STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 00 B. WING	10/12/2023

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

(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 the Investigation of Complaints IN00410616, IN00416449, IN00418979, IN00419005, and IN00419342. Complaint IN00410616- Federal/state deficiencies related to the allegation are cited at F600 and F609. Complaint IN00416449- No deficiencies are cited. Complaint IN00418979- Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00419005- Federal/state deficiencies related to the allegation are cited at F919. Complaint IN00419342- No deficiencies are cited. Unrelated deficiencies are cited at F657. Survey dates: October 11 and 12, 2023 Facility number: 000497 Provider number: 155606 AIM number: 100291530 Census Bed Type: SNF/NF: 97 Total: 97 Census Payor Type: Medicare: 10 Medicaid: 76 Other: 11 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Westside Village is requesting a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
sherice ricks	executive director	11/04/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on October 23, 2023.			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents reviewed for abuse was free from abuse which resulted in actual harm as Resident B was seen crying out and verbally indicated she was afraid when she was roughly put into bed, scolded, and threatened by nursing staff members. Using the reasonable person concept, the staff abuse was likely to have caused chronic and recurrent fear and anxiety for the resident (Resident B). Findings include: During a confidential interview it was indicated that Resident B had been mishandled and mistreated by several nursing staff members. She often complained that staff were too rough with her and when family reviewed video footage of her care, they were shocked to see how rough and	F 0600	F 600 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B was discharged from the facility on 4/12/23. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A one-time review has been completed with the current resident population with a BIMS score of 9 or above to validate no other residents had concerns with being fearful of others, had concerns of staff being rough or	11/03/2023

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	unkind the staff treated and spoke to her. A complaint was made to the Executive Director (ED), on 5/17/23, when a family member came into the building to formally request copies of the resident's medical record. At that time, the ED was shown screen shot pictures from the video footage of different staff members who had been seen mistreating Resident B, but the ED dismissed the concerns. The family member did not feel that the matter had been taken seriously. On 10/11/23 at 9:52 a.m., Resident B's family indicated Resident B would indicate, "They [staff] would talk rudely, yell at her, thrust her legs on the bed after resident asked them to be gentle. Point their fingers in her face." When she requested her bottle of soda, the nurse tossed it to her instead of politely handing it to her. One staff member even threatened, "you won't get anything until tomorrow." Video footage of Resident B's abuse was provided by the family. Videos provided showed the following: Video 1: Resident B was seated on the edge of her bed. Certified Nursing Aide (CNA) 7 lifted and quickly swung the Resident's legs into bed which caused the resident to fall back in bed without support. She cried out in pain and indicated she had already asked them not to throw her legs up like that. CNA continued to position her in bed without speaking or slowing down. Resident B continued to cry. Video 2: Resident B was seated on the edge of her bed and attempted to lay herself backward into bed. She had difficulty lifting her legs. CNA 7 picked up her foot and swung her legs into bed. Resident B shook her arms in frustration and said it hurt. CNA 7 scolded Resident B indicating, " ...your legs weight 300 pounds apiece! I can't just		rude, and care is being provided as per their choice. Residents with a BIMS score of 8 or below for current resident population had skin assessments completed to validate there were no signs of unknown origin injury or possible signs of abuse. The facility staff have been re-educated on abuse prevention. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? It is the responsibility of the facility staff to provide care in a caring manner, allowing residents to alert staff of how they prefer to be cared for. The Administrator/designee will be responsible to interview 10% of current resident population 5 times a week for 2 weeks, weekly for 6 weeks, and then monthly for 4 months. Interviews shall include skin assessments for residents with a BIMS score of 8 or below as well to monitor for possible signs of abuse. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	

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	lift them real slow, I gotta go fast! I tell you that all the time, I can't go slow, it hurts my back ...." Video 3: Resident B was reclined in bed and asked CNA 7 to get her "7-Up from over there." CNA 7 was out of frame, and tossed the bottle from where she stood in the room onto Resident B's bed, which dropped onto her thigh. Resident B picked up the bottle but indicated, it was not the cold one she wanted. CNA 7 comes to the side of Resident B's bed, leaned over her and pointed her finger in the Resident's face and scolded, "you're P------me the F--- off! You won't get it again because I'm not a F------ dog, do you understand me!" Resident B again asked for a cold soda. CNA 7 continued to lean over the Resident and wag her finger in her face then threatened, "I bet you won't get anything until tomorrow, I guarantee it!" Video 4: Resident B was reclined in her bed crying. Licensed Practical Nurse (LPN) 6 and CNA 8 were in the room setting up her breakfast tray. LPN 6 indicated as she waved her finger, "we are not going out there." Resident B asked why, and LPN 6 indicated, "I can't stay, I stayed here all day yesterday." LPN 6 interrupted Resident B in midsentence so Resident B raised her arm and pointed her fingers and indicated, "hey you wait a minute," but LPN 6 cut her off again and pointed her finger in the Resident's face and indicated, "don't you yell at me!" Resident B persisted and called CNA 7 by name and indicated, "she threw me in the bed, and then yelled at me and shut the door," her voice breaks with tears and she continued, "I don't like that one, you wonder why I'm afraid in here!" LPN 6 and CNA 8 continue to reposition the Resident in bed as she cried. When they pulled her up in bed, Resident B indicated, "no I'm getting out of bed, I can't lay here, I can't lay on this side I need to lay on my back," they		put into place? The results of these reviews will be discussed at the Quality Assurance Committee meeting monthly for 3 months and then quarterly for a total of 6 months. The QAPI Committee will determine if further monitoring or revision is required. The Administrator is responsible to ensure compliance. Date of Compliance: 11/3/23	

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	continued to position her in bed without speaking to her. LPN 6 raised the head of her bed with the remote, Resident B continued, "what are you doing?" CNA 8 pointed to her breakfast tray and indicated, "you need to eat your breakfast, then we will get you up." Resident B turned to LPN 6 and indicated, "you think I do it intentionally, you're wrong." LPN 6 replied, "I didn't say that." Resident B indicated while she cried, "that's what they've been doing to me." LPN 6 put the table over her bed and uncovered her tray to set up breakfast, but Resident B shook her head "no," and indicated, "I've got to get out of the bed outside," LPN 6 interrupted her again and indicated, "We'll get you up after breakfast, I want you to eat first." Resident B continued to cry. During an interview on 10/11/23 at 3:00 p.m., LPN 6 was asked questions about the residents right to be free from abuse. LPN 6 indicated all staff received education on Residents Rights and abuse, and it was unacceptable to abuse a resident. LPN 6 indicated it was not appropriate to point a finger in a resident's face and tell them not to talk back or yell. She was required to report immediately to her supervisor if a resident told her about mistreatment or abuse from another staff member. On 10/12/23 at 10:22 a.m., a copy of the April 2023-current grievance log was provided by the Director of Nursing (DON). The record lacked documentation of any concerns/grievances related to Resident B. During an interview on 10/12/23 at 10:46 a.m., the Executive Director indicated the grievance log had been updated and there were no grievances related to Resident B. When asked if she had a conversation with Resident B's family member on			

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	5/17/23, the ED indicated, "I don't remember." On 10/12/23 at 12:15 p.m., the videos were shown to the ED, DON, the Regional Clinical Consultant (RCC) and Vice President of Operations (VPO). After viewing the videos, it was indicated in consensus, staff had mistreated Resident B when roughly putting her to bed, yelling at her with curse words and pointing fingers in her face, and throwing her soda bottle instead of handing it to her. If a resident made allegations of mistreatment or abuse to a staff member, that staff member was required to report it to their supervisor so that it could be investigated. On 10/11/23 at 11:57 a.m., Resident B's medical record was reviewed. She was a long-term care resident who had diagnoses which included, but were not limited to, fibromyalgia (a chronic disorder that causes pain and tenderness throughout the body), rheumatoid arthritis (an autoimmune and inflammatory disease which causes inflammation and painful swelling to the affected areas of the body), dementia (a degenerative disease of the brain which causes permanent and irreversible cognitive decline and memory loss), and anxiety. Her most recent comprehensive assessment was an annual Minimum Data Set (MDS) assessment dated 10/16/22. The MDS indicated Resident B was severely cognitively impaired, no behavioral concerns were coded, and she required extensive to total assistance with most activities of daily living, (ADLS) such as bed mobility, transfers and personal hygiene. She had a comprehensive care plan, dated 11/11/22, which indicated she had an ADL self-performance deficit related to her diagnoses,			

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	poor safety awareness and lack of coordination. Interventions for the plan of care included, but not limited to, her need to have extensive assistance with bed mobility and needed a sit-to-stand lift for transfers. She had a comprehensive care plan, dated 6/23/21, indicated she sometimes made false accusation about staff related to her dementia. An intervention for this plan of care included, but was not limited to, " ...when resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmy in conversation; If response is aggressive, staff to walk away calmly, and approach later ...." She had a compressive care plan, dated 11/11/22, which indicated she had difficulty understanding or being understood due to her severe dementia. Interventions for this plan of care included, but were not limited to, " ...allow adequate time to respond, do not rush ...." Using the reasonable person concept, the staff abuse was likely to have caused chronic and recurrent fear and anxiety for the resident. On 10/12/23 at 10:00 a.m., the DON provided a copy of current facility policy titled, "Area of Focus: Resident Rights," reviewed 11/21/22. The policy indicated, "At the time of admission, a resident is afforded certain rights while residing in a long-term care facility. The facility and its associates have the responsibility for ensuring these rights are always upheld the residents is in their care ... The facility will ensure its associates are educated to the importance of resident's rights. Any violation or potential violation should be reported immediately to their supervisor, the DON, Social Service, or the ED ...."			

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	On 10/12/23 at 10:00 a.m., the DON provided a copy of current facility policy titled, "Abuse-Prevention," reviewed 7/18/23. The policy indicated, "It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation ...." This citation relates to complaint IN00410616.			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to report allegations of abuse for 1 of 3 residents reviewed for abuse (Resident B). Findings include: During a confidential interview it was indicated that Resident B had been mishandled and mistreated by several nursing staff members. She often complained that staff were too rough with her and when family reviewed video footage of her care, they were shocked to see how rough and unkind the staff treated and spoke to her. A complaint was made to the Executive Director (ED), on 5/17/23, when a family member came into the building to formally request copies of the resident's medical record. At that time, the ED was shown screen shot pictures from the video footage of different staff members who had been seen mistreating Resident B, but the ED dismissed the concerns. The family member did not feel that the matter had been taken seriously. On 10/11/23 at 9:52 a.m., Resident B's family indicated Resident B would indicate, "They [staff] would talk rudely, yell at her, thrust her legs on the bed after resident asked them to be gentle. Point their fingers in her face." Video footage of Resident B's abuse was provided by the family. In Video 4 the following was observed: Resident B was reclined in her bed crying. Licensed Practical Nurse (LPN) 6 and CNA 8 were in the room setting up her breakfast tray. LPN 6 indicated as she waved her finger, "we are not going out there."	F 0609	F 609 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B was discharged from the facility on 4/12/23. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A one-time review has been completed with the current resident population with a BIMS score of 9 or above to validate no other residents had concerns with being fearful of others, had concerns of staff being rough or rude, and care is being provided as per their choice. Residents with a BIMS score of 8 or below for current resident population had skin assessments completed to validate there were no signs of unknown origin injury or possible signs of abuse, or there has been an issue or concern not otherwise known by management staff. The facility staff have been re-educated on abuse reporting criteria and timeliness of reporting allegations and/or unusual occurrences. What measures will be put into place or what systemic changes will be made to ensure that the	11/03/2023

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	Resident B asked why, and LPN 6 indicated, "I can't stay, I stayed here all day yesterday." LPN 6 interrupted Resident B in midsentence so Resident B raised her arm and pointed her fingers and indicated, "hey you wait a minute," but LPN 6 cut her off again and pointed her finger in the Resident's face and indicated, "don't you yell at me!" Resident B persisted and called CNA 7 by name and indicated, "she threw me in the bed, and then yelled at me and shut the door," her voice breaks with tears and she continued, "I don't like that one, you wonder why I'm afraid in here!" LPN 6 and CNA 8 continue to reposition the Resident in bed as she cried. When they pulled her up in bed, Resident B indicated, "no I'm getting out of bed, I can't lay here, I can't lay on this side I need to lay on my back," they continued to position her in bed without speaking to her. LPN 6 raised the head of her bed with the remote, Resident B continued, "what are you doing?" CNA 8 pointed to her breakfast tray and indicated, "you need to eat your breakfast, then we will get you up." Resident B turned to LPN 6 and indicated, "you think I do it intentionally, you're wrong." LPN 6 replied, "I didn't say that." Resident B indicated while she cried, "that's what they've been doing to me." LPN 6 put the table over her bed and uncovered her tray to set up breakfast, but Resident B shook her head "no," and indicated, "I've got to get out of the bed outside," LPN 6 interrupted her again and indicated, "We'll get you up after breakfast, I want you to eat first." Resident B continued to cry. During an interview on 10/11/23 at 3:00 p.m., LPN 6 indicated she was required to report immediately to her supervisor if a resident told her about mistreatment or abuse from another staff member. LPN 6 indicated it was not appropriate to point a finger in a resident's face and tell them not to talk		deficient practice does not recur? It is the responsibility of the facility staff to be informed of and report in a timely manner allegations of abuse and/or unusual occurrences. The Administrator/designee will be responsible to interview 10% of current resident population 5 times a week for 2 weeks, weekly for 6 weeks, and then monthly for 4 months to validate residents or others do not have any concerns with abuse/unusual occurrence not previously reported. Interviews shall include skin assessments for residents with a BIMS score of 8 or below as well to monitor for possible signs of abuse. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The results of these reviews will be	

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	back or yell. On 10/12/23 at 10:22 a.m., a copy of the April 2023-current grievance log was provided by the Director of Nursing (DON). The record lacked documentation of any concerns/grievances related to Resident B. During an interview on 10/12/23 at 10:46 a.m., the Executive Director indicated the grievance log had been updated and there were no grievances related to Resident B. When asked if she had a conversation with Resident B's family member on 5/17/23, the ED indicated, "I don't remember." On 10/12/23 at 12:15 p.m., the videos were shown to the ED, DON, the Regional Clinical Consultant (RCC) and Vice President of Operations (VPO). After viewing the videos, it was indicated in consensus, staff had mistreated Resident B when roughly putting her to bed, yelling at her with curse words and pointing fingers in her face, and throwing her soda bottle instead of handing it to her. If a resident made allegations of mistreatment or abuse to a staff member, that staff member was required to report it to their supervisor so that it could be investigated. On 10/12/23 at 10:00 a.m., the DON provided a copy of current facility policy titled, "Area of Focus: Resident Rights," reviewed 11/21/22. The policy indicated, "At the time of admission, a resident is afforded certain rights while residing in a long-term care facility. The facility and its associates have the responsibility for ensuring these rights are always upheld the residents is in their care ... The facility will ensure its associates are educated to the importance of resident's rights. Any violation or potential violation should be reported immediately to their supervisor, the		discussed at the Quality Assurance Committee meeting monthly for 3 months and then quarterly for a total of 6 months. The QAPI Committee will determine if further monitoring or revision is required. The Administrator is responsible to ensure compliance. Date of Compliance: 11/3/23	

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	DON, Social Service, or the ED ...." Cross reference F600. This citation relates to complaint IN00410616.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview, the facility failed to revise and follow care plans for 1 of 2 residents reviewed for care	F 0657	F 657 What corrective actions will be accomplished for those residents	11/03/2023

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	155606	A. BUILDING 00 B. WING	10/12/2023

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

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	planning (Resident F). Findings include: On 10/10/23 at 10:30 a.m., Resident F was observed lying on her back in bed. She was alert and responded to questions asked of her. On 10/10/23 at 1:00 p.m., Resident F was observed lying on her back in bed. On 10/10/23 at 2:00 p.m., Resident F was observed lying on back in bed. On 10/10/23 at 2:15 p.m., Physician 10 and RN 11 entered room to provided wound care for Resident F. RN 11 indicated the mattress that Resident F was on alternates the pressure on resident's buttocks, therefore, she did not need to be turned side to side. When RN 11 questioned about signage in the resident's room hang on a cabinet referring to a turn schedule for Resident F, she indicated Resident F was not turned due to the type of mattress she was on, and she was unsure why the signage was hanging up in the room. RN 11 indicated Resident F did not to lie on her sides and she will cry out when turned to her side. RN 11 indicated this was addressed on Resident F's care plan. On 10/11/23 at 10:00 a.m., a record review was completed. She had diagnoses which include but not limited to multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms), iron deficiency anemia, atrial fibrillation (an irregular and often rapid heartrate),		found to have been affected by the deficient practice? Resident F discharged from the facility. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A one-time review of residents requiring use of specialty surfaces has been reviewed to validate turning and repositioning needs are care planned accurately. The Nursing staff have been re-educated on turning and repositioning requirements for residents on a specialty surface. The Interdisciplinary Team has been re-educated on reviewing/revising care plans to reflect the current status of the residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? It is the responsibility of the facility staff to provide required assistance with turning and repositioning. The Director of Nursing/designee will be responsible to audit 10% of current resident population requiring specialty surfaces 5 times a week for 2 weeks, weekly for 6 weeks, and then monthly for 4 months to validate turning and repositioning is occurring per care plan. Any issues identified will be immediately corrected, 1:1	

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	hypertension (high blood pressure), diabetes mellitus, heart failure, GERD (gastro-esophageal reflux disease), and constipation. Resident F's care plan, dated 2/7/23, indicated the resident had potential for break in skin integrity to right buttock related to immobility, incontinence of bowel and bladder, requiring assistance with mobility, positioning and history of pressure ulcers, diabetes, quadriplegia, iron deficiency anemia, CHF (congestive heart failure), and spasmic hemiplegia. Resident F currently had a stage four pressure ulcers on admission and a stage three pressure ulcer present on readmission. An intervention dated 2/7/23 indicated the resident needed assistance to turn/reposition at least every 2 hours and more often as needed or requested. Her care plan lacked documentation regarding refusal to lie on her sides and her crying out when on her sides. A policy titled, "Skin Integrity and Pressure Ulcer/Injury Prevention and Management," was provided by the Executive Director (ED) on 10/10/23 at 2:30 p.m. It indicated, " ...reposition at least every 2-4 hours (per NPIAP (National Pressure Injury Advisory Panel) standards) as consistent with overall patient goal and medical condition ....". 3.1-35(c) 3.1-35(l)		re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The results of these reviews will be discussed at the Quality Assurance Committee meeting monthly for 3 months and then quarterly for a total of 6 months. The QAPI Committee will determine if further monitoring or revision is required. The Administrator is responsible to ensure compliance. Date of Compliance: 11/3/23	
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 -			

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	§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 prevent the potential for accidents when the secured memory care doors were not adequately monitored during a malfunction which unlocked the secured door, and a resident was able to exit two separate doors and was later found walking in the parking lot for 1 of 3 residents reviewed for elopement (Resident D). Findings include: On 10/4/23 the facility reported, Resident D had been able to exit the secured memory care unit. Upon their investigation it was discovered that the magnetic lock door had malfunctioned and been unlocked for an unspecified amount of time. On 10/11/23 at 10:05 a.m., Resident D was observed in the secured memory care unit, in his room. He sat on the edge of the bed and worked on a large coloring picture. On 10/11/23 from 11:35 a.m. until 12:15 p.m., Resident D was observed. He independently walked from his room into the main dining room where he retrieved a broom and dustpan. He returned to his room and swept up colored-pencil shavings. He returned the broom and dustpan. He returned to his room. After a few minutes he left his room and walked to the nurses' station where he sat in a chair across from the desk. A few moments later he returned to his room. After a bit,	F 0689	F 689 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident D has been reassessed by the Interdisciplinary Team to ensure the resident is in the appropriate setting. The care plan has been updated to reflect the current status of the resident. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A one-time review of current resident population has been completed reviewing elopement risk. The staff have been re-educated on Elopement prevention, expectations of monitoring doors during interruption of service. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? It is the responsibility of the facility staff to prevent elopements. The Social Services Director/designee will be responsible to review 10% of current resident population 5	11/03/2023

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	he exited his room again and walked into the activity lounge to participate for a few minutes until he returned to his room again. On 10/11/23 at 11:54 a.m., Resident D's medical record was reviewed. He was a long-term care resident who resided on the secured memory care unit and had diagnoses which included, but were not limited to, dementia, muscle weakness and Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe). An admission Minimum Data Set (MDS) assessment, dated 7/21/23, did not indicate wandering behaviors. A nursing progress note, dated 10/3/23 at 3:27 p.m., indicated Resident D had been found walking in the parking lot, was assisted back inside to the memory care unit and placed on one-on-one observations. A head-to-toe skin assessment was completed, and he had not sustained any injuries. During an interview on 10/11/23 at 1:50 p.m., Licensed Practical Nurse, (LPN) 12 indicated he had been the nurse on the floor at the time Resident D eloped. Resident D had been sitting in a chair across from the nurses' station within line of sight from the desk. LPN 12 noticed another resident was attempting to exit the main entrance door, so he got up to immediately stop her. By the time he got back to the nurses' station, Resident D was gone, but LPN 12 thought he probably just returned to his room or went to the bathroom. He did not go look for the resident because he did not know Resident D had gotten out. The other aides on the floor who were also supposed to help watch the doors, must have been assisting other		times a week for 2 weeks, weekly for 6 weeks, and then monthly for 4 months to validate elopement risk has been identified, staff are alerted if there is service interruption, and enacting door monitoring as noted with a service interruption. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The results of these reviews will be discussed at the Quality Assurance Committee meeting monthly for 3 months and then quarterly for a total of 6 months. The QAPI Committee will determine if further monitoring or revision is required. The Administrator is responsible to ensure compliance. Date of Compliance: 11/3/23	

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	residents in their rooms at that time because they had not seen him exit either. During an interview on 10/11/23 at 4:00 p.m., the Executive Director (ED) indicated it had been determined that when the Independent Living (IL) building had conducted routine fire-door safety checks, it had affected and unlocked the memory care doors because they were on a "shared system." When they found out the memory care doors were unlocked, the ED had instructed staff to monitor the door, but was not required to put a staff member at each door. The facility policy only stated they needed to supervise/monitor the doors. When another resident attempted to exit the main entrance, the nurse got up to assist her from getting out and within that split second Resident D had gotten out of the other hallway and courtyard doors. On 11/12/23 at 2:45 p.m., an interview was conducted with the nursing home Maintenance Director, and the IL Maintenance Director (IL-MD), with the ED present. The Maintenance Director indicated every year the facilities conducted comprehensive annual inspections of the Mag-Lock Fire safety door. The IL and nursing home were on a shared system. When IL conducted their inspections, it also interrupted service on the nursing home doors. When the IL conducted their inspection the IL-MD called the MD to give him the heads up. That morning, he received a text message from nursing staff around 8:30 a.m., to let him know the memory care doors were not locked and needed to be fixed as soon as possible. The Maintenance Director remembered at that time the IL-MD had notified him that they would be conducting tests, and something must have accidently disarmed the memory care doors. He let the ED know as soon as he found out and			

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	staff were supposed to me monitoring the doors. The ED indicated the facility had followed their policy, which again, did not specify a requirement to man each door, but to supervise. When asked if additional staff were sent to memory care to help monitor the doors, she indicated no. The nurse was watching the doors, but when he went to help another resident, and the aides must have been giving care in other rooms as well, so Resident D got out. On 11/12/23 at 2:00 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Area of Focus: Elopement," reviewed, 11/23/22. The policy indicated, "Elopement occurs when a resident leaves the premises or a safe area without authorization ... each resident must receive adequate supervision and assistance to prevent accidents ... a system will be implemented to notify staff that exit doors have been opened in areas accessible to residents and may include: documented routine testing of door alarms, documented and routine testing of staff's response to alarms, monitoring practices when door alarms are disabled or during instances of higher traffic such as holidays, special events, or tours and monitoring practices for exits that are not visible to staff but readily accessible to residents ...." This citation relates to complaint IN00418979.			
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-			

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	§483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation and interviews the facility failed to ensure a resident had their call light within reach for 1 of 1 resident reviewed (Resident F). Findings include: On 10/10/23 at 10:30 a.m., Resident F was observed lying on her back in bed. She was alert and responded to questions asked of her. She was unable to move her arms. When asked if she could reach the tube, she nodded her head in a side-to-side motion indicating no. She had a mouthpiece call light. This type of call light worked by the resident blowing air into a tube. The call light was on her left side and out of reach of her mouth. On 10/10/23 at 1:00 p.m., Resident F was observed lying on her back in bed. Her mouthpiece call light was on the left side of her bed and out of reach of her mouth. On 10/10/23 at 2:00 p.m., Resident F was observed lying on back in bed. Her mouthpiece call light was on the left side of her bed and out of reach of her mouth. On 10/10/23 at 2:00 p.m. during an interview with a family member, she indicated Resident F never had her call light within reach. On 10/11/23 at 10:00 a.m., a comprehensive record review was completed. She had diagnoses which include but not limited to multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain	F 0919	F 919 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident F has been discharged from the facility. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? A one-time audit has been completed for current resident population to validate call lights are within reach of residents. The facility staff have been re-educated on maintaining call lights within reach of residents regardless of ability to use the call light. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? It is the responsibility of facility staff to maintain call lights within reach of residents for use. The Director of Nursing/designee will be responsible to review 10% of current resident population 5 times a week for 2 weeks, weekly for 6 weeks, and then monthly for 4 months to validate call lights are within reach of resident for use. Any issues identified will be immediately corrected, 1:1 re-education completed with staff	11/03/2023

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	and spinal cord, whose symptoms a chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms), iron deficiency anemia, atrial fibrillation (an irregular and often rapid heartrate), hypertension (high blood pressure), diabetes mellitus, heart failure, GERD (gastro-esophageal reflux disease), and constipation. Resident F had a care plan dated 6/23/22 indicating she was at risk for falls related to MS (multiple sclerosis) spasticity of all limbs, functional quadriplegia, catheter use, total assistance for transfers, and muscle weakness. An intervention, dated 6/23/22, indicated call light within reach. A policy titled, "Call Light, Use of," was provided by the ED (Executive Director) on 10/11/23 at 12:00 p.m. It indicated " ...Provide resident with easy access to his/her call light. Placement should be within resident's reach ...." This citation relates to complaint IN00419005. 3.1-19(u)		personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The results of these reviews will be discussed at the Quality Assurance Committee meeting monthly for 3 months and then quarterly for a total of 6 months. The QAPI Committee will determine if further monitoring or revision is required. The Administrator is responsible to ensure compliance. Date of Compliance: 11/3/23	