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	09/01/2022

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00386291. Complaint IN00386291 - Substantiated. Federal/State deficiencies related to the allegations are cited at F760. Survey dates: August 25, 26, 29, 30, 31 and September 1, 2022. Facility number: 000497 Provider number: 155606 AIM number: 100291530 Census Bed Type: SNF/NF: 92 Total: 92 Census Payor Type: Medicare: 8 Medicaid: 73 Other: 11 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 13, 2022.	F 0000	This plan of correction is to serve as Westside Village Nursing Centers credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Westside Village Nursing Centers Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We are requesting paper compliance.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would			

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

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	endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to provide adaptive equipment for 1 of 1 resident reviewed for accommodation of needs (Resident E). Findings include: During an 8/25/22 at 10:08 a.m., Resident E was observed lying in bed with her bedside table over her bed. She had her breakfast tray in front of her. She did not have built-up utensils on her tray. During an observation on 8/26/22 at 2:47 p.m., Resident E was observed sitting up in her wheelchair. She had her lunch tray in front of her. She did not have built-up utensils on her meal tray. During an observation on 8/29/22 at 12:33 p.m., Resident E was observed sitting up in her wheelchair. Her bedside table was in front of her with her lunch tray sitting on it. The lid to her plate was still covering her food. Her chocolate milk was unopened, and lemonade was in a Kennedy cup without a straw in the cup. During an observation on 8/29/22 at 1:31 p.m., Resident E was observed sitting up in her wheelchair with her lunch tray in front of her. The tray was not set up for resident. She had a regular spoon and fork. She had a divided plate. She had a Kennedy cup without a straw in it. Her chocolate milk was unopened. Her ice cream was unopened. Resident E's hands were trembling as she attempted to open her milk. Eventually, she was able to open the milk. She took her spoon and dipped it into the stew. She was able to place the spoon in her mouth. She was able to get the gravy	F 0558	***F 558 Reasonable Accommodations Needs/Preferences*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** ·Resident E orders have been reviewed to ensure adaptive equipment needs at meals are listed on her meal ticket. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** ·An audit will be conducted by the DOR/designee to identify residents who have orders for adaptive equipment for meals are appropriately listed on the meal ticket. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·Dietary staff will be provided with education by the CDM/designee on ensuring that adaptive equipment for meal are sent on meal trays as ordered ·Nursing staff will be provided with education by the DON/designee on ensuring	10/08/2022

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	off the spoon, but the potatoes stayed on the spoon. During an observation on 8/29/22 at 1:59 p.m., Resident E continued to have her lunch tray in front of her. She consumed a boost supplement. During an observation on 8/29/22 at 3:00 p.m., Resident E continued to have her lunch tray in front of her. A record review was completed on 8/26/22 at 2:00 p.m. Resident E had the following diagnoses but not limited to osteoarthritis, Parkinson's disease, other disorders of bone density and structure, need for assistance with personal care, muscle weakness, major depressive disorder, iron deficiency disorder, hyperlipidemia, hypertension, and dystonia (involuntary muscle contractions). Resident E had an order, dated 5/2/22, for a regular diet, mechanically altered texture, and thin consistency liquids. An order, dated 3/31/22, indicated staff were to provide a plate guard for all meals. An order, dated 6/6/22, was to keep an 8-ounce bottle chocolate boost in the resident's refrigerator four times a day for weight management. An order, dated 6/6/22, indicated the resident was to have an adaptive device of built up utensils. Resident E's care plan included a problem, dated 7/12/2022, that Resident E had a nutritional problem with significant weight loss including unavoidable weight loss related to end stage Parkinson's disease process. Further weight loss was anticipated due to frequent non-compliance with meal intake, very slow eating habits. Interventions for the care plan problem included but were not limited to utilize adaptive equipment		adaptive equipment for meals listed on the meal ticket are provided to the resident for their meal. ·The CDM/designee will complete routine auditing during meal service to ensure resident's orders for adaptive equipment have been listed to their meal ticket, and have been provided with adaptive equipment for meals. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·DON/designee to conduct routine auditing during meal service to ensure residents with adaptive equipment needs per meal ticket have been provided for the meal. Auditing to occur: 4 random residents with adaptive equipment M-Fri x's 4 weeks, then 4 residents weekly x's 4 weeks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee and/or increased frequency/duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once	

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	as ordered, Kennedy cup at meal and bed side, and staff to assist with eating her meals as indicated. A Minimum Data Set (MDS) assessment, dated 7/6/22, indicated Resident E was coded a 3/2 for eating which indicated that Resident D required extensive assistance of 1 nursing staff to eat. During an interview on 8/29/22 at 11:33 a.m., Resident E indicated her appetite was not good, and she was unable to identify the reason for her poor appetite. She requested to eat in her room due to her neck contracture and shakiness due to Parkinson's disease. Staff helped her at times. She needed help guiding the spoon into her mouth or for staff to use a spoon to place food into her mouth. She could access the refrigerator in her room to obtain her boost supplement to consume. During an interview with the DON on 9/1/22 at 10:12 a.m., she indicated that the kitchen placed the utensils on the resident's trays. She indicated that Resident E required extensive assistance with meal consumption. The DON indicated that Resident E refused assistance from staff. No policy was provided regarding the use of adaptive equipment by the end of the survey. 3.1-21(h)		full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interviews the facility failed to notify the physician for elevated blood sugars for 1 of 5 residents reviewed for unecessary medications, (Resident 35). Findings include: On 8/25/22 at 2:48 p.m. a record review was completed for Resident 35. His diagnoses included, but were not limited to heart failure, type 2 diabetes, muscle weakness, chronic atrial fibrillation, cognitive communication deficit, hypertension, anemia, and hyperlipidemia. He had a current physician's order, dated 7/22/22, for "accu checks" (blood sugars per finger stick) two times daily for diabetes mellitus, type 2, with parameters to notify the physician if his blood sugars were less than 60 or greater than 300. On the following dates, the physician was not notified of Resident 35's blood sugars being out of range of the parameters: 7/27/22 at 9:00 p.m. his blood sugar was 339 8/6/22 at 9:00 p.m. his blood sugar was 309 8/7/22 at 9:00 p.m. his blood sugar was 330 8/17/22 at 9:00 p.m. his blood sugar was 330 8/21/22 at 9:00 p.m. his blood sugar was 379 8/31/22 at 9:00 p.m. his blood sugar was omitted During an interview on 8/31/22 at 2:30 p.m., the Director of Nursing (DON) was notified of the blood sugars being out of range of the parameters and requested documentation of notification of the physician.	F 0580	***F580 Notify of Changes*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** ·The DON/designee has notified the physician of Resident #35 blood sugars that were elevated outside of ordered parameters in July 2022 thru Sept 2022 on 9/15/2022. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** ·DON/designee to identify residents who have had elevated blood sugars outside of parameters x's last 7 days. The physician and responsible parties will be notified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·DON/designee to provide education to licensed nursing staff on ensuring the physician and responsible parties have been notified when blood sugars are	10/08/2022

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	During an interview on 9/1/22 at 11:30 a.m., the DON indicated that she was not aware of the requested documentation. The DON then presented the note with the request for the above-mentioned blood sugars and indicated that she would work on gathering the documentation. On 9/1/22 2:30 p.m. at the exit conference, the DON did not present the documentation requested. A policy titled, "Changes in Resident's Condition or Status" with no date was provide by the DON on 9/1/22 at 12:03 p.m., it indicated " ...nursing services will be responsible for notifying the resident's attending physician when there is a significant change in the resident's physical, mental or emotional status, there is a need to alter the resident's treatment or medications significantly and deemed necessary or appropriate in the best interest of the resident...." 3.1-5(a)		outside of ordered parameters. ·DON/designee to conduct routine auditing to ensure physician and responsible party notification of elevated blood sugars outside of parameters. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·DON/designee to conduct routine auditing of blood sugars elevated outside of ordered parameters to ensure that the physician has been notified. Auditing to occur: 4 random blood sugars M-Fri x's 4 weeks, then 4 residents weekly x's 4 weeks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee, and/or increased frequency/duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Health Facility Administrator	

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			at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)			

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	(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a			

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	mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interviews, the facility failed to ensure clinical information was sent to the hospital upon transfer and failed to give a copy of the bed hold policy and notice of transfer/discharge to a resident and/or their representative for 1 of 2 residents reviewed for discharge (Resident 35). Findings include: On 8/25/22 at 2:48 p.m. a comprehensive record review was completed for Resident 35. He had the following diagnoses of, but not limited to heart	F 0623	***F623 Notice Requirements Before Transfer /Discharge*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** · A bed hold policy and Notice of Transfer/Discharge will be provided to Resident #35 for the 6/28/22 transfer to the hospital by the SSD/designee · Resident #35 had no	10/08/2022

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	failure, type 2 diabetes, muscle weakness, chronic atrial fibrillation, cognitive communication deficit, hypertension, anemia, and hyperlipidemia. On 6/28/22 at 5:00 p.m., 911 was notified to transfer Resident 35 to the hospital for evaluation and treatment related to a low hemoglobin. Resident 35 was transferred to the hospital and readmitted to the facility on 6/30/22 at 5:13 p.m. Resident 35's record lacked an order to send him to the emergency room. A discharge assessment was incomplete. The chart lacked documentation that the facility sent pertinent information with Resident 35 to the hospital, to include physician contact information, special precautions for ongoing care, care plan goals and physician's orders, to include medications that Resident 35 was ordered to take. On 9/1/22 at 11:11 a.m., the Director of Nursing (DON) provided an interact SBAR (Situation, Background, Assessment, Response) tool that was completed on 6/28/22 at 12:32p.m. The DON indicated that the facility sent the SBAR communication form to the hospital with residents. The SBAR was a tool that was used to collect an assessment of a resident's condition prior to notify the resident's physician for treatment. The physician responded to the SBAR completed on 6/28/22. The physician indicated to keep Resident 35 in the facility and complete vital signs every 4 hours. On 9/1/22 at 11:21 a.m., the DON was unable to collect further documentation to demonstrate that Resident 35 was sent to the hospital with a discharge assessment. The DON was unable to provide documentation that Resident 35 or Resident 35's family representative received a		negative outcome from failure to send paper bed hold policy and paper notification of transfer or discharge. The resident was readmitted to the facility without incident on 6/30/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who have been transferred to the hospital have the potential to be affected. · Residents who have been transferred to the hospital x's last 30 days will be identified to ensure a bed hold policy and notice of transfer/discharge was provided to the resident and/or responsible party. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DON/designee will provide licensed nursing staff and SSD with education to ensure that residents and/or their responsible party who are transferred to the hospital are provided with a bed hold policy and notice of transfer/discharge. · SSD/designee will conduct routine auditing to ensure residents and/or their responsible party are provided with the bed	

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	notice of transfer/discharge or bed hold policy. 3.1-12(a)(6)(A)		hold policy and notice of transfer/discharge when they are transferred to the hospital. Any findings will be addressed. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·DON/designee to conduct routine auditing to ensure that residents and/or their responsible party are provided with a bed hold policy and notified of transfer/discharge. Auditing to occur: 4 random residents who have had a hospital transfer daily Mon-Fri if they occur x' 4 weeks, then 4 residents who have had a hospital transfer weekly if they occur, then 4 random residents who have had a hospital transfer monthly if they occur monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee and/or increased frequency/duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be	

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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
			increased as needed, if areas of noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were coded accuratly for 3 of 19 residents reviewed for MDS accuracy (Residents 50, 35, and 1). Findings include: 1. On 8/26/22 at 1:29 p.m., Resident 50 was observed as she sat up in her electric power wheelchair. She indicated she did have a wound on her bottom that they were treating although she was not sure if it was getting any better or worse. During a follow up interview on 8/29/22 at 1:52 p.m., Resident 50 was observed as she sat up in her electric power wheelchair. At this time, she indicated she was waiting to get laid down after lunch. She was supposed to get off her bottom every so often so the wound could heal. She was supposed to be encouraged to lay down and assisted to turn/reposition every two hours, but that did not always happen.	F 0641	***F 641 Accuracy of Assessments*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** · The MDS Coordinator/designee will correct the MDS noted in this statement of deficiencies for Residents # 50, 35, 1. · No resident was affected from inaccurate coding of the MDS assessment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who have pressure wounds and require an MDS have the potential to be affected. · Current residents who have	10/08/2022

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	On 9/1/22 at 10:00 a.m. Resident 50's medical record was reviewed. She admitted to the facility on 7/20/22 with diagnoses which included but were not limited to chronic instability of the left knee, pain in left and right knee and left hip, difficulty in walking and a history of falling. An admission nursing progress note, dated 7/20/22 at 10:58 p.m., indicated Resident 50 admitted with a healing stage 2 pressure ulcer to her right buttock which was covered by a foam dressing. An admission nursing assessment, dated 7/20/22 at 10:56 p.m., also indicated the presence of a stage II healing pressure ulcer. Her admission Minimum Data Set (MDS) assessment was dated 7/27/22 and was not coded to reflect the presence of a stage II pressure ulcer upon her admission. 2. On 8/29/22 at 12:19 p.m., a comprehensive record review was completed for Resident 35. He had the following diagnoses of, but not limited to, heart failure, type 2 diabetes, muscle weakness, chronic atrial fibrillation, cognitive communication deficit, hypertension, anemia, and hyperlipidemia. Resident 35 had a MDS with an Assessment Reference Date (ARD) of 7/15/22. Section M of the MDS indicated that Resident 35 did not have any pressure ulcers. Resident 35 had an order dated 8/15/22 to cleanse sacrum with soap and water, pat dry, apply Aquaphor sparsely to the buttock once daily, every evening shift for wound care until 9/18/22. Resident 35 had an order dated 8/18/22 to cleanse left heel with wound cleanser, pay dry, apply		a pressure wound and have had a transmitted MDS x's last 90 days will be reviewed for accuracy. Any findings will be addressed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Regional MDS Consultant/designee will provide education to the facility MDS Coordinator on coding MDS assessments accurately. · The MDS Coordinator/designee will conduct routine auditing of MDS assessments to ensure accuracy. Any findings will be addressed. **How the corrective action will be monitored to ensure the deficient practice will not recur:** · The MDS Coordinator/designee will conduct routine auditing of completed MDS assessments on residents with pressure wounds to ensure accuracy. Auditing to occur: on residents with pressure wounds x's 6 months of monitoring. MDS assessments. Any findings of non-compliance will be addressed through associate re-education by the DON/designee and/or increased frequency/duration of auditing. The results of these reviews will be	

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	Santyl ointment and foam dressing once daily, every day shift for wound care and every 8 hours as needed for soilage and dislodgement. Wound assessments were completed weekly. Wounds assessment present during the ARD were a left heel pressure ulcer, unstageable, assessed on 7/13/22 and measured 4 centimeters (cm) by (x) 5 cm. An assessment for a sacrum pressure ulcer, stage 3, assessed on 7/13/22 and measured 2.6 cm x1.2 cm. Resident 35 had a care plan, dated 6/19/22, the resident had a pressure ulcer to sacrum and left heel noted on 6/14/22. Goals included the resident will have intact skin, free of redness blisters or discoloration and the resident's pressure ulcer to left heel will show signs of healing and remain free from infection. 3. On 8/25/22 at 10:49 a.m. Resident 1 was observed to have a dressing on her left lower leg and foot. The dressing was dated 8/25/22. On 9/1/22 at 11:39 a.m., a comprehensive record review was completed for Resident 1. She had the following diagnoses but not limited to type 2 diabetes mellitus, chronic obstructive pulmonary disease, cellulitis of left lower limb, muscle weakness, difficulty breathing, cognitive communication deficit, end stage renal disease, unspecified open wound of left foot, dependence on supplemental oxygen, congestive heart failure, anemia, hyperlipidemia, hypertension, and dependence on renal dialysis. Resident 1 had a MDS with an ARD of 8/23/22. Section M of the MDS indicated that Resident 1 did not have any pressure ulcers.		discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	

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	Resident 1 had an order dated 6/2/22 to float heels while in bed, nursing to document non-compliance every shift for wound care, an order dated 6/7/22 adaptive equipment, prevalon boot to left foot, at all times. An order, dated 7/18/22, to cleanse left plantar foot with one quarter strength Dakin's solution, pat dry, apply collagen over the center of the wound bed, apply Santyl ointment over the posterior portion of the heel with eschar, cover the wound bed with calcium alginate and follow with an abdominal pad, secure with kerlix (rolled gauze) and tape, every shift for wound care. Resident 1 had a wound assessment dated 8/23/22. The assessment indicated that Resident 1 had a stage 4 pressure ulcer to her left plantar foot ulcer, that was present upon admission on 12/31/21. Resident 1 had a care plan dated 8/28/22 that resident has a pressure ulcer to left plantar and is at risk for development of additional pressure, blisters and delayed healing related to lymphedema, end stage renal disease, history of cellulitis of both lower extremities, anemia, diabetes type 2, and non-compliance with positioning devices. The goal included the resident's pressure ulcer would show signs of healing and remain free from infection. An interview was conducted with the MDS Coordinator on 8/31/22 at 10:07 a.m. She stated that regional MDS should have coded the pressure ulcers on the end of therapy assessment dated 7/15/22. When Resident 35 readmitted and the pressure ulcers were not acquired, the facility would not have completed a significant change MDS. The MDS Coordinator indicated that she would complete a modification of the MDS.			

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	An interview was conducted with the MDS Coordinator on 9/01/22 at 12:50 p.m. The MDS for Resident 1 was not coded for a stage 4 ulcer. The MDS Coordinator indicated that the corporate nurse coded MDS and should have coded the stage 4 pressure ulcer to her left heel. The MDS Coordinator indicated that she would correct the MDS once it was accepted. The RAI (Resident Assessment Instrument) manual, dated 7/2010, indicated, " ...enter the number of pressure ulcer are currently present and whose deepest anatomical stage is stage 3, enter the number of Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission AND-for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (e.g., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital). and enter the number of pressure ulcers that are unstageable related to a non-removable dressing/device that were first noted at time of admission AND-for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization ...."			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II			

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	determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to obtain a new Pre-Admission Screening and Resident Review (PASRR) Level II for a resident admitted to the facility with a short term approval for 1 of 3 residents reviewed for PASRR Level II (Resident 53), and failed to ensure a resident with a new diagnoses of mental health disorders had a new Level 1 screening (initiated when there was a significant change in the mental condition of a resident) for 1 of 3 residents reviewed for PASRR (Pre-admission screening and record review) after a significant change (Resident 79). Findings include: 1. On 8/29/22 at 11:27 a.m., the medical record was reviewed for Resident 53. The diagnoses included, but were not limited to, bipolar disorder (a mental illness), anxiety and major depressirve disorder. The most recent Minimum Data set assessment, dated 7/7/22, indicated Resident 53 did not have a PASARR Level II assessment. On 8/26/22 at 3:00 p.m., the Executive Director provided a copy of a PASARR Level II assessment, dated October 14, 2021, for Resident 53. This document indicated Resident 53 had a short term approval which expired on January 12,	F 0644	***F644 Coordination of PASRR and Assessments*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** · Resident # had a new Level 2 completed · Resident # 79 had a new Level 1 completed · No resident had a negative outcome for lacking an updated PASRR assessment. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents admitted to the facility with a short term approval who require a Level 2 have the potential to be affected. · Residents who obtain a new mental health dx that require a new Level 1 have the potential to be affected. · Residents that require a	10/08/2022

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	2022. On 8/29/22 at 12:09 p.m., during an interview the Social Service Designee indicated they must "have just missed it." Resident 53 was admitted last year, in 2021. It should have been submitted for a new level II. A current policy, titled, "Pre-Admission Screening and Resident Review (PASARR)," dated 8/7/21, was provided by the Executive Director (ED), on 8/31/22 at 8:29 a.m. A review of the policy indicated, " ...Ensure Level I PASARR screening has been completed on all potential admissions prior to admission ...A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later ...A positive Level 1 screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility ...." 2. On 8/29/22 at 3:37 p.m., Resident 79's record was reviewed. She was admitted to the facility on 10/20/20. Her admission diagnoses included, but were not limited to, cerebral infarction (stroke), diabetes mellitus (blood sugar disorder), and hemiplegia (paralysis and weakness) affecting her left side. On 8/6/21, she was diagnosed with major depressive disorder (MDD) (long term loss of pleasure or interest in life). On 2/14/22, she was diagnosed with delusional disorder (unshakeable belief in something that is untrue).		PASRR have been identified to ensure they are updated **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Executive Director/designee will provide education to the SSD and assistant SSD to ensure residents have PASRRs completed when indicated. ·ED/designee will complete routine auditing to ensure newly admitted residents and residents with a new mental health diagnosis have a updated PASRR completed. Any findings will be addressed. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·ED/designee will complete routine auditing to ensure newly admitted residents and residents with a new mental health diagnosis have a updated PASRR completed. Auditing to occur: 4 random residents weekly‘s 4 weeks, then 4 random residents monthly for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee, and/or increased frequency/duration of	

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	On 7/20/22, she was diagnosed with dementia with behavioral disturbance (progressive brain disorder with physical or verbal aggression). Her mental health care plans were reviewed and included: Resident 79 had a mood problem showing moderate signs and symptoms of depression. This care plan was created on 11/8/21. Resident 79 used antidepressant medications related to depression. This care plan was created on 11/23/20. Resident 79 was at risk for change in mood or behavior due to her having delusions. This care plan was created on 5/5/22. Resident 79 had moderately impaired cognitive ability; this care plan was created on 11/8/21. A nursing progress note, dated 7/19/22, indicated Resident 79 was having hallucinations. On 8/13/21, Resident 79 had a Minimum Data Set (MDS) significant change after her diagnosis of MDD. During an interview, on 8/30/22 at 10:44 a.m., the Social Services Designee (SS) indicated she did not have information regarding Resident 79 prior to her start date of August 2021. Resident 79 should have had a new Level 1 screening on 8/6/21 due to a new diagnosis of MDD, delusional disorder, and dementia with behaviors. During an interview, on 8/30/22 at 11:05 a.m., the Director of Nursing (DON) indicated she would verify whether an admitted resident who did not		auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. Compliance Date: 10/8/2022	

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	admit with psychiatric issues and developed them while at the facility, should have received another Level 1 screening. During an interview, on 8/31/22 at 11:03 a.m., the DON indicated when a resident had a new diagnosis, a care plan should have been entered within the correct time frame. During an interview, on 8/31/22 at 11:50 a.m., the DON indicated Resident 79's care plan for delusions should have been created when she was diagnosed with delusions. A current policy, titled, "Pre-admission Screening and Resident Review (PASARR)," dated 8/7/21, was provided by the Executive Director (ED), on 8/31/22 at 8:26 a.m. A review of the policy indicated, " ...A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review ...." 3.1-16(d)			
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the			

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	following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observations, interview, and record review, the facility failed to ensure comprehensive care plans were developed for 5 of 19 residents reviewed for comprehensive care planning (Residents 50, 66, 22, 79 and 35). Findings include:	F 0656	***F 656 Develop/Implement Comprehensive Care Plans*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:**	10/08/2022

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	1. On 8/26/22 at 1:29 p.m., Resident 50 was observed as she sat up in her electric power wheelchair. She indicated she did have a wound on her bottom that they were treating although she was not sure if it was getting any better or worse. During a follow up interview on 8/29/22 at 1:52 p.m., Resident 50 was observed as she sat up in her electric power wheelchair. At this time she indicated she was waiting to get laid down after lunch. She was supposed to get off her bottom every so often so the wound could heal. She was supposed to be encouraged to lay down and assisted to turn/reposition every two hours, but that did not always happen. On 9/1/22 at 10:00 a.m. Resident 50's medical record was reviewed. She admitted to the facility on 7/20/22 with diagnoses which included but were not limited to chronic instability of the left knee, pain in left and right knee and left hip, difficulty in walking and a history of falling. An admission nursing progress note, dated 7/20/22 at 10:58 p.m., indicated Resident 50 admitted with a healing stage 2 pressure ulcer to her right buttock which was covered by a foam dressing. An admission nursing assessment, dated 7/20/22 at 10:56 p.m., also indicated the presence of a stage II healing pressure ulcer. A weekly skin assessment, dated 7/27/22, indicated Resident 50's skin was intact. The next weekly skin assessment, dated 8/3/22, indicated the presence of an open area/wound and was described as "red beefy- sacrum wound		· The MDS Coordinator has updated the care plan for residents #50 to accurately reflect skin condition. · The MDS Coordinator has updated the bowel and bladder care plan for resident #66 to reflect total incontinence of urine and frequent incontinence of bowel. · The MDS Coordinator has updated the care plan for resident #22 to reflect a dx of constipation. · The MDS Coordinator has updated the care plan for resident #79 to reflect a dx of delusional disorder. · The MDS Coordinator has updated the care plan for resident #35 a dx of insomnia **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who have pressure wounds, incontinence of B&B, dx of constipation, dx of delusional disorders, and dx of insomnia have the potential to be affected. · No resident was negatively affected due to the C/P not being updated · MDS Coordinator/designee will update current resident care plans to reflect current conditions. · Current residents who have pressure wounds, incontinence of B&B, dx of constipation, dx of	

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	with TX [treatment] in place." There were no measurements. Weekly Wound assessments were completed on 8/6, 8/9, and 8/16. On 8/6 the wound was documented as a stage II pressure, but on 8/9 and 8/16 it was documented as shearing. Resident 50's comprehensive care plan were reviewed and lacked documentation of a plan of care for her open areas. Instead, she had a care plan initiated 8/9/22 which only indicated she was at risk for a break in skin integrity. During an interview on 9/1/22 at 9:29 a.m., the Director of Nursing, (DON) indicated she had reviewed Resident 50's care plan and there had not been a care plan developed to capture the area to her bottom. During an interview on 9/1/22 at 10:45 a.m., the Wound Doctor indicated he had been following and treating the wound. Initially it had been classified as a stage II pressure ulcer, but he had reclassified it to shearing since the area was not located over a bony prominence. On 9/1/22 at 10:00 a.m., the DON provided a copy of current facility policy title, "Skin Integrity and Pressure Ulcer/Injury Prevention and Management," dated, 10/2019. The policy indicated, "Intent- [to] provide associates and licensed nurses with procedures to manage skin integrity ... and provide treatment and care of skin and wounds utilizing professional standards ... Measures to protect the patient against the adverse effects of external mechanical forces, such as pressure, friction, shear are implemented in the plan of care ...."2. On 8/26/22 at 11:04 a.m., Resident 22's record was reviewed. He was		delusional disorders, and dx of insomnia will be identified by the MDS Coordinator/designee and will have care plans created/updated to reflect these conditions. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Regional MDS Coordinator will educate the MDS Coordinator on the require to develop and/or updated resident care plans who have: pressure wounds, incontinence of B&B, dx of constipation, dx of delusional disorders, and dx of insomnia have the potential to be affected. · The MDS Coordinator will conduct routine auditing to ensure care plans for: pressure wounds, incontinence of B&B, dx of constipation, dx of delusional disorders, and dx of insomnia have been developed and or accurately updated. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·MDS/designee to conduct routine auditing of resident care plans who have: pressure wounds, incontinence of B&B, dx	

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	155606	A. BUILDING 00 B. WING	09/01/2022

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	admitted to the facility on 5/28/22. His diagnoses included, but were not limited to, encephalopathy (brain disease that alters brain structure or function), diabetes mellitus (blood sugar disorder), and vascular dementia (brain disorder). An active physician order was for Sennosides-Docusate Sodium (stool softener and laxative) tablet 8.6-50 mg, give 1 tablet by mouth two times a day for constipation. An active physician order was for Polyethylene Glycol 3350 (treats constipation) to give 17 grams by mouth two times a day for constipation. An active physician order was for Bisacodyl (laxative) suppository 10 mg (milligram), insert 1 suppository rectally every 24 hours as needed for constipation (less than 3 bowel movements per week). The nursing progress notes were reviewed. On 6/24/22 at 10:18 a.m., the Certified Nursing Aide (CNA) was bathing Resident 22 and noted a large amount of blood in his disposable brief. On 6/24/2022 at 10:25 a.m., Resident 22's physician, the DON, and the family were notified. On 6/24/2022 at 10:34 a.m., Emergency Medical Services (EMS) had the resident enroute to a nearby hospital. Resident 22 was alert and responsive. On 6/29/2022 at 1:41 p.m., Resident 22 was readmitted to the facility with diagnoses of constipation, generalized weakness, hematochezia		of constipation, dx of delusional disorders, and dx of insomnia to ensure they have been developed and or accurately updated. Auditing to occur: 4 random care plans daily Mon-Fri x's 4 weeks, then 4 random care plans weekly x's 4 weeks, then 4 random care plans monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the Regional MDS/designee, and/or increased frequency/duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	

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	(rectal bleeding), and vascular dementia. On 8/31/22 at 10:54 a.m., the Executive Director (ED) provided a constipation care plan for Resident 22; it was created on 8/30/22. During an interview, on 8/31/22 at 11:50 a.m., the DON indicated Resident 22 should have had a constipation care plan created after he returned from the hospital. 3. On 8/29/22 at 3:08 p.m., Resident 66's record was reviewed. He was admitted on 6/22/22. His diagnoses included, but were not limited to, dementia (brain disorder), diabetes mellitus (blood sugar disorder), and major depressive disorder (loss of interest in life). He had a care plan for self-care performance deficit related to dementia. The goal was for Resident 22 to toilet himself with toilet hygiene with cueing from the staff, with an intervention indicating he needed some help with his toileting needs. His additional care plans included risk for pain due to diagnosis of dementia, mood problems related to a diagnosis of major depression, and care plans for use for psychotropic (medication that affecting a person's mental state), and antidepressive medications. No bowel and bladder incontinence care plan was found. The MDS (Minimum Data Set), dated 7/10/22, indicated Resident 66 was always incontinent of urine and frequently incontinent of bowel.			

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	During an interview, on 8/31/22 at 11:50 a.m., the DON indicated Resident 66 should have had a care plan for bowel and bladder. 4. On 8/29/22 at 3:37 p.m., Resident 79's record was reviewed. She was admitted to the facility on 10/20/20. Her admission diagnoses included, but were not limited to, cerebral infarction (stroke), diabetes mellitus (blood sugar disorder), and hemiplegia (paralysis and weakness) affecting her left side. On 2/14/22, she was diagnosed with delusional disorder (unshakeable belief in something that is untrue). Her mental health care plans were reviewed. Resident 79 was at risk for change in mood or behavior due to her having delusions; this care plan was created on 5/5/22. A nursing progress note, dated 7/19/22, indicated Resident 79 was having hallucinations. During an interview, on 8/31/22 at 11:03 a.m., the DON indicated when a resident had a new diagnosis, a care plan should have been entered within the correct time frame. During an interview, on 8/31/22 at 11:50 a.m., the DON indicated Resident 79's care plan for delusions should have been created when she was diagnosed with delusions. 5. On 8/29/22 at 12:19 a.m., a comprehensive record review was completed for Resident 35. He had the following diagnoses of, but not limited to, heart failure, type 2 diabetes, muscle weakness, chronic atrial fibrillation, cognitive communication deficit,			

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	hypertension, anemia, and hyperlipidemia. His orders, dated 6/14/22, included to give 3 tablets of melatonin 3 milligrams (mg) by mouth at bedtime for insomnia. Resident 35's record lacked a diagnosis for insomnia. The record lacked a care plan to address the insomnia and medication (melatonin) to treat his insomnia. A policy titled "Care Plan Comprehensive" dated December 2010, was provided by the DON on 9/1/22 at 12:17 p.m., it indicated, " ...An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes ...." 3.1-35(c)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure the appropriate treatment was in place for a resident, (Resident 57)	F 0684	***F684 Quality of Care*** **What corrective action will be**	10/08/2022

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	for 1 of 1 resident reviewed for skin conditions. Findings include: On 8/30/22 at 3:00 p.m., Resident 57's medical record was reviewed. She admitted to the facility on 7/7/22 and received Hospice services with diagnoses which included, but were not limited to, dementia, adult failure to thrive, and severe protein-calorie malnutrition. A comprehensive care plan, initiated 7/9/22, indicated Resident 57 had the potential for skin break down due to her fragile skin. Interventions for this plan of care included to place treatments as ordered. A nursing progress note, dated 8/1/22 at 3:56 p.m. indicated Resident 57 had sustained a skin tear during personal care when the aids glove tore, and she scratched the resident's right forearm which resulted in a nickel-sized skin tear. A new order was received to apply triple antibiotic ointment and cover until healed. A nursing progress note, dated 8/6/22 at 11:36 a.m., indicated Resident 57 sustained two additional skin tears during personal care when she was bathed to both her upper arms. Skin tear #1 measured 4 cm (centimeters) long by 2.1 cm wide. Skin tear #2 measured 1.5 cm long by 1.5 cm wide. The older skin tear remained covered and new skin tears were cleansed and dressed as ordered. A nursing progress note dared 8/8/22 at 1:21 p.m., indicated, the wound nurse had assessed Resident 57's right and left skin tears. Steri-strips were applied to reinforce closure of the skin flaps, Xeroform and kerlix dressing with paper tape were		**accomplished for those residents found to have been affected by the alleged deficient practice?** · Resident 57 did not have a negative outcome from the adhesive foam dressing · MD/RP was notified of the adhesive dressing being used. No new orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who have an order to not use adhesives have the potential to be affected · The DON/designee will identify residents who have an order to not use adhesives, have an allergy or other sensitivity to not use adhesives have been identified. DON/designee to verify the appropriate non-adhesive treatment is in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DON/designee will provide education to the wound nurse and licensed nursing staff to ensure adhesives are not used on residents who have an order for no adhesives, allergy or other adhesive sensitivity · The wound/nurse designee	

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	used to secure the dressing. A current physician's order dated 8/17/22 indicated to cleanse skin tears to the bilateral upper extremities with normal saline and pat dry, then cover with xeroform gauze and wrap with krelix gause roll. Special instructions for this order indicated, in all caps: "do not use adhesive foam dressing. Only kerlix wrap." On 8/31/22 at 11:17 a.m., a wound observation was conducted with the Director of Nursing (Don) present. Areas to her right arm had been healed and no dressing was in place. An adhesive foam dressing with no date, or nurses' initials was observed in place over the left skin tear just below the resident's elbow. When the DON removed the dressing, and confirmed it was an adhesive foam bandage. The adhesive pulled tightly against the resident's skin, and the DON had to gently and slowly, push her skin back down as she pulled the dressing up. The DON indicated Resident 57's skin was very fragile. During an interview on 8/31/22 at 3:53 p.m., the Wound Nurse indicated Resident 57's skin was very tender and fragile. The adhesive dressings had caused bruising and had the potential to pull her skin too tightly and cause additional skin tears which was why her treatment had been ordered to not to use adhesive and to use rolled gauze instead. On 9/1/22 at 10:00 a.m., the DON provided a copy of current facility policy titled, "Skin Integrity and Pressure Ulcer/Injury Prevention and Management," dated 10/2019. The policy indicated, "Intent- [to] provide associates and licensed nurses with procedures to manage skin integrity ... and provide treatment and care of skin		will complete routine auditing of dressing change auditing of residents who are to not use adhesives to ensure the appropriate tx is being used. **How the corrective action will be monitored to ensure the deficient practice will not recur:** · DON/designee will complete random of dressing change observations of residents who are to not use adhesives to ensure the appropriate tx is being used. Observations to occur: 2 random dressing change observations daily Mon-Fri x's 4 weeks, 2 random dressing change observations weekly x's 4 weeks then 4 medication dressing change observations monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee and/or increased frequency/duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of	

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	and wounds utilizing professional standards ... Measures to protect the patient against the adverse effects of external mechanical forces, such as pressure, friction, shear are implemented in the plan of care ...." 3.1-37		noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 0689 SS=E 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 prevent a nurse from dispensing all morning medications at the same time and failed to prevent the nursing from leaving them in the resident's room unattended for 1 of 1 randomly observed resident with medications bedside. (Resident E). Findings include: During an observation on 8/29/22 at 1:41 p.m., Resident E had a cup of medications to the right of her lunch tray. She was unaware that the cup was on her table. The cup had 9 a total of 9 medications. There were 2 red gel pills, 3 yellow pills, 1 white football shaped pill, a small white pill, an orange-red pill, and a blue pill. Resident picked up the cup of medications and placed on her lunch tray.	F 0689	***F689 Free of Accident Hazards/Supervision/Devices*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** · Resident E's physician was notified by the DON on 8/29/2022 of untimely medication administration and medications being left at bedside. No new orders were given by the physician. Resident did not experience any negative outcomes from untimely medication administration.	10/08/2022

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	During an observation on 8/29/22 at 1:42 p.m., Resident E was assisted to the bathroom after turning her call light on. During an observation on 8/28/22 at 1:59 p.m., Resident E was sitting up in her wheelchair with her lunch tray in front of her. She indicated that she would finish her boost and may eat a little more, but her food was cold. She indicated that the staff do not warm her food up for her. Her medication cup was empty. She indicated that she took the medications inside the cup. Resident E indicated that the medications she took were her morning medications that she got at noon. An interview was conducted with LPN 12 regarding Resident E's medications. LPN 12 indicated that she was to blame for the medications sitting on the bedside table. Resident E told LPN 12 that she could take her medications without LPN 12 present because Resident E could only take pills one at a time. LPN 12 indicated that she meant to go back to Resident E, but something came up next door. An interview and review of Resident E's medication was conducted with the DON on 8/29/22 at 3:46 p.m., to identify the medications in the cup. The 2 red gel pills were vitamin B12, 1 blue pill was lamotrigine, 3 yellow pills were Sinemet, 1 whit pill was selegiline, 1 football shaped pill was biotin, and 1 orange-red pill was ibuprofen. A comprehensive chart review was completed on 8/26/22 at 2:00 p.m. for Resident E. She had the following diagnoses but not limited to osteoarthritis, Parkinson's disease, other disorders of bone density and structure, need for assistance with personal care, muscle weakness, major		· LPN #12 was immediately provided with education by the DON on (list date). Education included administering medications per physician orders and staying with the resident until medications have been safely swallowed by the resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who are administered medications have the potential to be affected · LPN #12 was an agency nurse and has been marked as a “do not return. She is prohibited from picking up any further shifts at facility. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DON/designee will provide education to licensed nursing staff and Qualified Medication Aides on best practices of Medication Administration. · Current licensed nursing staff and Qualified Medication Aides will be required to complete and pass a skills validations competency with the DON/designee on medication	

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	depressive disorder, iron deficiency disorder, hyperlipidemia, hypertension, spasmodic torticollis (a painful condition in which your neck muscles contract involuntarily, causing your head to twist or turn to one side) and dystonia (involuntary muscle contractions). Resident E had the following orders for 8:00 a.m.: lamotrigine 200 mg tablet, 1 tablet by mouth two times daily for Parkinson's disease vitamin B12 tablet 500 mcg, give 2 tablets by mouth one time daily for muscle weakness Aricept 10mg tablet, give 1 tablet by mouth two times daily for dementia vitamin C tablet chewable, give 125 mg by mouth one time daily for supplement related to iron deficiency anemia ipratropium bromide solution 0.03% 1 spray in each nostril three times daily for allergy voltaren gel 1%, apply to right upper arm/shoulder topically two time a day for pain house moisturizer to whole body excluding skin folds and web spaces two times daily for skin care Colace 100mg by mouth two times daily for constipation maxzide-25, tablet 37/5-25mg, give 1 and a ½ tablet one time a day for hypertension, oxcarbazepine tablet 300 mg, give 1 tablet by mouth two times a day for convulsions related to spasmodic torticollis chocolate boost in resident's refrigerator four times a day for weight management, give 8 ounce bottle, boost in resident's room refrigerator, Resident E had the following orders for 9:00 a.m.: multivitamin gummies adult tablet chewable, give 2 gummies by mouth one time a day for supplement related to muscle weakness, biotin tablet 1000 mcg, give 1 tablet by mouth one time a day for supplement,		administration. · Newly hired licensed nursing staff and Qualified Medication Aides will complete and pass a skills validations competency with the DON/designee on medication administration before being given an assignment to pass medications unsupervised. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·DON/designee will complete random medication pass observations with licensed nursing staff and Qualified Medication Aides. Observations to occur: 2 random medication observations daily Mon-Fri x's 4 weeks, 2 random medication observations weekly x's 4 weeks then 4 medication administration observations monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee and/or increased frequency/duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved	

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	calcium tablet 500mg, give 2 tablets by mouth one time a day for supplement, paroxetine hcl tablet, give 1 tablet by mouth one time daily related to major depressive disorder, recurrent mild, lidocaine patch 4%, apply to right upper arm topically one time a day for pain, Resident E had the following orders: At 11:00 a.m., carbidopa-levodopa (Sinemet) 25-100 mg tablet, give 2 tablet by mouth four times a day related to Parkinson's disease, At 2:00 p.m., acetaminophen 325mg, give 2 tablets by mouth three times daily, Resident E's record lacked a medication self-administration assessment. Requested a medication self-administration assessment for Resident E and a policy for medications at bedside. No medication self-administration assessment for Resident E nor a policy for medications at bedside was provided at the survey exit. A current policy, titled, "Storage and Expiration Dating of Medications, Biologicals," dated 1/1/22, was provided by the Executive Director (ED), on 8/26/22 at 1:39 p.m. A review of the policy indicated, " ...Store all drugs and builogicals in locked compartments ...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors ...Facility should store bedside medications or biologicals in a locked compartment within the resident's room ...Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications ...."		for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	

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	A current policy, titled, "Disposal/Destruction of Medications/Controlled Substances," with no date, was provided by the ED, on 9/1/22 at 11:00 a.m. A review of the policy indicated, " ...Facility should place all discontinued or outdated medications in a designated secure location ...A licensed nurse should disposed of all non-controlled substances ...." 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review the facility failed to provide oxygen humidication for 1 of 3 residents reviewed for oxygen administration (Resident 53). Findings include: On 8/25/22 at 3:35 p.m., during a random observation Resident 53 was observed. She was wearing oxygen at 4 liters/minute per nasal cannula. The date on tubing was 8/21/22. She did not have humification at that time. On 8/29/22 at 1:30 p.m., Resident 53 was observed as she rested in her bed, was wearing oxygen at 4	F 0695	***F 695 Food Procurement, Stoe/Prepare/Serve-Sanitary*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** Items in the kitchen that were observed to not be dated were dated during the survey process on 8/25/22 **How other residents having the potential to be affected by the same deficient practice will be**	10/08/2022

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	155606	A. BUILDING 00 B. WING	09/01/2022

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	liters per minute (lpm) per nasal cannula. The date on tubing was 8/27/22. She did not have humification at that time. On 8/29/22 at 11:21 a.m., the medical record for Resident 53 was reviewed. The diagnoses included, but were not limited to chronic obstructive pulmonary disease, diabetes and chronic respiratory failure. A physician order, dated 8/14/22, indicated, "Change and date oxygen tubing and humidification with new label and bag, every night shift every Sunday." An order dated 9/29/21 indicated, "Oxygen at 4 liters/minute continuously per nasal cannula. May Titrate to keep SpO2 > [greater than] 92%, every shift." An order dated 10/3/21 indicated, "Clean oxygen concentrator filter with soap and water weekly every Sunday." A care plan, created on 1/20/22 and revised 9/29/21with a target date of 10/4/22, indicated "The resident has oxygen therapy with COPD diagnosis. At risk for respiratory distress..." The goal indicated, "The resident will have no s/sx of poor oxygen absorption through the review date." The interventions were listed as: Change residents position every 2 hours to facilitate lung secretion movement and drainage. Encourage or assist with ambulation as indicated. For residents who should be ambulatory, provide extension tubing or portable oxygen apparatus. Give medications as ordered by physician. If the resident was allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula).		**identified and what corrective action will be taken:** · Residents who receive food from the kitchen have the potential to be affected · Required food items were labeled and dated on 8/25/22 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · CDM/designee to provide dietary staff with education on labeling and dating required food items · CDM/designee to complete routine auditing to ensure required food items are labeled and dated **How the corrective action will be monitored to ensure the deficient practice will not recur:** · CDM/designee to complete routine auditing to ensure required food items are labeled and dated. Auditing to occur: M-Fri x's 4 weeks, then 2 x's weekly x's 4 weeks, then monthly x's 4 weeks for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee, increased frequency and/or duration of auditing. The results of these reviews will be discussed at the monthly facility	

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	Return resident to use oxygen delivery method after the meal. Maintain head of bed in elevated position due to inability to lie flat related to shortness of breath secondary to COPD diagnosis. Observe for signs and symptoms of respiratory distress and report to physician. On 8/31/22 at 11:51 a.m., during an interview, the Director of Nursing indicated the policy stated any resident with oxygen administer by nasal canula at 4 Lpm or greater should have humidification. On 8/31/22 at 8:26 a.m., the Executive Director (ED) provided a current policy, dated as reviewed 5/15/20 and revised 8/2/21, titled Oxygen Administration/Safety/Storage/Maintenance, from chapter 7 of the Clinical Services Manual. This policy indicated "...Humidifiers are required on NC [nasal cannula] with liter flows 4 lpm [liters per minute] or greater...." 3.1-47(a)(6)		Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure pre and post dialysis assessments were completed for 1 of 1 resident reviewed for Dialysis, (Resident 1). Findings include:	F 0698	***F 698 Dialysis*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:**	10/08/2022

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	On 9/1/22 at 11:39 a.m., a comprehensive record review was completed for Resident 1. She had the following diagnoses but not limited to type 2 diabetes mellitus, chronic obstructive pulmonary disease, cellulitis of left lower limb, muscle weakness, difficulty breathing, cognitive communication deficit, end stage renal disease, unspecified open wound of left foot, dependence on supplemental oxygen, congestive heart failure, anemia, hyperlipidemia, hypertension, and dependence on renal dialysis. Resident 1 had an order, dated 5/11/22, for dialysis patient: receives dialysis at an outside dialysis center. Do not take blood pressure on left arm with fistula/shunt. Send to dialysis on Monday, Wednesday and Friday for dialysis treatment. On 5/11/22 was an order to assess shunt site for thrill/bruit and bleeding every shift for dialysis. On 5/11/22 was an order for dialysis resident: assess bruit/thrill upon return from dialysis. An order, dated 5/11/22, indicated dialysis resident's medication orders reflected appropriate times around dialysis (at least 2 hours prior to or after return). An order on 5/17/22 requested the facility to provide a sack lunch from dietary two times a day every Monday, Wednesday, and Friday. An order from 8/31/22 indicated to perform a pre/post dialysis assessment on days left arm access site, assess for bleeding, warmth, redness, edema, pain, drainage, every day and evening shift Monday, Wednesday, Friday related to end stage renal disease, and notify the physician of any positive findings. An order dated 8/30/22 was for a full set of vitals pre and post dialysis every day and evening shift on Monday, Wednesday and Friday. Resident 1's had a care plan dated 3/6/22 for hemodialysis every Monday, Wednesday, and		· Resident # 1 did not experience any negative outcomes from lacking a pre/post dialysis assessment. Pre and post assessments were done at the dialysis center with no abnormal findings. · DON/designee completed an assessment of the resident's shunt/fistula on 8/30/2022. No new or concerning findings were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who receive dialysis treatments have the potential to be affected · No other residents were identified in this statement of deficiency. Resident # 1 is currently the only resident requiring dialysis. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The DON/designee will provide education to licensed nursing staff on the requirement that dialysis residents have a pre and post dialysis assessment documented on dialysis treatment days. · The Director of	

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	Friday at 2 p.m., a goal was that the resident would have no signs or symptoms of complications from dialysis. Interventions included to assess bruit and thrill, dialysis treatments as ordered, do not take blood pressure on arm with shunt, dry weights obtained from dialysis center (these weights are noted on dialysis assessment), observe for bleeding at dialysis access site and therapeutic diet as ordered. She had another care plan, dated 2/25/21, indicated the resident had renal failure related to end stage renal disease with goals that resident was to have no signs or symptoms of complications related to fluid overload with interventions to assist resident with activities of daily living and ambulation as needed, dietary consult to regulate protein and potassium intake, fluids as ordered, restrict or give as ordered, give medications as ordered by physician, labs as ordered, observe and report as needed any signs or symptoms of depression, obtain order for mental health consult if needed, and fistula left arm. Pre and Post dialysis assessments were provided by the DON on 8/30/22 at 9:00 a.m. The pre and post assessments were not part of the electronic medical record. They were kept in medical records in a file folder. Pre and post dialysis assessments were missing for the following dates. 4/11/22, 4/13/22, 4/15/22, 4/18/22, 4/20/22, 4/22/22, 4/25/22, 4/27/22, 4/29/22, 5/2/22, 5/6/22, 5/9/22, 5/16/22, 5/18/22, 5/25/22, 5/27/22, 5/30/22, 6/3/22, 6/8/22, 6/10/22, 6/17/22, 6/24/22, 6/29/22, 7/1/22, 7/4/22, 7/6/22, 7/8/22, 7/11/22, 7/13/22, 7/15/22, 7/18/22, 7/20/22, 7/22/22, 7/25/22, 7/27/22, 7/29/22, 8/3/22, 8/5/22, 8/10/22, 8/17/22, and 8/22/22. An interview was conducted with the DON on 9/1/22. She indicated that she corrected the lack		Nursing/designee will be responsible for ensuring pre and post dialysis assessments are completed. The DON/designee will contact the dialysis center upon residents return to the facility if the communication was not completed by the dialysis center. **How the corrective action will be monitored to ensure the deficient practice will not recur:** · The Director of Nursing will monitor the pre and post dialysis assessments 3 x's wkly x's 4 weeks, then monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	

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	of pre and post dialysis assessments by entering a new order for pre and post dialysis assessments. The documentation will be included in the medical record under the orders. A policy was provided by the DON on 9/1/22 at 12:19 p.m. The policy was titled "Dialysis" with a reviewed date of 5/12/2020. The policy indicated " ...Initiate the pre/post dialysis communication form to be sent to the dialysis clinic with the resident. (Med Pass Form #LLCA-528) ....". 3.1-37(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and			

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	responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observaton, record review, and interview, the facility failed to ensure staff were competent to perform a narcotic count properly for 1 of 1 observation. Findings include: On 8/29/22 at 3:15 p.m., met with DON to review Resident E's medications in the medication cart. LPN 13 was counting off with the oncoming nurse. LPN 13 was overheard calling out numbers regarding controlled substances. LPN 13 did not state who the controlled substance was for, the name of the medication, or dosage. The DON approached LPN 13 and requested that she report the resident's name, the medication and dosage, along with the number of tablets on hand instead of a number only. LPN 13 loudly indicated that she was counting and did not want to be disturbed. The DON explained to LPN 13 that she was not counting correctly and provided education on the appropriate way to count controlled substances. LPN 13 indicated that she had no idea what the DON was talking about and continued to count the controlled substances by calling out a number. On 9/1/22 at 11:00 a.m., the Executive Director (ED) provided a policy titled, "Routine Reconciliation	F 0726	***F 726 Competent Nursing Staff*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** · LPN #13 followed facility policy on narcotic reconciliation that was in place during the survey process on 8/29/22. · The DON/designee completed a narcotic reconciliation on medications that were behind a double lock secured cart that LPN #13 was assigned to. There were no missing medications, medication errors, or any negative resident outcome. ·LPN # 13 was immediately educated during the survey process on 8/29/22 by the DON. · LPN #13 was an agency nurse and has been marked as a “do not return” and is prohibiting from picking up any further shift at the facility. **How other residents having the potential to be affected by the same deficient practice will be**	10/08/2022

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	of Controlled Substances" dated 1/1/22. "To conduct a routine reconciliation of controlled substances, the facility staff should: ensure two licensed nurse conduct the medication count, report any discrepancies to the Director of Nursing, verify the number of doses recorded as remaining on the medication-specific declining inventory, both nurses should sign the reconciliation worksheet, and retain the worksheet per facility policy for controlled substance records ...."		**identified and what corrective action will be taken:** · Residents who have orders for controlled substances have the potential to be affected. · No other residents were listed in this statement of deficiencies · Facility process has been updated to include verbalizing the resident name, medication and dose in addition to doses remaining during narcotic reconciliation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·DON/designee to provide education to Licensed Nursing staff and Qualified Medication Aides on the appropriate narcotic reconciliation count process. ·Routine narcotic reconciliations will be observed by the DON/designee to ensure the updated process is being followed. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·DON/designee to complete monitoring of Licensed Nurses and Qualified Medication Aides on completing a narcotic	

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			reconciliation count. Monitoring to occur: 2 random narcotic reconciliation counts daily Mon-Fri x's 4 weeks, then 4 wkly x's 4 weeks, then 4 monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through re-education of the non-compliant associate by the DON/designee and a passing score on a skills validation competency before conducting further medication administrations. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 0760 SS=E Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.			

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	Based on record review, observation, and interview, the facility failed to ensure that 1 of 2 residents were free of significant medication errors (Resident 31) failed to administer medications on time for 4 of 5 residents reviewed for medication (Residents C, D, E, and B) Findings include: 1. A comprehensive record review was completed on 8/30/22 at 9:26 a.m. for Resident 31. Resident 31 had the following diagnoses but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia (difficulty swallowing), muscle weakness, contracture of left hand, need for assistance with personal care, contact dermatitis, anemia, hyperlipidemia, essential hypertension, diabetes mellitus (type 2), major depressive disorder, and long-term use of insulin. Resident 31 had orders for the treatment of diabetes mellitus (type 2). An order, dated 4/13/21, Humalog solution (insulin lispro) inject 36 units subcutaneously with meals, hold if blood sugar was less than 100, order dated: 12/8/20 humalog kwikpen solution pen-injector 100 unit/ml (insulin lispro), inject per sliding scale four times daily: if blood sugar 201-250 give 4 units, if blood sugar 251-300 give 6 units, 301-350 give 8 units, if blood sugar is 351-450 give 10 units, 3/30/22 lantus solostar solution pen-injector 100unit/ml inject 42 units subcutaneously two times daily, 10/25/19 Janumet tablet 50-500mg (sitagliptin-metformin) give 1 tablet two times daily and 10/28/19 trulicity solution pen-injector 1.5mg/0.5ml (dulaglutide) inject 1.5mg subcutaneously one time per week on Monday.	F 0760	***F 760 Free from Significant Med Errors*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** ·The DON/designee notified Resident #31 physician and responsible party on 8/30/22 r/t insulin orders not being held for blood sugars that were below ordered parameters. No new orders were given. ·DON notified the physicians and responsible parties for resident # C, D. E, B r/t untimely medication administration. No new orders were given. ·None of the residents identified in this statement of deficiencies experienced a negative outcome. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** ·Residents who have orders to hold insulin when blood sugars are outside of ordered parameters have the potential to be affected. ·Residents who are administered medications in the facility have the potential to be affected by untimely medication administration. ·Education will be provided to licensed nursing staff and qualified	10/08/2022

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	Resident 31's MAR (Medication Administration Record) was reviewed. Resident 31's order to hold Humalog 100unit/ml kwikpen, inject 36 units with meals and to hold if Resident 31's blood sugar is less than 100 was administered when her blood sugar was less than 100. On 7/2/22 at 8:00 a.m., Resident 31's blood sugar was 92. Humalog was administered. On 7/10/22 at 4:00 p.m., Resident 31's blood sugar was 98. Humalog was administered. On 7/14/22 at 12:00 p.m., Resident 31's blood sugar was 92. Humalog was administered. On 7/23/22 at 4:00 p.m., Resident 31's blood sugar was 98. Humalog was administered. On 7/27/22 at 4:00 p.m., Resident 31's blood sugar was 75. Humalog was administered. On 8/3/22 at 8:00 a.m., Resident 31's blood sugar was 88. Humalog was administered. On 8/16/22 at 4:00 p.m., Resident 31's blood sugar was 87. Humalog was administered. On 8/17/22 at 4:00 p.m., Resident 31's blood sugar was 90. Humalog was administered. On 8/25/22 at 8:00 a.m., Resident 31's blood sugar was 88. Humalog was administered. On 8/26/22 at 4:00 p.m., Resident 31's blood sugar was 88. Humalog was administered. The DON was interviewed on 9/1/22 at 1:31 p.m. regarding Resident 31 receiving Humalog when the order indicated to hold the insulin if her blood sugar was than 100. The DON indicated that she could not find any documentation to show that Resident 31's Humalog was held at the times her blood sugar was less than 100. 2. A comprehensive record review on 8/30/22 at 2:00 p.m., for Resident C. Resident C had the following diagnoses but not limited to pain, depression, osteoarthritis, insomnia,		medication aides on medication administration best practices by the DON/designee. Licensed nursing staff and qualified medication aides will complete and pass a skills validation before being assigned to pass medications. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·DON/designee will provide education to licensed nursing staff and Qualified Medication Aides on medication administration including the 5 right of medication administration. ·Facility will implement an open medication administration process to allow for timely medication administration. ·Routine medication administration auditing to be conducted by the DON/designee to ensure timely medication administration and insulin is being administered per the physician orders. **How the corrective action will be monitored to ensure the deficient practice will not recur:** ·DON/designee will conduct Medication Administration observations to ensure timely medication administration and	

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	hyperlipidemia, and hypothyroidism. Resident C's medication administration record was reviewed. Resident C had the following orders for medications for dayshift (7:00 a.m.-3:00 p.m.) on 8/29/22. 7:00 a.m., check fentanyl patch for placement. 8:00 a.m., cholecalciferol tablet 1000 unit, give 1 tablet by mouth 1 time per day for low vitamin D. 8:00 a.m., second nurse to witness fentanyl patch removal one time every 3 days. 8:00 a.m., folic acid 1mg, give 1 tablet by mouth 1 time a day for supplement related to age-related cognitive decline. 8:00 a.m., protonix tablet delayed release 40mg, give 1 tablet by mouth 1 time a day for gastro-esophageal reflux disease without esophagitis. 9:00 a.m., 2 cal med pass, give 120cc 2 times daily for weight. 9:00 a.m., sertraline hcl tablet 100mg by mouth 1 time a day for depression. On 8/30/22 at 1:12 p.m., Resident C's medication administration audit report was provided by the DON. It indicated that LPN 13 administered Resident C's 7:00 a.m., 8:00 a.m., and 9:00 a.m. medications at 1:39 p.m. 3. A comprehensive record review was completed on 8/30/22 at 2:30 p.m. for Resident D. Resident D had the following diagnoses but not limited to gout, Alzheimer's disease, weight loss, hyperlipidemia, and diabetes mellitus. Resident D's medication administration record was reviewed. Resident D had the following orders for medications for dayshift (7 a.m.-3:00 p.m.)		insulin is being administered per the physician orders. ·Observations to occur: 2 random med observations daily Mon-Fri x's 4 weeks, 2 random med observations wkly x's 4 wks, then 2 random observations monthly x's 4 months for a total of 6 months of monitoring. Any associate who fails the med admin observation will be re-educated by the DON/designee and must pass before being assigned to complete a medication pass. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	

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	155606	A. BUILDING 00 B. WING	09/01/2022

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	8:00 a.m. ascorbic acid tablet 250 milligrams (mg), give 1 tablet by mouth 1 time per day for supplement. 8:00 a.m., allopurinol tablet 100 mg, give 1 tablet by mouth 1 time a day for gout. 8:00 a.m., memantine hcl tablet 10 mg, give 1 tablet by mouth 2 times a day related to Alzheimer's disease. 8:00 a.m., daily vite tablet, give 1 tablet 1 time daily related to deficiency of other specified B group vitamins. 8:00 a.m., aspirin tablet chewable, 81mg, give 1 tablet by mouth 1 time a day for heart health 10:00 a.m., 2 cal med pass, give 90 milliliters (ml) 3 times per day weight loss. On 8/30/22 at 1:12 p.m., Resident D's medication administration audit report was provided by the DON. It indicated that LPN 13 administered Resident D's 8:00 a.m., 10:00 a.m. medications at 1:07 p.m. 4. A comprehensive record review was completed on 8/30/22 at 3:00 p.m. for Resident E. Resident E had the following diagnoses but not limited to diabetes mellitus, hypertension, depression, muscle weakness, and vitamin deficiency. Resident E's medication administration record was reviewed. Resident E had the following orders for medications on dayshift (7:00 a.m.-3:00 p.m.) on 8/29/22. 8:00 a.m., sertraline hcl 25mg tablet, give 25mg by mouth in the morning for depression. 8:00 a.m., coreg tablet 3.125mg, give 1 tablet by mouth two times per day for hypertension. 8:00 a.m. and 12:00 p.m., novolog solution (insulin aspart) inject 5 units with meals for diabetes mellitus.			

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	8:00 a.m. and 12:00 p.m., novolog solution (insulin aspart) inject subcutaneously as per sliding scale: if blood sugar was 150-200 give 2 units, if blood sugar was 201-250 give 4 units, if blood sugar was 251-300 give 6 units, if blood sugar was 301-350 give 8 units, if blood sugar was 351-400 give 10 units, if blood sugar was 401-450 give 12 units, notify the physician for blood sugar less than 70 or higher than 450. 9:00 a.m., multi-vitamin/mineral tablet, give 1 tablet by mouth one time a day for supplement related to muscle weakness. 9:00 a.m., aspirin tablet 81mg, give 1 tablet by mouth one time a day for anticoagulation related to hypertension. 9:00 a.m., vitamin D3 tablet 25mcg (1000UT), give 1 tablet by mouth 1 time a day for vitamin deficiency. 9:00 a.m., polyethylene glycol powder (polyethylene glycol 1450), give 17 grams by mouth 1 time a day for constipation. Give in 8 ounces of water. On 8/30/22 at 1:12 p.m., Resident E's medication administration audit report was provided by the DON. It indicated that LPN 13 administered Resident E's 8:00 a.m., 9:00 a.m., and 12:00 p.m. medications.5. During a confidential interview, it was indicated, medications were passed late, and when they did come, sometimes it would be as late as lunch when morning medications finally came. If they asked questions, the nurse would just give a bad attitude or tell them, they did not have time for the questions. It was important to receive insulin on time as they were a type II diabetic and had been insulin dependent for nearly 20 years. During a confidential interview, it was indicated, there were several times Resident B thought she was given the wrong medication, and when she			

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	asked about it, the agency nurses had a bad attitude with her and acted like they did not care. Her mediations came late on several occasions with no explanation. On 8/31/22 at 2:00 p.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, type II diabetes mellitus with diabetic neuropathy and long-term use/dependence on insulin, hypertension (high blood pressure), and depression. A quarterly MDS (minimum data set) assessment dated 7/11/22 indicated Resident B was cognitively intact with a BIMS (brief interview for mental status) score of 15. She had physician's orders for insulin, Humulin R U-500 on a sliding scale to be administered three times a day. She had a comprehensive care plan dated 6/6/22 which indicated she had diabetes and was at risk for complications. Interventions for the plan of care included, but were not limited to, give medications as ordered. Resident B's July MAR/TAR (medication/treatment administration records) were reviewed and revealed the administration of her insulin (and several additional mediations) were late. Below is a sample of late administrations for example, but was not limited to: Day Shift: 7/1/22- scheduled 9:00 a.m. medications were administered nearly 3 hours late, at 11:58 a.m. Her insulin, which was scheduled for 12:00 p.m. was			

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	administered an hour and 2 minutes late at 1:20 p.m. 7/7/22- 8:00 a.m. scheduled insulin was not administered until 10:11 a.m., more than 2 hours late. 7/8/22- 8:00 a.m. scheduled insulin was not administered until 1:22, more than 5 hours late. 7/11/22- scheduled 9:00 a.m. medications were administered more than 3 hours late at 11:03 a.m. 7/14/22- 8:00 a.m. scheduled insulin was not administered until 10:18, more than 2 hours late. 7/16/22- scheduled 8:00 a.m. and 9:00 a.m. medications were not administered until 11:08 a.m. 7/19/22- scheduled 8:00 a.m. and 9:00 a.m. medications were not administered until 12:07 p.m. 7/24/22- scheduled 8:00 a.m. and 9:00 a.m. medications were not administered until 12:50 p.m. 7/31/22- scheduled 8:00 a.m. and 9:00 a.m. medications were not administered until 11:18 a.m. Evening Shift: 7/1/22- scheduled 4:00 p.m. medications were administered at 5:35 p.m., which included her insulin. 7/3/22- scheduled 4:00 p.m. medications were administered more than 2 hours late at 6:15 p.m., which included her insulin. 7/11/22- scheduled 4:00 p.m. medications were administered nearly 3 hours late at 6:59 p.m. which included her insulin. 7/27/22- scheduled 8:00 p.m. medications were administered nearly 3 hours late at 10:58 p.m. which included her insulin. The DON was notified of the late administration of medications for Residents B, C, D, and E on 8/30/22 at 2:00 p.m. On 8/31/22 at 1:20 p.m. during an interview with the DON, she indicated that the physician was			

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	notified for Residents B, C, D, and E that their medications were administered late. A policy titled, "Administration of Medications" with a date of 10/04 was provided by the DON on 9/1/22 at 11:22 a.m. The policy indicated, " ...contact the physician if medications are to be administered late for any reason. Obtain and order that allows for administration within a specific amount of time. Notify responsible party of all new orders ...." On 9/1/22 at 11:22 a.m., a policy titled, "Administration of Medication" with a date of 10/04 was provided by the DON. The policy indicated, " ...All medications are administered safely and appropriately. A physician order is required for administration of medication, give resident medication, and remain with resident to ensure that medication is swallowed, circle initials on the MAR if medication is not administered as ordered and record reason on MAR/nursing notes ...." This Federal tag relates to Complaint IN00386291. 3.1-48(c)(2)			
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 the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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	§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 and interview the facility failed to label an over the counter medication for identification in the medication cart for 1 of 3 residents observed during a random medication pass observation (Resident 54). Findings include: On 8/30/22 at 9:00 a.m., during a random medication observation, Licensed Practical Nurse (LPN) 8 was observed at the medication cart as she prepared medications for Resident 54. The medication orders included, but was not limited to, "Gluten Cutter - Dietary Supplement Give 1 Capsule - Supplied by family with meals for Supplement -Order Date 06/22/2022 1544." LPN 8 searched all the medication drawers in the medication cart and checked the labels on all over the counter medications in medication cart. She indicated she could not find the gluten cutter for Resident 54.	F 0761	***F 761 Labeling of Drugs and Biologicals*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** · LPN #8 followed the facility and pharmacy policy for labeling OTC medications and follows best practices. The medication was labeled with the resident name immediately upon it being opened by the DON on 8/30/22 in the surveyor's presence. The expiration date, medication name, medication dose and potential side effects are on the medication container per manufacture packaging. · Resident #54 did not experience a negative outcome	10/08/2022

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	On 8/30/22 at 9:20 a.m., LPN 8 asked the Director of Nursing (DON) about Resident 54's gluten cutter medication. The DON indicated it was in the cart. Her family had brought in a new box yesterday. She opened a drawer that contained a separate locked narcotic box (for narcotic medications). The unlabeled green cardboard box was found behind the narcotic box. During an interview, the DON indicated the box was not labeled for Resident 54 because it had not been opened for use yet. Once opened for use they were required to open date it. She then opened the box and wrote the resident's name in marker on the outside of the box and handed it to LPN 8. When asked how LPN 8 could have identified the medication belonged to Resident 54, the DON indicated because no one else took that medicine. A policy for over the counter (OTC) medications was requested but not provided. On 9/1/22 at 11:00 a.m., the Executive Director provided a current pharmacy policy, dated effective 12/07, titled "Storage and expiration dating of Medications, Biologicals." This policy indicated "...Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility should record the open date on the primary medication container...." This policy did not address OTC medications or medications not supplied by pharmacy with no resident identifier on the package. 3.1-25(j)		due to her name labeled on the medication immediately upon opening. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who prefer to purchase OTC medication from another entity other than facilities pharmacy have the potential to be affected. · Residents with OTC medication orders that are not provided by our pharmacy will be audited to ensure appropriate labeling to include residents name **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · DON/designee to provide education to licensed nursing staff and Qualified Medication Aides on labeling OTC medications. Name is to be labeled to the medication when it is received. Date will be added if the medication expires sooner than the manufacture expiration date once opened. · DON/designee to complete routine auditing of medication storage areas to ensure OTC medications are labeled and dated appropriately. Any findings will be addressed.	

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	3.1-25(l)(1) 3.1-25(l)(2) 3.1-25(l)(3) 3.1-25(l)(4) 3.1-25(l)(5)		**How the corrective action will be monitored to ensure the deficient practice will not recur:** ·DON/designee to conduct an audit of medication carts and medication rooms to ensure that OTC medication are appropriately labeled with resident name, and dated if indicated. Auditing to occur: 4 random medication storage areas (medication cart and/or medication rooms) daily Mon-Fri x's 4 weeks, then 4 random medication storage areas wkly x's 4 wks, then monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed through re-education by the DON/designee, increased frequency and/or duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this	

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			plan of correction. Compliance Date: 10/8/2022	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure the preparation of pureed foods was according to the recipe for 5 of 5 residents who received pureed foods. Findings include: On 8/25/22 at 10:24 a.m., Cook 13 was observed making pureed vegetables for 5 residents. She indicated she seasoned them, added water or broth and thickener, sometimes she added more water if they were too thick, until they were a consistency she wanted. No recipe was used. On 8/25/22 at 10:30 a.m., Cook 13 was observed making pureed chicken patties for 5 residents. She added water and thickener, then added more water. No recipe was used. During an interview, on 8/25/22 at 9:09 a.m., the Executive Director (ED) indicated when kitchen	F 0804	***F 804 Nutritive Value/Appear, Palatable/Prefer Temp*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** · Residents were not negatively affected d/t not following the recipe for puree foods · Cook was educated during the survey process on 8/25/22 by the CDM on following the recipe for puree foods. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	10/08/2022

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	staff made pureed foods for the residents, they should have followed the recipe. On 8/26/22 at 1:39 a.m., the ED provided the recipe for, "PU [puree] Stir Fry Blend Vegetables." After a review of the recipe, no water or thickener was listed as ingredients on the recipe. It indicated, " ...Drain vegetables and place in food processor. Process until smooth and product reaches an applesauce consistency ...." On 8/28/22 at 9:01 a.m., the ED provided the recipe for, "PU Baked Chicken." After a review of the recipe, no water or thickener was listed as ingredients on the recipe. It indicated, " ...Place food in processor, process until smooth ...." During an interview, on 9/01/22 at 9:01 a.m., the CDM indicated the cook should have had the recipes to prepare the pureed food for the residents. Now, she was printing the recipes needed for each day. She did not have a recipe binder because the facility had about 20,000 recipes available to print. On 9/1/22 at 9:04 a.m., the CDM indicated the facility followed the Indiana Retail Food Establishment Sanitation Requirements. A current policy, titled, "Pureed Diet," dated 3/15/22, was provided by the ED, on 8/26/22 at 1:39 p.m.. A review of the policy indicated, " ...Effort is made to prepare the pureed food without the addition of a thickening agent, since the texture, taste, and nutritional content may be altered. 3.1-21(a)(1) 3.1-21(a)(3)		· Residents who have an order for puree foods have the potential to be affected · Orders have been reviewed and residents have been identified through that review on what residents require puree foods. The CDM/designee will provide education to the cooks on following the recipe. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Orders have been reviewed and residents have been identified through that review on what residents require puree foods. The CDM/designee will provide education to the cooks on following the recipe for puree foods. · The CDM/designee will conduct routine auditing of puree foods being made to ensure the recipe is being followed **How the corrective action will be monitored to ensure the deficient practice will not recur:** · The CDM/designee will conduct routine auditing of puree foods being made to ensure the recipe is being followed. Auditing to occur: Twice daily M-Fri x's 4 weeks, then twice weekly x's 4 weeks, then twice monthly x's 4	

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			months for a total of 6 months of monitoring. The CDM/designee will provide re-education for The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the food in the kitchen were labeled, and had open and expiration dating for 1 of 1 kitchen observation. Findings include: On 8/25/22 at 10:06 a.m., a tour of the kitchen was completed with the Certified Dietary Manager (CDM). In the Line Freezer, there were no labels, open and expiration dates on open plastic bags of chicken tenders, onion rings, and chicken nuggets. A single serve ice cream sandwich had no label or open and expiration dates. In the Reach-In Refrigerator, there were no dates on 9 strawberry dessert cups, 6 chocolate dessert cups, and 2 chef salads. The thickened liquids, water, punch, and juice had no open dates. In the Walk-In Refrigerator, there were no labels, open or expiration dates on wrapped sliced turkey, diced potatoes, and cheddar cheese. During an interview, on 8/26/22 at 9:06 a.m., the	F 0812	***F 812 Food Procurement, Store/Prepare/Serve-Sanitary*** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** Items in the kitchen that were observed to not be dated were dated during the survey process on 8/25/22 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** · Residents who receive food from the kitchen have the potential to be affected · Required food items were labeled and dated on 8/25/22 **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	10/08/2022

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	155606	A. BUILDING 00 B. WING	09/01/2022

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	Executive Director (ED) indicated everything in the kitchen should have labels and dates. A current policy, titled, "Food Safety," dated 4/27/22, was provided by the Executive Director (ED), on 8/26/22 at 1:39 p.m. A review of the policy indicated, " ...Food is stored and maintained in a clean, safety and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth ...Store, prepare, distribute and serve food in accordance with professional standards for food service safety ...." 3.1-21(i)(3)		**practice does not recur:** · CDM/designee to provide dietary staff with education on labeling and dating required food items · CDM/designee to complete routine auditing to ensure required food items are labeled and dated **How the corrective action will be monitored to ensure the deficient practice will not recur:** · CDM/designee to complete routine auditing to ensure required food items are labeled and dated. Auditing to occur: M-Fri x's 4 weeks, then 2 x's weekly x's 4 weeks, then monthly x's 4 weeks for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee, increased frequency and/or duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Facility Administrator at Westside Village is responsible for ensuring compliance with this plan	

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			of correction. Compliance Date: 10/8/2022	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should			

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	be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure residents, (Residents 40 and 13) who were placed in droplet isolation for suspected COVID-19 infections due	F 0880	***F 880 Infection Control and Prevention*** **What corrective action will be**	10/08/2022

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	to potential exsposure remained in their rooms and failed to ensure staff wore appropriate PPE (personal protective equipment) while in providing resident care/assistance for 2 of 2 residents reviewed for isolation precautions. The facility failed to ensure a blood glucose montoiring machine was cleaned before or after use for a resident for 1 of 1 random observation of accuchecks (Resident 85). Findings include: 1. During an initial tour of the facility on 8/25/22 from 10:40 a.m. until 11:12 a.m., multiple rooms were observed to have isolation bins and signs indicating those residents were in droplet isolation. During an interview on 8/25/22 at 10:55 a.m., the Social Service Director, (SSD) and Director of Therapy (DOT) indicated most of the rooms were "precautionary" isolation due to the resident's vaccination status. The "true isolation, Yellow Zone" was located between rooms 314-319 as those were newly admitted residents. On 8/25/22 at 11:00 a.m., Resident 40 was observed in her been through the open door of her room. There were signs posted on her door which indicated she was in droplet isolation. During a dining observation on 8/25/22 from 12:23 p.m. until 12:56 p.m., Resident 40 was observed in the 300-hall dining room. She was not wearing a mask. Certified Nursing Assistant (CNA) 15 sat with resident 40 and assisted her to eat her lunch. CNA 15 wore an N-95 face mask. She wore a pair of glasses that were open on the tops and side. She did not wear a gown or gloves.		**accomplished for those residents found to have been affected by the alleged deficient practice:** · Asymptomatic Residents # 40 and #13 were in contact/droplet isolation due not being up to date on COVID vaccines during a facility COVID outbreak which was the current guidance during the survey process on 8/25/22. Both residents' wanted to leave their rooms, and appropriate PPE when outside of their room. Neither resident were symptomatic. No negative outcome occurred as evidenced by no positive resident COVID results during required twice weekly outbreak testing x's 14 days. · CDC and ISDH guidance has since changed COVID guidance and gives direction that residents who are not up to date on COVID vaccines no longer need to be in isolation due to a facility outbreak. · Resident #85 did not experience a negative outcome from glucometer not being cleaned after use. LPN #8 was re-educated on glucometer cleaning and cleaned the glucometer during survey process on 8/30/22. LPN #8 completed and passed a return demonstration glucometer cleaning skills validations **How other residents having the potential to be affected by the same deficient practice will be**	

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	On 8/26/22 at 12:12 p.m., Resident 13 was observed in her room, through the open door. There were signs posted on her door which indicated the resident was in droplet isolation. She was slouched in her broad wheelchair an Staff 16 was observed in the room to help reposition Resident 13 in her chair. The CNA was not wearing a gown or gloves, and the eye protection she worse did not cover the top or sides of her face. During an interview on 8/26/22 at 12:15 p.m., CNA 16 indicated the signs on the door meant the residents were in isolation but she did not know why, so she went to find out. Upon returning shortly after, Staff 16 indicated Resident 13 was in "precautionary" isolation due to her vaccination status, however, Staff 16 continued to assist Resident 13 out of her room and down into the main dining room. In the dining room, Resident 13 was seated at a table with other unidentified residents and assisted by Staff 16 who did not don gown or gloves to provide resident care. During an interview on 8/26/22 at 2:53 p.m., the Infection Preventionist indicated, the facility was in COVID-19 outbreak testing due to staff members who had tested positive for the virus. Because there were several residents who had potentially been exposed to those staff members, if they were unvaccinated, or not up to date with their vaccination series, the residents had been placed in precautionary isolation. This meant they should not come out of their rooms, and staff should wear the appropriate PPE as indicated on the signs until it was determined those residents could come out of isolation. During the survey entrance conference on 8/25/22 at 10:00 a.m., the facilities current covid-19 polices		**identified and what corrective action will be taken:** · Residents no longer have the potential to be affected by other residents leaving their room who are in isolation only due to not being up to date on vaccinations during a facility outbreak or staff wearing inappropriate PPE in resident rooms who are in isolation only due to being unvaccinated during a facility outbreak as this is no longer the current guidance. CDC and ISDH guidance has changed since the survey process on 8/25/22, and no longer recommends unvaccinated residents be in isolation due to facility outbreak unless they are symptomatic. · Staff was provided with education by the IP/designee on 8/26/22 r/t appropriate PPE to be worn in resident rooms that are in contact/droplet isolation precautions. · Residents who require blood sugar testing in the facility have the potential to be affected from failing to clean glucometer appropriately after use. · Licensed nurses and qualified medication aides were provided with education by the IP/designee on 8/30/22 on appropriate glucometer cleaning.	

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	and procedures were requested and provided by the Executive Director. A policy titled, "Coronavirus (COVID-19))SARS-CoV-2) revised 2/2022 indicated, " ...Up to Date means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible ... Empiric use of Transmission-Based Precautions (quarantine) is recommended for patents who have had close contact with someone with SARS-CoV-2 infection if they are not up to dare with all recommended COVID-19 vaccine doses ..." A second policy titled, "Personal Protective Equipment (PPE) for SARS-CoV-2," revised 6/2022 indicated, " ....PPE recommended for symptomatic, suspected, or confirmed COVID-19: HCP [healthcare provider] who enters the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection ... eye protection (i.e. goggles/protective eye wear or a face shield that covers the front and sides of the face) ...."2. On 8/30/22 at 9:25 a.m. during a medication pass observation, with Licensed Practical Nurse (LPN) 8, she prepared to perform a blood sugar test on Resident 85. She indicated the resident had a low blood sugar, of 70, earlier that morning and had been treated with orange juice. She was going to recheck it at that time because the resident had not received any insulin per her sliding scale coverage. She removed the glucometer machine from the medication cart drawer and took it to Resident 85's room, where she put on gloves. She then cleaned the resident's finger with alcohol and used the lancet to prick her finger. She then placed the first drop of blood on the test strip and received an		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · IP/designee to provide education to associates on updated guidance as related to TBP during a COVID outbreak. Will also provide education on appropriate PPE to be worn when caring for residents who are in contact/droplet isolation precautions. . · The QIO nurse provided education to facility on 9/25/2022 r/t F880 citation. · IP/designee will complete routine observations of residents who are in contact/droplet isolation precautions to ensure they are restricted to their rooms per guidance unless documentation is in place to indicate non-compliance and or medical need. · IP /designee to complete routine observations of glucometer cleaning when obtaining a blood sugar. **How the corrective action will be monitored to ensure the deficient practice will not recur:** · The IP/designee will complete routine observations of residents who are in contact/droplet isolation to ensure they are restricted their rooms	

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	error code. LPN 8 the recleaned resident 85's finger with alcohol and milked her finger to encourage the blood flow. A drop was placed on the new test strip and the meter resulted at 147. LPN 8 returned to the medication cart and checked the medication administration record (MAR) for the sliding scale insulin order. She determined sliding scale was only ordered for administration if the blood sugar was greater than 200. At that time she placed the glucometer machine back in the medication cart drawer. She did not clean the glucometer machine before or after use. On 8/30/22 at 10:00 a.m., during an interview, the Director of Nursing (DON) indicated there was one glucometer machine for blood sugar testing on each medication cart. The machine was shared by all the residents who had tests ordered on that hall. On 8/31/22 at 11:53 a.m., during an interview the DON indicated the glucometers should have been cleaned before and after each use. On 8/31/22 at 8:26 a.m., the DON provided a current policy, dated 8/3/20 and revised 8/3/21, titled "Blood Glucose Quality Control Check." A second current policy, dated 5/14/20 and revised 7/30/20, titled "Blood glucose Monitoring," was provided. This policy indicated to follow the Lippincott procedure and refer to the glucometer user manual. Upon request 6 pages of the Lippencott Manual, titled "Blood glucose monitoring, long-term care." Upon review of the provided policies, none of them addressed the cleaning of a glucometer		until criteria has been met. Observations to occur: 2 random observations of residents in contact/droplet isolation daily x's 4 weeks, 2 random observations weekly x's 4 weeks, then 2 random observations monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee, increased frequency and/or duration of auditing. · IP/designee will complete routine observations of nursing staff donning and doffing PPE to ensure it is being utilized appropriately. Observations to occur: 4 random observations daily x's 4 weeks, 4 random observations weekly x's 4 weeks, then 4 random observations monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee, increased frequency and/or duration of auditing · The IP/designee will complete random Glucometer cleaning observations with Licensed Nurses and Qualified Medication Aides. Monitoring to occur: 2 random observations daily x's 4 weeks, 2 random observations weekly x's 4 weeks, then 2 random observations	

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	machine used on several different residents or shared. 3.1-18(b) 3.1-18(j) 3.1-18(a)		monthly x's 4 months for a total of 6 months of monitoring. Any findings of non-compliance will be addressed through associate re-education by the DON/designee, increased frequency and/or duration of auditing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. The Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. Compliance Date: 10/8/2022	
F 9999 Bldg. 00	IC 12-10-5.5-3 DISCLOSURE FORM CONTENTS Sec. 3. A health facility and a housing with services establishment that provides or offers Alzheimer's and dementia special care or programing shall prepare a written disclosure in a form provided by the division that has been	F 9999	Alzheimer's Dementia Special Disclosure was completed and submitted.	10/08/2022

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	developed in conjunction with the long term care ombudsman's office and that contains the following information: (1) The health facility's or housing with services establishment's mission or philosophy statement concerning the needs of residents with Alzheimer's disease, a related disorder, or dementia. (2) The process and criteria the health facility or housing with services establishment uses to determine placement, transfer, or discharge from Alzheimer's and dementia special care. (3) The process for the assessment, establishment, and implementation of a plan of Alzheimer's and dementia special care, including how and when changes are made to a plan of care. (4) The following information concerning the staff of the Alzheimer's and dementia special care unit: (A) The staff-to-patient ratio for each shift. (B) The positions and classifications of staff. (C) The initial training or special education requirements of the staff. (D) The qualities and amount of continuing education and in-service training required for staff. (5) A description of the Alzheimer's and dementia special care unit and the unit's design features. (6) The frequency and types of activities for the residents of the health facility or housing with services establishment who have Alzheimer's disease, a related disorder, or dementia. (7) The extent that the health facility's Alzheimer's and dementia special care unit and program or housing with services establishment's program offers family support programs and solicits input from family members. (8) Guidelines for using physical and chemical restraints in providing Alzheimer's and dementia special care. (9) An itemization of the health facility's or			

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	housing with services establishment's charges and fees for Alzheimer's and dementia special care and related services. (10) Any other features, services, or characteristics that the health facility or housing with services establishment believes distinguishes the health facility or housing with services establishment from Alzheimer's and dementia special care offered by other facilities and establishments. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure the Alzheimer's/Dementia Special Disclosure form was completed by December 1st annually and was completely filled out before submission during the survey. Findings include: During an interview, on 9/1/22 at 1:00 p.m., the Executive Director (ED) indicated she was overseeing everything in the building. The Social Services Director (SSD) was overseeing the basic functions of the memory care (MC) unit. The SSD was also a Certified Dementia Care Practitioner (CDCP). On 9/1/22 at 1:03 p.m., the ED indicated the facility had not completed and submitted an Alzheimer's and Dementia Special Care Disclosure form in the last 12 months. She indicated the form would be submitted today. On 9/1/22 at 1:30 p.m., the ED indicated she was not aware of the need to annually submit the Alzheimer's/Dementia Special Care Unit form to the Division of Aging. After completing and			

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	submitting it, a copy was provided. It did not list a mission or philosophy for the Alzheimer's/Dementia unit, the education for the MC facilitor was not listed, and the itemization of, "Fees and Charges," questions were left blank. This form was not submitted by December 1, 2021. No policy was provided.			