someone is not satisfied with whom they are residing will be offered a room change. If a room change cannot be accommodated they will be placed on a waiting list for an appropriate room. Any time a resident will be getting a roommate due to a new admission the Admissions Director will notify the current resident prior to the new admission moving in and documented appropriately. Any resident getting a new roommate due to a room change will be notified by the Social Service Director and documented appropriately. The Administrator or designee will be responsible to audit the documentation of roommate changes within 72 hours of change for 6 months and reported to the Quality Assurance	07/18/2014

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	<p>During an interview on 6/18/14 at 10:07 A.M., the Social Service Assistant (SSA) #2 indicated Resident #28 received a new roommate on May 15, 2014. She indicated documentation was not available which indicated Resident #28 had been provided notification prior to receiving the new roommate.</p> <p>An undated policy titled "Resident Room Relocation" identified as a current policy by the Administrator on 6/19/2014 at 12:14 P.M., indicated, "...As members of the Interdisciplinary team, the Social Services staff are involved in all resident room relocations. The resident's social, emotional, and cognitive needs are assessed and considered before relocating a resident... The Social Services staff develop a plan to ensure that the needs and concerns related to the resident's ability to cope and adjust to the relocation are addressed by taking the following steps. 1. Providing the resident, legal guardian, and interested family member with a verbal notice and documenting this in the medical record... 3. Introducing the resident to his or her new roommate...."</p> <p>3.1-3(v)(2)</p>		Committee on a monthly basis to assure compliance or need for further intervention.				

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview the facility failed to avoid use of adaptive equipment known to cause a pressure area to the foot, resulting in a stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) for 1 of 3 residents reviewed for pressure ulcers. (Resident 63)</p> <p>Findings include:</p> <p>During observation on 6/18/14 at 10:27 a.m., the wound nurse provided a treatment to Resident #63's right outer ankle and right lateral foot.</p>	F000314	<p>Resident #63 wounds are healed. The boot has been placed in the trash.</p> <p>Other residents with adaptive equipment have the potential to be affected by the deficient practice. An audit has been completed to ensure adaptive equipment is appropriate for the resident by members of the nursing management team. An order will be obtained. The careplan and care directive will be updated accordingly by nursing management by July 18, 2014</p> <p>The nursing staff has been educated on validating any new adaptive equipment is appropriate for the resident by the Staff Development Coordinator &/or designee by July 18, 2014. All staff, therapy included, are instructed not to place any adaptive equipment in or on a</p>	07/18/2014

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	<p>During interview of the "Wound Nurse" on 6/16/14 at 1 p.m., the nurse indicated the resident's two pressure areas on the right foot were caused by a boot that had been placed on the resident's foot. The wound nurse indicated the boot had been implemented in May of 2013, from a therapy recommendation, hoping to improve the contracture of the resident's right foot and that the boot had caused pressure areas to the resident's foot and the boot was removed. The nurse indicated the wounds healed, however on April 30th, 2014 the boot was placed back in the resident's room, and a CNA placed the boot on the resident. The resident was then taken out for a Physician's appointment and was out of the facility for several hours and when returned, the boot was removed and two pressure areas were observed on the resident's right foot.</p> <p>During interview of the DON (Director of Nursing) on 6/19/14 at 9:30 a.m., the DON indicated when the boot was discontinued in May of 2013, the boot was placed in the unit manager's office. When the unit manager was cleaning her office, she placed the boot back in therapy. The DON indicated on, 4/30/14, the boot was placed back in the resident's room. The DON indicated she wasn't sure</p>		<p>resident without validating equipment with the charge nurse. For new adaptive equipment, an order will be obtained. The resident's careplan and care directive will be updated accordingly. Nursing management will conduct daily clinical rounds using the care directives, as well validate current physician orders, to observe for any adaptive equipment implemented without following the proper procedure. The results of these rounds will be reported to the Performance Improvement committee monthly for 6 months. The Performance Improvement Committee will determine if further auditing is required.</p>	

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	<p>how the boot was removed from the therapy department and ended up back in the resident's room. The DON indicated the CNA caring for the resident on 4/30/14, was a new employee.</p> <p>Resident #63's clinical record was reviewed on 6/18/14 at 10:44 a.m. A NP's (nurse practitioner) progress note, dated 4/30/14, indicated "Nursing requested visit [due to] OA [open area] found on [right ankle] today. Has been wearing shoe to foot this week. Hx [history] of OA [open area] [with] MRSA [methicillin resistant staphylococcus aureus] to same area." (R) [Right] ankle OA with yellow slough and area of black eschar 4 X 2 cm [centimeter] plus serous d/c [discharge]. (R) [right] Lat [lateral] foot 2 x 1 cm [centimeter] area of hyperpigmentation.</p> <p>Review of a form titled "Pressure Ulcer Status Record", documentation on, 5/6/14, indicated the resident's open area on the right lateral foot was unstageable and measured 1.0 cm x 2.0 cm. Documentation on, 6/7/14, indicated the area was a stage 3 measuring 0.3 cm x 0.7 cm with 0.1 cm depth.</p> <p>An "IU (Indiana University) Geriatrics Subsequent Visit Form", dated 6/12/14, had a NP (Nurse Practitioner) progress</p>			

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F000371 SS=E	<p>note indicating, "PU (pressure ulcer) [stage] 3 (R) right ankle-improving. Continue with dressing change orders and pressure relief.</p> <p>A policy and procedure titled "Pressure Ulcer Prevention Program Overview" dated, 10/07/2010, received on 6/19/14 at 11:20 a.m. from the Administrator, indicated, but was not limited to, "Follow the residents' care plans and update as necessary."</p> <p>This federal tag relates to complaint IN00150427.</p> <p>3.1-40(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on interview, observation, and record review the facility failed to ensure that foods were labeled to identify the food item and/or date opened for 1 of 1 kitchen observed and failed to ensure proper hand sanitation and handling of food containers to prevent contamination during dining service for 2 of 3 dining areas observed. This deficient practice</p>	F000371	Dietary Manager inspected refrigerators, freezers, and dry storage area and discarded any items that were not labeled and dated. There were no residents that were negatively affected by the alleged deficient practice. Dietary Staff were inserviced by the Registered Dietician on properly labelling and dating of food items and staff that	07/18/2014

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	<p>had the potential to affect 86 of 87 residents being served food from the dietary department.</p> <p>Findings include:</p> <p>1. During a tour of the kitchen with the Dietary Manager (DM) on 6/12/14 at 9:51 a.m., the following foods were found improperly stored in the walk in refrigerator:</p> <ul style="list-style-type: none"> -shredded cheese with no open date -shredded carrots with an open date of "5/20 " -cottage cheese "opened 6/3 " -cottage cheese "opened 6/6 " -ranch dressing with a received date of "10/4" and no open date or discard date -french dressing labeled "5/30" with no open date or discard date -container identified by the DM as " egg salad "dated 6/11/14" with no identifying label -undated tomato mixture in tin container with no date or identifying label <p>The Dietary Manager was observed discarding several of the improperly labeled items listed above at this time.</p> <p>During an interview with the Dietary Manager on 6/12/14 at 10:26 a.m., she indicated, she thought cottage cheese has until the expiration date printed by the</p>		<p>work in Dining Rooms and/or kitchens have been inserviced on Proper Food handling including utensils, plates, and glassware. The Dietary Manager will make documented inspections 3 times per week for 6 months of Food Storage Areas to assure there are no unlabeled and/or dated items. The Dietary Manager will make documented reviews of the food handling in the dining rooms to assure staff are properly handling food and plates, glassware, and utensils as well as proper handwashing is taking place. The reviews will occur 3 times per week for 6 months. Audits and reviews will be reviewed by the Quality Assurance Committee for 6 months to assure compliance or the need for further intervention.</p>	

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	<p>manufacturer once the container was opened.</p> <p>A review of an undated policy and procedure, received from the Executive Director on 6/18/14 at 2:05 p.m., titled, "Use by Date" Guide, "indicated, "Ready-to-Eat Potentially Hazardous Foods, included but not limited to, milk yogurt, cottage cheese ...use by 7 days ..." of the open date.</p> <p>A review of the policy and procedure, dated 01/01/14, received from the Executive Director on 6/18/14 at 2:02 p.m., titled, "Labeling Food Items,"indicated," To prevent food items from being confused with one another or with chemicals, the type of food item should be clearly identified on the label...." This policy further indicated, "...Once the name of the food item is written on the label, the date that the item was opened also is written there...."</p> <p>2. During dining observation in the main dining room, on 6/12/14 from 12:00 p.m., until 1:00 p.m., CNA #1 was observed to touch the rims of Residents # ' s 126, 148, 130, 34, and 104 ' s drinking glasses with her bare hands. CNA #1 was observed wheeling a cart through the dining room which contained uncovered bowls of salad, and cottage cheese that were then</p>			

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F000504 SS=D	<p>served to the residents throughout the dining room. CNA #1 was observed to return to the dining room at the end of tray service wheeling a cart of uncovered deserts including but not limited to, cake, pudding, and fruit that she then served to residents throughout the dining room.</p> <p>During an interview with the Dietary Manager on 6/19/14 at 12:45 p.m., she indicated she was not aware these items needed to be covered during dining service.</p> <p>A review of the policy and procedure, dated 1/01/14, received from the Executive Director on 6/18/14 at 2:02 p.m., titled, "Labeling Food Items," indicated, "Food items such as water, drink mix juice and applesauce that are sent to the dining room or placed on a hydration or med cart must be labeled with their contents and dated."</p> <p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on interview and record review, the facility failed to ensure lab services were obtained only when ordered by a physician for 1 of 5 residents reviewed</p>	F000504	The PT/INR orders have been clarified for #233. Any resident with PT/INR laboratory service orders have the potential to be affected by the	07/18/2014

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NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
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	<p>for lab services (Resident #233).</p> <p>Findings include:</p> <p>Resident #233's record was reviewed on 6/18/14 at 12:32 P.M. Resident #233 was admitted to the facility on 6/2/14, and had a physician's order for daily partial prothombin time and international normalized ratio PT/INR (blood lab test to monitor blood clotting factors).</p> <p>A lab report dated 6/3/2014, indicated a PT/INR was collected. Documentation on the lab report indicated a physician's order to recheck the PT/INR on "6/5/14."</p> <p>A lab report dated 6/6/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR lab test. Documentation on the lab report indicated a physician's order to recheck the PT/INR on "6/9/14."</p> <p>A lab report dated 6/7/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR. Documentation on the lab report indicated a physician's order to recheck the PT/INR on "Monday" 6/9/14.</p> <p>A lab report dated 6/8/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for</p>		<p>deficient practice. A 100% audit has been completed by members of the nursing management team to validate that the physician order match the labs that are being obtained. Audit will be completed by July 10, 2014. The licensed nursing staff have been educated on writing physician orders for PT/INR labs obtained by the Staff Development Coordinator &/or designee by July 18, 2014. The new physician order supercedes and discontinues all previous lab orders. The nursing staff needs to discontinue all previous lab orders and ensure that the lab has been notified. The unit manager &/or designee will collate the physician orders with the physician's instructions on the lab report daily to validate accuracy. Results of these audits will be reported to the Performance Improvement Committee for 6 months. The Committee will determine if further auditing needs completed.</p>	

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	<p>the PT/INR.</p> <p>A lab report dated 6/9/2014, indicated a PT/INR was collected. Documentation on the lab report indicated a physician's order to have the PT/INR rechecked on "6/12/14."</p> <p>A lab report dated 6/10/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR. Documentation on the lab report indicated a physician's order to have the PT/INR rechecked on "6/12/14."</p> <p>A lab report dated 6/11/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR.</p> <p>A lab report dated 6/12/2014, indicated a PT/INR was collected. Documentation on the lab report indicated a physician's order to recheck the PT/INR on "Monday 6/16/14."</p> <p>A lab report dated 6/13/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR. Documentation on the lab report indicated a physician's order to recheck the PT/INR on 6/16/2014.</p>			

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	<p>A lab report dated 6/14/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR.</p> <p>A lab report dated 6/15/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR lab.</p> <p>A lab report dated 6/17/2014, indicated a PT/INR was collected. Documentation on the lab report indicated a physician's order to recheck the PT/INR on 6/19/14.</p> <p>A lab report dated 6/18/2014, indicated a PT/INR was collected. The record lacked documentation of a physician's order for the PT/INR lab.</p> <p>During an interview on 6/18/2014 at 1:13 P.M., the Assistant Director of Nursing (ADON) indicated Resident #233 had the PT/INR labs obtained without physician's orders because the orders were entered incorrectly. She indicated the daily standing ordered should have been discontinued or clarified when the physician changed the dates she wanted the PT/INR to be obtained.</p> <p>During an interview on 6/18/14 at 1:24 P.M., Resident #233 indicated he did not understand why they were taking blood</p>			

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	<p>test everyday. He stated, "I couldn't understand it. Every day. That's one thing I don't like but I didn't say anything. I just went along with it."</p> <p>During an interview on 6/19/14 at 10:04 A.M., the facility's Medical Director indicated when a resident was discharged from a hospital on Coumadin they arrived at the facility with orders for daily PT/INR lab orders. She indicated when she got the results she adjusted the lab orders and medication accordingly. She indicated she questioned why the facility was getting daily PT/INRs on Resident #233. She indicated she found out it was because the lab order had not been changed from the original daily order.</p> <p>3.1-49(f)(1)</p>						