STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 2,3,4, and 5, 2024 Facility number: 00473 Provider number: 155389 AIM number: 100290410 Census Bed Type: SNF/NF: 39 Total: 39 Census Payor Type: Medicare: 3 Medicaid: 33 Other: 3 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4-15-2024.	F 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations. The facility requests a desk review.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karl Eck	RDO	05/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to immediately notify the Administrator of an allegation of abuse for 2 of 2 residents reviewed for abuse. (Resident 1 and 28) Findings include: 1. The clinical record for Resident 1 was reviewed on 4/2/24 at 1:30 p.m. His diagnoses included, but were not limited to: anxiety, major depressive disorder, insomnia, and type 2 diabetes. An interview was conducted with Resident 1 on 4/2/24 at 1:33 p.m. He indicated Resident 6 grabbed him and kicked him in the back of his wheel chair last week, in the dining room. He told staff about it and they followed up with him. Now, he stayed away from Resident 6.	F 0609	F 609 – Reporting of Alleged Violations 1. The residents' incidents were immediately reported to IDOH. Residents 1 and 28 had no adverse outcomes related to the deficient practice2. All residents have the potential to be affected by the deficient practice. 3. Administrator/DON / Designee will educate staff on the Abuse Prevention Program including when and who to report abuse to. This education was completed on or before 5/3/2024.4. At the daily CQI morning meeting, the progress notes written since the previous daily CQI morning meeting will be reviewed to ensure that any event	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The 3/30/24 Nursing Progress Note for Resident 1 read, "Unwitnessed incident the resident was kicked by another resident in the back of his w/c [wheel chair] and pinched on his left upper arm and back, no apparent injuries, statement was taken from the resident whom was hit, head to toe assessment done on this resident who was stuck, he had no apparent injuries, NP [Nurse Practitioner,] DON [Director of Nursing,] and Family notified." An interview was conducted with the ED (Executive Director) on 4/2/24 at 1:45 p.m. She indicated she knew about the altercation between Resident 1 and Resident 6. It happened on Saturday, 3/30/24. She didn't find out about it until Monday, 4/1/24, at Monday Morning Meeting through a progress note and risk management entry. The nurse who created the progress note entered the altercation into a risk management entry for both residents. The nurse thought the ED would find out about the altercation through risk management. The nurse should have reported it to her immediately. An interview was conducted with Resident 1 on 4/4/24 at 10:30 a.m. He indicated the pinch hurt, but not too much, and didn't leave a bruise or anything. It hurt his feelings at the time, but he was okay now. 2. The clinical record for Resident 28 was reviewed on 4/2/24 at 1:13 p.m. Resident 28's diagnoses included, but not limited to, borderline personality disorder, bipolar disorder, Lupus, anxiety disorder, major depressive disorder, and fibromyalgia. A nursing note dated 12/15/23 at 8:26 a.m. indicated, Resident 28 had told the writer of the nursing note of an incident that happened during		that meets reportable criteria was initially reported, investigated and had all appropriate protocol followed as per policy and regulation. On weekends and holidays, the supervisor on each shift will ensure that incidents of abuse or potential abuse as well as grievances, are addressed per policy and regulation. Any concerns will be addressed if found. The Administrator and /or designee will conduct random ongoing audits of the Grievances and daily reports to ensure they are documented, investigated, followed up, and reported to ISDH if required. Audits will be completed by the Administrator/designee 5 days a week for 4 weeks; 3 days a week for 2 weeks; 1 day a week for 2 weeks; then monthly for 4 months. The results of the audits done by the administrator/designee, will be presented to the QAPI committee at the monthly meetings. Any concerns will be addressed if found. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Acton Plan will be monitored by the administrator weekly until resolved.5. DOC 5/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the evening shift on 12/14/23. Resident 28 indicated, she was verbally abused by her roommate and wanted staff to be aware but did not want to move rooms. An interview with Resident 28 conducted on 4/2/23 at 2:36 p.m. indicated, when she was roommates with Resident 13, Resident 13 would yell at her to get off the phone, say that she is good for nothing, and that she needed mental help. An interview with ED (Executive Director) conducted on 4/2/24 at 3:17 p.m. indicated, the alleged verbal abuse between Resident 28 and Resident 13 on 12/14/23 had not been reported to her or the management staff. ED further indicated, the alleged verbal abuse had not been reported to the Indiana State Department of Health as of yet, but she was going to report it immediately and an investigation into the incident was to begin. The investigation file for the alleged verbal abuse was received on 4/4/24 at 1:20 p.m. It contained, but not limited to, an Indiana State Department of Health incident report dated 4/2/24 at 3:39 p.m. The incident report indicated, the actual identified date of the incident being reported had occurred on 12/15/23 at 8:26 a.m. The alleged verbal abuse incident was not reported timely. An Abuse Prevention Program policy received on 4/3/24 at 2:14 p.m. from ED indicated, "... Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, or mistreatment they observe, hear about of suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator. The Administrator is the Abuse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Coordinator...Supervisors shall immediately inform the Administrator or in the absence of the Administrator, the person in charge of the facility of all reports of incidents, allegations, or suspicion of potential mistreatment. Upon learning of the report, the Administrator or in the absence of the Administrator, the person in charge of the facility shall indicate an incident investigation...The Administrator or designee utilizing the ISDH [sic, Indiana State Department of Health] Incident Report form will immediately notify the ISDH by email or fax...Verbal Abuse: Any use of oral, written, or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability." 3.1-28(c)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to provide showers, as care planned and preferred, for 1 of 3 residents reviewed for ADL (Activities of Daily Living) care (Resident 35). Findings include: The clinical record for Resident 35 was reviewed on 4/2/24 at 1:17 p.m. The Resident's diagnosis included, but were not limited to, parkinsonism and tremors.	F 0677	F 677 1. Resident #35 bathing preferences were reviewed with resident and updated per resident preference. Resident #35 was provided a shower on 4/5/2024 2. All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. The DON/designee will complete an audit with current residents to verify/update resident bathing	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A care plan, initiated on 8/1/23, indicated Resident 35 needed assistants with adl care related to his impaired mobility and tremors. The goal was for him to have all adl needs met by staff. The interventions included, but were not limited to, bathe per resident preference 2 x weekly and as needed, initiated 8/1/23. An Activity Resident Interview, completed 1/12/24, indicated it was very important to Resident 35 to choose between a tub bath, shower, bed bath or sponge bath. A Quarterly MDS (Minimum Data Set) Assessment, completed 2/5/24, indicated he was cognitively intact. During an interview on 4/2/24 at 1:17 p.m., Resident 35 indicated he did not always get his showers. He thought his shower day was on Fridays. He did not always get showers twice a week and that he preferred showers, not bed baths. During an interview on 4/3/24 at 1:44 p.m., the DON (Director of Nursing) indicated his showers were scheduled for Wednesday and Sunday evenings. During an interview on 4/3/24 at 3:15 p.m., CNA (Certified Nursing Assistant) 20 indicated Resident 35 normally did not refuse his showers. March and April showers should have been performed on 3/3, 3/6, 3/10, 3/13, 3/17, 3/20, 3/24, 3/27, 3/31, 4/3. On 4/3/34 at 3:30 p.m., the RNC (Regional Nurse Consultant) 1 provided shower sheets for		preferences and care plans updated, the audit will be completed by 05/03/2024 3. The DON/designee will complete education with the nursing staff by 05/03/2024 related to honoring resident bathing preferences. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. 4. The "F 677 – Honoring resident bathing preference per care plan will be completed on 10 random residents weekly for 4 weeks, 5 random residents weekly for 4 weeks, 3 random residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. 5. DOC 05/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident 35 for March 2024, which indicated that he had received the following: 3/6/24- shower, 3/9/24- shower, 3/16/24- bed bath, 3/20/24- he had refused, 3/23/24- shower, 3/27/24- shower, and 3/30/24- shower. On 4/4/24 at 10:06 a.m., the RNC 1 provided the current Activities of Daily Living policy which read "...ADL care is provided throughout the day, evening and night as care planned and / or as needed. ADL care is coordinated between the resident and the care giver with emphasis on resident preferences as much as possible..." 3.1-38(3)(b)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to clarify and administer a resident's medication, as ordered; to ensure physician orders were followed, as ordered, for a resident with elevated blood sugars; and to monitor blood pressure, as ordered, prior to administering a medication for 3 of 5 residents reviewed for unnecessary medications. (Resident 10, 11, and 21) Findings include:	F 0684	1. Resident # 10 current Haldol order was reviewed with psych services on 4/3/2024 by the DON with no changes made. Residents 21's blood sugars and insulin were reviewed with the physician and no new orders, and physician made aware that recheck of blood sugar not completed on 3/6/2024 on 04/10/2024 by the DON. Resident #11 blood pressure has	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	1. The clinical record for Resident 10 was reviewed on 4/3/24 at 1:49 p.m. His diagnoses included, but were not limited to paranoid schizophrenia. The paranoid schizophrenia care plan, revised 2/21/23, indicated he was at risk for the behavioral expressions of paranoia, delusions, and making false accusations at times. Interventions were to GDR (gradual dose reduction) per schedule and provide medications as ordered. The 3/18/23 Note To Attending Physician/Prescriber read, "This resident is due for a trial reduction of Haloperidol 5 mg three times a day for schizophrenia. Please consider a gradual dose reduction, while monitoring for re-emergence and/or withdrawal symptoms...Recommend to change to: Haloperidol 5 mg twice daily and 4 mg in the afternoon for schizophrenia." The Physician/Prescriber Response section of the note, completed by the facility's Psyche NP (Nurse Practitioner) on 3/22/24, indicated she agreed with the recommendation and to change the order to the recommended Haloperidol 5 mg twice daily and 4 mg in the afternoon. The 3/22/24 psychiatry progress note, written by the facility Psyche NP, read, "[Name of Resident 10] is assessed today in his room, he is resting in his bed underneath the blanket. Addressed his name, he barely responded that he wants to sleep. He appears without any distress. Staff reported resident is doing same and no concerns with sleep, appetite, anxiety or depression or any mood or behavior symptoms. So, reduced his haloperidol slightly as per GDR today. Continue psychiatric services to monitor resident's mood, behaviors, diagnoses, and medications, making appropriate adjustments when clinically		been reviewed since 4/17/2024 and has not been below 100 systolic. Physician made aware of medication error on 4/10/2024 by the DON related to lack of blood pressure monitoring. 2. All residents with recommended GDR's have the potential to be affected by the alleged deficient practice. All residents with orders to recheck a blood glucose have the potential to be affected by the alleged deficient practice. All residents with orders to hold blood pressure medication related to blood pressure reading have the potential to be affected by alleged deficient practice. DON/designee will review previous 30 days of Pharmacy recommendations related to GDR's to verify accuracy of physician orders to be completed by 5/3/2024. DON/Designee will audit residents with blood glucose checks to verify any follow up blood glucose orders were documented, to be completed by 5/3/2024. DON/Designee reviewed residents with blood pressure monitoring orders related to administration of BP medications with NP on 04/10/2024 and updated orders as needed. 3. DON/designee educated staff on by 5/3/2024 following GDR recommendations, follow up blood glucose monitoring, and BP monitoring per physicians order. Additionally, any employee who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	indicated....Paranoid schizophrenia Mod [moderately] stable - 1. REDUCE Haloperidol Lactate concentrate 5 mg [2.5 ml] BID [twice daily,] and haloperidol 4 mg daily in the afternoon." The March and April, 2024 MARs (medication administration records) indicated he received 2.5 ml of Haloperidol Lactate Oral Concentrate 2 mg/ml by mouth at bedtime only from 3/24/24 through 4/3/24, which was not in accordance with the facility Psyche NP's 3/22/24 pharmacy recommendation response or 3/22/24 psychiatry progress note. An interview was conducted with the DON (Director of Nursing) on 4/4/24 at 10:36 a.m. She indicated on 3/22/24 the Psyche NP put the Haloperidol order in for intramuscularly, the wrong route. Then the evening shift nurse, LPN (Licensed Practical Nurse) 5, noticed it, so she switched the order to 2.5 ml, but didn't have an order to do so. LPN 5 took it upon herself to change the order. Resident 10 should have been administered his Haloperidol, as ordered, in accordance with the 3/22/24 Psyche NP note and 3/22/24 pharmacy recommendation response. 2. The clinical record for Resident 21 was reviewed on 4/3/24 at 9:03 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. A physician order dated 1/31/24 indicated Resident 21 was to receive novolog insulin with meals utilizing a sliding scale. The scale was the following: blood sugars 0 - 150 = 0 units of insulin, blood sugars 151 - 200 = 2 units of insulin, blood sugars 201 - 250 = 4 units of insulin, blood sugars 251 - 300 = 6 units of insulin, blood sugars 301 - 350 = 8 units of insulin, and		fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. 4. GDR verification, blood glucose re-check, and blood pressure monitoring audits will be completed 5 days a week x 4 weeks, weekly x 4 weeks, then monthly x 4 months. If the facility is within 95% compliance after the 6 months, the monitoring will be stopped. 5. DOC 05/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	blood sugars 351 - 400 = 10 units of insulin The staff were to call the medical provider if the resident's blood sugar was greater than 425. The March 2024 Medication Administration Record (MAR) indicated Resident 21's blood sugar reading was 486 on 3/6/24 at 11:00 a.m., and 497 on 3/7/24 at 5:00 p.m. A MAR nursing note dated 3/6/24 indicated "Writer notified of resident's elevated BG [blood glucose] level; 486. Notified NP [Nurse Practitioner]. Order to give sliding scale per MAR 10 units plus additional 2 units. Recheck after 1-2 hours. Will continue with plan of care." The resident's clinical record did not indicated the resident's blood sugar was rechecked in 1-2 hours as ordered. A MAR nursing note dated 3/7/24 indicated the resident's "BS [blood sugar] is 497, Nurse notify And 13 units given and to be checked back in 1 hr [hour]. The resident's clinical record did not indicate the resident's blood sugar was rechecked 1 hour as ordered. An interview was conducted with Regional Nurse Consultant 1 on 4/4/24 at 2:08 p.m. She indicated she was unable to find any notations that Resident 21's blood sugars were rechecked as ordered after treating elevated blood sugars of greater than 425 on 3/6/24 and 3/7/24. 3. The clinical record for Resident 11 was reviewed on 4/2/24 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, hypertension and congestive heart failure.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A care plan, initiated 10/5/2019, indicated Resident 11 had a diagnosis of hypertension. The goal was for her to have no complications with blood pressure. The interventions, initiated 10/5/2019, were to administer medication as ordered, monitor blood pressure per physician order or facility policy, and to notify the physician and family as needed. A physician's order, dated 2/24/24, indicated Resident 11 was to received metoprolol 75 mg (milligram) tablet twice daily. Hold if systolic blood pressure is less than 100. The March and April 2024 MAR (Medication Administration Record) indicated the metoprolol 75 mg had been administered twice daily. There were no blood pressure recorded on the MAR to indicate what the systolic blood pressure was at the time of administration. The blood pressures recorded in the vital signs section of the electronic health record were 3/15/24 -109/69, 4/2/24- 105/ 65, and 4/3/24- 110/76. On 4/3/24 at 3:40 p.m., the DON (Director of Nursing) indicated that the blood pressures should have been completed prior to administering the metoprolol. The Verbal Orders/Admission/Readmission Orders policy was provided by (Regional Nurse Consultant) 2 on 4/4/24 at 11:22 a.m. It read, "Question the authorized prescriber if there is any uncertainty regarding the order." The following physician orders policy was provided by the Director of Nursing on 4/4/24 at 2:10 p.m. It indicated "...Policy: It is the policy of the facility to follow the orders of the physician.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	At the time of admission the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission...4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility." 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview and record review, the facility failed to ensure vision services was provided for 1 of 1 residents reviewed for vision services. (Resident 38) Findings include: The clinical record for Resident 38 was reviewed on 4/2/24 at 10:30 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. The resident was admitted to the facility on 12/4/23.	F 0685	F 685 – Treatment/Devices to Maintain Hearing/Vision 1. Resident 38 is scheduled to receive vision services on 5/7/2024.2. All residents have the potential to be affected by the deficient practice. 3. Administrator/DON / Designee will educate social services and the interdisciplinary team on the importance of ensuring residents receive timely	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A eye consultant consent dated 12/6/23 indicated Resident 38 would like vision services. An interview was conducted with Resident 38 on 4/2/24 at 10:39 a.m. He indicated he was having trouble with his vision and would like to see an eye doctor. The eye visits were provided by the Regional Nurse Consultant 2 on 4/4/24 at 2:00 p.m. It indicated eye services was provided in the facility on 3/27/24. Resident 38 had not been seen. An interview was conducted with Social Services Director on 4/5/24 at 9:12 a.m. She indicated Resident 38 had signed a consent to receive vision services. She was unsure why the resident had not been seen. There have been some concerns with delays on vision services with the vision company the facility current uses. A vision services policy was provided by Regional Nurse Consultant 3 on 4/5/24 at 10:47 a.m. It indicated "...The vision and hearing services standard has been to assist with achieving compliance standards found within the State Operations Manual pertaining to proper treatment to maintain vision and hearing abilities. Purpose: To promote, comply, and ensure compliance with state and federal regulations pertaining to vision and hearing services...Policy: It is the standard of the organization to ensure that residents receive the proper treatment and assistive devices to maintain hearing and vision abilities..." 3.1-39(a)(1)		vision services. This education was completed on or before 5/3/2024.4. At the daily CQI morning meeting, the progress notes written since the previous daily CQI morning meeting will be reviewed to ensure that any concerns related to vision services are timely addressed. On weekends and holidays, the supervisor on each shift will ensure that concerns related to ancillary services are addressed per policy and regulation. Any concerns will be addressed if found. The Administrator and /or designee will conduct random ongoing audits of the concerns related to vision services. Audits will be completed by the Administrator/designee 5 days a week for 4 weeks; 3 days a week for 2 weeks; 1 day a week for 2 weeks; then monthly for 4 months. The results of the audits done by the administrator/designee, will be presented to the QAPI committee at the monthly meetings. Any concerns will be addressed if found. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Acton Plan will be monitored by the administrator weekly until resolved.5. DOC 5/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview and record review, the facility failed to ensure dental services were provided for 2 of 2 residents reviewed for dental (Resident 25 and Resident 38) Findings include: 1. The clinical record for Resident 38 was reviewed on 4/2/24 at 10:30 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. The resident was admitted to the facility on 12/4/23. The dental consultant consent dated 12/6/23 indicated Resident 38 would like dental services. An observation was made of Resident 38 on 4/2/24 at 10:39 a.m. The resident's oral cavity was observed with missing and broken teeth. The resident indicated at that time he was having trouble with some of his teeth. He had several teeth missing and cavities. He had not seen a dentist since he had been in the facility. 2. The clinical record for Resident 25 was reviewed on 4/2/24 at 10:30 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. The resident was admitted to the facility on 8/2/23. The dental consultant consent dated 8/9/23 indicated Resident 25 would like dental services. An observation was made of Resident 25 on 4/2/24 at 10:24 a.m. The resident was observed	F 0791	F 791 – Routine/Emergency Dental Srvcs in NFs 1. Residents 25 and 38 received dental services on 4/25/2024 and 5/2/2024.2. All residents have the potential to be affected by the deficient practice. 3. Administrator/DON / Designee will educate social services and the interdisciplinary team on the importance of ensuring residents receive timely ancillary services. This education was completed on or before 5/3/2024. 4. Audits will be completed on concerns related to dental services. Audits will be done 5 days a week for 4 weeks; 3 days a week for 4 weeks, then monthly for 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	with a dark rotten front tooth. He indicated he would like to be seen by a dentist, but haven't seen one. The dental visits were provided by the Regional Nurse Consultant 2 on 4/4/24 at 2:00 p.m. It indicated the dental provider had been in the facility providing services on 3/22/24 and 4/3/24. Resident 25 nor Resident 38 had been seen on those dates. An interview was conducted with Social Services Director (SSD) on 4/5/24 at 9:12 a.m. She indicated Resident 38 and Resident 25 had signed consents to receive dental services. It should take approximately a month to set up for routine dental services. She was unsure why the residents had not been seen. She was unaware Resident 38 had been having trouble with his teeth until the care plan meeting that had been conducted on 4/2/24. She had received a dental report dated 12/18/23 indicating Resident 25's payer source was still pending. She had not followed up with the dental provider. A dental services policy was provided by Regional Nurse Consultant on 4/5/24 at 9:02 a.m. It indicated "...Policy: It is is the policy of the facility to provide medically related social services to attain or maintained the highest practicable physical, mental and psychosocial well-being of each resident. This includes meeting any need for dental/denture care to include routine as well as emergency indicated services..." 3.1-24(a)(1)(2)		resolved. 5. DOC 05/15/2024	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure food items were stored closed and labeled with open dates. This had a potential to effect 38 of 39 residents that eat food prepared in the kitchen. Findings include: An observation was made of the kitchen with Cook 5 on 4/2/24 at 8:06 a.m. During the tour, the refrigerators and freezers were observed with the following food items opened and/or not labeled with open dates: One freezer had 1 half full container of orange sherbet and 1 cardboard box that contained 5 lime sherbet containers individual size with no open dates. A 2nd freezer was observed with a bag of french fries opened to air with no open date and 1 bag of chicken tied shut,	F 0812	F 812 - Food Procurement, Store/Prepare/Serve-Sanitary It is the policy of this facility to ensure food is stored closed, and labeled with open dates. 1. All opened and undated food was discarded on 04/02/2024 by dietary staff. Items in the walk in freezer and dry storage were removed from the floor by dietary staff on 04/02/2024. 2. All residents have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents of the facility. 3. Administrator/designee educated dietary employees on	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	but no open date. The refrigerator was observed with 1 half full bag of spring salad mix closed with no open date. An interview was conducted with Cook 5 on 4/2/24 at 8:30 a.m. She indicated all food items should be labeled with open dates and sealed shut. The food storage policy was provided by the Regional Director of Operations on 4/3/24 at 11:22 a.m. It indicated "...Policy: Food shall be stored on shelves in a clean, dry area, from containments. Food shall be stored at appropriate temperatures and using appropriate methods to ensure highest level of food safety. Procedure: I. General storage guidelines to be followed: Label all food items. The label must include the name of the food and the date by which it should be sold, consumed or discarded..." The date marking policy was provided by the Regional Director of Operations on 4/3/24 at 11:22 a.m. It indicated "...Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date..." 3.1-21(i)(1) 3.1-21(i)(2) 3.1-21(i)(3)		the labeling and dating of foods. This education will be completed on or before 5/3/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined. 4. Audits will be completed on the proper storage of food and dating and labeling of food. Audits will be done 5 days a week for 4 weeks, 3 days a week for 4 weeks, then weekly for 4 months. If the facility is within 95% compliance at the end of 6 months; than monitoring can be stopped. Results of the monitoring will be reviewed monthly in the QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed action plan will be written by the QAPI committee. Any written action plan will be reviewed by the Administrator weekly until resolved. DOC: 05/15/2024	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 0921	**F 921 –**	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on observation and interview, the facility failed to maintain the floors in good repair with the potential to affect 39 of 39 residents residing at the facility. Findings include: On 4/4/24 at 10:55 a.m., an environmental tour of the facility was conducted with the DOM (Director of Maintenance), RDO (Regional Director of Operations), and the ED (Executive Director). The following areas of concern were noted: 1. The flooring in the hallway outside of room 42 had a crack in the floor tiles approximately 4 ft long. 2. The flooring in the hallway outside of room 32 had cracks in the tiles which was approximately 25 ft long and 3 inches at the widest part. 3. the flooring outside of room 28 had a crack in the tiles which was the width of the hallway and 11/2 inch at the widest part. 4. The metal threshold between the new and older part of the building had a divot that was approximately 2 inches x 2 inches and 1/4 inch deep. There were 4 broken tiles present at the threshold. 5. The hallway flooring outside of room 18, room 23, and room 25 had a broken tiles present. 6. The tiles outside of room 25 had a stained and dirty appearance. 7. The hallway flooring outside of room 45 had stained tyles. 8. The vinyl flooring by the janitors' closet was buckled and pulled from the floor. 9. The vinyl flooring in the hallway by room 9 was pulled up from the floor by the cove base. 10. The vinyl flooring at the thresholds of room 8 and 12 were pulling away from the floor.		**Safe/Functional/Sanitary/Comfortable Environment** **1. No resident were affected by the alleged deficient practice.** 2. All residents have the potential to be affected by the deficit practice, therefore this plan of correction applied to all resident's of the facility. All flooring will be remedied by 5/15/2024 3. Administrator/designee educated the maintenance director related to repairs related to environmental concerns. This education will be completed on or before 5/3/24. **Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.** 4. Audits will be completed on repairs related to environmental concerns. Audits will be done 5 days a week for 4 weeks; 3 days a week for 2 weeks; 1 day a week for 2 weeks; then monthly for 4 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. 5. DOC 5/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	11. The vinyl flooring in the hallway outside of room 3 had divots in the floor and cracks in the vinyl. During an interview on 4/4/24 at 11:10 a.m., Resident 94 indicated the floors were "like a roller coaster" in some parts of the building. The hallway flooring could use some work. During an interview on 4/4/24 at 11:12 a.m., Resident 1 indicated the flooring in the facility was bumpy in places. During an interview on 4/4/24 at 11:15 a.m., the ED, RDO, and DOM indicated the building floors had settled and caused the cracks in the tiles. The tiles were cleansed and waxed regularly, however due to the age of the flooring, some of the tiles were permanently stained. The vinyl flooring had been installed improperly causing a bumpy, unevenness to the floor. 3.1-19(a)(4)		=" " span=" "> =" " p=" "> =" " p=" "> =" " p=" ">	
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in	F 9999	=" " span=" "> br=" "> =" " span=" "> br=" "> =" " span=" "> br=" "> =" " p=" "> =" " span=" "> F9999 1. LPN #5, RN#10, and HSK #11 received their tuberculin testing on 4/26/2024 2. The BOM/designee completed	05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (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. (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 person 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 administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid 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		an audit of employee files and any staff lacking their tuberculin skin test received on 04/26/2024. 3. Administrator/designee will educate BOM/HR on what needs to be in the employee files, including PPDs by 5/3/2028. Additionally, any staff that fails to comply with the points of this inservices will be further educated and/or disciplined as indicated. 4. The BOM/designee will audit new employee files to ensure the employee received the two step tuberculin skin test weekly x 6 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring can be stopped. Results of this monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any need Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. DOC: 05/15/2024 ="" p="">="" p="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (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. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide staff members with tuberculin skin (TB) testing for 3 of 10 employee personnel files reviewed. (Licensed Practical Nurse[LPN] 5, Registered Nurse [RN] 10, and Housekeeping aide [HSK] 11). Findings include: The staff employee records were provided by the Regional Director of Clinical Operations (RDCO) on 4/2/24 at 2:44 p.m. A review of the facility's Personnel files was completed on 4/5/24. The following Personnel files were reviewed on 4/5/24 and the following was found to be missing: 1. LPN 5's file did not contain a second step TB (tuberculosis) test. LPN 5's date of hire was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	11/21/23. The personnel file contained evidence of one TB test administered on 1/3/24 and read on 1/5/24. The personnel file did not contain evidence a second step TB test had been administered or read. 2. RN 10's personnel file did not contain a second step TB test. RN 10's date of hire was 2/21/24. The personnel file contained evidence of one TB test administered on 2/13/24 and read on 2/15/24. The personnel file did not contain evidence a second step TB test had been administered or read. 3. HSK 11's personnel file did not contain a second step TB test. HSK 11's date of hire was 2/8/24. The personnel file contained evidence of one TB test administered on 2/2/24 and read on 2/5/24. The personnel file did not contain evidence of a second step TB test had been administered or read. A review of HSK 11's time sheet, provided by ED (Executive Director) on 4/5/24 at 12:32 p.m. indicated, between 2/26/24 and 3/9/24 HSK 11 had worked at the facility on 2/26/24, 2/27/24, 2/28/24, 2/29/24, 3/2/24, 3/3/24, 3/6/24, 3/7/24, 3/8/24, 3/9/24 thus giving the facility opportunities to complete the second step TB testing timely. An interview with ED conducted on 4/5/24 indicated, she was unable to locate/provide evidence of the second step TB tests. 3.1-14(a) 3.1-14(k) 3.1-14(l) 3.1-14(p)(1) 3.1-14(p)(2) 3.1-14(p)(4) 3.1-14(q)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTPARK A WATERS COMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-14(t) 3.1-14(u)			