

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155389	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/10/2016
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NAME OF PROVIDER OR SUPPLIER  WESTPARK A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 5, 6, 7, 8, 9, and 10, 2016</p> <p>Facility number: 000473 Provider number: 155389 AIM number: 100290410</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 14 Medicaid: 30 Private: 5 Other: 4 Total: 53</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. <b>The facility respectfully requests paper compliance for all citations.</b>	
F 0246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF			

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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Bldg. 00	<p><b>NEEDS/PREFERENCES</b></p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to address a resident's need for longer oxygen tubing for 1 of 1 resident reviewed for accommodation of needs. (Resident #48)</p> <p>Findings include:</p> <p>The clinical record for Resident #48 was reviewed on 6/6/16 at 9:30 a.m. The diagnoses for Resident #48 included, but were not limited to: congestive heart failure and obstructive sleep apnea.</p> <p>The 5/10/16 Admission MDS (minimum data set) assessment indicated Resident #48 had a BIMS (brief interview for mental status score) of 13, indicating Resident #48 was cognitively in tact.</p> <p>The 6/3/16 Physician's Order for Resident #48 indicated, "Oxygen @ 2 liters via nasal cannula every shift."</p> <p>On 6/6/16 at 11:56 a.m., an interview was conducted with Resident #48. She indicated the oxygen tubing from her</p>	F 0246	<p><b>The facility respectfully requests paper compliance for this citation. F-246</b> It is the policy of the facility to provide the residents with reasonable accommodation of their needs and preferences. Resident #48 (as stated in the survey) has been provided with longer oxygen tubing making it possible for her to go to the bathroom independently, especially at night. Any resident who resides in the facility and receives oxygen and is able to ambulate has the potential to be affected by this finding. An audit was conducted in order to create a list of targeted residents who receive oxygen. These residents were observed by DON/Designee for ambulation ability. Those who were interviewable, were interviewed as to their preference for longer oxygen tubing. If by observation or by interview it was determined that longer oxygen tubing would enhance mobility, then longer tubing was provided. The DON/Designee will monitor all residents who are receiving oxygen to see if they are using the desired length of oxygen tubing. This monitoring will take place 3 days weekly and it will be</p>	07/15/2016

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	<p>oxygen concentrator was not long enough for her to use the restroom at night. She indicated she had to call for help, if she needed to use the restroom at night. She indicated if her tubing was longer, she'd be able to use the restroom on her own. She indicated she informed one of the nurses she needed longer tubing. At this time, her oxygen concentrator was located next to her bed. The tubing from her concentrator was observed approximately 6 feet long, not long enough to reach the restroom.</p> <p>An interview was conducted with Resident #48 on 6/10/16 at 11:45 a.m. She indicated she still hadn't received longer oxygen tubing. She further explained the problem occurred at night. She indicated she had to transfer into her wheel chair, from bed, and connect to the portable tank to use the restroom. She indicated she was unable to shut the restroom door, because her wheel chair didn't fit in the restroom, so she had to shut her room door instead, to have privacy. She indicated, if she had longer tubing, she'd be able to use her walker to go to the restroom, and be able to shut the restroom door. She indicated she informed one of the nurses of this on 6/6/16.</p> <p>An observation of Resident #48 in her</p>		<p>ongoing. Any concerns will be addressed as found. Going forward, when tubing is changed on the oxygen—the resident will be interviewed and observed to see if longer tubing is desired or needed. Tubing will be added as indicated. This will also be part of the CQI process during order reviews. Orders for oxygen will include care planning for the oxygen. A preference for longer tubing will be established when the oxygen order is received. This preference will be care planned. At an in-service for nursing staff held June 29, 2016, Resident's Rights and Accommodation of Needs was reviewed with emphasis on honoring preferences and requests as much as possible to include any request for longer oxygen tubing. CNAs were educated as to notifying the charge nurse with any such request for longer oxygen tubing by use of the "I Would Like To Know" form, which is a process encouraging residents/families to ask questions or make requests in a written form to be acted upon and responded to by the appropriate facility staff. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings, the results of the monitoring by the DON/Designee as well as the "I Would Like To Know" forms will</p>	

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F 0278 SS=A Bldg. 00	<p>room was made with the DON (Director of Nursing) on 6/10/16 at 11:50 a.m. Resident #48 informed the DON of her concern with her oxygen tubing length. The DON informed her she would be provided longer tubing by the end of the day. Resident #48 informed the DON she told one of the night nurses of her concern.</p> <p>An interview was conducted with the DON on 6/10/16 at 12:01 p.m. She indicated Resident #48 was provided longer oxygen tubing, and she walked with her into the restroom after providing the longer tubing. The DON indicated Resident #48 did a "great job."</p> <p>3.1-3(v)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>		<p>be reviewed to see that all follow up has been done. Any patterns will be identified, however, any concerns will have been addressed as found. If necessary an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolved.</p>	

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	<p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, interview, and record review, the facility failed to ensure accuracy of the MDS (minimum data set) assessment regarding oral/dental status for 1 of 3 residents reviewed for dental status. (Resident #96)</p> <p>Findings include: The clinical record for Resident #96 was reviewed on 6/8/16 at 9:38 a.m. The 1/20/16 MDS Admission assessment, under section L, indicated no problem related to missing teeth or being edentulous (lacking teeth; toothless). The 1/14/16 admission nursing assessment indicated Resident #96 was edentulous.</p>	F 0278	<p><b>The facility respectfully requests paper compliance for this citation. F-278</b> It is the policy of the facility to see that the accurate oral status is reflected in the resident's MDS. Resident #96's MDS is accurate for their oral status based on assessment. Any resident who resides in the facility has the potential to be affected by this finding. An audit was conducted at which time all MDSs were reviewed to ensure that they accurately reflected the oral status of the residents. Corrections were made as applicable. The DON/Designee and the MDS Coordinator will meet weekly to review the MDSs completed that week. At this</p>	07/15/2016

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F 0279 SS=D Bldg. 00	<p>A Physicians Order, dated 1/14/16, indicated Resident #96 may be seen by dentist.</p> <p>An interview was conducted with MDS Coordinator on 6/9/16 at 9:35 a.m. She indicated she doesn't mark edentulous if a resident has dentures or unless there is concerns related to dental status.</p> <p>An interview was conducted with MDS Coordinator on 6/9/16 at 10:04 a.m. She indicated she coded none of the above were present under oral/dental status, section L, on the MDS Admission assessment. She further indicated Resident #96 was edentulous and the MDS Admission assessment should have been marked edentulous to trigger in the CAA (Care Area Assessment) Summary to be addressed.</p> <p>Section L, Oral/Dental Status, of the RAI (Resident Assessment Instrument) indicated the following, "Coding Instructions...Check L0200B, no natural teeth or tooth fragments(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth." 3.1-31(i)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the</p>		<p>time, Section L will be reviewed to check for accuracy based on assessment. Any concerns will be addressed at that time. This monitoring will continue until 4 consecutive weeks of zero negative results is achieved. After that, to ensure ongoing compliance, for a period of not less than 6 months 3 MDSs will be reviewed weekly for accuracy of Section L. After that, random monitoring of Section L will occur.</p> <p>At an in-service held for the MDS Coordinator June 24, 2016, the accuracy of the MDS per assessment was emphasized. Failure to comply with this expectation will result in further education and/or progressive discipline as indicated. At the monthly QA meetings the results of the monitoring meetings of the DON/Designee and the MDS Coordinator will be reviewed. Any concerns will have been addressed as found.</p>	

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	<p>assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a care plan for an anticoagulant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #64)</p> <p>Findings include:</p> <p>The clinical record for Resident #64 was reviewed on 6/8/16 at 12:23 p.m. The diagnosis included but was not limited to, pulmonary embolism.</p> <p>A physician order dated 5/14/16, indicated Resident #64 was to receive a 0.8 milliliters injection of an anticoagulant medication one time a day for a diagnosis of PE (pulmonary</p>	F 0279	<p><b>The facility respectfully requests paper compliance for this citation. F-279</b> It is the policy of the facility to ensure that a comprehensive care plan is developed for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs as identified through assessments. Resident #64 has a care plan in place that addresses their anticoagulant medication. Any resident who resides in the facility and who receives anticoagulant medication has the potential to be affected by this finding. A facility wide audit was conducted to create a targeted list of residents receiving anticoagulant medication. All of</p>	07/15/2016

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	<p>embolism).</p> <p>After review of Resident #64's care plans, no care plan was found addressing his anticoagulant medication.</p> <p>An interview was conducted with the Minimum Data Set (MDS) Coordinator on 6/9/16 at 12:29 p.m. She indicated a care plan for Resident #64's anticoagulant medication was missed by mistake.</p> <p>A care plan policy was provided by the Director of Nursing on 6/9/16 at 2:50 p.m. It indicated, "Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care...Procedure:..1. Each resident upon admission or a significant change of condition will be assessed by all disciplines..2. A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment. All areas of concern will be addressed by the interdisciplinary team. The documentation is to be in in the departmental notes and/or on the care plan. 3. The Initial Care Plan will be completed as soon as possible after admission...</p> <p>3.1-35(a)</p>		<p>these residents had their care plans reviewed to ensure that the anticoagulant medication was included. Going forward, the MDS Coordinator will monitor the lab reports weekly as well as the list kept by the DON/Designee of residents on anticoagulant medication to see that these residents have an appropriate care plan in place to address this medication. This practice will be ongoing. Further, at the daily CQI meetings at the time orders are reviewed, any orders for anticoagulant medication will be followed up on to ensure that resident's name is added to the list of "like residents" on anticoagulant med kept by the DON/Designee. At this time these residents will have their care plans addressed to include anticoagulant therapy. Further, that resident's name will be added to the list of residents on anticoagulant meds kept by the DON/Designee. This practice will be ongoing. This list will be reviewed and documented that it was reviewed for accuracy weekly by the DON/Designee also ongoing. This will be part of the White Board" system in the facility which is a tracking system used in CQI meetings. At an in-service held for nurses on June 29, 2016, the following was reviewed: A.) Anticoagulant meds B.) P.T./I.N.R.—Normal Range C.) Care Planning for residents on anticoagulant</p>	

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow Physician's Orders for monitoring blood pressures and administering blood pressure medication for out of range blood pressures for 1 of 1 residents reviewed for dialysis. The facility also failed to implement fall care plan interventions for a resident with repeated falls for 1 of 3 residents reviewed for falls. (Resident #43 and Resident #48).</p>	F 0282	<p>therapy D.) What to watch for-When to notify physician/family E.) Documentation F.) Q &amp; A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring by the DON/Designee and the MDS Coordinator for tracking anticoagulant meds will be reviewed. Any patterns will be identified. However, any concerns will have been addressed as found. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolved.</p> <p><b>The facility respectfully requests paper compliance for this citation. F-282</b> It is the policy of the facility to provide and arrange services to be provided by qualified persons in accordance with each resident's written plan of care. Resident #48 receives all meds including blood pressure meds as per physician order. Resident #48 has their blood pressure taken as per physician's order. Resident</p>	07/15/2016

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	<p>Findings include:</p> <p>1a. The clinical record for Resident #48 was reviewed on 6/8/16 at 2:35 p.m. The diagnoses for Resident #48 included, but were not limited to, end stage renal disease, diabetes mellitus, and hypertension.</p> <p>A Physician's Order, dated 6/1/16, indicated to give hydralazine (blood pressure medication) 10 milligrams by mouth as needed for systolic blood pressure greater than 170 or diastolic blood pressure greater than 90, four times a day.</p> <p>A review of the blood pressures in the clinical record indicated the following blood pressures: 6/3/16 at 12:00 p.m.=176/84, 6/6/16 at 1:24 p.m.=197/90, 6/8/16 at 1:01 p.m.=184/84, &amp; 6/8/16 at 7:26 p.m.=172/78.</p> <p>The clinical record, including the Medication Administration Record, did not indicate hydralazine was given for the above blood pressures.</p> <p>1b. A Physician's Order, dated 6/1/16, indicated to check Resident #48's blood pressure 4 times a day for 2 days.</p>		<p>#43 has a complete care plan in place for fall prevention. Any resident who resides in the facility and has orders for blood pressure to be taken and medication to be given based on the blood pressure reading has the potential to be affected by this finding. Further, any resident who resides in the facility and is at risk for falls has the potential to be affected by this finding. An audit was conducted to identify all residents who have an ordered medication to be given based on their BP reading. The emars (electronic medical record/med sheet) of these residents will be monitored by the DON/Designee 5 days weekly to ensure that BP readings are being done as ordered and that their BP medication was given as indicated. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, the monitoring will occur 3 days weekly for a period of not less than 6 months to ensure ongoing compliance. Any concerns will have been addressed as found. Additionally, an audit was conducted to identify any resident at risk for falls. These residents had their care plans reviewed to be sure that they were accurate and that interventions were in place and that any devices mentioned in an intervention (such as a reacher or grabber) are available in the resident's unit.</p>	

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	<p>The clinical record did not indicate the blood pressures were checked 4 times a day as ordered.</p> <p>During an interview with the Director of Nursing (DON), on 6/9/16 at 1:47 p.m., the DON indicated the facility was not able to determine why the hydralazine was not given as ordered or the blood pressures were not taken as ordered.</p> <p>2. The clinical record for Resident #43 was reviewed on 6/8/16 at 11:45 a.m. The diagnoses for Resident #43 included, but were not limited to, multiple myeloma, contracture to bilateral knees, spinal stenosis, and gout.</p> <p>A Fall Care Plan, with a target date of 7/25/16 and remained current at the time of review, indicated Resident #43 had falls on the following dates: 5/9/16, 4/9/16, 3/9/16, 3/3/16, and 1/15/16. The care plan also indicated the following interventions, "...long handled reacher, keep close to him at all times when in his room...call light with in [sic] reach while in room...."</p> <p>During an observation, on 6/9/16 at 10:23 a.m., Resident #43 was in bed and there was not a reacher within reach nor was there a reacher observed in the room.</p>		<p>Any concerns will be addressed as discovered. The DON/Designee will monitor 10 care plans for residents at risk for falls weekly to ensure that the care plans are accurate and that any devices are available. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, 3 "fall" care plans will be reviewed weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will continue ongoing.</p> <p>At an in-service held for nurses June 29, 2015, the following was reviewed: A.) Following physician orders—(Such as taking BP readings 4 times daily) B.) Giving meds based on findings or values such as a BP reading or an INR or blood sugar reading etc.) C.) Falls—at risk for falls D.) Care Planning as related to Fall Prevention E.) Documentation F.) Q and A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring by the DON/Designee for taking blood pressures as ordered and administering meds appropriately based on the BP readings. The results of the DON/Designee monitoring of the care plans for residents at risk for</p>	

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	<p>At 11:05 a.m., on 6/9/16, Resident #43 was observed up in his wheelchair and the call light was placed on his bed out of reach. A reacher was not observed within reach nor was a reacher observed in the room.</p> <p>On 6/9/16, at 1:55 p.m., Resident #43 was in bed and a reacher was not observed within reach nor was a reacher observed in the room.</p> <p>At 9:12 a.m., on 6/10/16, during an observation with the Director of Nursing (DON), the DON looked throughout Resident #43's room for a reacher and was not able to locate it. The DON indicated at this time, she will follow up with facility staff to determine the location of the grabber.</p> <p>On 6/10/16 at 9:19 a.m., the Activity Director indicated there was a reacher left on a table and she was not sure whom it belonged to, so it must've been Resident #43's. The AD further indicated Resident #43 still used his grabber to reach objects.</p> <p>A policy titled, Falls-Initial Plan of Care, no date, was received from the DON, on 6/10/16 at 9:35 a.m. The policy indicated, "...individual plan of care will</p>		falls will be reviewed as well. Any concerns will have been addressed as discovered. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator until resolution.	

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F 0431 SS=D Bldg. 00	<p>need to be developed with appropriate interventions to prevent falls...Fall interventions area as varied and unique as each of the residents. When choosing an intervention look at the root cause of the fall along with the individuality of the resident. Choose the intervention which addressess the root cause and document on the care plan and fall intervention log...."</p> <p>3.1-35(g)(2) 3.1-45(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>			

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	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure an insulin pen was not expired for 1 of 2 medication storage refrigerators observed. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record for Resident #14 was reviewed on 6/10/16 at 1:139 p.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus with diabetic neuropathy.</p> <p>A physician order dated, 4/11/16, indicated Resident #14 was to receive 6 units of humalog insulin injections 3 times a day with meals.</p> <p>A random observation was made of a</p>	F 0431	<p><b>The facility respectfully requests paper compliance for this citation. F-431</b> It is the policy of the facility to employ or obtain the services of a licensed pharmacist to assist in all pharmacy related requirements in the facility. This includes destruction of any expired meds. He expired insulin pen for Resident #14 has been destroyed. A new insulin pen was ordered and no doses were missed. Any resident who receives insulin in the facility has the potential to be affected by this finding. An immediate audit was conducted on all med carts and refrigerators used for med storage. Any outdated meds including insulin pens were to be destroyed—none were found. Going forward, the DON/Designee or the Consultant Pharmacist will monitor all med</p>	07/15/2016

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	<p>refrigerator in the east hall medication storage room with License Practical Nurse (LPN) #1 on 6/10/16 at 12:10 p.m. The refrigerator contained a basket of insulin pens for the diabetic residents. Resident #14's humalog insulin pen had a written expiration date of 6/1/16. LPN #1 indicated at that time, the insulin pens were the current insulin medications that was used to administer to the residents. LPN #1 indicated Resident #14's humalog insulin pen was expired.</p> <p>An observation was made of the east hall refrigerator with LPN #1 on 6/10/16 at 1:00 p.m. LPN #1 indicated at that time the basket contained two additional humalog insulin pens for Resident #14. One of the humalog pens had a written open date of 6/7/16, and the other humalog pen was not marked opened.</p> <p>The June 2016, Medication Administration Record (MAR) for Resident #14 was provided by the Director of Nursing (DON) on 6/10/16 at 1:39 p.m. The medication records indicated Resident #14 had received expired humalog insulin June 1st through June 6th.</p> <p>A "MEDICATION STORAGE IN THE FACILITY" policy was provided by the DON on 6/10/16 at 1:39 p.m. It</p>		<p>carts and med storage refrigerators for expired meds including insulin pens. Any found will be destroyed. A new supply will be secured timely so as not to miss any doses. This monitoring will be done 3 days weekly and will continue until 4 consecutive weeks of zero negative findings is achieved. After that, this monitoring will be done 3 days weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. At an in-service for nurses held June 29, 2019, the following was reviewed: A.) Med Storage B.) What to do if you find an expired medication C.) Reordering meds for timeliness of doses D.) Documentation E.) Q &amp; A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring of the med storage areas by the DON/Designee or Consultant Pharmacist will be reviewed. Any patterns will be identified. However, any concerns will be corrected as found. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.</p>	

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F 0441 SS=D Bldg. 00	<p>indicated, "Policy: Medications and biologicals are stored safety securely, and properly following the manufacture or supplier recommendations...Procedures:..14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists."</p> <p>3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p>			

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	<p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to maintain infection control practices in regards to handwashing for 1 of 3 residents reviewed for pressure ulcers. (Resident #70)</p> <p>Findings include:  On 6/8/16 at 10:12 a.m., Resident #70's record was reviewed. Diagnoses included, but were not limited to, dementia, difficulty in walking, and muscle weakness.  Physician orders include, but were not</p>	F 0441	<p><b>The facility respectfully requests paper compliance for this citation. F-441</b> It is the policy of the facility to see that a comprehensive Infection Control Program is in place to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease. Resident #70 has her dressing change done using infection control practices as per policy including hand washing. Any resident who resides in the facility and requires a dressing change has the potential to be affected by this finding. The DON/Designee will monitor 5 dressing changes weekly involving various nurses to</p>	07/15/2016

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	<p>limited to, apply collagen (treatment that helps to promote the healing of wounds) to coccyx wound bed, apply silver alginate (antimicrobial, highly absorbent wound dressing) over collagen, cover with abd (abdominal) pad and secure with tape daily. Physician order indicated to do treatment daily on day shift for wound healing with a start date of 6/1/16.</p> <p>On 6/10/16 at 11:10 a.m., an observation was conducted of Resident #70's pressure ulcer dressing. RN #3 was observed applying new gloves and proceeded to get Resident #70's bedside table with the wound care supplies noted on top. There was a phone cord wrapped around the bedside table stand with the cord noted on the floor. RN #3 picked up the phone and cord to attempt to untangle from the bedside table. She proceeded to take off gloves and apply new gloves without handwashing in between. She proceeded to clean Resident #70's coccyx wound with normal saline and took off gloves to perform handwashing for 12 seconds. She applied new gloves and proceeded with the treatment. She applied collagen, applied silver alginate, covered with an abdominal pad, and secured with tape. She took off gloves and performed handwashing for 15 seconds. She was observed utilizing her feet to open up a clear trash bag for her to discard the</p>		<p>ensure that proper infection control practices are maintained during the procedure including proper hand washing technique. Any concerns will be corrected before a breach in technique is committed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, monitoring will take place for 3 dressing changes weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. At an in-service held for nurses June 29, 2016, the following was reviewed: A.) Infection Control as related to dressing changes B.) Hand washing policy C.) Q &amp; A Note: Nurse will do return demonstrations of a proper dressing change for competency. Any staff who fail to comply with the points of the in-service will be further educated and/or progressive discipline as indicated. At the monthly Q.A. meetings the monitoring of the dressing changes (technique) by the DON/Designee will be reviewed. Any concerns will have been addressed as found prior to a breach in technique. Any patterns will be identified If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator until resolved.</p>	

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	<p>wound care supplies that included, packaging of collagen wound dressing, silver alginate wound dressing packaging, normal saline containers, and gauze that was used to absorb the normal saline while the wound was being cleansed. There was an empty trash bin an arm-length away next to the trash bag noted on the floor.</p> <p>On 6/10/16 at 11:35 a.m., an interview was conducted with RN #3. She indicated it was not an ideal spot to put the trash bag onto the floor and discard of wound care supplies while the trash bag was on the floor.</p> <p>On 6/10/16 at 11:45 a.m., an interview was conducted with RN #3. She indicated to perform handwashing for 40-60 seconds.</p> <p>On 6/10/16 at 12:20 p.m., an interview was conducted with the DON (Director of Nursing). She indicated you should perform handwashing for 40-60 seconds.</p> <p>A policy titled Hand Hygiene, revised 8/21/13, was provided by DON on 6/10/16 at 2:10 p.m. The policy indicated the following, "Indications for Hand Washing and Hand Antisepsis...Hand Washing...Wash hands with either a non-antimicrobial soap and water or an</p>			

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F 0465 SS=E Bldg. 00	<p>antimicrobial soap and water when hands are visibly dirty or are visibly soiled with blood or other body fluids such as urine or feces...Hand antisepsis and Alcohol Based Hand Rubs...If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations...Decontaminate hands after removing gloves...Hand Washing Procedure - Duration of the entire procedure: 40-60 seconds...."</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a homelike environment for 4 of 30 residents observed for environmental concerns. (Resident #4, #14, #37, and #96)</p> <p>Findings include:</p>	F 0465	<p><b>The facility respectfully requests paper compliance for this citation. F-465</b> It is the policy of the facility to provide a safe, functional, sanitary and comfortable environment for the residents and staff and public. Residents #4, #14, #37 and #96 have had their rooms repaired of</p>	07/15/2016

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	<p>1. An observation of Resident #4's room was made on 6/6/16 at 2:03 p.m. There was a baseball size hole in the wall, above an electrical outlet, next to the air conditioning/heating unit. Resident #4 indicated the hole needed to be covered, because moisture from the air conditioning unit could get inside the electrical box. There was also a baseball size hole near the head of his bed.</p> <p>An environmental tour was conducted with the Administrator and Housekeeping Supervisor on 6/9/16 at 1:55 p.m. The hole above the outlet in Resident #4's room was observed. The Administrator indicated the outlet was moved, and the wall was not repaired afterwards.</p> <p>An interview was conducted with Resident #4 on 6/10/16 at 11:15 a.m. He indicated the hole in the wall above the outlet had been there for a while, since he'd been in that room.</p> <p>An interview was conducted with the Maintenance Director on 6/10/16 at 11:25 a.m. He indicated he moved the outlet about 2 weeks prior, but didn't have any paperwork associated with the outlet being moved.</p> <p>2. An observation of Resident #14's restroom was made on 6/6/16 at 11:16</p>		<p>the findings as follows A.) The holes in the wall by the air conditioner unit as well as by the head of the bed in Resident #4's room have been repaired. B.) The baseboard in the bathroom of Resident #14 has been repaired. C.) The ceiling in the bathroom of Residents #37 and Resident #96's bathroom has been repaired. Also, the pink board in the bathroom has been removed and the area has been repaired. The baseboard has been replaced. Any residents who reside in the facility have the potential to be affected by this finding. The Administrator and Maintenance Director will make a facility wide tour of resident rooms and common areas noting needed repairs and listing them. The Maintenance staff will complete at least 5 repairs off of the list weekly as well as continue to perform day to day maintenance duties. The Administrator and the Maintenance Director will tour the facility weekly to verify the repairs as well as to add any newly found issues. This practice will be ongoing as part of the Preventive Maintenance Program. At an all staff in-service held June 29, 2016, the following was reviewed: A.) What is a safe, functional, sanitary, comfortable, homelike environment? B.) How to report a Maintenance request C.) Who is responsible to report a maintenance issue? D.) Why</p>	

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	<p>a.m.</p> <p>The black baseboard/trim on the wall was pulling away from the wall in 3 different locations.</p> <p>An environmental tour was conducted with the Administrator and Housekeeping Supervisor on 6/9/16 at 1:55 p.m. The baseboard/trim was observed. The Housekeeping Supervisor indicated housekeeping staff should check for concerns like this daily, and no one reported this to her.</p> <p>3. An observation of Resident #37 and 96's restroom was made on 6/6/16 at 10:01 a.m. A volleyball size brown spot was observed on the ceiling, above the commode. A 2 X 2 and 1/2 foot pink board covered a hole in the bottom of the wall, between the commode and sink. There was no baseboard/trim along this wall.</p> <p>An environmental tour was conducted with the Administrator and Housekeeping Supervisor on 6/9/16 at 1:55 p.m. The brown spot on the ceiling and pink board were observed. The Administrator indicated it looked like the maintenance staff fixed a problem, but did not finish it, cosmetically. The Administrator indicated she did not know what the brown spot on the ceiling was. The</p>		<p>should a maintenance issue be reported timely? E.) Discussion Additional in-servicing for Maintenance staff included a review of the Preventive Maintenance Program as well as planning and discussion of the weekly tours to be done by the Administrator and the Maintenance Director to verify repairs as well as to note new concerns to be added to the list. These weekly tours will be ongoing. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as needed. At the monthly Q.A. meetings the results of the weekly findings by the Administrator and the Maintenance Director on their tours will be reviewed. Any concerns will be identified at that time. An agreed upon plan will be devised by the Administrator and the Maintenance Director. Further, submitted maintenance requests since the last meeting will be reviewed to ensure that they are either resolved or in process of resolution. Any patterns will identified. Any concerns will be addressed at that time by adding them to the ongoing list or noting them on the list as resolved.</p>	

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NAME OF PROVIDER OR SUPPLIER  WESTPARK A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Administrator indicated she would expect staff to report the spot on the ceiling. The Housekeeping Supervisor indicated housekeeping staff were in resident restrooms everyday for cleaning.</p> <p>An interview was conducted with Resident #37 on 6/10/16 at 11:20 a.m. She indicated the wall in the restroom had been that way for 3 or 4 months, after their room flooded. She indicated she was glad to have it fixed, because "it was ugly."</p> <p>An interview was conducted with the Maintenance Director on 6/10/16 at 11:25 a.m. He indicated he wasn't sure how long the wall had been in that condition, but was aware it was after the room flooded. He indicated he did not have any paperwork, regarding the flood or the fixing of the wall.</p> <p>3.1-19(f)</p>			