

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/16/2016
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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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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00202070 and IN00202116.</p> <p>Complaint IN00202070 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00202116 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 15 &amp; 16, 2016</p> <p>Facility number: 000497 Provider number: 155606 AIM number: 100291530</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 25 Medicaid: 45 Other: 26 Total: 96</p> <p>Sample: 6</p> <p>This deficiency reflects state findings</p>	F 0000	<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 to liability and such liability here in denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings or constitute a deficiency, or that the scope and severity regarding any of the areas being cited correctly. Please accept this Plan of Correction as our credible allegation of compliance. Westside retirement Village also request a desk review for this citation</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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F 0323 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16-2-3.1.</p> <p>Quality review completed 6/20/16 by 29479.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure adequate supervision and staff to transfer a resident with a mechanical lift for 1 of 3 residents reviewed for accidents/hazards (Resident C).</p> <p>Finding includes:</p> <p>The record for Resident C was reviewed on 6/15/16 at 11:25 a.m. Diagnoses included, but were not limited to, quadriplegia, encephalopathy, and contractures of upper extremities.</p> <p>A current care plan, dated 10/9/14, indicated Resident C had self-care deficits related to quadriplegia. One intervention was to use a mechanical lift for transfers. The resident's "Care Directive" (assignment sheet), provided by the DON (Director of Nursing) on</p>	F 0323	<p>1. Resident C has since discharged from the facility.</p> <p>2. Residents who require mechanical lift transfers have the potential to be effected, therefore those residents care plan and care guides will be reviewed and updated. All mechanical lift machines were serviced and found to be in working order. Care plan and care guide audits to be completed by 7/2/16.</p> <p>3. The SDC or designee will in-service staff on Mechanical Lift Transfers. In-serving to be completed by 7/2/16.</p> <p>4. Nursing administration to audit 5 staff members with mechanical lift transfers. Audits will be completed daily for 30-days, then weekly for 90-days, then monthly. Results will be presented to PI monthly. PI to determine the need for further audits.</p> <p>5. Date of compliance 7/2/16.</p>	07/02/2016

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	<p>6/15/16 at 9:50 a.m., indicated the resident required a mechanical lift with assistance of 2 for transfers.</p> <p>A nursing progress note, dated 6/3/16 at 3:47 p.m., indicated the resident had been sent to the hospital Emergency Department at 3:30 p.m. due to having hit the resident's head during ADL (activities of daily living) care. The "Nursing Home to Hospital Transfer" form, dated 6/3/16, indicated "resident hit head on hooyer lift [mechanical lift] during transfer."</p> <p>During an interview with the DON on 6/15/16 at 11:45 a.m., she indicated CNA #1 was going to give the resident a shower and independently transferred Resident C via mechanical lift. CNA #1 asked a nurse to assess a bump on the resident's head sustained during the transfer. The resident was sent to the hospital for a CT scan (scan of many X-ray images from different angles to produce cross-sectional images of specific areas of a scanned object) which was negative for bleeding or fracture.</p> <p>During an interview with CNA #1 on 6/15/16 at 2:45 p.m., she indicated there were no CNAs or nurses in the hallway, so she transferred the resident by herself with the mechanical lift. The CNA indicated the resident's head hit the</p>			

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	<p>mechanical lift during the transfer and a bump was present on the resident's head. The CNA indicated she called to another CNA who came in, and then went to get the nurse who assessed the injury and notified the DON.</p> <p>A current facility policy, undated, titled "Mechanical Lift Use" was provided by the DON on 6/15/16 at 9:50 a.m.. The policy indicated, "The purpose of this procedure is to help lift residents using a mechanical lifting device.....General Guidelines....3. Two (2) persons are required to perform this procedure.....,"</p> <p>This federal tag relates to Complaint IN00202070.</p> <p>3.1-45(a)(2)</p>				