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	09/14/2022

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00377198 and IN00383174. Complaint IN00377198 - Unsubstantiated due to lack of evidence. Complaint IN00383174 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: September 11, 12, 13, and 14, 2022 Facility number: 000473 Provider number: 155389 AIM number: 100290410 Census Bed Type: SNF/NF: 28 Total: 28 Census Payor Type: Medicare: 7 Medicaid: 15 Other: 6 Total: 28 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 20, 2022	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 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Based on interview and record review, the facility failed to ensure accuracy of a resident's MDS (Minimum Data Set) assessment for 1 of 16 residents whose MDS assessments were reviewed, and accurately complete a discharge tracking MDS Assessment for 1 of 3 discharged resident records reviewed. (Resident 23 and 28) Findings include: 1. The clinical record for Resident 23 was reviewed on 9/12/22 at 10:56 a.m. The diagnoses included, but were not limited to: bipolar 2 disorder, insomnia, and major depressive disorder. The diagnosis section of the electronic health record indicated "Bipolar II Disorder," with an onset date of 7/22/22. The 8/9/22 Notice of PASRR (PreAdmission Screening Resident Review) Level II Outcome indicated, "You have mental health diagnosis of Major Depression, Bipolar 2, Sleep disorder, Anxiety. You are taking your mental health medications, helps with stabilizing your symptoms....DSM [Diagnostic and Statistical Manual of Mental Disorders] Diagnoses...Bipolar II Disorder." Section A1500 of Resident 23's 8/18/22 Annual MDS assessment, completed by the MDSC (MDS Coordinator,) indicated she had not been evaluated by Level II PASRR and determined to have a serious mental illness. An interview was conducted with the MDSC and RDCR (Regional Director of Clinical Reimbursement) on 9/13/22 at 10:23 a.m. The MDSC indicated she completed Resident 23's 8/18/22 Annual MDS Assessment. The MDSC	F 0641	A plan of correction is not required for this cited deficiency.	10/02/2022

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	and RDCR reviewed the assessment and diagnosis section in the electronic health record. The RDCR indicated the PASRR section was incorrect, because she had a diagnosis of bipolar disorder, and would ensure the assessment was corrected. An interview was conducted with the RDCR on 9/13/22 at 11:05 a.m. She indicated they used the RAI (Resident Assessment Instrument) manual as their policy. The Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual Version 1.17.1 October 2019 indicated, regarding Section A1500, "Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD [Intellectual Disability/Developmental Disability] or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.2. The clinical record for Resident 28 was reviewed on 9/13/22 at 10:19 a.m. The Resident's diagnosis included, but were not limited to, diabetes and hypertension. A Discharge Tracking Minimum Data Set Assessment, completed 8/9/22, indicated Resident 28 had been discharged to the hospital. On 9/13/22 at 10:36 a.m., the Regional Director of Operations provided the Recapitulation of Resident's Stay for Resident 28. It indicated she had been discharged to her daughter's home on 8/9/22. During an interview on 9/13/22 at 11:11 a.m., the Regional Director of Clinical Reimbursement indicated she had coded the Discharge Tracking Minimum Data Set Assessment incorrectly. It			

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	should have been coded as a discharge to home.			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on interview and record review, the facility failed to provide an activity program to meet the interests of and support the physical, mental, and psychosocial well-being of each resident on the weekends for 2 of 2 residents reviewed for activities. (Residents 8 and 25) Findings include: An interview with Resident 8 conducted on 9/12/22 at 10:34 a.m. indicated, lately on the weekends it had been "terribly boring" and scheduled activities had not occurred. An interview with AC (Activities Consultant) 2 conducted on 9/13/22 at 1:06 p.m. indicated, the scheduled activities per the activity calendar had not been happening on the weekends. She stated, she does not work on the weekends and because of the lack of activity staff, the activity program was not occurring on the weekends. She indicated, there used to be a person that worked the weekends and conducted the activity program, but they no longer work at the facility.	F 0679	F679 – Activities All residents were directly affected by the cited deficient practice. A new activities director and an assistant was recently hired to ensure activities are conducted on the weekends. All residents have the potential to be affected by the citied deficient practice. The Regional Director of Operations educated the facility administrator on 9/28/2022 that activities must be conducted 7 days each week. The facility administrator educated the activities director on 9/28/2022 that activities must be conducted 7 days each week. The facility administrator recently hired an activities director and an activities	10/02/2022

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	An interview with Resident 25 conducted on 9/13/22 at 1:23 p.m. indicated, they haven't had activities on the weekends for quite a while because the activity person who worked the weekends no longer works there. She further indicated, they used to have religious services as well but that hasn't happened either. She indicated, the scheduled activities listed on the activity calendar did not occur last weekend. An interview with ED (Executive Director) conducted on 9/13/22 at 1:31 p.m. indicated, the weekend activity person's last day worked was 8/31/22. She further indicated, some residents had requested to watch movies on Sundays however, she was unable to confirm if a movie was played or which/if any residents participated in a movie viewing activity or if it occurred. A copy of the September 2022 activity calendar was received on 9/13/22 at 1:15 p.m. from AC 2. It indicated, the following activities were to occur: Saturday, 9/3/22: 12:30 p.m. - Exercises 2:30 p.m. - Book Club 4:30 p.m. - Card Games 6 p.m. - Today's Topic Summer Sports Sunday, 9/4/22: 12:30 p.m. - Exercises 2:30 p.m. - Coloring 4:30 p.m. - Lemonade and Life Lessons Saturday, 9/10/22: 12:30 p.m. - Exercises 2:30 p.m. - Book Club 4:30 p.m. - Card Games 6 p.m. - Today's Topic Summer Sports		assistant to ensure activities are conducted on the weekends. The facility administrator/designee shall conduct a weekly audit x8 weeks and then monthly x 4 months to ensure activities are conducted on the weekends. The facility administrator/designee shall conduct a weekly audit x8 weeks and then monthly x 4 months to ensure activities are conducted on the weekends. 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. /p> Date of Compliance: October 2, 2022	

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	Sunday, 9/11/22: 12:30 p.m. - Exercises 2:30 p.m. - Coloring 4:30 p.m. - Games An Activities Program policy was received on 9/13/22 at 2:26 p.m. from RDO (Regional Director of Operations). The policy indicated, "3. Facility will offer activities both individual and group to enhance the physical, mental and psychosocial well-being of residents...6. Facility will provide activities that are appropriate for residents related to their interests, culture and backgrounds...10. Activities will be provided during evenings as well as weekends...12. The Activity Director will ensure that timely, organized records are kept to show the participation/attendance of residents in both individual and group activities." 3.1-33(a)			
F 0727 SS=C Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility	F 0727	F727 – RN Coverage	10/02/2022

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	failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. This had the potential to affect 28 of 28 residents who resided at the facility. Findings include: The nursing staff schedule for the time period of 9/1/22 to 9/28/22 was provided by RDO (Regional Director of Operations) on 9/14/22 at 10:29 a.m. The nurse staffing schedule indicated, on 9/10/22, the facility did not have the services of a registered nurse (RN) for 8 consecutive hours. An interview with RDO conducted on 9/14/22 at 10:59 a.m. indicated, the facility did not have RN coverage on 9/10/22 for at least 8 consecutive hours. An interview with SCH (scheduler) 3 conducted on 9/14/22 at 11:04 a.m. indicated, the following dates did not have adequate RN coverage: - 8/20/22; only had 4 hours of RN coverage for the day - 8/27/22; had no RN coverage for the day - 9/10/22; had no RN coverage for the day 3.1-17(b)(3) 3.1-17(b)(4)		All residents were directly affected by the cited deficient practice. The facility MDS Coordinator (RN) and the facility DON (RN) have agreed to work a sliding schedule that will require one of them to each work every day if the facility lacks RN coverage that day. All residents have the potential to be affected by the citied deficient practice. The Regional Director of Operations educated the facility administrator on 9/28/2022 that RN coverage must be conducted 7 days each week. The facility administrator educated the DON on 9/28/2022 that RN coverage be conducted 7 days each week. The facility administrator recently hired a RN to ensure RN coverage is conducted 7 days each week (8 consecutive hours). The facility administrator/designee shall conduct a weekly audit x8 weeks and then monthly x 4 months to ensure RN coverage is conducted 7 days each week (8 consecutive hours). The facility administrator/designee shall conduct a weekly audit x8 weeks and then monthly x 4 months to ensure RN coverage is conducted 7 days each week (8 consecutive hours). Any deficiencies will be corrected	

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			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. /p> Date of Compliance: October 2, 2022	
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure provision of vision services, a care plan meeting was conducted, and an ancillary services consent form was obtained for a resident to receive dental services for 1 of 1 residents reviewed for dental care, vision and care planning meetings. (Resident 3 and 17) Findings include: 1a. The clinical record for Resident 17 was reviewed on 9/12/22 at 10:45 a.m. The resident's diagnosis included, but was not limited to, seizures. The resident was admitted on 2/17/22. A Quarterly MDS (Minimum Data Set) Assessment, dated 7/22/22, indicated Resident 17 was cognitively intact. An interview was conducted with Resident 17 on 9/12/22 at 10:38 a.m. She indicated she had not	F 0745	F745 – Social Services Residents 3 and 17 were directly affected by the citied deficient practice. Residents 3 and 17 now have consent forms signed, care plans scheduled, and ancillary services scheduled. All residents have the potential to be affected by the citied deficient practice. The Regional Director of Operations educated the facility administrator on 9/28/2022 that all residents must have signed consent forms for ancillary services, must receive timely ancillary services, and must have scheduled quarterly care plans for	10/02/2022

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	had a care plan meeting in a long time. An interview was conducted with Social Services Director on 9/13/22 at 3:20 p.m. She indicated the last care plan meeting conducted with Resident 17 was on 3/3/22. A care plan policy was provided by the Regional Operations Director (RDO) on 9/14/22 at 10:01 a.m. It indicated "...As the resident remains in the nursing home, additional changes will be made to the comprehensive care plan based on the assessed needs of the resident,...Each resident will remain actively engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of the changes to the care plan. 5. The facility Social Services Director or designee will notify the resident's responsible party either by letter or a phone call to inform them of the scheduled care plan conference to include the date and time...6. The facility Social Service Director or designee will notify the resident of their scheduled Care Plan Conference and will invite and encourage the resident to attend. This notification will continue for any subsequent Care Plan Conferences...9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues..." 1b. An interview was conducted with Resident 17 on 9/12/22 at 10:46 a.m. She indicated she would like to see a dentist, but had not seen one since she had been in the facility. She had asked staff to be seen approximately 3 weeks ago. During and interview with the Social Services		each resident. The facility administrator educated the social services director on 9/28/2022 that all residents must have signed consent forms for ancillary services, must receive timely ancillary services, and must have scheduled quarterly care plans for each resident. The facility administrator/designee shall conduct a weekly audit x8 weeks and then monthly x 4 months to ensure all residents have signed consent forms for ancillary services, receive timely ancillary services, and have scheduled care plans. The facility administrator/designee shall conduct a weekly audit x8 weeks and then monthly x 4 months to ensure all residents have signed consent forms for ancillary services, receive timely ancillary services, and have scheduled care plans. 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. /p> Date of Compliance: October 2, 2022	

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	Director on 9/13/22 at 3:20 p.m., she indicated the dentist was out on 6/14/22 and on 8/9/22. Resident 17 was not seen. She was unable to locate a ancillary services consent that had been completed for Resident 17. An interview was conducted with the Regional Operations Director on 9/14/22 at 10:09 a.m. He indicated social services was unable to locate a consent for ancillary services for Resident 17 to receive dental services. The facility does not have a policy regarding ancillary services. Resident 17 should have had one completed. 2. The clinical record for Resident 3 was reviewed on 9/12/22 at 10:30 a.m. The diagnoses included, but were not limited to, heart failure. The impaired visual function care plan, revised 1/13/22, indicated the goal was for her to use appropriate visual devices to promote participation in activities of daily living and other activities. The physician's orders indicated, "Resident may be seen by optometrist," effective 7/6/20. The 2/14/22 optometry services consent was provided by the SSD (Social Services Director) on 9/13/22 at 11:14 a.m. An interview and observation was conducted with Resident 3 on 9/12/22 at 10:42 a.m. She indicated she couldn't read well, even while wearing her glasses. It was blurry, and she couldn't remember the last time she saw they eye doctor. There were no optometry notes found in Resident 3's clinical record.			

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	An interview was conducted with the SSD on 9/13/22 at 11:14 a.m. She indicated she'd been working at the facility for 3 months and was responsible for ensuring residents received vision services. When she first started working at the facility, she went through and made sure all residents had a consent form or documented declination of services in their electronic health record. The last times the optometrist was in the facility was on 8/2/22 and 5/11/22. Resident 3 was not on the list to be seen for either date. She reviewed Resident 3's electronic health record and stated, "I don't see an optometry consult for her ever." She was unsure how residents were scheduled to see the optometrist prior to her working there, but now the provider sent her a list of who they would be seeing at their next visit. If a resident or nursing informed her they wanted to be seen, she would add them to the list or have them sent out to their own provider of choice. On 9/13/22 at 8:57 a.m., the RDO (Regional Director of Operations) provided a list of the residents seen by their vision services provider on 8/2/22 and the vision services notes for residents from the 5/11/22 visit. Resident 3 was not on the 8/2/22 list and did not have a note from the 5/11/22 visit. An interview was conducted with the RNC (Regional Nurse Consultant) on 9/13/22 at 2:37 p.m. She indicated they could not locate an optometry consult for Resident 3 since admission, but was placed on the list to be seen next week. An interview was conducted with the RDO on 9/14/22 at 10:09 a.m. He indicated the facility does not have a policy regarding ancillary services. 3.1-34(a)(2)			

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to wear the appropriate PPE (personal protective equipment) into a resident's room who was in TBP (transmission based precautions) for 1 of 1 resident reviewed for TBP. (Resident 15) Findings include:	F 0880	F880 – Infection Prevention It is the practice of this facility to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease.	10/02/2022

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	155389	A. BUILDING 00 B. WING	09/14/2022

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	The clinical record for Resident 15 was reviewed on 9/12/22 at 11:00 a.m. The diagnoses included, but were not limited to: chronic obstructive pulmonary disease, diabetes mellitus type 2, congestive heart failure, hypertension, dementia, and atrial fibrillation. She was readmitted to the facility from the hospital on 9/4/22. A list of residents and their Covid-19 vaccination status was provided by the DON (Director of Nursing) on 9/12/22 at 3:12 p.m. It indicated Resident 15 had received one dose of a 2 dose Covid-19 vaccination, declined the second dose, and refused any boosters. The physician's orders indicated, "Transmission Based Contact/Droplet Isolation...every shift for Suspected or + [positive] COVID-19," starting 9/7/22. On 9/12/22 at 11:24 a.m., an observation was made in the hallway, just outside of Resident 15's room. There was a yellow sign on the door that read, "YELLOW ZONE TRANSMISSION BASED PRECAUTIONS CONTACT DROPLET PPE REQUIRED: N95 MASK - Approved KN95 UNIVERSAL EYEWEAR: FACESHIELD OR GOGGLES Single gown - with each encounter GOWNS MUST BE SINGLE USE PER RESIDENT IF CRISIS CAPACITY - FOLLOW THIS RULE ONE GOWN PER EACH STAFF MEMBER, PER EACH RESIDENT, PER SHIFT GLOVES (hand hygiene donning/doffing.)" There was a white bin containing PPE, including gowns and gloves, in the hallway just to the right of her door. The light above her door was lit, indicating her call light was activated. LPN 4 walked into Resident 15's room wearing an N95 mask and face shield. She did not wear a gown or gloves into Resident 15's		All residents residing in the facility have the potential to be affected; however, no resident was affected. Staff and vendors were educated on or before 10/1/22 by DON/Designee, the following was reviewed: A.) Proper PPE for zone B.) Hand Hygiene C.) Demonstration of the correct way to wear a N95 D.) Return demonstration of donning a N95 Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. Newly hired staff will receive the in-servicing prior to working. This will be tracked and documented by the Administrator/DON/Designee. A Root Cause Analysis was conducted by the Infection Preventionist, Administrator, Nurse Consultant, and the Medical Director to determine the Root Cause of the facility's Infection Control Citation. The facility has an opportunity to improve its education, and to ensure that all	

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	room. Immediately after LPN 4 exited the room, LPN 4 was interviewed. She indicated they usually wore gowns and gloves into her room. During the interview with LPN 4, Resident 15's light above her door remained lit, and CNA (Certified Nursing Assistant) 5 then entered the room wearing an N95 mask and face shield. CNA 5 did not wear a gown or gloves into Resident 15's room. LPN 4 reminded CNA 5 from the hallway about Resident 15 being in TBP. CNA 5 exited the room and stated, "She's in isolation?" CNA 5 was interviewed immediately after exiting the room. CNA 5 indicated she didn't usually work that hall. CNA 5 then retrieved a gown and gloves from the white bin of PPE and went back into Resident 15's room. An interview was conducted with the DON (Director of Nursing) on 9/12/22 at 2:47 p.m. She indicated she was aware of the above observation and understood why it was concerning. The Quarantine & Isolation Guidelines for Residents was provided by the RDO (Regional Director of Operations) on 9/13/22 at 8:55 a.m. It read, "Personal Protective Equipment 1. HCP [Health Care Personnel] who enters the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the from and sides of the face)." 3.1-18(a)		staff has adequate knowledge of the facility's infection control practices, proper donning and doffing, hand hygiene, and proper way to wear a N95. Reviewed and updated the LTC infection control assessment was completed on 10/1/22. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure that proper PPE for zone, hand hygiene being performed when needed and N95 mask are being worn properly. DON/Designee will audit 3 random staff by skills validation for performing hand hygiene when required, proper PPE for zone and proper wearing of the N95 5 days a week for 6 weeks, 4 days a week for 6 weeks, 3 days a week for 8 weeks, and weekly for 4 weeks. Auditing will be done on various shifts and some weekend days/shifts. Staff in non-compliance will be re-educated or up to progressively disciplined. Any concerns will be addressed if found. Results of the monitoring will be presented to the QAPI committee weekly until compliance is achieved. Any patterns identified will be addressed immediately. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed	

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			for sustaining substantial compliance for no less than 6 months. Any written Action Plan will be monitored by the Administrator or designee until resolved. Date of Compliance: October 2, 2022	