STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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. This visit included a State Residential Licensure Survey. Survey dates: March 21, 22,23, and 24, 2023 Facility number: 000084 Provider number: 155167 AIM number: 100284600 Census Bed Type: SNF/NF: 119 Residential: 73 Total: 192 Census Payor Type: Medicare: 11 Medicaid: 73 Other: 35 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 28, 2023	F 0000	April 7, 2023 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID HGRJ11 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during our Annual Recertification and State Licensure Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Shannon Harris Administrator	
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;			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Harris	Administrator	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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, interview, and record review, the facility failed to carry out activities of daily living (ADLs) for a resident who was unable to perform oral hygiene by not providing the appropriate oral care as prescribed by a dentist and/or dental hygienist for 1 of 3 residents reviewed for ADLs. (Resident 11) Findings include: The clinical record for Resident 11 was reviewed on 3/22/23 at 3:47 p.m. Resident 11's diagnoses included, but not limited to, Alzheimer's disease, diabetes type II, and chronic obstructive pulmonary disease. Resident 11's quarterly MDS (minimum data set) dated 2/20/23 indicated, Resident 11 required extensive assistance of one person for dressing, toileting, and personal hygiene. Resident 11 had an upper denture with natural teeth lower teeth. An observation of Resident 11's teeth was made on 3/21/23 at 2:45 p.m. Resident 11's lower teeth appeared unbrushed. She had a white substance built up on her lower teeth next to her gums. A physician's order dated 12/13/18 indicated, to assist Resident 11 with daily oral hygiene every day shift. A dental evaluation performed on 12/9/22 indicated, Resident 11's periodontal health as "light plaque on teeth and upper denture...Recommended Cleaning: prophy (sic, a medical term used to describe any treatment which prevents a disease from occurring) and denture cleaning. A dental hygienist's note dated 2/7/23 indicated,	F 0677	PROPOSED PLAN OF CORRECTION F677 1 – Resident 11, referenced in the 2567, does require assistance with oral hygiene. Staff providing that care were addressed and educated immediately. Resident's CNA assignment was determined to have that information listed correctly. 2 – The facility has determined that all residents needing oral hygiene assistance have the potential to be affected. 3 – The DON, QA/In-Service Coordinator or ADON will educate appropriate nursing staff on providing adequate oral care as part of the resident's care plan. 4 – The DON, ADON or Unit Manager (or designee) will conduct 5 weekly random audits for 6 weeks. These audits will assess whether the residents have a need for oral care assistance and if it was provided properly. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	"2/7/23 Patient is not able to care for her own daily dental hygiene (sic) needs of brushing her teeth and gums and cleaning and soaking her denture-(sic)nursing staff needs to do this...Patient was seen in the dental room in a wheel chair. Patient presented with generalized- moderate plaque, light calculus (sic, when plaque stays on teeth for 2-3 days, it hardens and mineral to form tartar on teeth), moderate bleeding, generalized moderate gingivitis-gingiva red, swollen and sensitive-patient has poor oral hygiene...Maxillary denture presented with moderate plaque." A dental evaluation performed on 2/13/23 indicated, Resident 11's periodontal health as "poor", oral hygiene as "poor", and calculus/tartar accumulation as "moderate". Oral hygiene instructions indicated, "Brush teeth 2 x/day (sic, two times per day). Floss 1 x/day (sic, one time per day), mouth rinse as appropriate". Resident 11's care plan dated 4/18/22 indicated, she will have adequate oral care daily and included, but not limited to the following interventions: assist with oral care during a.m./p.m. care and as needed and ensure that dentures are clean and available daily for resident. An interview with DON (Director of Nursing) on 3/22/23 at 3:38 p.m. indicated, Resident 11's dental hygiene order should have been changed to reflect the required dental care needed. DON indicated, Social Services should have forwarded the dental recommendations to the unit managers regarding the needed change to oral care. A Dental Services policy was received on 3/22/23 at 4:03 p.m. from DON. The policy indicated, the purpose was to ensure that each resident receives adequate dental services and assures facility staff		(6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 04/07/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	are providing proper oral hygiene...11. The attending dentist will provide a written progress note and orders for care as appropriate for each resident visit, which will be included in the medical record. The attending physician will be notified of orders for medications, treatments, and authorization for administration requested." 3.1-38(a)(3)			
F 0684 SS=E 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 observation, interview, and record review, the facility failed to monitor and assess the condition of a resident's wound, ensure two residents with wounds were provided wound care in accordance with their physician's orders, and to ensure timely application of a resident's geri-sleeves, as ordered, for 4 of 4 residents reviewed for skin conditions and to timely clarify with the medical provider to restart a medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 21, 29, 59, 88 and Resident 178) Findings include: 1. The clinical record for Resident 88 was reviewed on 1/30/23 at 11:40 a.m. Diagnosis included, but was not limited to, Alzheimer's Disease, chronic	F 0684	F684 1 – Residents 68, 21, 59 and 29, all referenced in the 2567, were immediately assessed for concerns during the survey. Education with staff and changes to orders were completed. 2 – The facility has determined that all residents have the potential to be affected. 3 – The DON, QA/In-Service Coordinator or ADON will educate appropriate nursing staff on monitoring and assessing wounds, providing appropriate care to	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	kidney disease and methicillin resistant staphylococcus (MRSA) infection, and abscess of buttock. A progress note dated 2/5/23 indicated "CNA [Certified Nursing Assistant] was putting Res [Resident 88] to bed. Res. sat on the edge of the bed and could not move self back further and could not get his feet under himself. H (sic) was starting to slide off - CNA spun Res. body around into the bed. Res hit wheelchair with his L [left] leg and got a skin tear on outer lower part of the L leg..." A skin observation assessment dated 2/5/23 indicated Resident 88 had a skin tear on left lower outer leg. The measurements were 2 centimeters by 2 centimeters. A physician order dated 2/5/23 indicated the staff was to place a polyment every 3 days to Resident 88's skin tear wound every 3 days until healed. The March 2023 treatment record for Resident 88 indicated the staff were changing the dressing every 3 days. The most recent treatment was on 3/22/23. The resident's clinical record did not include continuing staff monitoring and assessing the resident's skin tear wound that included measurements and appearance of the wound. An interview was conducted with Director of Nursing (DON) on 3/24/23 at 10:28 a.m. She indicated the nursing staff should be monitoring and assessing Resident 88's skin tear wound that included measurements and wound characteristics. The wound team would not be monitoring the skin tear. The wound assessments		wounds by following physician's orders, and residents wearing appropriate protective sleeves as ordered by the physician. 4 – The DON/ADON/MDS Manager or designee will conduct 5 weekly random audits for 6 weeks. These audits will assess residents with wounds and for proper placement of protective sleeves (if ordered). As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	conducted by the nursing staff should be documented in the nursing progress notes. 2. The clinical record for Resident 21 was reviewed on 3/23/23 at 9:52 a.m. Resident 21's diagnoses included, but not limited to, traumatic subdural hemorrhage, gastrostomy (G-tube), dysphagia (difficulty with eating/swallowing), and Alzheimer's disease. Resident 21's significant change MDS (minimum data set) dated 2/4/23 indicated, he required extensive assistance of one person for bed mobility, dressing, and toileting; limited assistance of one person for personal hygiene; and was totally dependent on one person for bathing. An observation of and interview with Resident 21 was conducted on 3/21/23 at 12:06 p.m. Resident 21 was sitting in his wheelchair getting ready to go to lunch. He was wearing a grey T-shirt that had a dried spot, the size of a baseball, on it. When asked, what got on his shirt, he replied, it was from the wound on his stomach area. He proceeded to lift up his shirt and reveal an abdominal dressing which was saturated with green/yellow drainage. He indicated, he had his G-tube (feeding tube) removed the previous day (3/20/23). The dressing did not have a date or initials on it. An observation of Resident 21's dressing was made on 3/22/23 at 2:31 p.m. with Resident 21's wife. The wound had a new dressing over the previous site of his G-tube. The dressing did not have a date or initials on it of when it was placed. A review of Resident 21's current orders was performed on 3/21/23 at 12:10 p.m. and 3/22/23 at 2:33 p.m. At those dates and times, Resident 21's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	orders did not contain a physician's order for the wound's care and/or dressing. An interview with DON (Director of Nursing) was conducted on 3/22/23 at 3:28 p.m. DON indicated, when Resident 21 returned from having his G-tube removed, the site should have assessed/observed not only at that time, but on each shift; any wound dressings should be dated with date applied as well as nursing initials of who applied the dressing. She indicated, if no treatment orders were noted, the nurse should have contacted the surgery department the same day for physician's order regarding wound care. A physician's order for wound care and dressing changes required for Resident's 21 former G-tube site weren't received until 3/22/23. 3. The clinical record for Resident 59 was reviewed on 3/23/23 at 10:29 a.m. Resident 59's diagnoses included, but not limited to, Alzheimer's disease, generalized anxiety disorder, and adjustment disorder with depressed mood. Resident 59's quarterly MDS dated 2/13/23 indicated, she required extensive assistance of two persons for bed mobility and transfers; and extensive assistance of one person for toileting and personal hygiene. An observation of Resident 59 was made on 3/21/23 at 3:05 p.m. Resident 59 was lying in her bed and had an adhesive bandage across her nose with a date of 3/17 handwritten on it. The adhesive bandage appeared greasy. An observation of Resident 59 was made on 3/23/23 at 10:41 a.m. in her wheelchair in the activity area. Resident 59 had an adhesive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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

bandage on her nose with the date of 3/17 on it.

A physician's order dated 11/10/22 indicated to perform a weekly skin assessment on Resident 59 every Thursday day shift. The weekly skin assessments dated 3/9/23 and 3/16/23 indicated, Resident 59 had a lesion on her nose.

An interview with DON was conducted on 3/23/23 at 11:06 a.m. DON indicated, there should be an order for the dressing on Resident 59's nose.

An interview with LPN (Licensed Practical Nurse) 11 conducted on 3/23/23 at 11:07 a.m. indicated, at that time, Resident 59 did not have an order for the skin lesion on her nose.

A Dermatology note dated 3/24/23 and received on 3/24/23 at 8:47 a.m. from ADON (Assistant Director of Nursing) indicated, "This is to certify that [sic, Resident 59's name and date of birth] was seen in office on 2/20/23 at which time a biopsy of right nasal ala [sic, lower, lateral surface of the nose] was performed. Patient will be receiving radiation for the lesion with [sic, name of radiology/oncology center]. Until patient starts radiation please provide wound care to lesion. you will clean site with warm water and soap then apply a thick coating of Vaseline or Aquaphor ointment followed by a bandage. Please do this daily. Further wound care instructions will be provided from [sic, initials of oncology/radiology center] once patient starts radiation."

4. The clinical record for Resident 29 was reviewed on 3/21/23 at 3:35 p.m. His diagnoses included, but were not limited to, Parkinson's disease and dementia.

The 2/22/21 potential for alteration in skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	integrity care plan indicated he was to have geri-sleeves to bilateral arms, remove for hygiene, effective 2/20/23. The physician's orders for Resident 29 indicated to apply xerofoam to a skin tear on his left hand one time a day from 2/14/23 to 3/16/23 and "Geri-sleeves to bilateral arms, may remove for hygiene. Check placement Q [every] shift. Every shift for protection," starting 2/20/23. An interview with Family Member 7 and observation of Resident 29 was conducted with Family Member 7 on 3/21/23 at 3:30 p.m. in Resident 29's room. Family member 7 was assisting Resident 29 with eating donut holes and coffee. Resident 29 had darkened areas on both of his hands. Family Member 7 pointed to Resident 29's left hand and indicated his hands were all black and blue and he had "areas on his hands." Family Member 7 indicated it was described to her as "compromised." Family Member 7 pointed to Resident 29's top drawer and indicated he'd been wearing "those brown sleeves" in the drawer, but he didn't have them on today. Upon observation, there was one geri-sleeve in the top drawer. An observation of Resident 29 was made on 3/22/23 at 3:45 p.m. He was sitting in his Broda chair in the common area of the unit, rubbing his right hand with his left hand. He was not wearing geri-sleeves on either hand. The tops of both hands still had darkened areas. On 3/22/23 at 3:47 p.m., one of the staff members reorganized some items on Resident 29's lap, but did not address his lack of geri-sleeves. An interview was conducted with CNA (Certified Nursing Assistant) 8 on 3/22/23 at 3:48 p.m. She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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 she was unsure whether Resident 29 was supposed to wear geri-sleeves and suggested speaking with CNA 9, who knew him better. An interview and observation was conducted with CNA 9 on 3/22/23 at 3:50 p.m. She indicated she'd worked at the facility for almost 2 years, and Resident 29 normally wore geri-sleeves, but he didn't like them. She was unsure if they were placed on him today or what happened. They were supposed to be on in the morning and off at night. She liked to leave them on him during the day, especially if he had skin tears or his hands were bruised, "like they are now." She would check the supply closet to see if there were any in there, so she could put them on him. CNA 9 left the common area to check the supply closet, returned to the common area, and indicated there were no geri-sleeves in there, so she would check his room. An observation of Resident 29's room was made with CNA 9. CNA 9 found one geri sleeve in his top drawer and another one in the top bedside chest drawer. CNA 9 then returned to the common area and applied the geri-sleeves to Resident 29. After application, Resident 29 rubbed his right hand a bit then folded them. He did not try to take them off. A wound policy was provided by the DON 3/23/23 at 8:34 a.m. It indicated "...Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines:.. 2. In the absence of treatment orders, the lisenced nurse will notify physician to obtain treatment orders...5. Treatment decisions will be based on: a. Etiology of the wound:..iii. Incidental (i.e. skin tear...) b. Characteristics of the wound: i.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	Pressure injury stage (or level of tissue destruction if not a pressure in jury). ii. Size - including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Condition of the tissue in the wound bed. vii. Condition of peri-wound skin. c. Location of the wound... 7. Treatments will be documented on the Treatment Administration Record... 8. The effectiveness of treatments will be monitoring will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound..." 5. The clinical record for Resident 178 was reviewed on 3/24/23 at 1:00 p.m. Diagnosis included, but was not limited to, dementia, restlessness and agitation. A physician order dated 3/14/23 indicated Resident 178 was to receive 50 milligrams of Seroquel at bedtime for anxiety for 5 days. The March 2023 Medication Administration Record (MAR) for Resident 178 indicated the 50 milligrams of Seroquel was administered to the resident on 3/14/23, 3/15/23, 3/16/23, 3/17/23 and 3/18/23. The MAR did not include any other administrations of the 50 milligrams of Seroquel after 3/18/23. A nursing progress note dated 3/18/2023 at 6:51 a.m., indicated "...res [resident] awake since 0500 [a.m.] being combative smacking, punching, trying to kick staff. BS [blood sugar] under 70, trying to get res to take shake, refusing 2 staff at bedside. after 40 min was able to get 1/3 of shake down. BS recheck et was 149. assisted res up into w/c [wheelchair]. requested et given water to drink.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	demanding breakfast and was given PB&J [peanut butter and jelly], took approx [approximately] 6 bites. hydroxyzine given with scheduled Tylenol. res started begging to go back to bed and was assisted into bed. did fall asleep, but approx 0640 [a.m.] came walking down the hall after removing his pants and shoes. assisted into w/c." A nursing progress note dated 3/21/23 indicated "Note Text: Resident [178] continues to be anxious and trying to get out of wheelchair, and standing while in common area Staffs attempted couple times to calm resident but he refused and started yelling at staffs and being combative towards staffs and throwing his drinks on staff. Resident was taken away from common area and 1:1 [with] staff..." A medical provider visit note for Resident 178 dated 3/21/23 indicated "visit per staff request due to inability to keep resident safe...He is requiring 1 on 1 care for safety...Plan:...Cont [continue] Seroquel 50 mg [milligrams] QHS [every night]...." The resident's clinical record did not indicate clarification with the medical provider if the resident was to continue and/or restart receiving 50 milligrams of Seroquel after 3/18/23. An interview was conducted with the DON on 3/24/23 at 10:28 a.m. She indicated she would clarify with medical provider if she wanted to restart the 50 milligrams of Seroquel for Resident 178. The 3/14/23 Seroquel order was only written for 5 days. She was unaware the medical provider visit note on 3/21/23 indicated to continue the 50 milligrams of Seroquel. 3.1-37			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to recognize and address an issue with a resident's fall intervention and to assure fall interventions were implemented for 2 of 2 residents reviewed for accidents. (Resident 51 and 35). Findings include: 1. The clinical record for Resident 51 was reviewed on 3/21/23 at 12:07 p.m. Her diagnoses included, but were not limited to: Alzheimer's disease, anxiety, and major depressive disorder. She resided on the memory care unit of the facility. The 2/13/23 Significant Change MDS (Minimum Data Set) assessment indicated she was severely cognitively impaired and required extensive assistance of 2 persons for bed mobility, transfers, and toilet use. She required extensive assistance of 1 person for dressing and personal hygiene. When moving from a seated to standing position, she was not steady and only able to stabilize with human assistance. The fall care plan, revised 2/20/23, indicated she was at high risk for falls with injuries related to	F 0689	F689 1 – Resident 51 and 35, referenced in the 2567, were immediately assessed upon notification during the survey process. Resident 51's wheelchair was fixed. Resident 35's call light was placed in the proper place and the assignment sheets for staff were made to be clear. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Maintenance Director and DON, QA/In-Service Coordinator or ADON will educate maintenance staff and nursing staff on ensuring resident wheelchairs with anti-roll back or anti tippers are installed and working properly. Staff will also be educated on the importance of call lights within reach or clipped to the resident for safety.	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	impaired cognition, gait/balance problems, and unaware of safety needs. She would transfer herself and ambulate independently without seeking assistance and had repeat falls. An intervention was for her to have an anti-roll back device to her wheel chair to reduce falls. An observation of Resident 51 was made on 3/22/23 at 3:57 p.m. She was in the common area in her wheel chair entering the activity room. The left anti rollback prong was not over the left wheel. The edge of the prong was along the side of the wheel. An observation of Resident 51 was made on 3/23/23 at 9:54 a.m. She was in her wheel chair in the common area of the facility. The left anti rollback prong was in the same position, not over the wheel, rather along the side of the wheel. An interview was conducted with PTA (Physical Therapy Assistant) 10 on 3/23/23 at 10:09 a.m. She indicated anti rollback devices were used for residents who didn't remember to lock their regular wheel chair brakes. They were attached underneath the wheel chair seat and the prongs went over the wheels, so the brakes on the wheels would lock the wheel chair upon the resident standing. As far as the required position of the prongs, they needed to be positioned so they could actually lock the wheels. Maintenance attached anti rollback devices to wheel chairs, so they would know better than her, as far as the exact positioning on the wheel chair. An interview was conducted with MT (Maintenance Technician) 12 on 3/23/23 at 10:18 a.m. He indicated he'd worked at the facility for 35 years and attached anti rollback devices to residents' wheel chairs. There was a pole in the		4 – The Maintenance Staff will conduct 5 weekly random audits for 6 weeks of wheelchairs with anti-roll back and anti-tippers. The audits will happen on various units. The Unit Coordinators will conduct 5 random audits for 6 weeks of proper call light placement. The audits will happen on various units, at various times. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	back of the wheel chair, and the rest went underneath the wheel chair seat. If the resident got out of the seat, the prongs over the wheels would "go down" onto the wheels and clamp the wheels. Maintenance inspected wheel chairs quarterly for proper functioning and as needed, but they relied on nursing to inform maintenance of any problems with a resident's wheel chair. He stated, "We really rely on that." An observation of Resident 51's wheel chair was made with MT 12 on 3/23/23 at 10:24 a.m. MT 12 looked at the left anti rollback brake prong. It was not touching the left wheel at all, as it was positioned completely to the left of the wheel. MT 12 manually fiddled with the brake mechanism a bit in an attempt to position the prong over the wheel, but was unsuccessful. An interview was conducted with MT 12 on 3/23/23 at 10:24 a.m. after the above observation. He indicated he was unsure how the prong became positioned like that. He stated, "I've never seen that before." He would need to fix it, when Resident 51 was not in her wheel chair, by taking the anti rollback mechanism off of the chair and adjusting it, so that the prong was positioned over the wheel. In the current position, the prong could not lock the wheel, so if Resident 51 stood up, only the right wheel would lock. No one informed him the anti rollback mechanism needed adjusted and was just now seeing and hearing about it for the first time. 2. The clinical record for Resident 35 was reviewed on 3/21/23 at 3:19 p.m. The Residents diagnosis included, but were not limited to, osteoporosis and vascular dementia. A physician's order, last revised on 9/22/21, indicated she could transfer with gait belt, 2 person assistance, and use pivot disc to decrease			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	risk for falls. This order was discontinued on 3/7/2023. A physician's order, sated 9/24/21, indicated she was to have a soft touch call light. Ensure call light is clipped to resident while she is in her room. A care plan, initiated 9/28/21, indicated Resident 35 had a potential for falls related to gait and balance problems, unaware of safety needs, and visual problems. The goal was for her to be free of falls. The interventions included, but were not limited to, ensure soft touch call light is clipped to resident while in the room and transfer with gait belt and 2 person assist using a pivot disk to decrease risk for falls, last revised 3/10/23. A Quarterly MDS (Minimum Data Set) Assessment, completed 12/26/22, indicated she was severely cognitively impaired and required extensive assistance of 2 staff members for transfers. A physician's order, dated 3/7/23, indicated she was to transfer with assist of 2 persons, using a gait belt. A health status note, dated 3/9/23 at 7:25 a.m., indicated that Resident 35 had been lowered to the floor during a transfer. The CNA (Certified Nursing Assistant) had been transferring her when Resident 35 began pushing against the CNA and was lowered to the floor to prevent her from falling. On 3/21/23 at 3:19 p.m., Resident 35 was observed sitting in her wheelchair in her room. The soft touch call light was laying on the bed and not attached to her.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	On 3/22/23 at 2:21 p.m., Resident 35 was observed sitting in her wheelchair in her room. She was watching television and her call light was laying on her bed, not attached to her. On 3/23/23 at 9:35 a.m., Resident 35 was observed sitting in her wheelchair in her room. Her call light was laying on her bed and not attached to her. During an interview on 3/23/23 at 9:37 a.m., UC (Unit Coordinator) 3 indicated Resident 35 should have her call light attached to her while she is in her room. During an interview on 3/23/23 at 10:51 a.m., UC 3 indicated had been working on 3/9/23 when Resident 35 was lowered to the floor. The CNA had transferred Resident 35 without a second person present and that Resident 35 requires 2 people to transfer her. On 3/23/23 at 1:50 p.m., the Director of Nursing provided the current Accident/ Incident and Unusual Occurrence Policy which read "...It is the policy .... that all accidents and incidents are recorded in writing and thoroughly investigated to prevent, when possible, future occurrences..." 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to assure an indwelling urinary catheter bag and tubing were not touching the floor for 1 of 2 residents reviewed for urinary catheters (Resident 12). Findings include: The clinical record for Resident 12 was reviewed on 3/22/23 at 10:35 a.m. The Resident's diagnosis included, but were not limited to, neuromuscular	F 0690	F690 1 – Resident 12, referenced in the 2567, had their catheter bag and tubing adjusted immediately upon notification. 2 – The facility has determined that all residents with catheters have the potential to be affected. 3 – The DON, QA/In-Service	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	disfunction of the bladder and urinary tract infection. A care plan, last revised 8/9/22, indicated she had an indwelling urinary catheter due to neuromuscular dysfunction of the bladder. The goal was for her to remain free from catheter-related trauma. the interventions included, but were not limited to, position the catheter bag and tubing below the level of the bladder, initiated 8/9/22, and check tubing for kinks during care times each shift, initiated 8/9/22. A Quarterly MDS (Minimum Data Set) Assessment, completed 1/4/2023, indicated she was severely cognitively impaired and had a urinary catheter present. On 03/22/23 10:35 a.m., Resident 12 was observed sitting in her recliner in her room. Her catheter bag and tubing were touching the floor. On 3/22/22 at 2:25 p.m., Resident 12 was observed sitting in her recliner. Her catheter tubing and bag were touching the floor. LPN (Licensed Practical Nurse) 5 was observed entering the room and asking Resident 12 if she still had her lunch tray. LPN 5 exited the room. Resident 12's catheter bag and tubing were still touching the floor. During an interview on 3/24/23 at 11:40 a.m., CNA (Certified Nursing Assistant) 4 indicated that urinary catheter bags and tubing should be positioned so that they do not touch the floor. On 3/24/23 at 9:50 a.m., the Infection Preventionist provided the current Urinary Catheter Care policy which read "...To establish guidelines to reduce the risk of, or prevent infections in the resident with an indwelling catheter... Urinary drainage		Coordinator or ADON will educate nursing staff on proper care of catheter bags and tubing. 4 – The DON/ADON/Informatics Nurse or designee will conduct 5 weekly random audits for 6 weeks. These audits will assess whether the catheter bag and tubing are properly covered and placed for infection control and dignity. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	bags and tubing shall be positioned to prevent either from touching the floor..."			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to provide a supplement, as ordered by the physician, for 1 of 1 resident reviewed for nutrition (Resident 35). Findings include: The clinical record for Resident 35 was reviewed on 3/21/23 at 3:19 p.m. The Residents diagnosis included, but were not limited to, osteoporosis and vascular dementia.	F 0692	F692 1 – Resident 35, referenced in the 2567, received the dietary supplement immediately after notification it was not on the tray during meal pass. 2 – The facility has determined that all residents with dietary supplement orders have the potential to be affected.	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	An Annual MDS (Minimum Data Set) Assessment, completed on 9/25/22, indicated she needed supervision and set up assistance with eating and that she weighed 113 pounds. She had not had weight loss. A Quarterly MDS Assessment, completed on 12/26/22, indicated she needed limited assistance of 1 person with eating and that she weighed 103 pounds. She had lost a significant amount of weight and was not on a physician prescribed weight loss regimen. She was severely cognitively impaired. A care plan, last revised on 12/26/22, indicated Resident 35 had a nutritional problem and had a significant weight loss with a BMI (Body Mass Index) less than 22. The goal was for her to maintain adequate nutritional status as evidenced by maintaining weight as medically appropriate. The interventions included, but were not limited to, provide, and serve supplements and fortified foods as ordered, initiated 6/27/22, and RD (Registered Dietician) to evaluate and make diet change recommendations as needed, initiated 9/20/21. A nutrition/ dietary note, dated 3/1/23 at 12:18 p.m., indicated Resident 35 was reviewed in the SWAT (Skin and Weight Assessment Team) meeting due to having a wound. Her weight on 9/1/22 was 112.8 pounds. Her weight on 12/7/22 was 104.8 pounds. On 2/28/23 she had weighed 104.1 pounds. Her oral intake was usually between 50 and 100 %. She had a new pressure area to her left outer foot, a venous area on her left great toe and a traumatic area on her left bunion. The recommendations from the meeting were to add 8 ounces of milk three times a day.		3 – The Dietician, Health Center Dietary Manager or designee will educate dietary staff on the importance of following the tray cards to ensure that residents are getting all proper dietary supplements with meals. 4 – The Dietician, Dietary Manager or designee will conduct 5 weekly random audits for 10 weeks. These audits will assess if the resident received the appropriate supplement (according to the card/order) with their meals. The audits will happen on random days, random meals and various residents. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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 physician's order, dated 3/1/23, indicated she was to receive 8 ounces of milk three times a day. On 3/24/23 at 9:37 a.m., the DM provided the Nutritional and Dietary Supplements policy, dated 1/31/2023, which read "...The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs and physician orders..." 3.1-46(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to follow the appropriate	F 0693	F693	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	guidelines for tube feedings per facility policy by not labeling tube feeding bags as required, not capping a tube feeding properly when not in use, and not administering the tube feeding as ordered for 1 of 1 residents with tube feedings. (Resident 20) Findings include: The clinical record for Resident 20 was reviewed on 3/23/23 at 1:57 p.m. Resident 20's diagnoses included, but not limited to, Parkinson's disease, dementia, dysphagia (difficulty with eating/swallowing), stage IV pressure ulcer, and moderate protein-calorie malnutrition. An observation of Resident 20 was made on 3/22/23 at 9:43 a.m. Resident 20 was lying in her bed and had her tube feeding running. The tube feeding bag nor the water flush bag contained a label indicating the contents of each bag, the resident's name, the date and time of administration, nor the initials of the nurse who prepped the feed. A 60 ml (milliliter) syringe was dated 3/21/23 was on the bedside table in its opened package. An observation of Resident 20 was made on 3/23/23 1:27 p.m. Resident 20 was sitting in a broda chair in front of the TV in the common area. Resident 20 did not have the tube feeding present with her in the common area. An observation of Resident 20's room was made immediately following and in Resident 20's room, her tube feeding tubing was hanging from the IV pole without a cap on the end of the tubing. The cap was located on the IV pole pushed down upon on the hook top IV holder. The bag containing the tube feeding was not labeled with the time the feeding was hung and the water flush bag was not		1 – Resident 20, referenced in the 2567, was immediately assessed for proper administration of the feeding and placement of a label on the bag. 2 – The facility has determined that all residents with tube feedings have the potential to be affected. 3 – The DON, QA/In-Service Coordinator or ADON will educate nursing staff on properly labeling the feeding bag, properly capping and administration of the tube feeding. 4 – The DON/ADON/Informatics Nurse or designee will conduct 5 weekly random audits for 6 weeks. These audits will assess proper labeling of the feeding on the bag and proper administration of the tube feeding according to the physicians/dieticians orders. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	labeled. A physician's order for Resident 20 dated 1/8/22 indicated, to change the feeding administration set with each new bottle, label the formula container, syringe, and the administration set with resident's name, date, time, and nurse's initials on every night shift. Another physician's order from the same date indicated, for Jevity 1.2(tube feeding) to run continuously at 60 ml/hour. Resident 20's physician order dated 1/10/22 indicated, the change the syringe daily. An interview conducted on 3/23/23 at 1:38 p.m. with ADON (Assistant Director of Nursing) indicated, if the tube feeding order was for a continuous feeding then, Resident 20's tube feeding should have been continued while sitting in her broda chair while in the common area of the unit. Resident 20's care plan dated 1/10/22 indicated, she required tube feedings related to dysphagia and Parkinson's disease. Interventions included, but not limited to, serve diet as ordered. A Tube Feeding policy was received on 3/24/23 at 9:22 a.m. from ED (Executive Director). The policy indicated, its purpose was to promote guidelines for the appropriate labeling of tube feeding administration and provide evidence-based treatments in accordance with current standards of practice and physician orders. The licensed staff member should set up the pump appropriately with prescribed rate and volume (continuous or intermittent) and the appropriate labeling for the medication prepared or compounded for tube feeding must include: "a. Name of the solution			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	b. The resident's name; c. The infusion rate (present on pump) d. The date and time of administration e. The initials of the nurse preparing the feed" 3.1-44(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to assess a location of a resident's pain, and develop and implement non-pharmacological interventions to address a resident's pain for 1 of 3 residents reviewed for pain. (Resident 88) Findings include: The clinical record for Resident 88 was reviewed on 3/21/23 at 11:40 a.m. Diagnosis included, but was not limited to, chronic pain, skin changes, and heart disease. The Quarterly Minimum Data Set (MDS) assessment dated 1/4/23, indicated Resident 88 was cognitively intact. A physician order dated 1/30/23 indicated Resident 88 was to receive 2 tablets of 325 milligrams of Tylenol every 4 hours for pain as needed. The March 2023 Medication Administration Record indicated Resident 88 had received the	F 0697	F697 1 – Resident 88, referenced in the 2567, was assessed for pain location and proper interventions were in place. 2 – The facility has determined that all residents have the potential to be affected. 3 – The DON, QA/In-Service Coordinator or ADON will educate nursing staff on documentation of appropriate pain information (location, level and cause) and developing and implementing non-pharmacological interventions to address a resident's pain prior to administering a PRN pain medication when appropriate. The DON, ADON, or QA/In-service	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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 tablets of Tylenol as needed utilizing a pain scale of 1 being the least amount of pain to 10 being the most amount pain on the following days: 3/12/23 - pain level 3 - no documented pain location - documented as follow up pain level of a 2, 3/15/23 - pain level 10 - leg pain - documented as effective, 3/17/23 - pain level 6 - no documented pain location - documented as follow up pain level of a 2, and 3/23/23 - pain level 10 - headache - documented as effective, The resident's clinical record did not include non-pharmacological interventions that were attempted to address the resident's pain or location of the resident's pain on 3/12/23 and 3/17/23. An interview was conducted with Resident 88 on 3/21/23 at 11:31 a.m. He indicated when the staff change the bandage on his leg it was painful. During the changing of the bandage, the staff touch his leg, and "it hurts like the devil." The staff do not offer any other methods to address his pain other than Tylenol. An interview was conducted with Resident 88 on 3/23/23 at 3:17 p.m. He indicated last night he had the worst headache. It was a 10! He" yelled out" for staff to give him some Tylenol. The staff never offered to provide any other methods to help with his pain relief. After receiving the Tylenol, he had to then ask staff for a cold rag to put on his head to try anything to get rid of his headache. An interview was conducted with the Director of		Coordinator will provide education on the following: · Pain Assessments and Pain location · Documentation of Pain location, level and possible cause · Non-Pharmacological Interventions · Documentation of those interventions if applicable 4 – The DON/ADON/Informatics Nurse or designee will conduct 5 weekly random audits for 6 weeks. These audits will assess the pain assessments of a resident with PRN pain medication, specifically the location, level and cause of the pain and any non-pharmacological interventions tried and documented. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	Nursing on 3/24/23 at 10:28 a.m. She indicated the staff should be provided non-pharmacological interventions to address residents' pain. It should be documented in the progress notes. A pain management policy was provided by the Director of Nursing on 3/23/23 at 1:51 p.m. It indicated, "...Policy: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences...Pain assessment:...2. Based on professional standards of practice, an assessment or evaluation of pain by appropriate members of the interdisciplinary team (e.g., nurses, practitioner, pharmacist, and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident: ...e. Identifying key characteristics of the pain: i. duration of pain ii. frequency iii. location iv. timing v. pattern...vi. radiation of pain...6. Non-pharmacological interventions will include but are not limited to: a. environmental comfort measures...b. loosening any constrictive bandage, clothing or device, c. applying splinting, d. physical modalities, e. exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility, f. cognitive/behavioral interventions..." 3.1-37(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were stored in a secure location for 1 of 5 medication carts reviewed. Findings include: An observation was conducted of 1 of 2 medication carts on Willow Commons on 3/21/23 at 10:35 a.m. There were 4 medication cards containing Coumadin (blood thinning medication) for Resident 73 located within the narcotic log binder on the medication cart. An observation conducted on 3/21/23 at 11:22 a.m., still noted the 4 medication cards within the	F 0761	F761 1 – Medications were immediately secured and stored in the proper place. 2 – The facility has determined that all residents have the potential to be affected. 3 – The DON, QA/In-Service Coordinator or ADON will educate licensed nursing staff on appropriate storage of medications. 4 – The DON or ADON or	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	narcotic log binder for Resident 73. An interview conducted with Unit Coordinator 2, on 3/22/23 at 10:45 a.m., indicated she was organizing the medication cart and realized that Resident 73 no longer took Coumadin and she removed such from the medication cart. A policy titled "Medication Storage Policy", revised November 2017, was provided by the Director of Nursing on 3/24/23 at 8:48 a.m. The policy indicated the following, " ...Policy ...It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations ...1. General Guidelines ...a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls ...." 3.1-25(m)		designee will conduct 5 weekly random audits for 6 weeks. These audits will assess proper placement of medications while licensed nursing staff are at or near the medication carts. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	
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;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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)(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 §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 timely follow up on a dental recommendation for 1 of 1 resident reviewed for dental services (Resident 73). Findings include: The clinical record for Resident 73 was reviewed on 3/21/23 at 3:29 p.m. The Resident's diagnosis included, but were not limited to, cerebrovascular disease and heart failure.	F 0791	F791 1 – Resident 73, referenced in the 2567, was interviewed by Social Services immediately upon notification from Survey team regarding chipped tooth. Resident had a cleaning on 1/13/23 and no mention of #8 chipped tooth. Resident was interviewed on 3/23/23 and stated to SSA that	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
R 0000	A Quarterly MDS (Minimum Data Set) Assessment, completed 1/24/23, indicated she was cognitively intact. During an interview on 3/21/23 at 3:29 p.m., Resident 73 indicated she had a broken tooth and that it had been broken quite a while. She pointed to her right front tooth, which had a chip at the bottom of the tooth. She would like to have it fixed because she did not like how it looked. She had seen the dentist since chipping her tooth, but it had not been fixed yet. On 3/23/23 at 10:43 a.m., the Director of Nursing provided a dental consult report dated 9/30/22, which indicated that Resident 73 had her natural upper and lower teeth. Tooth # 8 presented with a chip which was to be restored. The recommendations for follow-up were to continue regular cleanings and restoration of tooth #8. On 3/23/23 at 10:43 a.m., the Director of Nursing provided a care plan for Resident 12 which indicated she had accepted dental services at the facility. The goal was for her to have medical ancillary needs met. 3.1-24		they were not experiencing in any pain and wasn't in a hurry to get the tooth fixed. Referral to dental services was made. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Social Services Director and Assistant will educate residents, staff and dental providers on the importance of letting us know if there is a change in the resident's dental needs. 4 – The Social Service Director, Assistant or designee will conduct 10 weekly random audits for 6 weeks to assess dental needs of our resident's and the timeliness of the response to get the services started. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 21, 22, 23, and 24, 2023 Facility number: 000084 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 28, 2023	R 0000	April 7, 2023 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID HGRJ11 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during our Annual Recertification and State Licensure Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Shannon Harris Administrator	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	(2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure electronic medication administration (EMAR) records were accurate regarding parameters for administration of Digoxin (Antiarrhythmic and Blood pressure medication) for 1 of 5 residents records reviewed. (Resident 334) Findings include: The clinical record for Resident 334 was reviewed on 3/23/23 at 12:40 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anemia, atrial fibrillation, hypertension, and mitral valve insufficiency. A physician order, dated 2/28/23, indicated the use for Digoxin tablet, 125 micrograms daily, for atrial fibrillation. There were parameters given to hold the medication if the heart rate was less than 60 beats per minute. The electronic medication administration record (EMAR) for March of 2023 indicated the Digoxin was administered when Resident 334's heart rate was documented as below 60 beats per minute on 3/2/23, 3/6/23, 3/15/23 and 3/21/23. An interview conducted with Nurse Manager 10, on 3/23/23 at 3:30 p.m., indicated she believed that she inputted that order and put the parameters in but was unsure if it was part of the physician's order.	R 0349	PROPOSED PLAN OF CORRECTION R349 1 –Resident 334 referenced in the 2567 was immediately assessed and there had been no adverse reactions to the medication given outside the parameters. The QMA was educated immediately on medication hold order parameters. 2 – The facility has determined that all residents with parameter orders have the potential to be affected. 3 –The Nurse Manager or designee will educate all Clinical Assisted Living Staff on medication hold order parameters. 4 – The Nurse Manager or designee will conduct 5 weekly random audits for 7 weeks. These audits will assess orders with hold parameters on various residents on a variety of shifts. As a means of quality assurance, results of the audits and any corrective actions taken shall be	04/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
			reviewed by the Quality Assurance Committee for a minimum 7 weeks, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/7/2023.	