

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
F0000	<p>This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00103418.</p> <p>Complaint IN00103418- Substantiated, Federal/State deficiencies related to the allegations are cited at F 441.</p> <p>Survey dates: January 30, 31, February 1, 2, 3, 6 and 7, 2012</p> <p>Facility number: 000497 Provider number: 155606 AIM number: 100291530</p> <p>Survey Team: Leia Alley, RN, TC Dinah Jones, RN (January 30, 31, February 1, 2, and 6 2012) Patty Allen, BSW (January 30, 31, February 1, 2, 3, and 6 2012) Marcy Smith, RN (February 1, 2, 3, 6, and 7, 2012)</p> <p>Census bed type: SNF/NF: 107 Total: 107</p> <p>Census payor type: Medicare 36 Medicaid: 33 Other: 38</p>	F0000	<p>This plan of correction is submitted under Federal and State regulations and status applicable to long term care providers.</p> <p>This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied.</p> <p>The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly.</p> <p>Please accept this plan as our credible allegation of compliance.</p> <p>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.

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>Total: 107</p> <p>Sample: 22 Supplemental sample: 1</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/13/12 Cathy Emswiller RN</p>			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRI ATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review, the facility failed to report an incident of physical and verbal abuse immediately to the Administrator to ensure resident protection for 2 of 2 residents reviewed for allegations of physical and verbal abuse in a sample of 23 residents. [Resident #41 and Resident #112]</p> <p>Findings include:</p> <p>The clinical record of Resident #41 was reviewed on 2/6/12 at 10:30 a.m. The resident's diagnoses Included, but were not limited to, hypertension (high blood pressure), hip fracture, anxiety, depression, and COPD (chronic obstructive pulmonary disease).</p> <p>The resident's most current MDS [minimum data set] assessment indicated Resident #41 required assistance with all ADL's (activities of daily living) and had mild cognitive impairment (a impaired ability for decision making and thought process).</p>	F0224	<p>F224-Abuse1. CORRECTIVE ACTIONResident # 41 was immediately protected and assessed for any injury with none noted. Resident # 112 has been discharged on 01/17/2012. SSD interviewed resident # 41 and the Executive Director did a phone interview with resident # 112 on 01/17/2012 with no injury reported. SSD interviewed other residents on the specific assignment of the employee in question. The employee was suspended and then terminated.</p> <p>2. IDENTIFICATION OF OTHERS POTENTIALLY AFFECTED Alert and oriented residents who received care by alleged staff member were interviewed on 01-17-12 by Social services. No other residents were affected. The nurse involved was educated by the unit manager on 02/20/2012 in relation to reporting guidelines of alleged abuse. A 100% audit of alert and oriented residents will be completed by department managers by March 7., 2012. Non-interviewable residents will be assessed by head-to-toe skin assessments, as well as, contacting families and</p>	03/08/2012

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>A "Facility Incident Reporting Form" was reviewed on 2/3/12 at 9:30 a.m. The "Facility Incident Reporting Form" indicated Resident #41 was force fed by a CNA (Certified Nursing Assistant) against her wishes by moving Resident #41's hand away from her mouth and forcing a spoon into her mouth. The form also indicated that the room mate of Resident #41, resident # 112 tried to intervene by saying that Resident #41 did not want to be fed and the same CNA told her to "mind her own business." The form also indicated after a facility investigation, the CNA was terminated from her position for how she treated Resident #41.</p> <p>The report indicated the incident occurred on 1/16/12 at 5:45 p.m. The nursing staff reported it to the ED (Executive Director) and DON (Director of Nursing) on 1/17/12, the day after the incident and not immediately, and the CNA involved was "immediately suspended pending the investigation". Assessments were done for physical abuse, both Resident #41 and room mate were interviewed, social services completed "resident interviews to determine if other residents were affected by this concern/incident. Interviews determined that no other residents were identified as being affected by this</p>		<p>interviewing staff by nursing administration by March 7, 2012. .</p> <p>3.Systemic Changes Facility Policy has been updated/ revised to reflect federal regulation requirment for reporting all alleged violations involving mistreatment, neglect, or abuse; including injuries of unknown source and misappropriation of resident property "immediately to the administrator of the facility."(See Attachment: Reporting Alleged Abuse Policy Revised)Education and in servicing related to abuse, neglect, reporting, resident rights and the policies will be completed by March 7, 2012 by the Executive Director and or their Designee to 100% of staff. Those staff members who have not been in-serviced will not be allowed to work until in-service has been completed. 4. Quality AssuranceFive resident interviews will be conducted weekly for psychosocial and physical well being by department managers on Monday through Friday x 4 weeks. Staff will be monitored for compliance of systemic change via the staff interview audit tool. Five staff members will be audited weekly for four weeks.Weekend managers will interview one resident per weekend day for four weeks.Regional Director of Clinical Services will audit findings monthly x twelve months. Audits will be reviewed by PI</p>	

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>concern". The CNA involved was "terminated for violation of Resident Rights".</p> <p>A facility policy titled "Abuse and/or Neglect Investigation" dated 02/09, indicates "Residents have the right to live at ease in a safe environment without fear...".</p> <p>3.1-27(a)(3) 3.1-28(a)</p>		<p>committee x twelve months, or until one hundred percent of audit threshold has been met. See attachment for facility policy for abuse prevention, reporting and investigating for Tags F-224, 225 and 226.5. Completion dateDate of Compliance March 8 th , 2012.</p>	

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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			
F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review, the facility failed to ensure resident protection for 2 of 2</p>	F0225	F225-Abuse1. CORRECTIVE ACTION Resident # 41 was immediately protected and	03/08/2012			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>residents reviewed for allegations of physical and verbal abuse in a sample of 23 residents. The facility also failed to report allegations of abuse immediately to the Administrator. This involved Resident #41 and Resident #112.</p> <p>Findings Include:</p> <p>The clinical record of resident # 41 was reviewed on 2/6/12 at 10:30 a.m. The resident's diagnoses Included, but were not limited to, hypertension (high blood pressure), hip fracture, anxiety, depression, and COPD (chronic obstructive pulmonary disease). The MDS [minimum data set] assessment indicated Resident #41 required assistance with all ADL's (activities of daily living) and had mild cognitive impairment (a impaired ability for decision making and thought process).</p> <p>A "Facility Incident Reporting Form" was reviewed on 2/3/12 at 9:30 a.m. The "Facility Incident Reporting Form" indicated Resident #41 was force fed by a CNA (Certified Nursing Assistant) against her wishes by moving Resident #41's hand away from her mouth and forcing a spoon into her mouth. The form also indicated that the roommate of Resident #41, resident # 112 tried to intervene by saying that Resident #41 did</p>		<p>assessed for any injury with none noted. Resident # 112 has been discharged on 01/17/2012. SSD interviewed resident # 41 and the Executive Director did a phone interview with resident # 112 on 01/17/2012 with no injury reported. SSD interviewed other residents on the specific assignment of the employee in question. The employee was suspended and then terminated.</p> <p>2. IDENTIFICATION OF OTHERS POTENTIALLY AFFECTED Alert and oriented residents who received care by alleged staff member were interviewed on 01-17-12 by Social services. No other residents were affected. The nurse involved was educated by the unit manager on 02/20/2012 in relation to reporting guidelines of alleged abuse. A 100% audit of alert and oriented residents will be completed by department managers by March 7., 2012. Non-interviewable residents will be assessed by head-to-toe skin assessments, as well as, contacting families and interviewing staff by nursing administration by March 7, 2012. .</p> <p>3.Systemic Changes Facility Policy has been updated/ revised to reflect federal regulation requirment for reporting all alleged violations involving mistreatment, neglect, or abuse; including injuries of unknown source and misappropriation of resident property "immediately to the administrator of the facility."</p>	

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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>not want to be fed and the same CNA told her to "mind her own business". The form also indicated after a facility investigation, 1/17/12, the day after the incident occurred, the Administrator was notified and the CNA was terminated from her position for how she treated Resident #41.</p> <p>The report indicated the incident occurred on 1/16/12 at 5:45 p.m. The nursing staff reported it to the ED (Executive Director) and DON (Director of Nursing) on 1/17/12 and the CNA involved was "immediately suspended pending the investigation". Assessments were done for physical abuse, both Resident #41 and room mate were interviewed, social services completed "resident interviews to determine if other residents were affected by this concern/incident. Interviews determined that no other residents were identified as being affected by this concern". The CNA involved was "terminated for violation of Resident Rights".</p> <p>A facility policy titled "Abuse and/or Neglect Investigation" dated 02/09, indicates "Residents have the right to live at ease in a safe environment without fear...".</p> <p>3.1-28(c)</p>		<p>(See Attachment: Reporting Alleged Abuse Policy Revised) Education and in servicing related to abuse, neglect, reporting, resident rights and the policies will be completed by March 7, 2012 by the Executive Director and or their Designee to 100% of staff. Those staff members who have not been in-serviced will not be allowed to work until in-service has been completed. 4. Quality Assurance Five resident interviews will be conducted weekly for psychosocial and physical well being by department managers on Monday through Friday x 4 weeks. Staff will be monitored for compliance of systemic change via the staff interview audit tool. Five staff members will be audited weekly for four weeks. Weekend managers will interview one resident per weekend day for four weeks. Regional Director of Clinical Services will audit findings monthly x twelve months. Audits will be reviewed by PI committee x twelve months, or until one hundred percent of audit threshold has been met. 5. Completion date Date of Compliance March 8 th , 2012.</p>				

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 02/07/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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			
F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review, the facility failed to ensure resident protection for 2 of 2 residents reviewed for allegations of physical and verbal abuse in a sample of 23 residents. The facility also failed to implement their policy and procedure and report an allegation of abuse immediately to the facility Administrator. This involved Resident #41 and roommate of Resident #41, Resident #112.</p> <p>Findings Include:</p> <p>The clinical record of resident # 41 was reviewed on 2/6/12 at 10:30 a.m. Resident # 41's diagnoses Included, but were not limited to, hypertension (high blood pressure), hip fracture, anxiety, depression, and COPD (chronic obstructive pulmonary disease).</p> <p>The current MDS [minimum data set] assessment indicated Resident #41 required assistance with all ADL's (activities of daily living) and had mild cognitive impairment (a impaired ability for decision making and thought process).</p>	F0226	<p>F226-Abuse1. CORRECTIVE ACTIONResident # 41 was immediately protected and assessed for any injury with none noted. Resident # 112 has been discharged on 01/17/2012. SSD interviewed resident # 41 and the Executive Director did a phone interview with resident # 112 on 01/17/2012 with no injury reported. SSD interviewed other residents on the specific assignment of the employee in question. The employee was suspended and then terminated.</p> <p>2. IDENTIFICATION OF OTHERS POTENTIALLY AFFECTED Alert and oriented residents who received care by alleged staff member were interviewed on 01-17-12 by Social services. No other residents were affected. The nurse involved was educated by the unit manager on 02/20/2012 in relation to reporting guidelines of alleged abuse. A 100% audit of alert and oriented residents will be completed by department managers by March 7,, 2012. Non-interviewable residents will be assessed by head-to-toe skin assessments, as well as, contacting families and interviewing staff by nursing</p>	03/08/2012			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>A "Facility Incident Reporting Form" was reviewed on 2/3/12 at 9:30 a.m.</p> <p>The "Facility Incident Reporting Form" indicated Resident #41 was force fed by a CNA (Certified Nursing Assistant) against her wishes by moving Resident #41's hand away from her mouth and forcing a spoon into her mouth. The form also indicated that the room mate of Resident #41, resident # 112 tried to intervene by saying that Resident #41 did not want to be fed and the same CNA told her to "mind her own business". The form also indicated after a facility investigation, the CNA was terminated from her position for how she treated Resident #41.</p> <p>The report indicated the incident occurred on 1/16/12 at 5:45 p.m. The nursing staff reported it to the ED (Executive Director) and DON (Director of Nursing) on 1/17/12, the day after the incident occurred, and the CNA involved was "immediately suspended pending the investigation". Assessments were done for physical abuse, both Resident #41 and room mate were interviewed, social services completed "resident interviews to determine if other residents were affected by this concern/incident. Interviews determined that no other residents were identified as being affected by this</p>		<p>administration by March 7, 2012. .</p> <p>3.Systemic Changes Facility Policy has been updated/ revised to reflect federal regulation requirement for reporting all alleged violations involving mistreatment, neglect, or abuse; including injuries of unknown source and misappropriation of resident property "immediately to the administrator of the facility." (See Attachment: Reporting Alleged Abuse Policy Revised)Education and in servicing related to abuse, neglect, reporting, resident rights and the policies will be completed by March 7, 2012 by the Executive Director and or their Designee to 100% of staff. Those staff members who have not been in-serviced will not be allowed to work until in-service has been completed. 4. Quality AssuranceFive resident interviews will be conducted weekly for psychosocial and physical well being by department managers on Monday through Friday x 4 weeks. Staff will be monitored for compliance of systemic change via the staff interview audit tool. Five staff members will be audited weekly for four weeks.Weekend managers will interview one resident per weekend day for four weeks.Regional Director of Clinical Services will audit findings monthly x twelve months. Audits will be reviewed by PI committee x twelve months, or</p>	

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 02/07/2012
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234		
(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>concern". The CNA involved was "terminated for violation of Resident Rights".</p> <p>A facility policy titled "Abuse and/or Neglect Investigation" dated 02/09, indicates "Residents have the right to live at ease in a safe environment without fear...".</p> <p>3.1-28(a)</p>		<p>until one hundred percent of audit threshold has been met. 5. Completion dateDate of Compliance March 8 th , 2012.</p>		

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
F0282 SS=D	<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 ensure laboratory blood draws and stool specimens were done as a physician ordered for 2 of 13 residents reviewed in a total sample of 23 residents. Residents B and D.</p> <p>1) The clinical record for Resident B was reviewed on 2/6/12 at 9:00 a.m.</p> <p>Diagnoses included but were not limited to; atrial fibrillation (a type of irregular heart beat).</p> <p>A physicians order written on 1/10/12 indicated "Check [check mark sign] PT/INR (Prothrombin time and international normalized ratio; blood test that determine the clotting tendencies of the blood) on 1/11/12".</p> <p>A physicians order written on 12/19/11 indicated "Check [check mark sign] PT/INR in A.M. (morning) and call result" [indicating the physicians office wanted the facility to call into the office with the result of the lab draw].</p>	F0282	<p>F282 Lab Services1. Corrective ActionResident B had a PT/INR scheduled to be drawn on 01/11/12. Lab was not drawn until 01/13/2012 but was due to resident's refusal on 01-11-12 and 01-12-12. This documentation can be found in the clinical record. Resident D was cited for a c-diff that was ordered on 01/27/2012. Upon further investigation the order written on 01/27/2012 was to begin an antibiotic for 10 days then do a repeat c-diff which would have occurred on 02/10/2012. Therefore the lab was not actually due until 02/10/2012, however this was not done due to the fact that the resident was admitted to the hospital on 02/08/2012. There were no adverse affects to either resident.2. Identification of others potentially affectedA lab audit was completed on 02/10/2012 by Madison lab services to assure no other residents receiving lab services had any missed labs and lab orders are accurate. Nursing administration completed an in house 100% audit on residents being treated for c-diff to assure no other c-diff labs had been missed on 02/6/2012 with none</p>	03/08/2012

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>During the record review, the lab results were not found in Resident B's chart. Further information was requested by the DON (Director of Nursing) on 2/6/12 at 12:30 p.m. regarding the lab results not being in the resident's clinical record.</p> <p>During an interview on 2/6/12 at 4:00 p.m. both the DON and 100 Hall Unit Manager indicated the laboratory blood draws were not done as ordered.</p> <p>2. The record of Resident #D was reviewed on 2/1/12 at 2:30 p.m.</p> <p>Diagnoses for Resident #D included, but</p>		<p>missed.3. Systemic Changes Labs will be checked daily by licensed nursing. The nurse will compare the computer print out daily to the lab log. If a discrepancy is noted the nurse will validate the order, notify the MD and the lab to assure compliance. If a resident refused to have a lab drawn it must be documented in the nurse's note, the MD and family notified. Madison Lab services in serviced licensed nursing on routine lab protocols on Feb 17 th 2012. Education and in servicing will be completed to licensed nursing by the staff development coordinator/designee on the above procedure by March 7, 2012 4. Quality Assurance Unit Managers are to audit lab log 5 times weekly until threshold is at one hundred percent for 90 days. The Don or designee will audit log 2 times weekly until threshold is at one hundred percent for 90 days.</p> <p>Information obtained from audits is to assure lab services are completed as ordered.</p> <p>5. Date of Compliance March 8 th , 2012</p>	

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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>were not limited to, dementia and Clostridium Difficile. (a bacterial infection causing severe diarrhea.)</p> <p>A physician's order dated 1/27/12 indicated "Send stool for C-diff, call office if results [negative]."</p> <p>No results were found in the resident's record to indicate the stool sample had been sent to lab.</p> <p>Further information regarding the 1/27/12 lab order for a stool for C-diff was requested from the Director of Nursing (DoN) on 2/1/12 at 4:45 p.m.</p> <p>No further information was provided by final exit on 2/7/12 at 12:00 p.m.</p> <p>3.1-35(g)(2)</p>						

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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			
F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure nutritional supplements were provided to a resident having significant weight loss for 1 of 10 residents reviewed for weight loss in a sample of 23. (#64)</p> <p>Findings included:</p> <p>The record of Resident #64 was reviewed on 2/1/12 at 10:00 a.m.</p> <p>Diagnoses for Resident #64 included, but were not limited to, Alzheimer's disease, depressive disorder, peripheral neuropathy, muscle weakness and cardiovascular disease.</p> <p>Review of a care plan for Resident #64, dated 10/20/11 and updated 1/20/12, indicated a problem of "Potential for alteration in Nutritional...status..." A goal was "No significant change in weight."</p>	F0325	<p>F325 Nutritional Status 1. Corrective Action Resident # 64 had MD assessment to determine weight loss unavoidable due to mouth cancer on 02/09/2012. Responsible party aware of weight loss due to hospice status. Magic cup added to medication sheet on 01/4/2012. Nurse involved in transcription error no longer employed at facility. Last day worked Dec 5 th , 2011.2. Identification of others potentially affected A 100% audit has been completed to determine significant weight losses of 10% for 180 days and or 5% for 30 days via weight history on 02/15/2012 by ADON. Nursing administration will complete an audit of medication sheets. Physician order sheets of residents found with weight loss and or supplements to ensure appropriate interventions and accuracy by 03/07/2012 by nursing administration 3. Systemic Changes Residents found to have a weight loss will</p>	03/08/2012			

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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>Interventions included "...Nutritional Supplements per Physician order..."</p> <p>Review of a Weight Change History for Resident #64, received from the Assistant Director of Nursing (ADoN) on 2/3/12 at 4:10 p.m. indicated the following weights:</p> <p>10/3/11: 143.9 pounds (lbs) 10/10/11: 143.1 lbs. 10/17/11: 138.3 lbs. 10/24/11: 134.0 lbs. 10/31/11: 132.6 lbs. 11/7/11: 132.6 lbs. 11/14/11: 130.3 lbs. 11/21/11: 132.3 lbs. 11/29/11: 130.2 lbs. 12/5/11: 125.6 lbs. 12/12/11: 127.3 lbs. 12/20/11: 122.6 lbs. 12/28/11: 123.6 lbs. 1/4/12: 125.4 lbs.</p> <p>During the above time frame (3 months) Resident #64 experienced a significant 12% weight loss.</p> <p>Nutritional Progress Notes indicated on 10/24/11 the Registered Dietitian suggested adding "Magic Cup," (a nutritional supplement) daily to Resident #64's diet. A physician's order was written for this. It was signed by the physician on 10/24/11.</p>		<p>be assessed and have appropriate interventions put in place by Feb 29 th , 2012 by the dietitian, ST (if needed) as well as MD and responsible party notified by nursing. In-servicing and education will be completed for licensed nursing in relation to taking off orders, notifying pharmacy and dietary, transcribing orders appropriately and validating orders on the monthly physician order sheets by the SDC/ designee by March 7, 2012.4. Quality AssuranceThe Nutrition at Risk chairperson/designee will audit 5 charts weekly until threshold is at one hundred percent for 180 days and the DON will audit 2 charts weekly until threshold is at one hundred percent for 180 days to assure compliance. The audit findings will be taken to the PI committee monthly. The plan to be updated as indicated. Information obtyained from audits is to assure nutritional supplements are being provided per plan of care.5. Completion dateDate of Compliance March 8 th , 2012.</p>				

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>Review of Medication Administration Records (MAR) for October and November 2011 indicated Magic Cup had been written by hand on the MAR with spaces provided for nurses to initial after giving the Magic Cup to the resident. The MARS for October and November indicated Resident #64 had received Magic Cup daily after it was ordered on 10/24/11.</p> <p>A review of the MAR for December, 2011, did not indicate that she received the Magic Cup. It indicated Magic Cup had not been written on the MAR.</p> <p>Review of a Nutritional Progress Note for 12/21/11 indicated "Continued wt. [weight] decline...10/24/11 Magic Cup ordered [daily], however, diet slip was not sent to the dietary...Add a Magic Cup to L [lunch] and D. [dinner] A Physician's order for this was not written until 1/3/12.</p> <p>Review of the MAR for January, 2012 indicated Resident #64 began receiving Magic Cup 2 times per day at lunch and dinner starting 1/4/12.</p> <p>During an interview with the ADoN on 2/2/11 at 3:30 p.m. she indicated if a resident receives Magic Cup once a day it is taken from a supply at the nurses'</p>			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>station and given to the resident. If it is given 2 times per day with meals it would be provided by the dietary department.</p> <p>During an interview with the Director of Clinical Services on 2/3/12 at 4:00 p.m. she indicated Resident #64 did not receive Magic Cup during December. She indicated she did not know why Magic Cup was not placed on the December MAR. She indicated "all orders" are faxed to the pharmacy and the pharmacy places the new orders on the MAR when the orders are recapitulated the following month. She indicated she did not know if the order was sent to the pharmacy or not.</p> <p>3.1-46(a)(2)</p>			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
F0368 SS=F	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on interview and record review the facility failed to offer snacks at bedtime daily in that 8 of 8 residents attending the Group Meeting . This had the potential to affect 106 of 107 residents. Resident #'s, 4, 33, 36, 58, 61, 63, 71,and 93.</p> <p>Findings Include:</p> <p>1. On 1/31/12 at 1:45 p.m. the group meeting was held. There were eight residents in attendance,(Resident #'s, 4, 33, 36, 58, 61, 63, 71,and 93) who indicated there were no bedtime snack (HS) offered daily. The residents indicated that they had discussed the</p>	F0368	<p>F368 Frequency of Meals (HS Snacks)1. Corrective ActionResident # 4, 33, 36, 58, 63, 71, and 93 had no adverse affect but were interviewed by the executive director on 2-23-12 and have had no further complaints. Resident 61 was discharged shortly after survey. 2. Identification of others potentially affected 100% audit of alert and oriented residents will be completed by March 7, 2012 by department heads and nursing staff to assure snacks are being delivered. 3. Systemic ChangesEducation and in servicing will be completed by March 7, 2012 by the Staff Development Coordinator /</p>	03/08/2012

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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>bedtime snacks in resident council and the staff offered bedtime snack (HS), but now they have stopped offering, only offered a couple of day.</p> <p>2. The Resident Council Minutes for January 2012 were review on 2/1/12 at 9:15 a.m.. The minutes indicated the residents had discussed bedtime snacks on 1/16/12. The Resident Council : Department Response from Nursing Department was reviewed on 2/1/12 indicated Eve snack protocol reviewed, Inservice planned for Nursing Department. Dietary is to send out appropriate snack.</p> <p>3. On 2/3/12 Interview with dietary staff # 14 indicated snacks are taken to the nurses station, but there seems to be a problem with getting them offered to the residents. There was a form drafted for the dietary staff to sign off when they take bedtime snacks to the nursing stations.</p> <p>4. On 2/3/12 the snack cart form indicated dietary took the snacks to the nurses stations on following dates and times: 1/24/12 at 9:30 p.m. 1/25/12 at 9:00 p.m. 1/27/12 at 8:53 p.m. 2/1/12 at 7:27 p.m. 2/2/12 at 8:00 p.m.</p> <p>5. On 2/6/12 at 4:00 p.m. Interview CNA # 16 indicated he/she stayed over from first shift, CNA indicated he/she was not</p>		<p>designee in relation to HS snacks being passed, delivered, and the protocol with written documentation including signatures during this process by both nursing and dietary departments. 4. Quality AssuranceThe activity director/ designee will do random audits on alert and oriented residents 1 time weekly x 4 weeks as well as asking resident council monthly x 6 months if snacks are being served. Duration of audits will continue one time weekly until threshold is at one hundred percent x thirty days. Resident council audits will be conducted montly until one hundred percent threshold is met for one hundred eighty days. Audit findings will be reviewed by the PI committee monthly x 6 months. 5. Completion dateDate of Compliance March 8 th , 2012.</p>				

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>sure how to do bedtime snacks but they "will tell me". CNA #17 he/she usually worked on the 200 hall not on 300 Hall. On the 200 hall We receive the snacks from dietary and then we offer each resident who is awake a snack. We do not wake up a sleeping resident to give them snack and it is late sometimes when they bring the snacks.</p> <p>During an interview with the Dietary Manager on 1/30/12 at 10:45 a.m. , he indicated this had the potential to affect 106 of 107 residents who received meals from the kitchen.</p> <p>A Policy was provided by the Dietary Manager on 2/3/12 at 4:05 p.m.. The policy titled "Therapeutic Diets and Snacks" indicated "The facility offers snack at night-time (HS) on a daily basis or state regulation".</p> <p>3.1-21(e)</p>			

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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			
F0371 SS=F	<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</p> <p>Based on observation and interview, the facility failed to prepare, distribute and serve food under sanitary conditions and equipment used to prepare food was maintained in a sanitary condition during 2 of 2 kitchen observations. This had the potential to affect 106 of 107 residents who received meals from the kitchen.</p> <p>Findings Include:</p> <p>During the dietary walk through on 1/30/12 at 10:30 a.m., with the Dietary Manager the following were observed:</p> <ol style="list-style-type: none"> 1. Dietary Staff # 1 was observed to have facial hair uncovered, as he prepared food, handled the dishes. 2. The hood over the stove and deep fryer had loose, chipped, and missing paint. 3. The plate warmer had accumulation of food crumbs, greasy film, and dry stains. 4. The tower carts used to transport residents room trays had an accumulation of dust, dirt, greasy film, dry food crumbs and stains. 5. Kitchen serving carts, with plastic surface tops, had unidentifiable debris in the slits and dry food crumbs. The white cart was missing one of two handles 	F0371	<p>F 371 Sanitation 1. Corrective Action Dietary staff covered facial hair during the survey process with beard restraints, the hood over the stove and deep fryer was scrapped, cleaned and painted, the plate warmer, tower carts and kitchen serving carts were cleaned as well on 2/3/2012 by the dietary staff. The white cart was discarded on 2/3/2012 by dietary staff. 2. Identification of others potentially affected Residents were observed for any symptoms related to sanitation concerns none were noted. The 24 hour report was utilized, one on one communication with nursing staff and overall assessments by licensed nursing staff. The dietary manager completed 100% audit of kitchen equipment on 02/20/2012. 3. Systemic Changes In service and education was provided for dietary staff in reference to facial hair coverings on 02/02/2012 by the dietary manager. In servicing and education was provided to dietary manager by ED on the policy and procedure for cleaning of kitchen equipment on Feb 24 th , 2012.</p>	03/08/2012			

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 02/07/2012
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234		
(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>During an interview on 1/30/12 at 10:45 a.m. with the Dietary Manager , he indicated this had the potential to affect 106 of 107 residents who received meals from the kitchen.</p> <p>On 2-2-12 at 11:15 a.m. during the noon meal preparation and service the following were observed:</p> <p>6. The Dietary Staff # 1 and Dietary Manager were observed to have facial hair uncovered, as they prepared food, handled the dishes and served the meal.</p> <p>7. The following equipment identified as soiled on 1-30-12 during the dietary walk through remained soiled on 2-2-12 during noon meal observation. The plate warmer had accumulation of food crumbs and multiply color dry stains. The tower carts that were used to transport residents room trays had accumulation of dust, dirt, greasy film, dry food crumbs, and stains. Kitchen black and white serving carts with plastic surface top had unidentifiable debris in the slits and dry food crumbs. The white cart was missing one of two handle.</p> <p>Interview with the Dietary Manager on 2-2-12 at 3:00 p.m. indicated it was the facility policy the dietary staff with facial hair (mustaches and beards) to be covered when in the kitchen. Facial hair should be covered during handling, preparing, and serving food. The Dietary Manger indicated the above mentioned concerns had the potential to affect 100 of 101 residents who received meals from the kitchen.</p>		<p>Registered Dietician completed in-servicing on policy and procedures for cleaning kitchen equipment for Dietary Staff on February 24, 2012.4. Quality Assurance Kitchen observation rounds to be completed by RD 1 time weekly x 90 days then monthly ongoing. Dietary manager to complete kitchen observation rounds 3 times weekly until threshold is at one hundred percent for 90 days then weekly ongoing to ensure compliance.</p> <p>Information obtained from audits are to assure compliance with facial hair coverings, hood over stove, deep fryer, is clean, and free of loose or chipped paint, and plate warmers and food delivery carts are clean and sanitized, and kitchen serving carts are clean and in good condition.</p> <p>Audit findings will be reviewed by PI monthly. 5. Completion DateDate of Compliance March 8 th , 2012</p>		

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
	3.1-21(i)(3)			

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 02/07/2012
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234		
(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	
F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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 (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.</p> <p>1. Based on observation, interview and record review, the facility failed to ensure</p>	F0441	F441 Infection Control1. CORRECTIVE ACTIONRes D	03/08/2012	

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 02/07/2012
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234		
(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>appropriate infection transmission precautions were used to prevent the potential spread of infection during 1 of 1 observations on the secured unit. This had the potential to affect 20 of 20 residents residing on the secured unit. (Resident #D, #E and #F)</p> <p>2. Based on observation and record review the facility failed to ensure clean gloves were used to administer insulin injections for 1 of 2 insulin injections observed. (Resident #G)</p> <p>Findings included:</p> <p>1. The record of Resident #D was reviewed on 2/1/12 at 2:30 p.m.</p> <p>Diagnoses for Resident #D included, but were not limited to, C. Difficile, (a bacterial infection causing severe diarrhea) and dementia.</p> <p>A review of a "200 Hall Report Sheet" on 1/30/2012 at 10:50 a.m. indicated there were 20 residents that resided on the unit.</p> <p>During an observation on 2/2/12 at 9:00 a.m., Certified Nursing Assistant (CNA) #1 entered Resident #D's room with her breakfast tray. CNA #1 did not put on gloves or a gown. She placed the tray on</p>		<p>had isolation cart placed immediately, during survey process. CNA # 1 and 2 and LPN # 3 were educated immediately to appropriate infection control protocols on 02/02/2012 by the SDC. Res E and F were observed for symptoms of infection on 02/02/2012 by unit nurse with none noted. Employee # 4 was educated on infection control practices on 02/03/2012 by the unit manager and Res G was evaluated for any symptoms of infection on 02/2/2012 by the unit nurse with none noted. A designated blood pressure cuff, thermometer and stethoscope for resident D was obtained and placed in room on 02/2/2012 by unit manager. 2. Identification of others potentially affectedA 100% audit for isolation carts being in place was completed by unit managers on 02/03/2012. Residents identified with c-diff during the survey process had infection control practices put into place on 02/3/2012 by licensed staff. No other residents warranted isolation.3. Systemic ChangesEducation and In servicing related to appropriate Infection control guidelines, policies and procedures and insulin administration will be completed on March 7, 2012 by Staff Development Coordinator/designee to nursing staff to assure compliance. *See attachment for information provided to staff for infection</p>		

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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>Resident #D's bedside table, sat down in a chair next to her bed, adjusted the resident's gown, pushed the call light to ask someone to bring milk for the resident's cereal, began feeding the resident, touched the chair arm, the bed linen and the resident's pillow. CNA #2 entered the room to see why the call light was on and picked it up to turn it off. She was not wearing gloves. CNA #2 exited the room without washing her hands. She went to the beverage cart, picked up the milk bottle, poured some milk, brought it to the resident's room and exited without washing her hands. CNA #1 proceeded to feed Resident #D, at various times wiping the resident's mouth, touching her gown, her shoulder and the linen with both hands. When Resident #D was finished eating, at 9:20 a.m., CNA #1 picked up the tray, handed it to Licensed Practical Nurse (LPN) #3 who was outside the door. Then CNA #1 left Resident #D's room without washing her hands, entered the room across the hall, sat on Resident #E's bed and picked up the spoon he was using to eat breakfast. She then stood up and picked up the food tray of Resident #F, Resident #E's roommate, and exited the room with it. At no time was she observed to wash her hands.</p> <p>At 9:27 a.m. LPN #3 returned to Resident #D's room, bringing back her breakfast</p>		<p>control inservice.4. Quality AssuranceThe Infection Control Nurse will complete 3 Infection control competencies weekly until threshold is at one hundred percent for 90 days with nursing staff. The DON will complete one infection control competency weekly until threshold is at one hundred percent for 90 days with nursing staff. *See attacment for infection control competency. Audit findings will be taken to PI monthly. 5. Completion DateDate of Compliance March 8 th , 2012.</p>				

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>tray, and placed it in a bag. At this time she indicated "We're supposed to bag isolation trays to alert dietary." At this time she also indicated she did not have a stethoscope or blood pressure cuff dedicated to use only on Resident #D. LPN #3 washed her hands prior to leaving Resident #D's room.</p> <p>During an interview with the Assistant Director of Nursing on 2/2/12 at 11:10 a.m. she indicated if the staff was going to have contact with a resident with C. difficile they needed to wear gloves and wash their hands before and after contact.</p> <p>During an interview with the DoN on 2/2/12 at 4:00 p.m. regarding the contact with Resident #D the morning of 2/2/12, she indicated the nursing staff "should have been wearing gloves and washing hands. We will have to reeducate." She indicated CNA #1, CNA #2 and LPN #3 were assigned to this secured unit for the entire shift on 2/2/12.</p> <p>2) During an observation of insulin administration to Resident #G and in the presence of Employee #4, Employee #4 was observed dropping a glove onto his</p>			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>own shoe and then picking the glove up and putting it on his hand. He then proceeded to give the insulin injection to Resident #G and then disposed of his gloves and insulin syringe. He then used alcohol based hand sanitizer to sanitize his hands.</p> <p>An undated facility policy titled "Clinical Services Policy & Procedure, Medication Administration" indicates staff should "gather equipment, maintaining sterility and cleanliness".</p> <p>An undated facility policy, titled "...Handwashing Information," received from the Director of Nursing (DoN) on 2/3/12 at 4:10 p.m., indicated "... The single most important factor in preventing and controlling infections is that of handwashing...3. After caring for an infected or contaminated resident...10. Before entering and leaving and isolation room or area."</p> <p>Review of a facility policy, received from the Administrator on 2/2/12 at 1:00 p.m., dated 7/18/11, titled "Standard and Transmission-based Precautions; Isolation Procedure A Guide to Infection Control Clostridium Difficile," indicated residents who have been diagnosed with C. Difficile should be in a private room when possible. Staff should wear gloves when entering the room and they should wear a gown if "...substantial contact with the resident or environmental surfaces is</p>			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>anticipated...Gowns and gloves are removed before leaving the resident's room and hands must be washed immediately...Items such as a stethoscope, sphygmomanometer...are dedicated to use on that resident only..."</p> <p>This federal tag relates to Complaint IN00103418</p> <p>3.1-18(j)</p>			

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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			
F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to maintain documentation of blood sugar checks and insulin administration in a manner which enabled them to monitor treatment effects for 1 of 2 residents reviewed for treatment of diabetes mellitus in a sample of 23. (Resident #C)</p> <p>Findings included:</p> <p>The record of Resident #C was reviewed on 2/3/12 at 10:00 a.m.</p> <p>Diagnoses for Resident #C included, but were not limited to, diabetes mellitus and obesity.</p> <p>A recapitulated physician's order for February, 2012, with an original date of 1/1/12, indicated Resident #C was to have</p>	F0514	<p>F514 Ineligible Documentation 1. Corrective Action Resident C was observed for adverse reaction and none noted. 2. Identification of others potentially affected 100% Audit was completed on 02/5/2012 for residents receiving Blood Sugars and/or Insulin by the DON and no other residents have been affected. 3. Systemic Changes Pharmacy has been notified to send pre printed blood sugar and or insulin flow sheets to facility for residents taking oral diabetic agents, insulin, and or having blood sugars taken. The flow sheets are in the medication books. This will ensure accurate and readable documentation. Education and in servicing will be completed by nursing administration and or SDC involving the new flow sheets and readable documentation by March 7, 2012. 4. Quality Assurance Daily audits will be</p>	03/08/2012			

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 02/07/2012	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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>accuchecks (a fingerstick test to measure blood sugar) 4 times a day, before meals and at bedtime.</p> <p>A recapitulated physician's order for February, 2012, with an original date of....., indicated Resident #C was to receive Humalog insulin 3 times a day (8:00 a.m., 12:00 p.m. and 5:00 p.m.) according to the following sliding scale:</p> <p>Blood sugar = 150 - 200 Receive 2 units insulin Blood sugar = 201 - 250 Receive 4 units insulin Blood sugar = 251 - 300 Receive 6 units insulin Blood sugar = 301 - 350 Receive 8 units insulin Blood sugar = 351 - 400 Receive 10 units insulin</p> <p>A review of the Medication Administration Record for January, 2012, indicated Resident #C's blood sugar had been checked 4 times per day as ordered. On the following dates and times this surveyor was unable to read the blood sugar results: 8:00 a.m.: January 8, 22, 25; 12:00 p.m.: January 2,11,12,17, 20, 24, 26 and 27; 5:00 p.m.: January 9,13,20 and 30; Bedtime: January 5,9,12,17,23,28 and 29.</p>		<p>completed Monday through Friday by nursing administration until threshold is at one hundred percent for 90 days. The DON or designee will check 3 residents weekly x 90 days to assure compliance. Audit findings will be brought to PI monthly x 6 months. The PI committee will determine need for further audits. Plan will be updated as indicated.</p> <p>1.5. Completion Date Date of Compliance March 8 th , 2012.</p>				

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>A review of the corresponding insulin administration for January, 2012, indicated indecipherable documentation.</p> <p>On 2/3/12 at 11:50 a.m. the Director of Nursing (DoN) was asked to provide information regarding the above blood sugars and insulin amounts.</p> <p>On 2/3/12 at 4:00 p.m. the DoN indicated she was not able to decipher the above blood sugars and amounts of insulin given. She indicated at this time she had found a new record on which to document accuchecks and insulin administration and the nurses were going to be instructed on its use.</p> <p>3.1-50(a)(2)</p>			

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 02/07/2012
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234		
(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	
F9999	<p>State Findings:</p> <p>1. 16.2-3.1-14 Personnel:</p> <p>Sec. 14. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview the facility failed to provide documentation of pre-employment references for 3 of 11 employees reviewed for pre-employment references. (LPN #8, CNA #10 and CNA #11)</p> <p>Findings include:</p> <p>A review of employee records on 2/6/12 at 11:30 a.m. indicated no documentation of references for LPN #8 (start date of 1/12/12), CNA #10 (start date of 9/1/11) and CNA #11.(start date of 1/12/12)</p>	F9999	<p>F9999THIS STATE FINDING WAS NOT MADE AVAILABLE ON FORM 2567 RECEIVED BY FACILITY. FACILITY WAS NOT AWARE OF STATE FINDING UNTIL SUBMISSION OF PLAN OF CORRECTION ON 2/24/2012. Corrective ActionReference Checks All associates hired as of February 1, 2012 will have a minimum of two (2) reference checks prior to orientation. Dementia Training All new associates hired as of February 1, 2012 will have received the required inservice hours within 30 days for personnel assigned to the dementia special care unit and within 6 months of initial employment for all other assigned units.TB 100% audit of all associate files will be completed by March 7, 2012 to assure compliance by designee. Identification 100% audit of all associate records to validate references, dementia training, physicals, and TB screenings conducted by Human Resources February 14, 2012. Systematic ChangesEducation Inserviceing to hiring managers was completed by Human Resources. Quality Assurance Human Resources personnel will audit all associate files prior to scheduling orientation to assure compliance.</p>	03/08/2012	

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>During an interview with the Director of Nursing on 2/7/12 at 11:30 a.m. she indicated she was not able to find any reference checks on the above employees.</p> <p>3.1-14 (q)</p> <p>2. 16.2-3.1-14 Personnel:</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of 6 hours of dementia-specific training within 6 months of initial employment, or within 30 days for personnel assigned to the Alzheimer's and dementia special care unit, and 3 hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on review of the employee personnel files the facility failed to provide documentation of dementia training for 3 of 11 employees reviewed for dementia training. LPN #9, CNA #12 and CNA #13)</p> <p>Findings include:</p>		<p>Finding of audits will be presented to PI monthly. Date of compliance: March 8, 2012.</p>	

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>Review of the employee personnel files on 2/6/12 at 11:30 a.m. indicated only 1 hour of dementia training for LPN #9 (start date of 4/29/10) and CNA #13, (start date of 4/14/11) and no hours of dementia training for CNA #12, (start date of 6/30/11)</p> <p>In an interview with the Director of Nursing on 2/7/12 at 11:30 a.m. she indicated she couldn't find any other documentation of dementia inservice completed for these employees.</p> <p>3.1-14(u)</p> <p>3. 16.2-3.1-14 Personnel</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom</p>			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes:</p> <p>(A) a report of the preemployment physical examination; and</p> <p>(B) reports of all employment-related health examinations</p> <p>(4) An employee with symptoms or</p>			

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 02/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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>signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure an employee was screened for tuberculosis prior to employment for 1 of 11 employees reviewed for tuberculosis screening. (CNA #12)</p> <p>Findings include:</p> <p>A review of the employee record of CNA #12 on 2/6/12 at 11:30 a.m. did not indicate she had received a first step PPD, a 2nd step PPD or a physical to rule out active disease prior to starting employment on 6/30/11.</p> <p>During an interview with the Director of Nursing on 2/7/12 at 11:30 a.m. she indicated she had no further information regarding CNA #12's preemployment tuberculosis screening.</p> <p>3.1-14(t)</p>			

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 02/07/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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