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	12/04/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00420178, IN00422535, and IN00422417. Complaint IN00420178- No deficiencies related to the allegations are cited. Complaint IN00422417- Deficiencies related to the allegations are cited at F725, F804, and F812. Complaint IN00422535- Deficiencies related to the allegations are cited at F725, F804, and F812. Survey dates: November 27, 28, 29, 30, and December 1 and 4, 2023 Facility number: 000497 Provider number: 155606 AIM number: 100291530 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 11 Medicaid: 84 Other: 7 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 14, 2023.	F 0000	This plan of correction is submitted as required under federal and state regulation and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate. That the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. Westside Village Nursing Center respectfully request a desk review.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherice Ricks	Executive Director	01/02/2024

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

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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation, interview, and record review, the facility failed to ensure residents had the right to be treated with dignity for 4 of 5 residents reviewed for dignity (Residents 79, MM, 83, and R). Findings include: 1. On 11/27/23 on 12:47 p.m., Resident MM was heard requesting milk from the MC activity Assistant (MC AA) and was given water. On 11/27/23 at 12:50 p.m., Resident MM requested milk again, Licensed Practical Nurse (LPN) 5 told her he didn't know if they had milk. On 11/27/23 at 12:51 p.m., Resident MM raised her voice and requested milk again. LPN 5 and Certified Nursing Aide (CNA) 7 were in the MC dining room. They did not respond to her statement. On 11/27/23 at 12:52 p.m., CNA 7 asked Resident MM if she was ok, the resident indicated she wanted milk. CNA 7 did not provide milk, instead she began clearing lunch trays. On 11/27/23 at 12:54 p.m., Resident MM raised her voice and asked for milk again. LPN 5, CNA 7, and CNA 8 were observed in the dining room. No one addressed her or provided her milk. On 11/27/23 at 12:56 p.m., Resident MM asked CNA 7 for milk again. CNA 7 did not answer her. On 11/27/23 at 12:57 p.m., Resident MM requested milk again while CNA 7 assisted her with eating. On 11/27/23 at 12:58 p.m., Resident MM was heard requesting milk three more times. She told CNA 7 she had enough to eat. CNA 7 went to the 200	F 0550	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Facility staff were not given Residents MM and Rs identifying information. Residents 79 has been assessed for any mental status changes. Resident 79's wheelchair positioning has been re-evaluated for comfort. In addition, resident has been assessed by the physician team on the need for frequent toileting needs. There is no information on Resident 83 documented in the 2567. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** QIS interviews and observations were conducted to ensure no additional residents on Memory Care were affected by the alleged deficient practice. The facility staff have been re-educated on Residents Rights and Dignity. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility staff to uphold and maintain resident dignity and residents have the right to a dignified existence. The DON/designee will complete	01/04/2024

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	Nourishment Room and returned. She indicated there was no milk and provided the resident with a cup of coffee instead. On 11/27/23 at 1:10 p.m., CNA 9 was observed outside the main dining room, she indicated the facility was not out of milk. On 11/27/23 at 1:12 p.m., Cook 4 was observed at the entrance to the kitchen, he indicated the kitchen was not out of milk. On 11/27/23 at 1:16 p.m., CNA 9 asked if someone needed milk and indicated she would provide milk to Resident MM. 2. On 11/27/23 at 11:49 a.m., Resident 79 was heard talking with the MC AA, she requested to sit in a softer chair and indicated a chair near her in the activity room. The MC AA indicated she had to stay in her wheelchair because lunch was coming soon. She requested to move to the softer chair again. He told her no. She asked for a third time, and the MC AA did not answer her and walked away to talk with another resident. On 11/27/23 at 12:22 p.m., Resident 79 was observed to still be in her wheelchair, lunch had not arrived yet. She indicated she was feeling uncomfortable in her wheelchair when she asked to sit in a softer chair. On 11/27/23 at 12:33 p.m., lunch arrived in the Memory Care (MC) area. Sixteen residents were observed in the MC dining room. 3. On 11/27/23 at 12:24 p.m., Resident B quietly indicated to the MC AA that Resident 79 needed to go to the bathroom. He said out loud in front of other resident, "Again! She just went." He walked		interviews and observations to ensure resident rights and dignity are safeguarded 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months validating dignity of residents is maintained. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	farther away to tell the CNA 7, that Resident 79 had to go again. Resident P was observed to grimace as he stated that Resident 79 had to go to the bathroom again. 4. On 11/27/23 at 12:50 p.m., Resident R what heard to request juice three times. After the third time, LPN 5 who was sitting at the same table with Resident R, requested CNA 8 to get a drink. CNA 8 provided an orange drink, not juice. On 12/04/23 at 11:10 a.m., the Director of Nursing (DON) indicated the staff should have been providing resident drinks all day, according to their preference. Resident 79 should have been moved to a softer chair according to their preference. Staff stating a resident had to go to the bathroom "again" was a problem in regards to resident's dignity. A current policy, titled, "Resident Dining Services," dated 4/26/23, was provided by the Executive Director (ED), on 11/29/23 at 3:10 p.m. A review of the policy indicated, " ...The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility ...." 3.1-3(a)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family			

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	members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on observation, interview, and record review, the facility failed to ensure that Resident Council Grievances were followed up on and failed to ensure effective resolutions were achieved for 12 of 102 residents who attended a resident council meeting (Residents D, E, F, AA, BB, CC, DD, EE, FF, GG, HH and JJ).	F 0565	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident identifying information was provided for Residents D, E, F, AA, BB, CC, DD, EE, FF, GG,	01/04/2024

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	Findings include: 1. On 11/30/23 at 9:00 a.m., the Resident Council Minutes and Responses were reviewed and revealed the following: On 1/17/23- 12 residents were present. The minutes from the previous meeting were read, but not accepted. New business included, but was not limited to: Nursing- "Night shift will not change you when you need them to, turn off light, don't come back. Night shift will not answer call lights." Dietary- "Food is cold." Housekeeping: "lots of clothes still missing." There were not Grievance Responses for this resident council meeting. On 3/14/23- 13 residents were present. New business included, but was not limited to: Nursing: "CNAs will not change us when we need it and come in and turned light off." Dietary: "The food is always cold and served the same things." Laundry: "Is bad, clothes missing, everyone wearing each other's clothes." Activities: "Can't wait to go on bus and outside." A Nursing Grievance Response indicated, "CNAs will be educated and instructed on these concerns." A Dietary Grievance Response indicated, "We have a new process in place to get trays out more diligently and will be monitoring closely to get trays out." An Activities Grievance Response indicated the bus was in the shop. On 4/11/23- 11 residents were present. The minutes from the previous meeting were reviewed but only some concerns had been resolved. New		HH, and JJ. **How other random interviews/observations er residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A special resident council meeting was conducted on 1/3/24. Concerns identified via 2567 were re- addressed. The Life Enrichment Director will schedule at a minimum of 2 outings per month. The Interdisciplinary Team has been provided with re-education on the review and completion of resident grievances. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the Interdisciplinary Team to follow up on reported grievances by the Resident Council members. The Life Enrichment Director/designee will be responsible for maintaining follow up and presentation of follow up to the Resident Council members monthly for 6 months, and then quarterly for 2 quarters. The DON/Designee will be responsible for performing call light monitoring across shifts 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be	

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	business included, but was not limited to: Nursing: "CNAs come in and say, 'not your aide' or will be back, never come back." Dietary: "Meals are late ever meal and usually cold." Laundry: "Missing clothes and floors are dirty and slippery." Activities: "Still want to go out on the bus." A Nursing Grievance Response indicated, "educate staff on customer service." A Laundry Grievance Response indicated, "working on getting better staff that is determined and that is dedicated to their line of duty." An Activities Grievance Response indicated, "the bus was being used for medical transportation." There were no Dietary Grievance Response. On 5/22/23- 16 resident were present. Although the previous minutes were accepted, "it is still a work in progress." New business included, but was not limited to: Nursing: "CNAs are leaving us wet and at night will not answer our call light, ongoing!" Laundry: "Got new clothes bleached, a lot of missing clothes and takes a long time to get clothes back." Housekeeping: "Carpet is ugly and stinks and lots of bad smells." Dietary: "Why do we have to have broccoli everyday? Put condiments on trays for rooms. Food is luke-warm or cold. Have different drink options like root beer floats or orange pop, something good." A Laundry/Housekeeping Grievance Response indicated, "lately is has been hard keeping a faithful laundry aide. I'm working on it, sorry for the delays and inconvenience." An Activities Grievance Response indicated, "Our bus has been in the shop, got it back this week, We will start outings on 5/24/23, first trip to the		immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	Dollar Tree." There was no Nursing or Dietary Grievance Response. On 6/21/23- 15 residents were present. New business included, but was not limited to: Nursing: "call lights: come in and turn lights off, don't come back or put lights on the floor, night shift being rude." Dietary: "Food is always late and cold." Laundry: "Clothes are coming back late and sometimes don't come back or given to other people. We see other people wearing out clothes." Activities: "need to get the bus." A Nursing Grievance Response indicated, "Staff educated on call light placement and response." A Dietary Grievance Response indicated, "Cooks are following the menus. Residents may request for cold cereal/alternatives for all/any meal. Foor temps are taken daily per state regulations." A Laundry Grievance Response indicated, "working on getting more staff in housekeeping and laundry to defuse problems." An Activity Grievance Response indicated, "Will be bringing puppy as much as can. Starting outings on June 27, will offer more boardgames." On 7/15/23- 11 residents were present. New business included, but was not limited to: Nursing: "CNAs make us wait a long time to be changed. lots of times we can't get up. They say they have no linen to get us washed and ready or have to wait on help. Short staffed." Laundry: "Our clothes are everywhere, we wear other people's clothes and they wear ours." Housekeeping: "The rooms are just dirty." Dietary: "our food is always lates and cold, and always missing somethings. The food is cold a lot of times not what we are supposed to have, we			

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	don't know what to do." There were no Grievance Responses from any department. On 8/21/23- 15 residents were present. New business included, but was not limited to: Nursing: "Need more nurses, insulins are late, sugars go high. We want CNAs to tell us who they are and what they are doing, stop hiding. Put call light on sometimes wait 2 hours or more. They say, "what do you want!" instead of, "how can I help. Less attitude would be nice. The Director of Nursing Assistant is not friendly, ignores us and never smiles. Nurses talk about us in the hallways." Housekeeping: "Some rooms not cleaned for weeks. Don't empty trash, floors are sticky and dirty." Laundry: "We see other people wearing our clothes. Clothes are missing, and takes a long time to get your clothes back." Dietary: "Food is always late and always cold, gets worse everyday." Activities: "Want to go on more trips." Social Service: "we Never see the [Social Service Director] and [Social Service Assistant] is not friendly and doesn't care what happens to them." A Laundry Grievance Response indicated, "Sorry for the inconvenience. I'm working harder to improve laundry needs." An Activities Grievance Response indicated, "Just started bus trips, will go more places as soon as we can." There were no Grievance Responses from the Nursing, Social Service, Housekeeping or Dietary departments. On 9/13/23- 18 residents were present. The minutes from the previous meeting were not excepted.			

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	Nursing: "Nurses don't answer lights, they come in and turn the lights off. We sit in wet and mess for over an hour. CNAs don't help, they say 'you can do it yourself.' Weekends are terrible residents are told they can't get up on the weekends because they don't have enough help." Dietary: "We are getting things on trays that they can't eat, will choke. They have told about it but still get them. Food is not good." Administration: "Need more people skills. Needs to stop residents that comes to our rooms and begs for Pop or takes it." A dietary Grievance Response indicated, "Residents likes/dislikes are updated, during Resident Council I stepped in and was able to speak on Residents voting on a special meal of the month each month." There were not Grievance Responses from the Nursing or Administrative departments. On 10/18/23- 16 residents were present. New business included, but was not limited to: Nursing: "Would like to have the same nurses on our unit everyday. They leave meds on our table and walk out to get. Need to get our meds on time. Would like to have CNAs introduce themselves. Most time leaves us in bed on weekends. They say the will come back and they don't." Dietary: "Still not on time. Meat is way too hard. Don't set our trays up and can't get a lot of the stuff. We are so tired of vegetables and rice is too hard. Usually never bring coffee. Our food is not good." Housekeeping: "No one cleans rooms on weekends." Laundry: "we don't get our clothes back, have to wear other people's clothes and it takes a long time to get clothes back." Business/Administration: "Don't like the decisions they make."			

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	Social Services: "Messes up our transportation, messes up our appointments." Activities: "Want to go on outings, need to get two bus drivers and get another van it's not fair. We want to go out." A Dietary Grievance Response indicated, "We don't have a dietary manager at this time. We are looking to hire one soon as possible. We do have a cook and assistant, so we are working on getting everything together soon. An Activities Grievance Response indicated, "We have been without a bus driver. We have hired a new bus driver. Our Executive Director said we are working on getting another van. I will try my best to get outings scheduled." An Administration Grievance Response indicated, "Administration will set up family council meetings to address areas of concerns with both families and residents." There were no Grievance Responses from the Social Service, Laundry, Housekeeping or Social Services departments. 2. A Resident Council meeting was scheduled with the Activities Director for 11/30/23 at 10:00 a.m. On 11/30/23 at 9:56 a.m., Residents began to gather for a Resident Council meeting. The meeting was scheduled for 10:00 a.m. but was delayed because the Resident Council President was not gotten up on time and did not arrive until 10:12 a.m. The following Residents were present for the meeting; D, E, AA, BB, CC, DD, EE, FF, GG, HH and JJ. Unanimously, the Residents agreed the facility did not have enough staff and call lights took too long to be answered. Their other biggest concerns included, but were not limited to, late and missing laundry, confused residents going			

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	155606	A. BUILDING 00 B. WING	12/04/2023

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	into their rooms, the administrative staff they felt never took them seriously and only cared about trying to make the facility look "nice" but left the residents to go without basic care needs being met. For months they had been asking to go on more outings, but the Executive Director had designated the bus for medical transport and outings were no longer permitted. One of their biggest concerns was the food. For months they continued to complain that meals were late, food was cold, food options were not available, the kitchen staff was too short staffed and they never got resolutions or responses from the kitchen about their concerns. Even though they complained for months about short staffing and no one answering lights in a timely manner, nothing ever got done about it, and it seemed to get worse and worse by the week. The residents indicated they used to take pride in living at the facility, it used to be one of the best ones around and was rated a 5-star building, but now, it had been run into the ground and they did not like living there and did not feel like they got the care, dignity or respect they deserved, especially not for the amount of money it cost each month to live there. During the meeting, at 10:35 a.m., Resident F joined the meeting. She indicated she was mad because she wanted to be at the meeting on time. She had been informed of the meeting the previous night and requested to be up on time to come, but she had not been gotten cleaned up or out of bed on time and missed most of the meeting. During a follow up interview on 12/1/23 at 11:00 a.m., the Activity Director (AD) indicated she had very good resident participation for the Resident Council. The biggest concerns they always			

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	seemed to have were related to availability and enough nursing staff, waiting on call lights, cold and late food, and they wanted to go on more outings with the bus. The AD indicated it was difficult to get Grievance responses from all the departments and a lot of the times she didn't get them at all. It seemed like the responses the residents were given, were all the same and repeated responses that never actually resolved the concerns. On 12/1/23 at 10:00 a.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Resident Council," reviewed 9/27/23. The policy indicated, " ...A resident or family group is defined as a group of resident or residents' family members that meets regularly to: Discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life ... The Activities Director of Social Service Director will facilitate follow-up on all complaints, suggestions and ideas presented at the resident council meeting and will report results at the next meeting for the residents' information ... Each department director will be responsible for filling out a comment and concern form, prior to the next meeting to provide his or her input ...." 3.1-3(l)			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-			

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	§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure Memory Care (MC) resident rooms and bathrooms were kept clean, toilets were safe to use without risk of falling, and failed to ensure all walls were intact for 18 of 24 MC resident rooms (Resident B, G, H, J,	F 0584	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident identifying information	01/04/2024

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	K, L, M, N, O, P, Q, R, S, T, U, V, and W). Based on observation, interview, the facility failed to keep the 100 Hall shower area warm enough for residents to use and the 300 Hall shower area was in disrepair, cluttered, and dirty for 2 of 3 hallway showers observed (Residents D, E, F, AA, CC, DD, EE, FF, GG, HH, and JJ). Findings include: 1a. On 11/27/23 at 10:01 a.m., Resident G's and Resident H's toilet was observed to be loose. The bathroom floor was not swept, had ground in dirt around the perimeter of the floor, and the bathroom floor was cracked. It was not homelike. 1b. On 11/28/23 09:40 a.m., Resident G's and Resident H's toilet was observed to be loose. The bathroom floor was not swept, had ground in dirt around the perimeter of the floor, and the bathroom floor was cracked. It was not homelike. 1c. On 12/01/23 09:04 a.m., Resident G's and Resident H's toilet was observed to be loose. The bathroom floor was not swept, had ground in dirt around the perimeter of the floor, and the bathroom floor was cracked. It was not homelike. 2a. On 11/27/23 at 10:04 a.m., Resident J's and Resident K's bathroom floor was not swept, had ground in dirt on the floor and around the perimeter, and had a brown substance on the floor at the base of the toilet. It was not homelike. 2b. On 11/28/23 at 9:41 a.m., Resident J's and Resident K's bathroom floor was not swept, had ground in dirt on the floor and around the perimeter, and had a brown substance on the floor at the base of the toilet. It was not homelike.		was provided for Residents B, G, H, J, K, L, M, N, O, P, Q, R, S, T, U, V, and W, in addition to Residents D, E, F, AA, CC, DD, EE, FF, GG, HH, and JJ. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time facility wide audit has been completed checking rooms and shower rooms for cleanliness and maintenance repair needs. The facility staff have been provided re-education on reporting maintenance repair needs, cleaning in the corners of floors, and maintaining shower rooms temperatures and to be free of unused clutter. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility staff to maintain resident environment in a clean and home like setting. The Maintenance Director/designee will be responsible for completing 10% room/shower room checks 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with	

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	2c. On 11/28/23 at 9:42 a.m., Housekeeping Aide (HA) 22 indicated he would clean the ground-in dirt on floor. He was observed taking a spray bottle and a hand-held scour pad into resident's bathroom. It was not homelike. 2d. On 11/28/23 at 9:45 a.m., after HA 22 cleaned part of the bathroom floor with the scouring pad, it was observed to be clean. However, he did not scour all the ground in dirt on the floor and around the perimeter of the room, so some remained. 2e. On 12/01/23 at 9:05 a.m., Resident J's and Resident K's bathroom floor was not swept, still had some ground in dirt on the floor and around the perimeter and had a brown substance on the floor at the base of the toilet. It was not homelike. 3. On 12/01/23 at 9:06 a.m., Resident L's bathroom floor was observed with ground-in dirt around the perimeter of the room and the resident's room floor was not swept around the perimeter of the room. It was not homelike. 4a. On 11/27/23 at 10:07 a.m., Resident M's and Resident N's bathroom wall had a hole in the wall near the toilet. The perimeter of the bathroom floor was observed to have ground-in dirt. It was not homelike. 4b. On 11/28/23 at 9:43 a.m., Resident M's and Resident N's bathroom wall had a hole in the wall near the toilet. The perimeter of the bathroom floor was observed to have ground-in dirt. It was not homelike. 4c. On 12/1/23 at 9:09 a.m., Resident M's and Resident N's bathroom wall had a hole in the wall near the toilet. The perimeter of the bathroom floor		disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	was observed to have ground-in dirt. It was not homelike. 5. On 12/1/23 at 9:10 a.m., Resident 83's bathroom had ground-in dirt around the perimeter of the room. It was not homelike. 6a. On 11/27/23 at 10:10 a.m., Resident O's and Resident P's bathroom had ground-in dirt around the perimeter of the room. It was not homelike. 6b. On 11/28/23 at 9:44 a.m., Resident O's and Resident P's bathroom had ground-in dirt around the perimeter of the room. It was not homelike. 6c. On 12/01/23 at 9:11 a.m., Resident O's and Resident P's bathroom had ground-in dirt around the perimeter of the room. 7. On 12/1/23 at 9:12 a.m., Resident Q's and Resident R's toilet had significantly shifted at an angle because it was loose. The front portion of the toilet was nearer to the wall than the base. The bathroom floor had a brown substance on the wall near the toilet and on the floor at the base of the toilet. A used disposable gloves was observed on the bathroom floor. It was not homelike. 8. On 12/1/23 at 9:28 a.m., Resident T's room had 2 wheelchair foot pedals under the bathroom sink. The toilet seat had a brown substance on it. The perimeter of the bathroom floor was not swept and had ground-in dirt. It was not homelike. 9. On 12/1/23 at 9:32 a.m., Resident MM's and Resident NN's bathroom had ground-in dirt around the perimeter of the floor. It was not homelike. 10a. . On 11/27/23 at 10:50 a.m., Resident B			

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	indicated his toilet was leaking last night, Maintenance came and fixed it. Water was observed on the floor, near the base of the toilet. Ground-in dirt was observed on the floor around the perimeter of the room. It was not homelike. 10b. On 11/28/23 09:48 a.m., Resident B and Resident U's bathroom had ground-in dirt on the floor around the perimeter of the room. It was not homelike. 10c. On 12/1/23 at 9:34 a.m., three red drops were observed on the bathroom floor leading to the toilet. The perimeter of the bathroom had ground-in dirt around the perimeter of the room and the resident's room floor was not swept around the perimeter of the room. It was not homelike. 11a. On 11/27/23 at 10:53 a.m., Resident S' and Resident T's bathroom floor had ground-in dirty around the perimeter of the room and 2 wheelchair foot pedals stored under the sink. It was not homelike. 11b. On 11/28/23 at 9:47 a.m., Resident S' and Resident T's bathroom floor had ground-in dirty around the perimeter of the room. It was not homelike. 12. On 12/1/23 at 9:35 a.m., Resident 79's bathroom had ground-in dirt around the perimeter of the floor. It was not homelike. 13a. On 11/27/23 at 10:57 a.m., Resident V's and Resident W's bathroom had ground-in dirt around the perimeter of the floor and a brown substance was on the floor around the base of the toilet. It was not homelike.			

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	13b. On 11/28/23 at 9:49 a.m., Resident V's and Resident W's bathroom had ground-in dirt around the perimeter of the floor and a brown substance was on the floor around the base of the toilet. It was not homelike. On 11/29/23 at 3:10 p.m., the Executive Director (ED) provided a list of MC residents that had a wandering care plan. A review of the list indicated 22 of 24 residents in the MC area wandered. 14. During a resident council meeting, on 11/30/23 at 9:40 a.m., Residents D, E, F, AA, CC, DD, EE, FF, GG, HH, and JJ complained their 100 Hall shower room was too cold. An observation of the shower room showed that it was dirty, clutter, and some of the tiles were cracked and broken off of the wall, the tile grout was dirty, and the shower curtain and the bottom of the shower walls were mildewed. All of the cabinet were empty, no supplies were observed. On 11/29/23 at 2:40 p.m., a tour with Maintenance Assistant 30 was completed. The 100 Hall shower room temperature was 68 degrees Fahrenheit (F). He indicated the heat and cooling was regulated by the air vent. He noticed the set temperature was down to 65 degrees F. The thermostat for this room was in the 100 hallway. He indicated it was a bit chilly and would be considered too cold for the residents. It was not homelike. On 11/30/2023 at 11:25 a.m., the 100 Hall shower room temperature was re-checked. The 100 hallway thermostat was programmed for 72 degrees F. The ambient shower room temperature remained chilly. Certified Nursing Aide (CNA) 9 and an unidentified resident in a shower room during temperature check. CNA 9 indicated the room was cool, but it felt good to her because she			

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	had been running around. No one asked the resident's comfortable level. On 11/29/23 at 2:48 p.m., the 300 Hall shower room was observed. It was cluttered with stored supplies: a shower bed, a bariatric wheelchair, a dirty, polyvinyl chloride (PVC) shower chair, a weight scale, and a dirty reclining shower chair. The floor tile grout was dirty, and mildew (fungus that grown on moist surfaces) was observed on the shower curtains and the bottoms of the shower wall. Several tiles were cracked and broken off as well. All cabinets were empty, no soap, shampoo, towels, or wash clothes were observed. It was not homelike. On 12/01/23 at 10:41 p.m., the 300 Hall shower room was observed again. It was still cluttered with stored supplies: a shower bed, a bariatric wheelchair, a dirty, a PVC shower chair, a weight scale, and a dirty reclining shower chair. The floor tile grout was dirty, and mildew was observed on the shower curtains and the bottoms of the shower wall. Several tiles were cracked and broken off as well. All cabinets were empty, no soap, shampoo, towels, or wash clothes were observed. It was not homelike. On 124/23 at 10:43 a.m., Maintenance Assistant 30 indicated he was over the housekeeping area too. He was unaware of a MC resident bathroom with a hole in the wall. In the MC area, they caulk the toilets to the floor and the wax ring corrodes over time, causing "nasty water" stains on the floors. When it came to repair and additional cleaning needed, he waited for the staff to contact him. He indicated the floor should have been clean in the MC bedrooms and bathrooms. There was only one person dedicated to cleaning the MC area, but because they were short staffed, he was			

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	pulled out of MC to clean other areas. He indicated it was very difficult to hire housekeepers. The facility had only 2 full-time housekeepers, one part-time laundry person, and one part-time laundry/housekeeper. On 12/1/23 at 2:49 p.m., the Execute Director (ED) indicated she would contact the Maintenance Assistant 30 to fix the two loose toilets in MC resident rooms. A current policy, titled, "Housekeeping - General Policy," dated 7/19/23, was provided by the ED, on 11/30/23 at 9:43 a.m. A review of the policy indicated, " ...The resident has a right to a safe, clean, comfortable and homelike environment ...." 3.1-19(a)(4) 3.1-19(f)(5)			
F 0641 SS=E 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 record review and interview, the facility failed to code the Minimum Data Set (MDS) with accurate information pertaining to PASRR (Pre-Admission Screening and Resident Review) (an assessment for screening for possible serious mental illness or intellectual disabilities) (Resident 2, E, 38, 21, EE and FF) and failed to accurately code a resident (Resident O) for a hospital discharge for 7 of 7 residents reviewed. Findings include: 1. A comprehensive record review was completed for Resident 2 on 11/27/23 at 2:45 p.m. She had the following diagnoses which included but were	F 0641	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident #2, 38, 21 MDS has been modified to reflect the Level 2 status for the residents. The facility was not provided any identification information for Residents E, EE, and FF. Resident O's discharge date was changed per the MDS C during the survey process. **How other residents having the**	01/04/2024

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	not limited to paranoid schizophrenia, intellectual disability, unspecified dementia, asthma and muscle weakness. She had a level II (indicating there is mental illness and/or intellectual disability) dated 8/10/18. Her MDS, dated 7/3/23, section A1500 was coded with a 0 indicating she did not have a level II. 2. A comprehensive record review was completed for Resident E on 11/28/23 at 4:22 p.m. She had the following diagnoses which included but were not limited to schizophrenia, type 2 diabetes, major depression, schizoaffective disorder bipolar type, and hyperlipidemia. She had a level II dated 8/23/19. Her MDS, dated 6/7/23, section A1500 was coded with a 0 indicating she did not require a level II. 3. A comprehensive record review was completed for Resident 38 on 11/28/23 at 2:24 p.m. She had the following diagnoses which included but were not limited to bipolar disease, anxiety disorder, obstructive sleep apnea, difficulty breathing, hypertension and heart failure. She had a level II dated 9/7/22. Her MDS, dated 8/19/23, section A1500 was coded with a 0 indicating she did not require a level II. 4. A comprehensive record review was completed for Resident 21 on 11/30/23 at 12:49 p.m. He had the following diagnoses which included but were not limited to major depressive disorder, insomnia, gastroesophageal reflux disease (GERD), mood		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of Level IIs for the facility have been reviewed and added to the MDS as appropriate. A one-time review of the past 30 days, 11/27/23 – 12/27/23, for discharge date accuracy on MDS completed. The Interdisciplinary Team has been re-educated on completion of items required for the MDS assessment for accuracy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the Social Service Directors to complete Section A of the MDS to capture the Level II information for a resident. It is the responsibility of the MDS C to accurately add date of discharge to the MDS assessment. The MDS C will be responsible for to audit MDS's completed weekly for 12 weeks, and then monthly for 3 months to validate Level II and discharge date information is accurately documented in the MDS assessment. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be	

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	disorder, hypertension, and constipation. Resident 21 had a level II dated 12/2/11. His MDS, dated 7/7/23, section A1500 was coded with a 0 indicating he did not require a level II. 5. A comprehensive record review was completed for Resident EE on 11/30/23 at 11:50 a.m. She had the following diagnoses which included but were not limited to type 2 diabetes, right sided weakness, dementia, depressive disorder, hypertension, hyperlipidemia, general anxiety disorder, and delusional disorders. Resident EE had a level II dated 3/6/23. Her MDS, dated 10/9/23, section A1500 was coded with a 0 indicating she did not require a level II. 6. A comprehensive record review was completed for Resident FF on 11/30/23 at 9:48 a.m. He had the following diagnoses which included but were not limited to weakness right sided, lack of coordination, muscle weakness, type 2 diabetes, major depressive disorder, generalized anxiety disorder, and bipolar disorder. Resident FF had a level II dated 9/16/19. His MDS, dated 8/7/23, section A1500 was coded with a 0 indicating he did not require a level II.. During an interview with the MDS Coordinator on 11/29/23 at 2:05 p.m., she indicated Social Services (SS) completes Section A of the MDS. If SS does not complete Section A, she is unable to code due to SS keeping level IIs in their office. 7. On 12/1/23 at 1:30 p.m., Resident O's record was		responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	reviewed. She was admitted on 12/24/22 with severe cognitive impairment. Her diagnoses included, but were not limited to, metabolic encephalopathy (brain disorder caused by chemical changes in the brain) and dementia (progressive and degenerative brain disorder). Her physician's order indicated to admit her to a secure unit due to a diagnosis of dementia. A care plan, dated 12/27/22, indicated Resident O had confusional episodes related to visual and auditory hallucinations. The intervention indicated to provided her medications as ordered. Her MDS status was reviewed. It indicated she was discharged on 6/21/23 to the hospital with an anticipated return. Her progress notes were reviewed from 6/21/23 to 6/28/23. The resident had appropriate charting for someone in the building at that time. On 6/28/23 at 9:51 a.m., the nursing progress note indicated the resident was picked up via stretcher and transported to a hospital. Her physician and family were notified. On 7/11/23 at 2:37 p.m., she was readmitted to the facility from the hospital. On 12/4/23 at 10:08 a.m., the Minimum Data Set (MDS) Coordinator indicated sometimes there were census problems. There was a communication gap between herself and the staff. If a resident was discharged today, the nursing staff might wait 24 to 48 hours before they discharge the resident. She indicated the nurses needed further education. She said she got her			

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	MDS information from the facility census before discharging a resident, but she needed to also look at the nursing progress notes more to see when residents actually leave. For the MDS, she indicated she discharged Resident O on 6/21/23, but after review of the nursing progress notes, she realized the resident did not leave the building for the hospital until 6/28/23. She would make the correction and provide documentation. On 12/4/23 at 10:24 a.m., the MDSC provided documentation of the MDS change. The new information provided to CMS (Centers for Medicare and Medicaid) was dated 6/28/23 for Resident O discharge to the hospital. On 12/4/23 at 11:13 a.m., the Director of Nursing indicated MDSC should have looked at the progress notes to be sure the MDS was accurate and matching what was submitted. A policy, titled, "Certification of Accuracy of the MDS," dated 6/4/23, was provided by the Executive Director (ED), on 12/4/23 at 1:57 p.m. A review of the policy indicated, " ...The assessment must accurately reflect the resident's status ...." 3.1-31(b)			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) 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			

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	comprehensive assessment. The comprehensive care plan must describe the 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility	F 0656	**What corrective action will be**	01/04/2024

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	failed to care plan advanced directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for 13 of 15 residents reviewed for care plans (Resident B, 83, L, Z, 38, 18, 43, P, 4, 87, 48, 256 and 74), end of life care/hospice services for 1 of 15 residents reviewed for care plans (Resident 13), and failed to address a resident's care plan for unnecessary medications for Resident P for 15 of 15 residents reviewed for comprehensive care planning. Findings include: 1 a. A record review was completed for Resident 38 on 11/28/23 at 2:24 p.m. She had the following diagnoses which included but were not limited to bipolar disease, anxiety disorder, obstructive sleep apnea, difficulty breathing, hypertension, and heart failure. Her comprehensive care plan lacked addressing her wish for do not resuscitate (DNR). b. A record review was completed on 11/28/23 at 1:45 p.m. Resident 18 had the following diagnoses which included but not limited to hypertension, benign prostatic hyperplasia, constipation, hyperlipidemia, cerebral infarction, hemiplegia, major depressive disorder, and cognitive communication deficit. His comprehensive care plan lacked addressing his wish for DNR. c. A record review was completed on 11/28/23 at 11:52 a.m. Resident 43 had the following diagnoses which included but were not limited to		**accomplished for those residents found to have been affected by the alleged deficient practice?** Residents 83, 2, 38, 18, 43, 4, 48, 256, 74, 7, and 97 care plans were updated to reflect the resident choice of code status. Residents 87, 259, 13, and 257 no longer reside at the facility. The facility staff were not provided resident identifier information for Residents B, L, P, and Z. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time audit of current resident population has been completed reviewing care planning needs to have a complete care plan. The IDT team has been provided with re-education on the need for timely care planning updates for the comprehensive care planning process. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the Interdisciplinary Team to review and revise resident care plans at time of admission, readmission, quarterly, and upon noted change of condition. The MDS C/designee will be responsible for auditing care plans 5 times a	

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	schizophrenia, protein-calorie malnutrition, constipation, behavior disorders, muscle weakness, and history of falling. Her comprehensive care plan lacked addressing her wish for DNR. d. On 11/28/23 at 2:06 p.m., Resident B's record was reviewed. He was admitted on 10/2/23. His Brief Interview for Mental Status (BIMS) indicated moderate cognitive impairment. His diagnoses included, but were not limited to, traumatic brain injury (physical brain injury), dementia (progressive, degenerative brain disorder), schizophrenia (mental illness), and delusional disorder (persistent, unshakeable beliefs that are not based on reality). His physician's order indicated he had a full code status. His care plans were reviewed, he did not have a care plan for his code status. On 11/29/23 at 12:08 p.m., the Regional Director of Clinical Services (RDCS) provided his code status care plan. It indicated his Advanced Directive was a full code and would be reviewed quarterly. It was created by the RDCS on 11/29/23. e. On 11/30/23 at 12:31 p.m., Resident 83's record was reviewed. She was admitted on 10/17/23. Her Brief Interview for Mental Status (BIMS) indicated severe cognitive impairment. Her diagnoses included, but were not limited to, dementia and schizoaffective disorder bipolar type (mental illness). Her physician's order indicated she had a full code		week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	status. Her care plans were reviewed she did not have a care plan for her code status. On 11/29/23 at 12:08 p.m., the RDCS provided her code status care plan. It indicated her Advanced Directive was a full code and would be reviewed quarterly. It was created by the RDCS on 11/29/23. f. On 11/28/23 at 2:06 p.m., Resident L's record was reviewed. He was admitted on 9/13/23. His BIMS indicated severe cognitive impairment. His diagnoses included, but were not limited to, dementia and hypertension (high blood pressure). His physician's order indicated his code status was a Do Not Resuscitate (DNR). His care plans were reviewed. He did not have a care plan for his code status. On 11/29/23 at 12:08 p.m., the RDCS provided his code status care plan. It indicated his Advanced Directive was a DNR and would be reviewed quarterly. It was created by the Social Services Assistant (SSA) on 11/29/23. g. On 11/28/23 at 1:29 p.m., Resident P's record was reviewed. She was admitted on 10/2/23. Her BIMS indicated severe cognitive impairment. Her diagnoses included, but were not limited to, dementia and metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood). Her physician's order indicated her code status was a DNR.			

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	Her care plans were reviewed, and she did not have a care plan for her code status. On 11/29/23 at 12:08 p.m., the RDCS provided her code status care plan. It indicated her Advanced Directive was a DNR and would be reviewed quarterly. It was created by the RDCS on 11/29/23. h. On 11/28/23 at 1:29 p.m., Resident 79's record was reviewed. She was admitted on 8/21/23. Her BIMS indicated severe cognitive impairment. Her diagnoses included, but were not limited to, traumatic subdural hemorrhage (bleeding in-between dura mater, lining of the skull, and the skull itself) and a neurocognitive disorder with Lewy bodies (abnormal deposits of proteins in the brain). Her physician's order indicated her code status was a DNR. Her care plans were reviewed. She did not have a care plan for her code status. On 11/29/23 at 12:08 p.m., the RDCS provided her code status care plan. It indicated her Advanced Directive was a DNR and would be reviewed quarterly. It was created by the RDCS on 11/29/23. i. On 11/29/23 at 12:41 p.m., the following care plans were reviewed for implementation/revision of advance directive orders. Resident 48 lacked a care plan for her full code status. Resident 87 lacked a care plan for his full code status.			

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	Resident 256 lacked a care plan for his full code status. Resident Z lacked a care plan for his full code status. Resident C lacked a care plan for his full code status. Resident 259 lacked a care plan for her full code status. Resident 257 lacked a care plan for her do not resuscitate (DNR) code status. Resident 7 lacked a care plan for her full code status. Resident 97 lacked a care plan for her DNR code status. On 11/30/23 03:00 p.m., the above residents' care plans were revisited, and the code status had been added by the Social Service Assistant on 11/30/23. 2. On 11/30/23at 2:04 p.m., Resident 13's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, Alzheimer's Disease (a degenerative and irreversible brain disease that effects memory). Resident 13's comprehensive care plans were reviewed. She had a weight loss care plan initiated on 11/8/23 which indicated she was at risk for unavoidable weight loss and was on hospice. The			

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	only intervention for this plan of care was to notify the doctor od weight changes. She had a nutritional care plan revised on 11/3/23 which indicated she was at risk for nutritional problems related to her diabetes and hospice status. The comprehensive care plan lacked implementation of a plan of care to coordinate with her hospice provider. There were no goals or interventions related to her hospice status revised on the care plan. On 12/1/23 at 3:20 p.m., the Vice President of Operations, (VPO) provided a copy of current facility policy titled, "Comprehensive Care Plans and Revisions," reviewed 8/22/23. The policy indicated, " ...The facility will ensure timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs ... the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care ... when changes occur, the facility should review and update the plan of care to reflect the changes to care delivery ...." 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral			

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	hygiene; Based on observation, record review, and interview, the facility failed to provide a resident shower twice a week for 1 of 1 resident reviewed for showers (Resident Y). Finding include: During a record review on 11/29/23 at 4:00 p.m., Resident Y had the following diagnoses which included but were not limited to hypertension, presence of a pacemaker, hypothyroidism, hyperlipidemia, GERD (gastro-esophageal reflux disease), anemia, osteoarthritis, and constipation. Resident had a BIMS (brief interview of mental status) of 15/15 which indicated she was cognitively intact. On 11/28/23 at 11:03 a.m., Resident Y was observed sitting in her chair in her room. She indicated she had not had a shower for 9 days. Prior to that it was 11 days. If the facility could provide her showers two times per week, she would be happy. Resident indicated her buttocks was hurting during the interview. On 11/30/23 at 3:27 p.m., Resident Y was observed sitting up in her chair in her room. She indicated she had a shower on 11/28/23. She had waited 9 days for a shower. On 12/1/23 at 9:39 a.m., Resident Y was observed lying in bed. She was approached with shower sheets provided by the facility for Resident Y. The shower sheets indicated she had a shower two times per week. Resident Y indicated she did not care what the sheets said. She knew she had not received showers two times per week as she requested.	F 0677	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility staff were not provided information on Resident Y's identity. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time audit of current resident population for missed showers for the past 30 days, 11/27/23-12/27/23, has been completed. The Nursing staff have been provided re-education on shower schedules and completing showers as per the schedule and resident preferences. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of nursing staff to ensure residents receive their scheduled showers. The DON/Designee will be responsible for auditing showers as given 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with	01/04/2024

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	During an interview with the Executive Director (ED) on 12/1/23 at 3:00 p.m., she indicated resident received her showers after hearing resident complained of not receiving her showers. A policy titled, "Activities of Daily Living" dated 8/23/23 was provided by the Director of Nursing (DON)12/1/23 at 10:00 a.m. indicated, " ...The resident will receive assistance as needed to complete activities of daily living (ADLS). Any change in the ability to perform ADLS will be documented and reported to the licensed nurse ...." 3.1-38(a)(3)		disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	
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.			

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	155606	A. BUILDING 00 B. WING	12/04/2023

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	Based on observation, interview, and record review, the facility failed to ensure a resident's wound treatment was done as ordered and expired solution was not used on the resident's wound for 1 of 4 wounds reviewed (Resident Q). Findings include: On 11/28/23 at 1:33 p.m., Resident Q's record was reviewed. She was admitted on 12/17/21 with severe cognitive impairment. Her diagnoses included, but were not limited to, dementia (progressive, degenerative brain disorder), squamous cell carcinoma of the skin (disease caused by uncontrolled growth of abnormal cells), and diabetes mellitus (blood sugar disorder). On 11/28/23 at 1:33 p.m., a physician's order indicated to cleanse the bridge of the nose with normal saline, pat dry, then apply Betadine (antiseptic for skin disinfection) paint every day shift for wound healing. A skin care plan, revised on 7/5/23, indicated she was at risk for skin impairment related to squamous cell carcinoma (cancer that occurs on the outer most part of the skin) of the skin. The intervention indicated to provided treatments as ordered. On 11/27/23 at 11:56 a.m., Licensed Practical Nurse (LPN) 5 indicated Resident Q had facial cancer on the bridge of her nose. Her treatment was betadine every day. On 11/29/23 at 4:29 p.m., the Wound Care Registered Nurse (WC RN) 51 indicated her supplies were Betadine and normal saline. She laid	F 0684	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility staff were not provided information on Resident Q's identity. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of current stock of normal saline or sterile water was reviewed with expired vials of liquids discarded. The Licensed Supervisory Nurses and Central Supply Clerk has been provided with re-education on discarding expired normal saline or sterile water. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of Licensed Supervisory Nurses and Central Supply to review stored items for expiration dates and discard of those items as needed. The Wound Nurse/designee will be responsible for auditing normal saline and sterile water supply 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1	01/04/2024

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	a clean towel on the resident's dresser. She opened sterile gauze, then opened the normal saline and put it on wipes. She wiped Resident Q's face two time. She removed her gloves, washed her hands, and put on new gloves. She opened a Betadine pain swab stick and put it on her face. The normal saline vials were checked for an expiration date and the vials were labeled Sterile Water for Inhalation, and it expired August 2022. On 11/29/23 at 4:36 p.m., the WC RN 51 went to the Wound Treatment Cart and threw away the Sterile Water vials, about 25 - 30 vials. She indicated they all came from the same box. A few Sterile Water vials were observed to be dated January 2022. On 12/4/23 at 11:15 a.m., the Director of Nursing (DON) indicated education should be completed for the WC RN regarding following the physician's order and she should have audited her cart for expired treatment supplies. A current policy, titled, "Resident Rights," dated 9/25/23, was provided by the Executive Director (ED), on 11/29/23 at 3:10 p.m. A review of the policy indicated, " ...The resident has the right to receive the services and /or items included in the plan of care ...." 3.1-37(a) 3.1-37(b)		re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record reviews, observations and interviews, the facility failed to provide services to intervene and promote skin integrity for 1 of 3 residents reviewed for pressure ulcers (Resident 18). Findings include: A comprehensive record review was completed on 11/28/23 at 1:45 p.m. Resident 18 had the following diagnoses which included but not limited to hypertension, benign prostatic hyperplasia, constipation, hyperlipidemia, cerebral infarction, hemiplegia, major depressive disorder, and cognitive communication deficit. Resident 18 had a stage IV (full thickness tissue loss with muscle and/or bone visible) pressure ulcer to his sacrum and a stage 2 (partial thickness tissue loss) pressure ulcer to his right heel. Interventions included but were not limited to a low air loss mattress, heel protectors to both heels, turn every 2 hours, use a wedge to prop him to his side, and nutritional support. On a wall in Resident 18's room was a picture of the control panel of his low air loss mattress. The picture demonstrated the therapy mode set to	F 0686	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident # 18 continues to require the use of the low air loss mattress and heel protection. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of residents with the use of low air loss mattresses has been completed to validate the bed function is set to alternate, and a one-time audit of heel protectors for current resident population has been completed to validate they are in use as per care plan. The facility staff have been provided with re-education on wound prevention, settings of the low air loss mattresses, and placement of heel protectors as per care plan. **What measures will be put into place or what systemic**	01/04/2024

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	"alternating" and comfort level set to "1-3." During an observation on 11/29/23 at 2:10 p.m., Resident 18's bed was not set according to the picture on the wall. It was set to "float." During an observation on 12/1/23 at 4:00 p.m., Resident 18's bed was not set according to the picture on the wall. It was set to "float." At this time, Resident 18 complained his bed was too hard and RN 31 changed his setting from 3 to 2 to make the bed softer. During an observation on 12/4/23 at 3:12 p.m., Resident 18's mattress was set to "floating", and his right heel was not in a heel protector. The Director of Nursing (DON) was made aware. The DON indicated she corrected the mattress and placed resident's heel in a heel protector. The Vice President of Operations provided a current policy on 12/4/23 at 10:43 a.m. The policy indicated, "...It is the intent of this center to provide a comprehensive treatment plan designated to meet the individual resident's goal utilizing a multidisciplinary approach...it is the intent of this center that a resident having a wound receives necessary medical treatmetn to prevent infection, deterioration or development of wounds in keeping with the resident's medical condition...."		**changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the nursing and therapy staff to review the low air loss mattress settings and heel protector placements are in place as per care plan. The DON/Designee will be responsible to validate LAL mattress settings and heel protectors in place 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until	

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			compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	
F 0688 SS=E Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to provide range of motion to maintain a resident's range of motion for 3 of 4 residents reviewed (Resident 18, 73 and FF). Findings include: 1. A comprehensive record review was completed on 11/28/23 at 1:45 p.m. Resident 18 had the following diagnoses which included but were not limited to hypertension, benign prostatic hyperplasia, constipation, hyperlipidemia, cerebral	F 0688	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Residents 18 and 73 have been assessed for range of motion needs and the care plans have been updated to reflect the current status of the residents. The facility staff were not given resident identification information	01/04/2024

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	infarction, hemiplegia, major depressive disorder, and cognitive communication deficit. His care plan lacked to address passive or active range of motion to prevent further decline in mobility and functioning. During multiple observations of Resident 18, he was always in bed. During an interview on 12/1/23 at 4:00 p.m., he indicated he preferred to stay in bed. He did not get out of bed to take showers. He preferred bed baths. 2. A comprehensive record review was completed for Resident 73 on 11/29/23 at 2:00 p.m. He had the following diagnoses which included but were not limited to paraplegia, constipation, GERD (gastro-esophageal reflux disease), iron deficiency anemia, pressure ulcer of sacral region, cardiac pacemaker, COPD (chronic obstructive pulmonary disease) osteomyelitis, and general muscle weakness. During an interview with Resident 73 on 11/27/23 at 12:01 p.m., he indicated he needed range of motion to his lower extremities and the facility did not provide any range of motion for him. 3. A comprehensive record review was completed for Resident FF on 11/27/23 at 2:45 p.m. He had the following diagnoses which included but were not limited to heart disease, type 2 diabetes mellitus, hypertension, bipolar disorder, neuropathy, contracture of left and right wrist, contracture of right knee, contracture of left and right ankle and hyperlipidemia. During multiple observations Resident FF was not		for Resident FF. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of current resident population has been completed for residents requiring Range of Motion exercises. The Therapy and Nursing staff have been provided with re-education on provision of restorative and functional maintenance programming. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the nursing staff to provide restorative programming as determined by the Interdisciplinary Team. The DON/Designee will be responsible for auditing completion of restorative programs 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the**	

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	wearing splints. A picture of him wearing the splints and how to wear the splints was on the wall in his room. Resident FF had an order, dated 11/3/22, to always wear right hand/wrist splint to right hand except during bathing and hand hygiene with completing skin checks every shift. Discontinue splint if reports or observations of increased redness, pain, swelling and/or discomfort. Resident FF had an orderx, dated 11/22/23c, to always wear left palm protector except during bathing and hand hygiene with completing skin checks every shift. Discontinue splint if report or observations of increased redness, pain, swelling and/or discomfort. Resident FF had care plans, dated 4/14/21, addressing the wear of the splints. During an interview with Certified Nursing Assistant (CNA) on 11/30/23 at 10:34 a.m., she indicated she did not know anything about his splints. During an interview with Licensed Practical Nurse (LPN) 13 on 11/30/23 at 10:36 a.m., she indicated she did not know about his splints. She indicated she would follow up. During an interview with LPN 13 on 11/30/23 at 11:14 a.m., she indicated Resident FF refused to put the splints on. During an interview with the Director of Nursing (DON) on 12/1/23 at 10:49 a.m., she indicated the facility did not do restorative programs. Restorative programs were considered done while performing care for residents.		**deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	During an interview with the DON and Rehabilitation Manager on 12/1/23 at 11:12 a.m., they indicated they do not perform restorative nursing at the facility. They do range of motion every day with resident's care and they do not do passive range of motion. A policy titled; "Restorative Nursing" dated 9/11/23 was provided by the Executive Director (ED) on 11/29/23 at 3:10 p.m. It indicated, "To promote the resident's optimum function, a restorative program may be developed by proactively identifying, care planning and monitoring of a resident's assessments and indicators. Nursing Assistants must be trained in the techniques that promote resident involvement in restorative activities. Restorative programs may be initiated by nursing and/or therapy ...." 3.1-42(a)(1) 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure a resident, (Resident 4) received sufficient monitoring and interventions to prevent falls, failed to ensure a resident (Resident 256) was free from the potential	F 0689	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?**	01/04/2024

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	for accidents related to his specialized diet orders, failed to ensure a resident (Resident 78) was free from the potential for accidents related to her fall interventions, and failed to prevent the potential for accidents for a Memory Care resident (Resident 86) who was found to have medication in her room for 4 of 4 residents reviewed for accidents. Findings include: 1. On 11/27/23 at 10:55 a.m., Resident 4 was initially observed in his room. He complained of pain in his side and back from a fall he sustained the previous day. No "call before you fall," or other reminder signs to ask for assistance were noted in his room. During an interview on 11/29/23 at 1:52 p.m., Resident 4's family member indicated he had finally been sent to the hospital but had to be transferred to the trauma hospital due to several fractured ribs. The family member indicated, Resident 4 had been back on the memory care unit but had a couple resident-to-resident altercations which made him more anxious, so he was moved to the 100-hall. Resident 4 should probably have stayed on the Memory Care unit because of his anxiety, unsteadiness and he needed extra supervision. Resident 4 fell on the evening of 11/26, around dinner time when staff were busy passing dinner trays. Resident 4 complained a lot of times that it took a long time for anyone to answer his call light which made him anxious, so he would often attempt to do things on his own. If they didn't come to help, he would go out and look for someone, and if he couldn't find anyone, he would try to do things on his own. He required both a colostomy and urostomy and he did not like for anything to be in them and would request		Resident #4 has been reviewed by the IDT for fall interventions, a fall assessment has been updated, and the care plan has been updated to reflect the current status of the resident, including prescribed medications. Pharmacy recommendations have been placed in the medical record. A care conference has been completed with the family. Resident # 256 has been assessed for activities interests as well as continues to have the NPO status. The Frazier Free water protocol was in place under the direct supervision of the ST during therapy sessions. The care plan has been updated to reflect the current status of the resident to address activities/behaviors, NPO status and resident attempts to consume liquids. Resident # 78 had the rug removed from the room. The IDT has reassessed the resident for fall interventions and toileting interventions, a fall assessment has been updated, and the care plan has been updated to reflect the current status of the resident. Resident G gave the medication to the Executive Director. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of residents experiencing falls for the past 30	

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	frequent changes. The family member indicated Resident 4 told them, the evening of the fall he had asked for help to clean up, but it was dinner time, and the nurse was busy passing medications, so he was trying to get out of his room to find someone else. After the fall he didn't immediately complain of pain he just wanted to get up, but soon after the soreness set in and just continued to get worse. He was only given his routine Tylenol and it had not controlled his pain as it continued to get worse until eventually, he complained of trouble breathing which was when they finally sent him out. During an interview on 11/30/23 at 12:07 p.m., with the Social Service Direct (SSD) and the Social Service Assistant (SSA) present, the SSD indicated, Resident 4 did not have many disruptive behaviors, but he was often anxious and fiddled with the colostomy bag. Resident 4 altered between ambulation with a walker and the use of a wheelchair. When asked about a previous fall, the SSD indicated Resident 4 had been fiddling with his colostomy bag and wanted it changed so he walked with the Resident back to his room. He stepped out of the room and then heard a "clatter and thud" which sounded like he had fallen into the side table. The SSD went back into the room and Resident 4 was already trying to get himself off the floor. The nurse came and did an assessment and he stepped out of the room. The SSD indicated he did not remember if he reported the fall, but nursing should have. Resident 4 was moved off the Memory Care unit because he had been assessed and was no longer considered at risk for elopement. During an interview on 11/30/23 at 11:34 a.m. LPN 54 indicated she had been passing evening medications around dinner time when she		days, 11/27/23-12/27/23, has been completed verifying fall interventions are identified and care planned. A one-time sweep of the unit verifying no other medications were in resident rooms was completed with no other issues noted. The facility staff have been re-educated on identification of fall interventions, completing immediate interventions at time of event, no use of rugs in rooms for prevention of fall interventions, and residents must have order and self-medication assessment approved by the IDT before medications can be in resident rooms. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of facility staff to make every effort to prevent falls, provide appropriate fall interventions, complete or implement fall interventions, and to keep medications secured. The DON/designee will be responsible for auditing falls upon occurrence and observe for medications at bedside 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff	

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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
	witnessed Resident 4 fall. She did not remember if his call light was on, or if he was waiting for help, and staff had all been busy passing dinner trays. On 11/29/23 at 3:40 p.m., Resident 4's medical record was reviewed. He was a long-term care resident and had diagnoses which included but not limited to, dementia (a progressive and degenerative brain disease which effects memory), heart disease and muscle weakness. A nursing progress note, dated 11/15/23 at 3:00 p.m., indicated the SSD followed Resident 4 to his room and that Resident 4 fell against his bedside table. A nursing progress note, dated 11/17/223 at 6:38 a.m., indicated Resident 4 denied having fell the other day. The record lacked documentation of an intervention placed after his fall. Resident 4's fall on 11/15/23 was not followed up on until 11/27/23, 12 days later, and after his second fall which resulted in rib fractures. The corresponding nursing note was dated 11/27/23 at 8:09 a.m. and indicated Resident 4 fell against his bedside table. The SSD had assisted him to his room due to him being found in the hallway in just his brief and a t-shirt. The intervention added at that time was to place a reminder sign in the resident's room. Resident 4 had a comprehensive care plan, dated 10/23/23, which indicated he was at risk for falls. The care plan lacked revision to add/place a reminder sign in the resident's room.		personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	A nursing progress note, dated 11/12/23 at 11:05 p.m., indicated the consulting Pharmacist made individual recommendations and to review full report for details. A nursing progress note, dated 11/13/23 at 1:51 p.m., indicated Resident 4 was started on buspirone (an antianxiety medication) 5 milligrams (mg) two times a day. A nursing progress note, dated 11/13/23 at 8:44 p.m., indicated Resident 4 had several medicine changes. A nursing progress note dated, 11/22/23 at 4:11 p.m., indicated Resident 4's sertraline (an antidepressant medication) was increased from 50 mg to 75 mg. A Post-Fall Assessment dated, 11/15/23 medication section asked, "1. Did resident receive any of the following medications in the last 7 days: anesthetic, antianxiety, anticonvulsant, Antidepressant...." The question was answered "no" even though he received both an antianxiety medication and antidepressant medication daily. On 11/16/23 Resident 4 filed a grievance and was unhappy with care and floor staff response times to call lights. The resolution for the grievance was to provide staff in-service. A corresponding In-Service sign-in log was, dated 11/16/23, but lacked documentation of what type of in-service was provided i.e. lecture, reading, digital/online learning etc. and what materials were used/discussed/trained on. A nursing progress note, dated 11/26/23 at 7:35 p.m., indicated, Resident 4 ambulated backwards			

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	into the door in his wheelchair. A bruise was noted on his right elbow and a small skin tear was noted on his right wrist. At the time of the fall, he complained of soreness to his right side, his ribs. "Resident complained of soreness noted to right side of ribs at this time. Vital within normal limits ... range of motion within normal limits, with no c/o pain." A nursing progress note, dated 11/28/23 at 7:23 p.m., indicated Resident 4 had been sent to the local hospital but required a transfer to the trauma hospital. A corresponding hospital report, dated 11/28/23, indicated Resident 4 had "minimally displaced right sided rib fractures spanning the sixth through ninth ribs and segmental fractures noted at the seventh through ninth levels." Resident 4's comprehensive care plans reviewed and lacked implementation and/or revision to include goals/approaches/interventions for the use of his antianxiety and antidepressant medication. On 11/30/23 at 12:12 p.m., a copy of Resident 4's pharmacy recommendations was requested of the Executive Director. On 12/1/23 at 1:00 p.m., a copy of Resident 4's pharmacy recommendations was requested of the Executive Director. On 12/4/23 at 3:16 p.m., a copy of Resident 4's pharmacy recommendations was requested of the Director of Nursing. Resident 4's pharmacy recommendations were not provided for review.			

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	On 12/2/23 at 3:20 p.m., the Vice President of Operations (VPO) provided a copy of current facility policy titled, "Comprehensive Care Plans and Revisions," reviewed 8/22/23. The policy indicated, "The facility will ensure timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs ... the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care ... when changes occur, the facility should review and update the plan of care to reflect the changes to care delivery ...." On 12/1/23 at 3:20 p.m., the Vice President of Operations (VPO) provided a copy of current facility policy titled, "Fall Management," reviewed 9/22/23. The policy indicated, "The facility will assess the resident upon admission/readmission, quarterly, with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls ... Avoidable Accident- this means that an accident occurred because the facility failed to: ... 3. Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident. 4. Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice ... Facilities are obligated to provide adequate supervision to prevent accidents.			

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	Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed ... Procedure: 1. Residents will be assessed for fall indicators upon admission, readmission, quarterly, change in condition and with any fall utilizing the fall Risk Assessment ...." 2. During an interview on 11/28/23 at 11:00 a.m., Speech Therapist (ST) 15 indicated Resident 256 was having trouble eating and drinking, he was on a strict NPO (nothing by mouth) diet because he was at high risk of aspiration or choking. He was only allowed to have small sips of water with a ST present. He called out for water a lot, but there was nothing they could really do. On 11/28/23 at 1:48 p.m., Resident 256 was observed at the 300-hall nurse's station. He called out for water, but staff passed by and ignored his request. The Director of Rehabilitation (DOR) was at the nurses' station, but his back was turned from Resident 256, and he ignored Resident 256's requests. With no responses or interventions to his requests, Resident 256 was observed to rummage in a container under the desk, next to his wheelchair. He picked out two gallons of water and began to try and open them. Before Resident 256 got the lid off the water, the DOR was notified. The DOR turned around, his eyes were big with surprise, and he briskly went around into the nurses' station to remove the water from Resident 256. He indicated to the resident, "you know you can't have this." He removed the water without offering anything else. Resident 256 called after him and indicated, "Give it back!" During an interview on 12/1/23 at 11:39 a.m., LPN 50 indicated Resident 256 was at high risk for			

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	choking or aspiration, so he needed a ST to sit with him for all small meal/beverage trials. On 11/30/23 at 12:41 p.m., Resident 256 was observed at the 300-hall nurses' station. He was pulled up to the desk and rummaged through the drawers. No staff were observed present or supervising Resident 256 as he opened the drawer to his left, found a bottle of shampoo and attempted to pick it up and open it. The Social Service Assistant exited the chart room and came to the front of the nurse's station to talk with Resident 256. The bottle was removed and some of his "toys," were offered. On 12/1/23 at 2:01 p.m., Resident 256 was at the nurse's station. There was a pump bottle of hand sanitizer directly in front of him that he fiddled with. At that time, Certified Nursing Assistant (CNA) 51 approached and was asked if he should have the hand sanitizer. She quickly removed it and indicated, "no, he will drink anything if he can." She indicated he was not supposed to have water due to his NPO order. During an interview on 12/4/23 at 2:09 p.m., The DOR indicated Resident 256 was on a "Frazier Free Water Protocol," (allows patients with dysphagia to freely consume thin liquid water with supervision) but was still on a strict NPO diet. Getting anything to eat or drink without supervision would be consider high risk for an accident as he could choke and/or aspirate. On 12/4/23 at 1:48 p.m., Resident 256's medical record was reviewed. He had diagnoses which included, but were not limited to, traumatic brain injury, dysphagia (difficulty speaking), anxiety and weakness.			

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	He had current physician's orders for an NPO diet and bolus tube feeding 5 times a day. The record lacked documentation of a physician's order for the Fraizer Free Water Protocol. He had a comprehensive care plan initiated 11/8/23 which indicated he was at risk for altered nutritional status due to the requirement of a feeding tube. The care plan lacked documentation of revisions to include his bolus feeding time/schedule and his NPO status. The care plan lacked documentation of implementation and/or revisions for his behaviors of repeated requests for water. The care plan lacked documentation of implementation and/or revisions for the potential for accidents related to his requests and attempts to get water. On 12/4/23 at 3:16 p.m., the Regional Nurse Clinical Specialist (RNCS) provided a copy of current facility policy titled, "Frazier Free Water Protocol," reviewed 8/24/23. The policy indicated, " ...Any resident on NPO or on a dysphagia diet may have water once they have been evaluated for and accepted into the Frazier Free Water Protocol per physician order ...." 3. On 11/27/23 at 11:05 a.m., Resident 78 was initially observed. She was seated in bed with the over-bed table in front of her. She was pleasantly confused. A blue and grey area rug was observed on the floor beside her bed. The corner edge of the rug was curled and turned up. There was no fall mat beside her bed. On 11/28/23 at 11:10 a.m., Resident 78 was			

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	observed in her bed. The area rug remained on the floor and no fall mat to the side of her bed. On 11/28/23 at 2:45 p.m., Certified Nursing Assistants (CNA) 51, 52 and Qualified Medication Aide (QMA) 53 were observed in Resident 78's room. They were preparing to get Resident 78 out of bed and rolled a Hoyer lift (a specialized mechanical lift used for transfers of dependent residents) into the room, but it snagged on the turned-up corner of the rug. CNA 52 indicated, the rug needed to be moved so it did not interfere with the Hoyer lift and CNA 51 kicked it out of the way. On 11/29/23 at 8:40 a.m., Resident 78 was observed and remained in bed. The area rug remained on the floor and there was no fall mat to the side of her bed. On 12/1/23 at 10:34 a.m., Resident 78 was observed and remained in bed. The area rug remained on the floor and there was no fall mat to the side of her bed. During an interview on 12/1/23 at 2:10 p.m., Licensed Practical Nurse (LPN) 50 indicated she had not noticed there was a throw rug in Resident 78's room. Residents should not have rugs in their room. Even though Resident 78 did not attempt to get out of bed, she required a Hoyer lift, and it was not a good idea to roll the lift over a rug, especially if the resident was in the sling because there would be a potential for accident if the rug got tangled in the foot/leg of the lift. On 12/4/23 at 3:00 p.m., Resident 78's room was observed, and the rug was no longer there. During a follow up interview on 12/4/23 at 3:07			

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	p.m., LPN 50 indicated, she had pulled the rug up, rolled it and placed it next to the refrigerator for the family to come pick up. On 12/1/23 at 1:43 p.m. Resident 78's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, Alzheimer's (a type of dementia, progressive and irreversible degeneration of the brain which significantly effects memory), muscle weakness and chronic heart failure. A nursing progress note dated, 9/28/23 at 4:57 a.m., indicated at approximately 4:00 a.m., Resident 78 was found sitting on the floor. She was incontinent of bowel and bladder, and her right arm was wrapped around the side rail of her bed. She complained of pain in her right leg but was able to move it when she was back in bed. The progress note indicated, "resident will be on toileting schedule every two hours for intervention." A nursing progress note dated, 9/28/23 at 6:22 a.m., indicated staff attempted to hang a "call before you fall" sign, but the resident indicated she did not need it. The staff informed her it was for safety and to help her remember not to get out of bed without assistance. Resident 78 had a comprehensive care plan, dated 7/5/23, which indicated, she was at risk for falls related to her confusion and gait/balance problems. Interventions for this plan of care included, but were not limited to, floor mat to side of bed. A comprehensive care plan dated 7/5/23, indicated Resident 78 resident had an Activities of Daily Living (ADL) self-care performance deficit related			

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	Alzheimer's and impaired balance. The care plan indicated she required a Hoyer lift by two staff members to move between surfaces. On 12/1/23 at 3:20 p.m., the Vice President of Operations (VPO) provided a copy of current facility policy titled, "Fall Management," reviewed 9/22/23. The policy indicated, "The facility will assess the resident upon admission/readmission, quarterly, with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls ... Hazards- refers to elements of the resident's environment that have the potential to cause injury or illness 1. "Hazards over which the facility has control" are those hazards I the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness ... refer to the following Lippincott procedures to assist with fall prevention and management: Lippincott Procedures, Fall Prevention in Long-Term Care ... " ...falls can result from extrinsic (environmental) factors, such as poor lighting, slippery throw rugs ...."4. On 11/27/23 at 10:58 a.m., Memory Care (MC) Resident G was observed lying in bed. Her purse was beside her pillow. She indicated she had shingles and treated it herself. She pulled a prescription medication, triamcinolone ointment 0.1% from her open purse. On 11/28/23 at 9:52 a.m., Resident G was observed not in her room. Her open purse was still beside her pillow. Without touching her purse, the prescription medication, triamcinolone ointment 0.1% was visible at the top of her purse. Housekeeper 22 was in the resident's room. On 11/27/23 at 2:34 p.m., Resident T was observed to wander into Resident L's room. Resident L and			

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	his wife repeatedly told her no and asked her to leave. Resident T did not leave right away and lingered by the door. Resident L indicated she would come into different resident rooms and would get in their bed whether they are in them or not. On 11/28/23 at 10:48 a.m., Resident G's record was reviewed. She was admitted on 10/13/22 with moderate cognitive impairment. She had no self-medication assessment. Her diagnoses included, but were not limited to, memory defect following a cerebral infarction (stroke), dementia (progressive, degenerative brain disorder), and psychotic disorder with delusions (severe mental disorder that causes abnormal thinking with false beliefs about reality). On 11/30/23 at 11:17 a.m., a weekly skin report indicated Resident G had a rash on 10/29/23. Subsequent weekly skin checks indicated she did not have a rash. Her physician orders indicated to admit her to the secure unit and provide donepezil 10 mg for delusions. A care plan, dated 12/14/22, indicated she had mood problems related to a psychotic disorder and provide behavioral health consults as needed. A care plan, dated 10/26/22, indicated she would wander aimlessly and to provide safe wandering. On 11/28/23 at 11:15 a.m., the Executive Director (ED) indication the facility found her prescription medication, triamcinolone ointment 0.1%, and removed it from her room. She indicated she did not know if the resident should have had it or not,			

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	but the resident did not have a self-medication assessment. A current policy, titled, "Self-Administration of Medication," dated 8/29/23, was provided by the ED, on 11/29/23 at 3:10 p.m. A review of the policy indicated, Residents have, " ...the right to self-administer medication if the interdisciplinary team has determined that this practice is clinically appropriate ...Bedside medication storage is permitted only when it does not present a risk to confused resident who wander into the room of, or room with, resident who self-administer ...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's			

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	clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and observation, the facility failed to ensure a resident's indwelling catheter bag and tubing did not contact the floor and failed to ensure residents were free from constipation for 2 of 5 residents reviewed for bowel and bladder (Resident Y and 18). Findings include: 1. A comprehensive record review was completed on 11/28/23 at 1:45 p.m. Resident 18 had the following diagnoses which included but not limited to hypertension, benign prostatic hyperplasia, constipation, hyperlipidemia, cerebral infarction, hemiplegia, major depressive disorder, and cognitive communication deficit. Resident 18 had an order, dated 7/21/23, for an indwelling catheter (suprapubic catheter). Resident 18 had an order, dated 7/21/23, for Miralax 17grams (used for constipation). Add 4-8 ounces of fluid and administer every 24 hours as needed for constipation. During an observation and interview on 11/28/23	F 0690	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility staff were not given resident identification information for Resident Y. Resident # 18 was reassessed by the medical team in relation to the complaints of constipation, his catheter tubing was secured as to not touch the floor and secured with a dignity bag, and the suprapubic catheter and constipation concern has been added to the resident care plan to reflect the current status of 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:** A one-time review of residents with catheters has been completed to validate catheter tubing does not	01/04/2024

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	155606	A. BUILDING 00 B. WING	12/04/2023

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

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	at 11:00 a.m., Resident 17 indicated the powder they mix in water did not help him have bowel movements (BM). He indicated he did not get out of bed and would have bowel movements in his brief. His catheter bag was on his right side and was not placed inside a dignity cover. The bag was exposed, and the rubber tubing was contacting the floor. During an observation on 12/1/23 at 4:00 p.m., the rubber tubing of the catheter bag was touching the floor. The catheter bag was not inside a dignity cover. During an observation on 12/4/23 at 11:30 a.m., Resident 18's rubber tubing from catheter bag was touching the floor. The bag was not placed inside a dignity cover. Resident's bowel movement flowsheets were reviewed. Resident did not have a bowel movement from 11/27/23 through 12/1/23. Resident 18's comprehensive care plan did not address his constipation or the supra-pubic catheter. 2. During a comprehensive record review on 11/29/23 at 4:00 p.m., Resident Y had the following diagnoses which included but were not limited to hypertension, presence of a pacemaker, hypothyroidism, hyperlipidemia, GERD (gastro-esophageal reflux disease), anemia, osteoarthritis, and constipation. During an interview with Resident Y, she indicated she had constipation. She indicated she did not have bowel movements for days at a time. Resident Y had an order for Senna 8.6 milligrams		touch the floor and a dignity bag is provided for coverage. A one-time review of residents with diagnosis of constipation has been completed to validate no other concerns were brought forth by other residents. The facility staff have been provided with re-education on securing catheter tubing off of floor, provision of dignity bag, care planning use of catheter, and interventions and treatment to aid in relief of constipation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility staff to assist residents with keeping catheter tubing up off of floor, using dignity bags for cover, and to assist residents with relief of constipation. The DON/Designee will be responsible for auditing catheter tubing and dignity bag placement, as well as bowel management results 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator.	

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	(mg) two tablets daily for constipation. She had a care plan, dated 10/20/21, indicating she was at risk for constipation related to decreased mobility. During an interview with the Director of Nursing (DON) on 11/30/23 at 3:00 p.m., she indicated she could not request reports for bowel and bladder elimination beyond 30 days for Resident 18 or Y. During an interview with the DON on 12/4/23 at 1:32 p.m., she indicated residents should have a BM daily. She indicated she followed her policy. When she was given the policy for review, she indicated there were components of the policy missing. A policy titled, "Bowel Protocol" dated 9/12/23, was provided by the DON on 12/1/23 at 10:00 a.m. It indicated, " ...Nursing staff will record, in the EHR (electronic health record) each time a resident has a bowel movement. The facility in coordination with the resident's attending practitioner will implement standing orders to address a lack of bowel movement ....". A policy titled, "Indwelling Catheter (Foley) Management," dated 8/24/23, was provided by the Executive Director (ED) on 11/29/23 at 3:10 p.m. It indicated, " ...Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor ...." 3.1-41(a)(1)		**How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic			

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	jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure resident's did not have significant weight loss and interventions were implemented to prevent further weight loss for 2 of 4 resident's reviewed for weight loss (Resident 34 and 53). Findings include: 1. A comprehensive record review was completed on 11/30/23 at 9:15 a.m. for Resident 34. She had the following diagnoses which included but were not limited to moderate protein-calorie malnutrition, right sided weakness, chronic kidney disease, hypothyroidism, type 2 diabetes mellitus, insomnia, gastro-esophageal reflux disease (GERD), osteoarthritis, generalized anxiety disorder, and insomnia. Resident 34 had the following weights: a.) 11/13/23: 117.0	F 0692	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident # 34 and 53 have been reassessed by the Registered Dietitian and IDT for current weight status and weight loss prevention interventions. The attending physician and family have been notified of the resident current status. The care plans have been updated to reflect the current status of the residents for weight loss prevention. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of weight	01/04/2024

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	b.) 10/9/23: 122.2 c.) 9/1/23: 130.0 d.) 8/3/23: 132.1 e.) 7/5/23: 134.0 f.) 6/6/23: 134.3 g.) 5/2/23: 135.0 Resident 34 lost 18 pounds in a 6-month period. She lost 13% of her body weight in 6 months. On 9/29/23 at 4:22 p.m., the Interdisciplinary Team met to discuss resident's care needs. It was noted Resident 34 had no immediate concerns. Her 10/9/23 Minimum Data Set (MDS) indicated she lost weight. Resident 34 had a care plan, dated 10/18/22, it indicated she had nutritional problem or potential nutritional problem related to diagnoses of dementia, depression, anxiety, difficulty swallowing, moderate malnutrition, weight loss occurring. A goal, dated 11/17/23, indicated she would maintain adequate nutritional status as evidenced by maintaining weight within 3% of 130 pounds with no signs and symptoms of malnutrition and consuming 50% of meals daily. Her diet order included a regular consistent carbohydrate diet with low potassium, low intake of potatoes, avocados, and bananas. No orange juice and tomato juice. She received house shakes with her meals. The facility did not provide documentation to indicate the family and physician were notified of Resident 34's weights. 2. A comprehensive record review was completed for Resident FF on 11/27/23 at 2:45 p.m. He had		monitoring for current resident population for the past 30 days has been completed to validate current weight issues. The facility staff have been provided with re-education on weight monitoring and addition of new interventions to help the resident prevent further weight loss. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility staff to monitor weights of residents and assist the residents with prevention of weight loss as able. The DON/Designee will be responsible for auditing resident weights obtained 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months for validation of new interventions, assessment of unavoidability of weight loss, care plan updated, and MD/FAM notification has been completed. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:**	

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	the following diagnoses which included but were not limited to heart disease, type 2 diabetes mellitus, hypertension, bipolar disorder, neuropathy, contracture of left and right wrist, contracture of right knee, contracture of left and right ankle and hyperlipidemia. Resident FF had the following weights: a.) 11/13/23: 129.8 b.) 10/3/23: 130.0 c.) 9/26/23: 134.0 d.) 8/16/23 134.0 e.) 7/6/23: 129.2 f.) 6/2/23: 148.0 g.) 5/2/23: 148.3 Resident FF lost had an 18.5-pound weight loss in 180 days. He lost 12% of his body weight in a 6 month timeframe. The Minimum Data Set (MDS), dated 11/7/23, other optional MDS indicated Resident FF had no weight loss or it was unknown if he lost weight. Resident FF record lacked notification of the family representative or physician of his weight loss. Resident FF lacked a care plan to address his weight loss. During an interview with the Registered Dietician (RD) on 12/1/23 at 12:03 p.m., she indicated she had been with the facility for a month and of the month she had been absent for 2 weeks. She indicated she started mid-October of 2023. She indicated they tried to meet weekly to discuss residents with weight loss.		The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	During an interview with the Director of Nursing on 12/4/23 at 3:15 p.m., she indicated they tried to meet weekly to discuss residents with weight loss. A policy titled, "Weight Monitoring, Long Term Care," dated 8/21/23 was provided by the DON on 12/1/23 at 10:00 a.m. It indicated, " ...Unplanned weight loss in residents is associated with increased mortality; a decrease in weight of 5% or more in a month or of more than 10% in 6 months should be reported to the practitioner for further evaluation. Assess the resident to help determine a possible cause of the weight change ....". 3.1-46			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to date a peripherally inserted central catheter (PICC) dressing and failed to date intravenous (IV) tubing for 1 of 1 resident reviewed for IVs (Resident 18). Findings include: A record review was completed on 11/28/23 at 1:45 p.m. Resident 18 had the following diagnoses which included but not limited to hypertension, benign prostatic hyperplasia, constipation, hyperlipidemia, cerebral infarction, hemiplegia, major depressive disorder, and cognitive communication deficit.	F 0694	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident #18 IV antibiotic therapy has been completed as per MD order and the PICC line has been removed. The care plan has been reviewed to reflect the current status of the resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	01/04/2024

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	Resident 18 had an order, dated 11/22/23, to change his PICC dressing every Sunday and to measure his arm circumference (10cm above the antecubital), measure external catheter length, and notify the physician if length changed since last measurement. He had an order, dated 11/22/23, to change the dressing as needed for concern of line movement or infection. He had an order, dated 11/22/23, to change the IV administration tubing every 24 hours. During an observation on 11/27/23 at 11:00 a.m., Resident 18 had a PICC line to his right upper arm. The PICC had a transparent dressing covering the insertion site. The transparent dressing lacked a date. IV tubing hanging on the pole lacked a date. During an observation on 11/28/23 at 1:00 p.m., Resident 18's PICC dressing lacked a date. The IV tubing lacked a date. During an observation on 11/29/23 at 12:24 p.m., Resident 18's PICC dressing lacked a date. The IV tubing lacked a date. During an interview with Licensed Practical Nurse (LPN) 29 on 11/29/23 at 12:30 p.m., she indicated she would have to look at his order to determine if Resident 18's dressing was due to be changed. She indicated the dressing should be dated when changed. During an interview with LPN 13 on 11/30/23 at 12:36 p.m., she indicated she was changing his tubing and dressing because today was the due date to change it.		**action will be taken:** A one-time review of residents with PICC lines in use for the past 30 days, 11/27/23 – 12/27/23, has been completed to validate changing of dressing and tubing being dated. The Licensed Supervisory Nurses have been provided re-education on PICC line dressing changes and dating changes as ordered as well as tubing. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the Licensed Supervisory Nurses to appropriately date PICC line dressing and tubing changes. The DON/Designee will be responsible for auditing PICC line changes and tubing dates 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be	

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	During an interview with the Director of Nursing (DON) on 12/4/23 at 3:00 p.m., she indicated she would have to look at his order to determine when his dressing should be changed. A policy titled, "Peripherally Inserted Central Catheter (PICC) Dressing Change," dated 8/21/23, was provided by the Regional Director of Clinical Services (RDCS) on 12/1/23 at 3:25 p.m. It indicated, " ...A transparent semipermeable dressing over the peripherally inserted central catheter (PICC) requires changing at least every 7 days. Label the dressing with date of the dressing change or the date it's due to be changed as directed by the facility ...." 3.1-47(a)(2)		responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 4) was treated for pain after a fall from which he sustained several rib fractures and the facility failed to ensure a resident (Resident P) was given effective interventions for pain after a fall from which she sustained a fractured wrist for 2 of 3 residents reviewed for pain. Findings include: 1. On 11/27/23 at 10:55 a.m., Resident 4 was	F 0697	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident #4 has been reassessed by the IDT for pain management and control of pain. The care plan has been updated to reflect the current status of the resident. The facility staff were not given resident identification information	01/04/2024

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	initially observed in his room. He complained of pain in his side and back from a fall he sustained the previous day. He grimaced with movement and indicated it hurt "very" bad. A family member was in the room to check on him and indicated he had fallen out of his wheelchair the day before and has complained of pain ever since. On 11/28/23 at 9:30 a.m., Resident 4 was observed a second time. He continued to complain of pain on his right side and said it was worse than the day before and rated his pain a 9 out of 10. He complained of pain with any movement and was unable to eat because it hurt to lift his arms. When an aide assisted him to put on a sweatshirt, he winced and moaned in pain. During an interview on 11/28/23 at 9:32 a.m., Licensed Practical Nurse (LPN) 13 indicated she had already administered his scheduled Tylenol, but it had not been effective. His pain seemed "much" worse, and she decided to send him to the hospital for further evaluation. During an interview on 11/28/23 at 9:40 a.m., Resident 4's family member indicated he was not his normal self, and she was concerned about the level and intensity of his pain. During a follow up interview on 11/29/23 at 1:52 p.m., Resident 4's family member indicated he had been sent to the hospital but had to be transferred to the trauma hospital due to several fractured ribs. Resident 4 had been back on the memory care unit, but he had a couple resident to resident altercations and was anxious about it. So, he was moved to the 100-hall. He had fallen in the evening around dinner time, and staff were busy passing dinner trays. Resident 4 complained a lot that it took a long time for anyone to answer his		for Resident P. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of residents with fractures for the past 30 days, 11/27/23-12/27/23, has been completed to validate pain management is effective as per the resident determination. The Licensed Supervisory Nurses and IDT have been provided re-education on pain management and revision of pain management with increased signs and symptoms of pain when noted, specifically at time of falls. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility staff to assist residents with pain management and/or new interventions as determined necessary. The DON/Designee will be responsible for auditing residents with falls and resulting in increase in pain 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as	

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	call light which made him anxious, so he would attempt to do things on his own. If they didn't come to help he would go out and look for someone, and if he couldn't find anyone he would try to do things on his own. He required both a colostomy and urostomy and he did not like for anything to be in them and would request frequent changes. The family member indicated Resident 4 told them the evening of the fall he had asked for help to clean up, but it was dinner time, and the nurse was busy passing medications. So, he was trying to get out of his room to find someone else. After the fall he didn't immediately complain of pain he just wanted to get up, but soon after the soreness set in and just continued to get worse. He was only given his routine Tylenol and it had not controlled his pain as it continued to get worse until eventually he complained of trouble breathing which was when they finally sent him out. During an interview on 11/30/23 at 11:34 a.m. LPN 54 indicated she had been passing evening medications around dinner time when she witnessed Resident 4 fall on 11/26/23. She immediately assessed him, and he was very anxious to get off the floor. The Nurse Practitioner (NP) was notified and told LPN 54 that she could apply an ice pack and if it did not help to call back for an x-ray. On 11/29/23 at 3:40 p.m., Resident 4's medical record was reviewed. He was a long-term care resident and had diagnoses which included but not limited to dementia (a progressive and degenerative brain disease which effects memory), heart disease, and muscle weakness. Resident 4 had a comprehensive care plan, dated 10/23/23, which indicated he expressed pain and		determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	discomfort related to chronic pain. Interventions for this plan of care included but were not limited to anticipate the resident's need for pain relief, respond immediately to any complaint of pain, and evaluate the effectiveness of pain interventions and pain medication as ordered. Resident 4 had a comprehensive care plan, dated 10/23/23, which indicated he had impaired cognitive ability related to his diagnoses of dementia. Interventions for the plan of care included, but were not limited to cue, orient and supervise as needed. Resident 4 had a comprehensive care plan, dated 10/23/23, which indicated he was at risk for falls. Interventions for this plan of care included but were not limited to anticipate the resident's needs. He had physician's orders to give two 325 mg (milligram) Tylenol twice a day and two 325 mg Tylenol every 12 hours as needed for mild pain. A nursing progress note, dated 11/26/23 at 7:35 p.m., indicated Resident 4 ambulated backwards into the door in his wheelchair. A bruise was noted on his right elbow and a small skin tear was noted on his right wrist. At the time of the fall, he complained of soreness to his right side, his ribs. "Resident complained of soreness noted to right side of ribs at this time. Vital within normal limits ... range of motion within normal limits, with no c/o pain." He was assisted back to bed and Tylenol was administered. The Medical Doctor (MD) was notified and gave orders to apply an ice pack to right ribs for pain and to call back if an x-ray was needed. A nursing progress note, dated 11/27/23 at 5:12 a.m., indicated Resident 4 continued to complain			

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	of right sided pain, 4 out of 10. Tylenol was administered at 4:00 a.m., with "fair relief," and an order was placed to obtain a STAT (immediate) x-ray. A nursing progress note, dated 11/28/23 at 9:00 a.m., indicated Resident 4 continued to complain of right rib pain and problems breathing. His oxygen saturation level was 94/95% on room air. The nurse contacted the MD to notify them of the x-ray results (which were negative) and the MD gave orders to conduct a Covid test and draw labs. The resident continued to complain of uncontrolled pain and the nurse called the MD back to request his transfer to the emergency room. The MD gave orders to send him out and 911 was contacted. A nursing progress note, dated 11/28/23 at 7:23 p.m., indicated Resident 4 had been sent to the local hospital but required a transfer to the trauma hospital. Resident 4's Medication Administration Record (MAR) was reviewed and revealed the following. On the 11/26/23, the day of his fall, a pain level of 4 was noted for observation. On 11/26/23, 11/27/23, and 11/28/23, a 0-pain level was documented for each administration of his scheduled Tylenol, even though he continued to complain of pain. No additional PRN Tylenol was provided. 2. On 11/29/23 at 11:23 a.m., Resident P's record was reviewed. She admitted on 8/11/23 with severe cognitive impairment. Her diagnoses included, but were not limited to,			

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	dementia with other behavioral disturbances (progressive, degenerative brain disorder) and metabolic encephalopathy (drain disorder caused by chemical changes in the body). Her physician orders include to admit Resident P to a secure unit due to a diagnosis of dementia and provide quetiapine 25 mg three times a day for severe psychotic disorder and major depressive disorder. On 11/28/23 at 9:00 a.m., Resident P was observed on the floor of the MC area lying on her right side. Her left arm was on her left side, there was an obvious deformity to her left wrist/forearm area. She was observed in pain, crying and screaming, requesting loudly "don't move me." Certified Nursing Aide (CNA) 9 was observed to lift the resident's head to place a pillow underneath it. Licensed Practice Nurse (LPN) 5 had not left the nurse's station yet. On 11/28/23 at 9:01 a.m., LPN 5 was trying to get vital sign readings (blood pressure, pulse, heart rate, and oxygen saturation). Resident P was observed in pain, crying and screaming, and was heard loudly to say stop two times. CNA 9 was sitting on the floor holding her right hand and rubbing her right forearm. The resident indicated to "just kill" her, "just shoot me now", several times. On 11/28/23 at 9:03 a.m., LPN was observed used the nurse's station phone. On 11/28/23 at 9:04 a.m., Resident L indicated to the LPN 5 that Resident P hit her head pretty hard to the handrail. On 11/28/23 at 9:06 a.m., Resident P was loudly			

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	heard saying, she needed an ambulance. On 11/28/23 at 9:08 a.m., Resident L indicated again, Resident P hit her head really hard on the wooden handrail. Resident G was heard loudly saying Resident P's arm (left) and head hurt a lot. On 11/28/23 at 9:09 a.m., Resident P was heard crying on the floor. LPN 5 was heard talking on the phone, he indicated he saw her fall. Then, he called her family and told them she was going to the hospital. On 11/28/23 at 9:12 a.m., the Director of Nursing (DON) arrived on the MC unit and went to the resident on the floor. On 11/28/23 at 9:12 a.m., LPN 5 indicated he would call 911. He told the DON he already took the vital signs. Her blood pressure was 143/88 and her pulse was 88. On 11/28/23 at 9:15 a.m., the DON asked LPN 5 to look and see if she had any pain medications to give. Resident P indicated loudly to the DON, "Just shoot me, the pain." On 11/28/23 at 9:16 a.m., LPN 5 indicated Resident P was just standing next to the wall and fell over. On 11/28/23 at 9:17 a.m., the DON was observed giving her cold water. On 11/28/23 at 9:18 a.m., the Resident indicated loudly, "the pain is terrible." On 11/28/23 at 9:22 a.m., the DON checked Resident P's pupils. This was the first neurological check.			

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	On 11/28/23 at 9:24 a.m., CNA 9 indicated Resident P was walking with Resident L coming back from breakfast when she fell. Resident P was still lying on the floor in severe pain. No pain medications had been given. On 11/28/23 at 9:25 a.m., Emergency Medical Services (EMS) arrived. EMS put her in a cervical collar to protect her neck from spine cord injury. On 11/28/23 at 9:27 a.m., Resident P was screaming, then yelling, "Don't move me!" She repeated it many times. On 11/28/23 at 9:28 a.m., Resident P was picked up by several EMS people and placed on the cart for transport. While on the cart, she was still screaming. One EMS person indicated there was no external bleeding and she had a fractured wrist. EMS was observed exiting the MC area with the resident. On 11/28/23 at 9:29 a.m., the DON indicated Resident P had a broken wrist. On 11/28/23 at 9:29 a.m., LPN 5 was observed with two Tylenol 324 mg blister sealed tablet in his hand. He indicated he was unable to give them to her. On 11/29/23 at 9:05 a.m., Resident P's nursing progress notes were reviewed. A nursing progress noted, dated 11/28/2023 at 9:00 a.m., indicated Resident P had a witnessed fall at 9:00 a.m., in memory care hallway. The nurse noted the resident standing in hallway, in front of her room and was noted to collapse. Nurse and staff unable to catch the resident prior to resident coming in contact with floor. Resident was alert to			

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	self with confusion at baseline. She was unable to give a description of her fall. Resident noted to have on non-skid socks at the time of fall. Resident P was encouraged to use her walker for stability with no successful attempts. Resident noted with steady gait prior to fall and self-ambulating approximately 10 minutes prior. Resident was toileted and ADLS (Activities of Daily Living) were performed before mealtime. Resident noted to have pain to right arm and hip at the time of fall. The resident was left on the floor and consoled by nurse and staff and not moved until EMS arrived for transport to ER, per MD order. The nurse attempted to give PRN (as needed) Tylenol for pain and went to obtain it from the Omnicell (automatic prescription dispensing machine). Upon arrival to the MC unit, the resident was transported to ER and was unable to administer the pain medication. The paperwork and the bed hold policy was provided to EMS and report was called to the ER. Vital signs and neuros (neurological checks) were obtained immediately, at time of fall, and noted in the chart. The resident remained conscious prior to EMS transport. ROM (range of motion) attempted with pain noted to right side and not further assessed related to pain. The DON and MD were notified with orders to not move the resident and send to her to the ER for evaluation and treatment. Her POA (power of attorney) was aware and would meet the resident at the ER. The physician and DON were aware. A nursing progress noted, dated 11/28/23 at 9:15 a.m., indicated the resident declined Tylenol 325 mg, give by mouth every 4 hours as needed for left arm pain. A nursing progress noted, dated 11/28/23 at 3:26 p.m., indicated acetaminophen 325 mg, give 2			

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	tablets every 4 hours as needed for pain. The order, dated 8/11/23, it indicated it was not pulled. A nursing progress noted, dated 11/28/2023 at 5:07 p.m., indicated Resident P returned from the hospital with a closed fracture to the left radius and ulna. It was immobilized and a sling was in place. The resident denied pain at this time. No medication change noted. A nursing progress noted, dated 11/29/2023 at 9:05 a.m., the Interdisciplinary Team (IDT) indicated Resident P had a witnessed fall on 11/28/23. The nurse noted the resident standing in hallway, in front of her room and was noted to collapse. Nurse and staff unable to catch the resident prior to resident coming in contact with floor. Resident was alert to self with confusion at baseline. She was unable to give a description of her fall. Resident noted to have on non-skid socks at the time of fall. Resident P was encouraged to use her walker for stability with no successful attempts. Resident noted with steady gait prior to fall and self-ambulating approximately 10 minutes prior. Resident was toileted and ADLS (Activities of Daily Living) were performed before mealtime. Resident noted to have pain to right arm and hip at the time of fall. The resident was left on the floor and consoled by nurse and staff and not moved until EMS arrived for transport to ER, per MD order. The nurse attempted to give PRN (as needed) Tylenol for pain and went to obtain it from the Omnicell (automatic prescription dispensing machine). Upon arrival to the MC unit, the resident was transported to ER and was unable to administer the pain medication. The paperwork and the bed hold policy was provided to EMS and report was called to the ER. Vital signs and neurological checks were obtained immediately, at time of fall, and noted in the chart.			

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	The resident remained conscious prior to EMS transport. ROM (range of motion) attempted with pain noted to right side and not further assessed related to pain. The DON and MD were notified with orders to not move the resident and send to her to the ER for evaluation and treatment. Her POA (power of attorney) was aware and would meet the resident at the ER. The physician and DON were aware. During an interview, on 12/4/23 at 11:17 a.m., the DON indicated Resident P should not have been moved or a pillow put under her neck prior to having a cervical collar placed. She indicated Resident P should have had pain medication due to her fall, prior to going out with EMS. A current policy, titled, "Pain Assessment and Management," dated 9/12/23, was provided by the Executive Director (ED), on 11/29/23 at 3:10 p.m. A review of the policy indicated, " ...The facility must ensure that pain management is provided to residents who require such services ...." 3.1-17(a) 3.1-37(a)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. 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			

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	in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to meet the needs and wants of the residents and failed to ensure call lights were answered in a timely manner for 6 of 6 days of observation and for 14 of 14 residents interviewed (Residents OO, PP, Z, AA, DD, D, E, BB, CC, EE, FF, GG, HH, and JJ). Findings include: During an interview on 11/27/23 at 11:38 a.m., Resident OO was observed in bed. She indicated, she hoped she would be assisted out of bed so she could go play bingo, but since she required the use a Hoyer lift and two staff members, she would probably not be able to get up since the aides would not have time to get to her. Resident OO indicated she had put her call light on earlier and was still waiting for help to get her brief changed. A smell of urine was noted, and she indicated she had not been changed since the night before. She thought her call light was still	F 0725	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility staff were not given resident identification information for Resident OO, PP, Z, AA, DD, D, E, BB, CC, EE, FF, GG, HH, AND JJ. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of the staffing schedule has been completed reviewing expected staffing PPD and staffing assignments for optimal staff placement for their tour of duty. A special Resident Council meeting was held to review resident concerns regarding	01/04/2024

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	on, but upon observation it was not. She put her call light on and indicated with frustration, "they always do that!" They come in and tell you they will be right back, turn off the light, and you never see them again. Resident OO indicated she had been waiting since 7:00 a.m. to get changed. On 11/27/23 at 11:40 a.m., the Director of Rehabilitation, (DOR) entered Resident OO's room and asked what her call light need was. Resident OO indicated she was still waiting to get cleaned up and the DOR indicated he knew Resident OO had been waiting and would go look for an aide. During a confidential interview, it was indicated there were not enough aides to get all the tasks done. It was almost lunch and there were still several residents that had not even had routine morning cares completed. There were only two aides on the floor at that time for the 300 hall which was not enough. During a confidential interview, it was indicated there was one nurse and two aides for the 300 hall and they were struggling to get all their tasks completed, which included getting residents cleaned up because night sift often left residents in soiled briefs. During a confidential interview it was indicated, a third aide had been on the schedule to help with resident care but got pulled away to accompany a resident to an appointment. During an interview on 11/27/23 at 12:17 p.m., Resident PP indicated she had been waiting since early morning to get up. She preferred to get up out of bed around 9:00 a.m., but she required a Hoyer lift and two aides, so she had to wait.		call light response. The facility staff have been provided with re-education on answering call lights in a timely manner. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of facility staff to respond to and address resident requests with call light use. The DON/designee will be responsible for auditing/observing for call light response across shifts 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or	

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	During an interview on 11/27/23 at 12:19 p.m., Resident Z was observed in bed. A smell of bowel was noted, and he indicated he had a bowel movement (BM) and was still waiting for someone to clean him up. The wound nurse and doctor made rounds earlier that morning but were unable to assess his wound because his brief was soiled with BM, and he was still waiting. On 11/27/23 at 12:50 p.m., Resident Z indicated he was still soiled and waiting for help. During an interview o 11/27/23 at 1:12 p.m., Licensed Practical Nure (LPN) 50 indicated, the last tray for the hall was for a resident that had not been gotten up yet. They did not have enough staff to get her up in time, but she had just sent an aide to go help get her up and into the dining room. On 11/27/23 at 2:32 p.m., Resident Z indicated he had just been cleaned up about 10 minutes earlier. A lunch tray was observed with less than 25% consumed. He indicated he had to eat lunch as he sat in his soiled brief which was why he couldn't eat much. During a confidential interview it was indicated, a third aide had been on the schedule to help with resident care but got pulled away a second time to accompany another resident to an appointment. The appointment went longer than expected so the aide had not returned until 2:09 p.m. During a confidential interview it was indicated, night shift did not do anything. Night shift had much more down time and could use it better to wash laundry and stock the linen closets, stock supplies, and change some residents before morning shift came in. The day shift was so busy		duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	and there were so many things to do, there were not enough staff to get it all done. On day shift, nursing had two meals to deliver and pick up, all resident morning care, ice water pass, showers etc. and there were at least 5 resident who required total assistance with transfers and needed to be fed. During a confidential interview, it was indicated, the Activity Director was pulled from activities to help vacuum the 100 hallway floors. There were not enough housekeeping staff and the meals had been delivered so late, it backed into the activity programming, so activity staff were pulled to help pass trays and clean. During an interview on 11/29/23 at 10:54 a.m., Resident AA indicated there were not enough staff, it was a big problem. One day she waited over 10 hours before she could get out of bed. The call light is a joke, they just come in and turn it off and never come back. During a confidential interview on 11/29/23 at 11:04 a.m., Resident DD indicated she thought the facility was short staffed. The aides they had she really loved and felt bad for them because they worked so hard and never got a break or recognition. "My feeling is that someone sitting in an office somewhere cramming numbers for if you have X number of patients you know you will need X number of staff, but it's not an accurate reflection of what we really need." Resident DD indicated she learned "a trick" to turn on the light before you need something, so that by the time someone comes, hopefully it can get taken care of. Because there weren't enough staff, the staff they did have were often overworked and rushing from place to place and sometimes, "I feel like they would rather be somewhere else than besides			

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	here, and it makes me feel like a burden." On 11/29/23 at 11:19 a.m., a resident interview was attempted, but after three separate interruptions of nursing staff who entered the room to get extra supplies from the resident's closet, the interview was postponed. During a confidential interview, it was indicated, staff constantly interrupted patient care to go into room and find needed supplies. The supply and linen closets were never stocked and in order to get resident care completed, staff had to get items from resident rooms and staff interrupted each other constantly to ask where to find certain items. On 11/29/23 at 12:05 p.m., CNA 9 was overheard in the 100 charting room indicating she couldn't answer lights because she had been told to complete her online required training. On 11/29/23 at 12:07 p.m., the Wound Nurse (WN) indicated CNA 9 had been clocked in since 7:00 a.m. and had not completed any resident care. The WN indicated she should have done resident care first then training in her spare time. On 11/29/23 at 2:35 p.m., the call light for room 117 was noted illuminated and flashed, which indicated it had been on longer than 5 minutes. The Director of Nursing (DON) walked down the hall and passed the room without answering the light. The DON returned up the hall several minutes later at 2:38 p.m. and did not answer the light. During an interview on 11/29/22 at 2:47 p.m., the Staffing Coordinator (SC) indicated she typically tried to keep the PPD (nursing hours allotted per			

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	day per resident) between 3.0 and 3.5 which broke down to 11 CNAs for day/evening and 6 or 7 on nights. Optimal staffing would be 5 CNAs and 1 shower aid for the 100 hall and 3 CNAs for the 100 and 200 halls. When asked how her PPD hours were reflected for CNAs that were pulled away from direct patient care on the floor to go to appointments, she indicated it did not change the allotted PPD. At that time there were 8 open nursing positions, 2 QMA open positions and 6 CNA open positions. The SC indicated there was a high turnover rate, but when asked what the facility did to help retain employees, she did not have an answer. The SC indicated management staff were supposed to help on the floor when they could, and she was also a CNA who could go on the floor to help out if needed. The SC indicated she also served at the Supply Coordinator and sometimes helped inn laundry too. On 11/30/23 at 9:56 a.m., Residents began to gather for a Resident Council meeting. The meeting was scheduled for 10:00 a.m. but was delayed because the Resident Council President was not gotten up on time and did not arrive until 10:12 a.m. The following Residents were present for the meeting; D, E, AA, BB, CC, DD, EE, FF, GG, HH and JJ. Unanimously, the Residents agreed the facility did not have enough CNAs. The "good" CNAs they did have were never helped by the Nurses because they were too busy doing medication pass or charting. The Residents indicated, it was common that a Nurse might come in to answer the call light, turn it off, then say, "I'll go get your aide." The Residents all complained that call light wait times were too long and the lights would be answered but turned off, and no			

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	one would come back. Resident AA indicated she has had to wait up to 10 hours at one time to get a soiled brief change and by then her skin was raw and burning. Resident CC indicated she waited as long as 4 hours one time. Resident BB indicated he would give up on using the call light because it never did any good and made him very frustrated. During the meeting, at 10:35 a.m., Resident F joined the meeting. She indicated she was mad because she wanted to be at the meeting on time. She had been informed of the meeting the previous night and requested to be up on time to come, but she had not been gotten cleaned up or out of bed on time and missed most of the meeting. On 11/30/23 at 12:47 p.m., Resident OO's call light was on and flashed. Licensed Practical Nurse (LPN) 5 was in the hallway on the medication cart next to Resident OO's room. He did not answer the light. During a confidential interview, it was indicated, there were only 2 aides on the 300 hall and at least 3-4 people who still needed routine morning cares completed. It was 12:47 p.m. During an interview on 11/30/23 at 12:52 p.m., Resident DD was observed in her bed as she received her lunch tray. She indicated she preferred to eat sitting up in her chair, but there had not been enough staff to get her up in time, even though lunch was nearly an hour late. On 11/30/23 at 2:25 p.m., two flashing call light were observed illuminated on the 300 hall. The nurse and Qualified Medication Aide (QMA) were busy counting narcotic medications before shift change. The Social Service Assistant (SSA) was			

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	observed as she sat at the nurse's station and did not offer to help answer the call lights. During a confidential interview it was indicated, there were only 4 aides on the 100 hall, and 2 aides on the 200 and 300 halls for a total of 8 Certified Nursing Assistants (CNA). The posted direct care staffing information on the 100 hall nurse's station indicated there were 10 CNAs present. During an interview on 12/4/23 at 11:33 a.m., Resident CC indicated she was very upset because she had to wait for over 7 hours in a soiled brief the night before. She had just had a shower and felt "wonderful and clean," but she had an accident in her brief shortly after because no one answered her call light on time. At that time, Resident CC's roommate corroborated the story and said, they often wait for hours before their needs are met. During a confidential interview, it was indicated, there was no one in laundry, so a CNA was pulled over to wash and dry resident clothing and supplies. The CNA however had never worked in laundry before and did not have anyone to show her what to do, she had to just "figure it out." During a confidential interview it was indicated, there were only 2 CNAs on the 300 hall and about 13 to 14 residents who required extensive to total assistance which made it very hard to get all the responsibilities completed. It was indicated CNAs sometimes did not get to clock out for breaks. On 12/4/23 at 3:39 p.m., Residents AA and DD were observed in bed. Resident DD wore a hospital gown and indicated she had not been assisted out of bed yet. She preferred to get up in her wheelchair in the mornings, but they were			

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	short on staff, and no one had come back to get her up. On 12/1/23 at 4:26 p.m., the Assistant Director of Nursing (ADO) provided copies of the nursing schedules and direct care staffing postings for the survey period and were reviewed at that time. The PPD was calculated to diving the total number of direct care staff hours, by the daily census and were as follows: 11/26/23, PPD = 2.7 11/27/23, PPD = 2.9 (calculated after removing 1 CNA's hours as she was pulled away to an appointment). 11/28/23, PPD = 3.4 (calculated after removing 1 CNA's hours as she was pulled away to an appointment). 11/29/23, PPD = 2.4 (calculated after removing CNA 9, as she had not provided care in lieu of training). 11/30/23, PPD = 3.2 (calculated after removing 2 CNA hours per interview and observation of 4 CNAs on 100 for the day shift). 12/1/23, PPD = 2.7 (calculated after removing 2 CNA hours per review of schedule) The Average PPD during the survey period was 2.8. On 12/1/23 at 3:20 p.m., the Vice President of Operations (VPO) provided a copy of current facility policy titled, "Staffing," reviewed 8/7/23. The policy indicated, "The facility maintains adequate staff on each shift to meet residents' needs, posts daily staffing data and furnishes staffing information to the state as specified in the Federal regulations."			

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	This citation relates to Complaints IN00422417 and IN00422535. 3.1-17(a)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure effective supervision and monitoring of residents with dementia (Residents 4 and 52) for 2 of 3 residents who were reviewed for Dementia care and services, and the facility failed to prevent intrusive wandering into peers' rooms by a resident with dementia for 1 of 3 residents who were reviewed for Dementia care and services (Resident 52). Findings include: 1. On 11/29/23 at 3:40 p.m., Resident 4's medical record was reviewed. He was a long-term care resident and had diagnoses which included but not limited to dementia (a progressive and degenerative brain disease which effects memory), heart disease, and muscle weakness. Resident 4 admitted to the facility on 10/20/23, into room on the 200 hall on the Memory Care Unit. He was subsequently moved four times until his discharge on 11/28/23. A late nursing progress note created on 10/30/23 at 8:15 a.m., but made effective for 10/26/23 at	F 0744	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident #4 has been re-assessed by the IDT for placement within the facility. The care plan has been updated to reflect the current status of the resident. Resident # 52 has been re-assessed by the IDT for placement within the facility. The care plan has been updated to reflect the current status of 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:** Staff interviews have been conducted to determine if other residents have been noted with wandering tendencies not reported or communicated for IDT to complete a review and address	01/04/2024

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	12:30 p.m., indicated Resident 4 had a resident-to-resident altercation. He yelled from his room into the hallway, "she hit me on my arm" and pointed to another resident. They were separated and assessed. An interdisciplinary team (IDT) note, dated 10/27/23 at 1:31 p.m., indicated, "...Resident recently admitted to dementia unit and continues with no concerns at this time. Resident experienced a resident altercation yesterday and has no psychosocial distress noted from the incident ...." The record lacked documentation of an intervention put in place to prevent future altercations. A later IDT note, dated 10/30/23 at 8:44 a.m., indicated Resident 4 had a resident-to-resident incident on 10/26/2023. The nurse had been alerted by Resident 4 as he yelled out from his room into the hallway. He pointed to another resident and indicated, "she hit me on my arm." The other resident was removed from Resident 4's room and the immediate intervention had been to place him on 15-minute safety checks. The record lacked documentation of the 15-minute safety checks. The next day, Resident 4 experienced a second resident-to-resident altercation with another resident. A nursing progress note, dated 10/27/23 at 3:10 p.m., indicated Resident 4 approached his roommate and the roommate stood up and punched Resident 4. They were separated and after they calmed down, the Executive Director		wandering affecting others. The facility staff have been provided with re-education on alerting the IDT of residents wandering affecting others, of completing room move assessment and documentation of, of completing immediate interventions such as 15 minute checks or safety checks, identification of other interventions to prevent future altercations, and care planning changes noted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility staff to ensure effective supervision and monitoring of residents with dementia, to monitor and address wandering affecting others, and to document interventions implemented. The Social Services Director/designee will be responsible for auditing for and/or interviewing facility staff to validate staff have provided effective supervision and monitoring of residents with dementia and follow up with documentation of interventions and room changes 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with	

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	(ED) came and spoke with each resident. As an intervention, Resident 4 was moved to a room on the 300 hall, but a nursing progress note dated 10/27/23 at 11:00 p.m., indicated he returned to his room on 200 hall with all his belongings and remained on 15-minute safety checks. The record lacked documentation of the 15-minute safety checks. A late IDT note, dated 11/2/23 at 8:21 a.m., indicated Resident 4 had a resident-to-resident interaction on 10/27/2023. Resident 4 was heard having a verbal misunderstanding with his roommate. They were separated and redirected. The roommate was taken out of the room and sat in a chair near the nurse's station. Approximately 5 minutes later, Resident 4 was observed as he walked towards his roommate, and before staff could intervene, Resident 4 was punched in the chest by his roommate and sustained a skin tear to his left hand. The Immediate intervention had been to place Resident 4 on safety monitoring and one on one (1:1) with a room change. The record lacked documentation of safety1:1 monitoring. A nursing progress note, dated 11/10/23 at 1:40 p.m., indicated Resident 4 was placed on 15-minute safety checks due to negative statements. A late progress note, dated 11/10/23 at 3:30 p.m., indicated Resident 4 had no desire, thoughts, or plans to hurt himself. He stated he, "just needed a moment" following a room change to calm down. Resident 4 heard another Resident making noises. Resident 4 stated that he would be OK as long as		disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	he could keep his door closed at night. Resident was placed on 15-minute checks to help ensure Resident safety. The record lacked documentation of a reason for the room change. The record lacked documentation of safety checks. An IDT progress note, dated 11/22/23 at 2:16 p.m., indicated Resident 4 was moved off the dementia unit to long-term care with no wandering noted. On 11/30/23 at 12:07 p.m., an interview was conducted with the Social Service Director, (SSD) his assistant (SSA) and the ED present. Resident 4 moved back to the facility from another facility and was placed on the Memory Care unit. He did have several room changes. The ED indicated Resident 4 was moved to a room on the 300 hall after he was hit by his roommate. The roommate was sent out, and so Resident 4 moved back into his original room. The SSD indicated he could not remember exactly, but though one of the room moves was due to family request. He had conducted psychosocial follow up and not noted any changes. The SSA indicated Resident 4 was moved off the Memory Care unit because he was not at risk for elopement. The SSA indicated Resident 4 did make some negative statements shortly after a room change, "something about wanting to shoot himself in the head." The National Institutes of Health study titled, "Health Effects of the Relocation of Patients With Dementia: A Scoping Review to Inform Medical and Policy Decision-Making," dated 11/16/19, "...the health effects of the relocation of older adults suffering from dementia were negative. A			

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	decline in physical, mental, behavioral, and functional well-being was reported. The most recurring effect was a higher level of stress, which is more problematic for patients with dementia. In general, unless it is carefully planned, it is best to avoid changing lives of people with dementia and it is recommended to actively work to reduce their exposure to stress ...." A care plan, initiated 10/22/23, indicated he was at risk for elopement, and staff were to monitor him for safe wandering. The care plan lacked revision that he was on Memory Care but assessed and no longer at risk for elopement. On 12/1/23 at 3:20 p.m., the Vice President of Operations, (VPO) provided a copy of current facility policy titled, "Resident Room Relocation," reviewed 8/9/23. The policy indicated, " ...the Social Service (SS) staff assess the impact of room relocation on the resident's psychosocial status, based on the following criteria: the resident's ability to cope with and adapt to change, how the change will affect the resident's current relationship and social supports and the resident's willingness to move to a new location ...." 2. On 12/4/23 at 11:00 a.m., a resident was heard upset in the hallway. Upon observation, Resident 6 was noted in the hallway outside of her room as she yelled, cried, pointed, and even kicked out at a staff member. She pointed into her room. At that time, another staff member entered the room and assisted Resident 52 out of the room. Resident 6 was assisted back into her room with a staff member to help calm her down. During an interview on 12/4/23 at 11:33 a.m., Resident CC indicated Resident 52 would often wander into her room and move things around			

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and steal things. Resident 52 was confused and needed to go back to the memory care unit. Resident 52 had gone into Resident 6's room earlier and it made her so mad she did it all the time.

During an interview on 12/4/23 at 11:40 a.m., Resident JJ indicated Resident 52 went in and out of all the rooms down the 100 hall and there were not enough staff to watch her and get her before she would go in. It really made Resident 6 mad.

On 12/4/23 at 12:08 p.m., Resident 6 was observed. She was seated in her wheelchair in the doorway of her room. She was still upset. Tears were observed in her eyes, and although she could not be verbally understood due to her aphasia, she scrunched her face and made upset sounds as she pointed down the hallway toward Resident 52.

During an interview on 12/4/23 at 12:10 p.m., the Wound Nurse (WN) indicated Resident 52 wandered into other resident's rooms quite often. She used to be in the Memory Care unit, and the WN did not know when or why she was moved off the unit.

During a confidential interview, it was indicated several residents had been moved off the Memory Care Unit and put into the long-term care hallway. They would wander into the other residents' rooms, especially Resident 52, and make other residents upset. It was indicated there were not enough staff member to supervise them to stop them from going into others' rooms, and what staff were on the halls they were too busy with resident care to stop her too.

On 12/4/23 at 3:16 p.m., the Regional Nurse Clinical Specialist (RNCS) provided a copy of

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	current facility policy titled, "Care of the Cognitively Impaired, (Dementia Care)," reviewed 8/22/23. The policy indicated, " ...The facility will provide dementia treatment and services which may include, but are not limited to the following ...ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety ... identify, address and/or obtain necessary services for the dementia care needs of residents, develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment ... modify the environment to accommodate resident care needs ...." Cross Reference F725 and F689. 3.1-37			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure blood glucose monitoring was obtained for a resident with diabetes mellitus with insulin to manage (Resident FF), failed to ensure a resident's medications had an appropriate diagnoses for use and an indication for medication use (Resident X), and failed to provide documentation pharmacy review of medications (Resident 4) for 3 of 5 residents reviewed for unnecessary medications. Findings include: 1.A comprehensive record review was completed for Resident FF on 11/27/23 at 2:45 p.m. He had the following diagnoses which included but were not limited to heart disease, type 2 diabetes mellitus, hypertension, bipolar disorder, neuropathy, contracture of left and right wrist, contracture of right knee, contracture of left and right ankle, and hyperlipidemia. Resident FF had an order, dated 6/10/23, for Basaglar Kwikpen subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 12 units subcutaneously at bedtime related to type 2 diabetes mellitus without complications. Staff were to call the physician if blood glucose was below 70 or above 450. Resident FF's blood sugars were not assessed daily. Over the past 90 days, his blood sugar was	F 0757	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility staff were not given resident identification information for Resident FF, X. Resident #4 has been reviewed by the IDT for the pharmacy consultant recommendations and the care plan has been updated to reflect the current status of the resident. The pharmacy recommendations have been added to the medical record for Resident #4. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time audit of current resident population has been completed reviewing residents with diagnosis of Diabetes Mellitus and blood glucose monitoring needs. A one-time audit of new admissions for the past 30 days, 11/27/23-12/27/23, has been completed to validate indications for use of medications are provided with medications ordered. A	01/04/2024

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	checked 4 days: On 11/16/23 result was 234, 11/09/23 result was 199, 11/07/23 result was118, 9/4/23 result was 118. During an interview with the DON on 12/4/23 at 1:30 p.m., she indicated he didn't have an order to check his blood sugars. 2. A comprehensive record review was completed for Resident X. She had the following diagnoses which included but were not limited to hyperlipidemia, migraine, history of urinary tract infection, unspecified dementia, multiple sclerosis, hypertension, muscle weakness, and history of falls. Resident X was prescribed an antibiotic called Cipro. The diagnoses for use were omitted. Upon further investigation of her record, it was discovered she received cipro prophylactically for dysuria (painful urination) and urinary incontinence. She received other medications that lacked an indication for use. a. Atorvastatin 40mg (a medication used for high cholesterol) at bedtime. b. Calcium Carbonate (a supplement) 600 milligram (mg) daily. c. Cholecalciferol (a supplement) tablet 50 mcg (2,000 UT) daily. d. Folic acid (a supplement) 80.8 mg daily. e. Glatiramer Acetate Subcutaneous Solution Prefilled Syringe (use to treat multiple sclerosis) 40 mg/ml every Monday, Wednesday, and Friday. f. Losartan Potassium (a medication for high blood pressure) 25 mg, ½ tablet daily. g. Memantine HCL (a medication used to treat dementia) 10 mg at bedtime. h. Prednisone (a steroidal medications) 2.5 mg		one-time review for the past 30 days, 11/27/23 – 12/27/23, has been completed of pharmacy recommendations to validate the recommendations are available in the medical records. The IDT has been provided re-education on monitoring of diabetic residents for blood glucose levels, indications for use of medications are part of the physician order, and pharmacy recommendations are to be available in the medical records. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of Licensed Supervisory Nurses and the IDT to ensure monitoring blood glucose levels are part of the physician orders, indications for use of medications are present as part of the orders, and pharmacy recommendations are available in the medical records. The DON/Designee will be responsible for auditing resident blood glucose levels are obtained as per MD order, indications for use of medications is part of the order for new admission and readmissions, and pharmacy recommendations are available in the medical records 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be	

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	daily. During an interview with the Director of Nursing (DON) on 12/4/23 at 1:30 p.m., she acknowledged the medications lacked an indication for use. A policy titled "New Order for Non-Controlled Substances," dated 1/1/22, was provided by the Executive Director (ED) on 12/4/23 at 1:57 p.m. It indicated, " ...the facility should provide new admission order to the pharmacy using a completed and reconciled physician's order sheet, telephone order sheet, or an electronically transmitted medication order. A new order should include the reason for use.3. On 11/29/23 at 3:40 p.m., Resident 4's medical record was reviewed. He was a long-term care resident and had diagnoses which included but not limited to dementia (a progressive and degenerative brain disease which effects memory), heart disease, and muscle weakness. Resident 4 admitted to the facility with a physician's order for Sertraline (an antidepressant medication) 50 mg (milligrams) daily. A nursing progress note, dated 11/12/23 at 11:05 p.m., indicated the consulting Pharmacist made individual recommendations and to review full report for details. A nursing progress note, dated 11/13/23 at 1:51 p.m., indicated Resident 4 was started on buspirone (an antianxiety medication) 5 mg two times a day. A nursing progress note, dated 11/13/23 at 8:44 p.m., indicated Resident 4 had several medicine changes.		immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	A nursing progress note, dated 11/22/23 at 4:11 p.m., indicated Resident 4's sertraline (an antidepressant medication) was increased from 50 mg to 75 mg. Resident 4's comprehensive care plans reviewed and lacked implementation and/or revision to include goals/approaches/interventions for the use of his antianxiety and antidepressant medication. On 11/26/23 Resident 4 sustained a fall from his wheelchair. A nursing progress note, dated 11/26/23 at 7:35 p.m., indicated Resident 4 ambulated backwards into the door in his wheelchair. A bruise was noted on his right elbow and a small skin tear was noted on his right wrist. At the time of the fall he complained of soreness to his right side, his ribs. On 11/28/23 he was sent to the hospital but transferred to another hospital for the trauma unit. A corresponding hospital report, dated 11/28/23, Resident 4 had "minimally displaced right sided rib fractures spanning the sixth through ninth ribs and segmental fractures noted at the seventh through ninth levels." On 11/30/23 at 12:12 p.m., copies of Resident 4's pharmacy recommendations were requested of the Executive Director. On 12/1/23 at 1:00 p.m., copies of Resident 4's pharmacy recommendations were requested of the Executive Director. On 12/4/23 at 3:16 p.m., copies of Resident 4's pharmacy recommendations were requested of the Director of Nursing.			

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	As of survey exit Resident 4's pharmacy recommendations were not provided for review. 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)			
F 0761 SS=E 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 §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.			

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	Based on observation and record review, the facility failed to date eye drops and insulin pens and failed to remove expired eye drops from the medication carts for 2 of 3 medication carts observed (Resident 11 and 22). Findings include: 1. On 11/29/23 at 1:27 p.m. the 100 hall medication cart 3 was observed to have eye drops belonging to Resident 11. There were 3 eye drops of his with no dates on the medications. a.) Refresh was undated. b.) Dorazalamide-Timolol was undated. c.) Alphagan 0.1% was undated. 2. On 11/29/23 at 1:45 p.m., the 100 hall medication cart 2 was observed to have eye drops belonging to Resident 11. The eye drops were expired. Rocklatan 0.05% were dated 10/2/23. The manufacturers recommendation was to keep eye drops in the refrigerator at a temperature of 36 degrees Fahrenheit to 46 degrees Fahrenheit until the bottle was open. Once the bottle had been opened, the drug could be kept at room temperature for up to 6 weeks. There was a pen of Lantus insulin on the cart belonging to Resident 22. The pen was missing a label. It had her name and room number written on the pen. Resident 22 had a pen of Humalog insulin. The pen was not dated. A policy titled, "Storage and Expiration Dating of Medications, Biologicals" dated 8/7/23 was provided by the Executive Director on 11/29/23 at 3:10 p.m. It indicated, " ...Once any medication or	F 0761	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The eye drops for Resident #11 were removed and discarded according to facility policy. The insulin pen for Resident #22 was re-ordered with label attached, and the other insulin pen was re-ordered to ensure medication was not outdated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of medications carts on each unit has been completed to validate there were no other expired eye drips, insulin pens were labeled with resident name and directions, and insulins were dated as opened. The Licensed Supervisory Nurses have been provided re-education on medication storage policy and procedures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the Licensed Supervisory Nurses to date medications upon opening, and to remove expired medications. The Director of Nursing/designee will be	01/04/2024

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	biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions. 3.1-48(j) 3.1-48(m) 3.1-48(n)		responsible for auditing medication carts on each unit 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months to validate insulins are dated upon opening, and expired medications are removed from the med cart at time of expiration. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this	

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			plan of correction.	
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, record review, and interview, the facility failed to provide diets and fluids according to residents' orders for 2 of 2 residents reviewed for diet orders (Residents 40 and 91). Findings include: 1. A comprehensive record review was completed	F 0803	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Residents #40 and 91's diet orders and fluid consistency have been reassessed by the IDT to validate the correct orders are in	01/04/2024

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	for Resident 40 on 11/29/23 at 10:15 a.m. He had the following diagnoses which included but were not limited to hypertension, chronic pain, obstructive uropathy, peripheral vascular disease, and malignant neoplasm of prostate. Resident 40 had a diet order, dated 11/1/23, for a regular diet, mechanically altered texture, nectar mild consistency. During an observation on 11/27/23 at 1:30 p.m., Resident 40 was served a lunch tray with regular fluids. Staff removed the fluids from his tray and did not replace his fluids with nectar thickened liquids. Resident 40 was yelling out that he was choking and needed fluids. RN 17 was made aware that Resident 40 had no fluids. While waiting for fluids, Resident 40 attempted to take a spray bottle of water and squirt into his mouth. During an observation on 11/28/23 at 3:07 p.m., Resident 40 had a glass of ice water on his bedside table. CNA (Certified Nursing Assistant) 14 indicated he had regular fluids not nectar consistency as ordered. She removed the water and replaced with nectar thickened water. Resident 40 indicated he was not going to drink that because it made him gag. 2. A comprehensive record review was for Resident 91 on 11/30/23 at 1:12 p.m. He had the following diagnoses which included but were not limited to cerebral hemorrhage, difficulty swallowing, and hemiplegia and hemiparesis. Resident 91 had an order, dated 9/30/23, for regular diet puree texture, nectar, mildly thick consistency. On 11/27/23 at 1:00 p.m., Resident 91 was served a		place. The care plans have been updated to reflect the current status of the residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of residents with mechanically altered diets or thickened liquids has been completed validating the orders are accurate. The facility staff have been provided with re-education on serving the accurate diets as per the resident orders, of replacing liquids with the ordered consistency if fluids are removed from meal tray or room, if therapy is working with resident on meal advancement, the tray is not served to the resident until therapy staff are in attendance, and to intervene with residents when not following physician orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of facility staff to serve the correct diet and liquid consistency. The Dietary Manager/Designee will be responsible for auditing meal trays at time of service to validate the meal and liquids being served are per physician order 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks,	

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	mechanical soft diet with regular liquids. The liquids were removed from the tray and replaced with nectar thickened liquids. Resident 91 started eating the mechanical soft diet without supervision. The Speech Therapist (ST) came in and sat down with Resident 91 to observe him. ST indicated she had gone to the kitchen to get a mechanically soft meal to observe him with the upgraded diet (mechanical soft). She indicated the diet that was sent to him was an error. Resident 91 had consumed 50% of his meal before ST made it to the room. A policy titled, "Therapeutic and Modified Diets" was provided by the DON on 11/29/23 at 12:08 p.m. It indicated, " ...Therapeutic diets are prepared and served according to physician orders. Therapeutic diets are ordered to assist in managing problematic health conditions. When medically possible, the least-restrictive diet is used. Pre-thickened beverage is used to the extent possible. A commercial thickener may be used when pre-thickened beverages are unavailable. The manufacturers' direction for commercial thickeners are followed to obtain the desired consistency ...." 3.1-20(i)(1)		and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	
F 0804 SS=F 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			

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	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 timely meal service, failed to maintain food temperatures before serving meals to residents, and failed to provide appealing meals per resident preference and repeated complaints. This deficient practice had the potential to effect 102 of 102 residents who were served from the kitchen. Findings include: 1. During the initial pool sample selection of the survey, the majority of residents interviewed complained about the food. The residents' general consensus was that meals were served late, the food was cold, they were not allowed to be warmed up, and the food looked and tasted awful. On 11/27/23 at 12:23 p.m., a lunch observation was conducted. An uncovered, uninsulated metal rolling rack was pushed from the service hall into the lobby. The Business Office Manager was noted to hold the door open as Cook 4 went to get a second tray. A cold breeze was felt as it drafted from the service hall and past the rack of food. At 12:30 p.m., the lunch rack was delivered to Memory Care. Four lunch trays were noted to be uncovered. The nurse was made aware of the	F 0804	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No specific resident was 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 of the facility have the potential for having issues with meal services. A one-time review of the scheduled meal time service and activities schedule has been completed to validate meal times are not interfering with the activity schedule. A special Resident Council meeting has been held addressing dietary concerns, their ability to have take out food if desired, and of the availability of the Registered Dietitian. The Dietary staff have been provided with re-education on meal preparation and presenting palatable meals, of expected serving temperatures, of timely serving of meals as per established schedule, honoring	01/04/2024

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	uncovered plates and requested they not be served. At 12:43 p.m., lunches were still being served in Memory care and temperatures were requested. A lunch tray from a resident who was out for an appointment was sampled. The lid was removed and the chicken and rice with broccoli stew was observed discolored and yellowed as it had sat for at least 20 minutes before it was served. Cook 4 tempted a large stem of broccoli from the stew and indicated it was 118 degrees. He temped the corner of a cooked carrot and it was 106 degrees. Cook 4 indicated it was too cold and should be served at 145 degrees. At 1:10 p.m., trays were still being served on the 300-hall and the temperatures were requested for a second tray. During an interview o 11/27/23 at 1:12 p.m., Licensed Practical Nure (LPN) 50 indicated the last tray for the hall was for a resident that had not been assisted up yet. They did not have enough staff to get her up in time, but she had just sent an aide to go help get her up and into the dining room. At 1:20 p.m., as the last resident was being assisted up, Cook 4 temped the corner of a piece of chicken and indicated it was 92 degrees and the vegetables were 86 degrees. He indicated it was too cold and he removed the tray to get a new one. 2. On 11/27/23 at 10:12 a.m., a Resident Council Meeting was conducted. The following Residents were present for the meeting; D, E, AA, BB, CC, DD, EE, FF, GG, HH		resident dislikes or providing alternate food items if resident is allergic to food items, of having alternate meal available as per menu, of posting the menu to allow residents to be aware of menu, and of following the cleaning schedule of dishes to avoid late service of meals. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the Dietary Staff to provide meals per meal times, honoring resident likes/dislikes/allergies, and providing palatable meals. The Dietary Manager/Designee will be responsible for auditing/observing meal services to validate meals are served on time, meal temperatures are palatable temperatures at service, and resident likes/dislikes are honored 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Administrator. **How the corrective action will be monitored to ensure the**	

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	and JJ. Unanimously, the Residents agreed the food service was "awful." They had repeatedly complained but nothing was ever done about it. Cross reference F565- Resident Council Grievance Response review. During Resident Council, the residents indicated the food was always late, and always cold. They were no longer allowed to use a microwave to reheat meals, and no one would ever get them a new tray if they asked. Often the food they were supposed to be served was not what was prepared. They complained rice was not cooked thoroughly, the fried potatoes were not cooked through, they never got good eggs, and the oatmeal was too watery. The resident's indicated they never got a choice about the food, and everyone was served the same thing whether they wanted it or now. Cook 4 had told them if they wanted something different they should let him know before 10:00 a.m., but the residents did not think that was fair since they never knew what they would get, so how could they ask for something different if they wanted? They used to put a copy of the menu in with the Daily Chronical so they could choose what they wanted for the day, but now they were never given a menu. The resident's complained the Registered Dietitian (RD) never came to speak with them. They did not know who the RD was. Meals would come so late they missed activities. Once a month they used to be able to pick and choose food orders from a restaurant, but the ED said they couldn't waste facility money like that and took that away too. 3. On 11/28/23 at 10:03 a.m., Resident Z was observed. He laid in bed and had eaten less than 50% of his breakfast. A bowl of unidentifiable food was observed. There was deep layer of		**deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	standing water, and when asked what it was, Resident Z indicated it was supposed to be oatmeal, but it was too watery, and he did not want to eat it. On 11/29/23 at 9:24 a.m., the Activity Director (AD) was observed to vacuum a section of the 100-hall carpet. She indicated breakfast had come out and backed into the scheduled activity, so it had to be cancelled. While she waited for meals service to be over to start her next activity, she had been pulled to help housekeeping since they were short staffed. 4. On 12/1/23 at 11:24 a.m., during a puree observation, 4 racks of room trays from breakfast were observed. They had not been scraped or loaded into the dishwasher. At that time, Cook 55 indicated the dishwasher had not come in that morning and she was leaving for the day. Cook 55 indicated they needed more staff, it was just her, the dishwasher and Cook 4. There was one new girl, but she was still training and not very helpful. During an interview on 12/1/23 at 11:26 a.m., Cook 4 indicated lunch would probably be late because he still needed to turn over the breakfast trays and get them washed. He indicated they needed more help. On 11/29/23 at 3:10 p.m., the ED provided a copy of current facility policy titled, "Meal Service," reviewed 8/24/23. The policy indicated, "Each resident is served a minimum of three well-balanced, attractive meals per day ...." On 11/28/23 at 4:28 p.m., the ADON provided a copy of current facility policy titled, "Sanitation and Maintenance," revised 4/26/23. The policy indicated, "The Director of Food and Nutrition			

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	Services is responsible for ensuring that the department is maintained according to the standards of sanitation and in compliance with federal, state and local requirements ... prepared food should be transported to other areas properly covered, inside closed food carts, or covered containers ...." On 11/29/23 at 12:08 p.m., the Business Office Manager (BOM) provided a copy of current facility policy titled, "Resident Dining Services," revised 4/26/23. The policy indicated, "The facility has an established process to ensure food is served in accordance with professional standards for food service safety and in a safe, clean, homelike environment. Dining Services will include foods served timely, at proper temperature, diets served according to physician orders and appropriate assistance provided to meet the individual needs of the residents to create a pleasant experience ... to ensure timely delivery of meals, it is suggested that facility associates refrain from taking breaks during resident dining ...." On 11/29/23 at 12:08 p.m., the BOM provided a copy of current facility policy titled, "Food Temperature Control," revised 4/25/23. The policy indicated, "Food temperatures are maintained during mealtimes to ensure residents receive safe food served at acceptable temperatures ... hot food are held at a minimum of 135 degrees or per state requirements ...." This citation relates to Complaints IN00422417 and IN00422535. 3.1-21(a)(1) 3.1-21(a)(2)			

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F 0812 SS=F 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 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. A. Based on observations, interviews and record review, the facility failed to ensure the kitchen was maintained in a general state of cleanliness, failed to ensure proper label/dating of foods, failed to remove expired items from rotation, failed to ensure hair restraints were in use during food preparation and failed to cover foods during meal preparation to prevent the potential for contamination. This deficient practice had the potential to effect 102 of 102 residents who were served from the kitchen. B. Based on observations and interviews, the facility failed to ensure staff utilized hand hygiene during meal service for 2 of 2 dining observations	F 0812	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The bulk storage containers were removed from the dry storage area and discarded. The thick and easy bottles were removed and discarded, the bucket of chicken base was removed and discarded. The storage rack was cleaned of debris. The facility staff were not provided with resident identifier information for Residents G, MM,	01/04/2024

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	observed in Memory Care (Residents G, MM, NN, U, and P) Findings include: A1. On 11/27/23 at 9:46 a.m., in initial kitchen tour was delayed when the Executive Director (ED) requested the tour not to be conducted until the cook arrived. The ED indicated there was no kitchen manager but Cook 4 was filling in and on his way. She indicated Cook 55 could assist until Cook 4 arrived. Cook 55 arrived back from delivering breakfast trays at 9:55 a.m., and the tour was initiated. Dry storage was observed first. There were two unlabeled and undated large plastic bulk storage containers. Cook 55 indicated they were cornmeal and breadcrumbs. At 10:10 a.m., Cook 4 arrived and the walk-in refrigerator was observed. There were two bottles of "thick and easy" which were open and expired. There was an open bucket of chicken base which was not labeled or dated. The grated metal storage rack was observed to have built up debris and what appeared to be mold. Cook 4 indicated stock should be inventoried weekly and expired items should be removed. He had not had a chance to get to it because they were short staffed in the kitchen. He did not know what the black substance on the storage racks were and indicated they needed to be cleaned. 2. On 12/1/23 at 10:16 a.m., the kitchen was visited for a second time to inquire and schedule a time to watch the puree process. Upon entrance to the kitchen, Cook 4 was observed to be sweeping a copious amount of debris observed on the floor.		NN, U, and P. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of the dietary department has been completed validating foods are labeled and dated, no expired food/liquid items are present, and storage racks are free of debris. Dietary staff have been provided with re-education on hand washing procedures, use of facial hair covers during food preparation, of not using fans or avoiding other causes of wind in the kitchen area during meal preparation, of not using bare hands during meal preparation, even on utensils, of pots, pans, dishware, and equipment being completely air dried before use, of cleaning schedules, of labeling food items, and of removing expired food items. Nursing and Activity staff have been provided re-education on hand sanitation following touching contaminated objects between service of residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of facility staff to serve and prepare food in sanitary conditions. The Dietary Manager/Designee will be	

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	He indicated a company came out the night before to work on the sprinkler system and one of the sprinklers malfunctioned and made a huge mess. Ceiling tiles were observed missing and some wires dangled from the hole. There were two large pans of cooked brownies that were uncovered. Cook 4 continued to sweep the floor directly under the uncovered brownies. 3. Cook 4 indicated he would start the puree process around 11:00 a.m. On 12/1/23 at 11:12 a.m., a final visit to the kitchen was conducted to watch the puree process. Upon entrance into the kitchen, Cook 4 was observed leaning over the two large pans of brownies and cut them into small squares. He did not wear a beard restraint. The SSA was noted at the stove stirring a large pot of food. She indicated she helped in the kitchen a lot since they were short staffed. She indicated she was preparing Al-Gratin potatoes. There were three large pans of cut potatoes was observed next to the stove, and two pans of frozen dinner rolls on top of the hot box also uncovered. The kitchen floor was wet, and there was a large fan turned on high, which blew across the floor directly under the brownies and circulated the air above the uncovered potatoes and rolls. At 11:15 a.m., Cook 4 began the process of pureeing the vegetables. He started to wash his hands, but after putting soap in his palm, he put his hand directly under the running water, no lather was made and his handwashing duration		responsible for observing the dietary staff and kitchen area to validate food and liquid items are labeled and dated, expired items are discarded, fans or other causes of wind are controlled or not in use during meal service, hand washing is completed per policy, and beard covers are in place during food service preparation 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas	

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	was only a few seconds long. He measured out 5 portions and put them in a blender. The blender was not completely dry and some water was observed at the bottom. When asked if it should be dry, he indicated no, since it was going in the hot box to bring it back to temperature. He grabbed a metal tablespoon to measure out thickener. He ran the spoon under cold water and rubbed it with his bare thumb. At the sink where he rinsed the spoon, a large plastic bucked which contained an orange beverage was observed in the sink. There was no label or date as a kitchen assistant poured the beverages into cups for lunch. When he was finished, Cook 4 washed his hands a second time. He rinsed the soap from his hands before a lather and the duration was only a few seconds long. On 11/28/23 at 4:28 p.m., the Assistant Director of Nursing (ADON) provided a copy of current facility policy titled, "Food Safety," revised 4/26/23. The policy indicated, "Food is stored and maintained in a clean, safe and sanitary manner following federal, state, and local guidelines to minimize contamination and bacterial growth ... the "use by date" guide is easily accessible to all associates involved with resident food storage ... foods are prepared and served with clean [utensils] ...." On 11/28/23 at 4:28 p.m., the ADON provided a copy of current facility policy titled, "Cleaning Schedule," reviewed 2/45/23. The policy indicated, "The Director of Food and Nutrition Services develops a cleaning schedule, with assistant form the Registered Dietician, to ensure that the Food		of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	and Nutrition Service department remains clean and sanitary at all times ... the cleaning schedule is posted in a location where it can be easily read ...." On 11/28/23 at 4:28 p.m., the ADON provided a copy of current facility policy titled, "Sanitation and Maintenance," revised 4/26/23. The policy indicated, "The Director of Food and Nutrition Services is responsible for ensuring that the department is maintained according to the standards of sanitation and in compliance with federal, state and local requirements ... all food grinders, choppers, slicers, mixers etc. should be cleaned, sanitized, dried and reassembled after each use ... physical facilities are cleaned as often as necessary to keep them clean. Cleaning is done during periods when the least amount of food is exposed ...." B1. On 11/27/23 at 12:33 p.m., sixteen residents were observed in the MC dining room when lunch arrived. On 11/27/23 at 12:33 p.m., the MC Activity Assistant (MC AA) was observed to touch Resident G's and Resident MM's napkins. He did not wash his hands and served one tray to an unidentified resident. The MC AA served Resident NN's lunch tray, then without hand hygiene, served Resident U's lunch tray. On 11/27/23 at 12:56 p.m., CNA 7 was observed pulling out a chair beside Resident MM. She did not use hand hygiene and began assisting the resident with eating. 2. On 12/01/23 at 8:37 a.m., eleven resident were observed having breakfast in the MC dining room. CNA 27 was observed moving a stand up lift in the MC hallway. Without hand hygiene, she served breakfast to an unidentified resident.			

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	Again, without hand hygiene she served breakfast to Resident P. On 12/01/23 at 8:50 a.m., CNA 27 was observed moving the breakfast tray cart with her bare hands, Resident P asked for sugar, without hand hygiene, she opened the sugar into her oatmeal and picked up Resident P's spoon, stirred her oatmeal, and left the spoon in the bowl. On 12/04/23 at 11:21 a.m., the Director of Nursing (DON) indicated hand hygiene should have been completed between residents and when a resident was visibly soiled. A current policy, titled, "Resident Dining Services," dated 4/26/23, was provided by the Executive Director (ED), on 11/29/23 at 3:10 p.m. A review of the policy indicated, " ...The resident has a right to a safe, clean, comfortable and homelike environment ...The facility must store, prepare, distribute and serve food in accordance with professional standards for food service safety ...." This citation relates to Complaints IN00422417 and IN00422535. 3.1-21(i)(1) 3.1-21(i)(3)			
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.			

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

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(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
	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 glucometers (machines to take blood sugars) were cleaned between residents and in a manner to ensure the machines were disinfected for 4 of 5 observations of Accuchecks (Residents 62, 67, 80, and 94). Findings include: 1. During an observation on 11/30/23 at 11:55 a.m. Qualified Medication Aide (QMA) 16 collected supplies for Accuchecks (test to check blood sugar levels in blood) and placed them in a cardboard box. The glucometer was not observed to be cleaned prior to use. QMA 16 used the glucometer to perform an Accuchecks on	F 0880	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident # 62 has been assessed by a Registered Nurse for signs and symptoms of infection on hands or fingers in relation to accucheck readings. The facility was not provided resident identifier information for Residents 67, 80, and 94. The QMA was provided re-education on cleaning glucometers immediately upon identification of improper procedures.	01/04/2024

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	Resident 62. All supplies were placed back into the cardboard box and QMA 16 left the resident's room. The glucometer was not cleaned after use. On 11/30/23 at 12:01 p.m., QMA 16 entered Resident 67's room with the Accuchecks supplies and glucometer. The glucometer was not cleaned prior to use. QMA 16 cleaned the resident's finger with an alcohol swab and fanned her finger with his hand to dry it. Then took the resident's Accuchecks. The glucometer was not cleaned after use. On 11/30/23 at 12:06 p.m., QMA 16 entered Resident 80's room with the glucometer and Accuchecks supplies in the cardboard box. QMA 16 placed cardboard box on resident's bedside table without a barrier. After going into the resident's bathroom to wash his hands. QMA 16 donned gloves and then realized he did not have enough alcohol swaps in box. QMA16 left the resident's room to get more without telling the resident. At 12:10 p.m. Resident 80 started searching through the box that was left. Resident 80 touched strips and lancets numerous times. QMA16 returned bathroom to rewash his hands and donned gloves. QMA 16 cleaned the resident's finger with an alcohol swab then fanned her finger to dry it. After using the lancet to puncture the resident's finger for a blood sample, QMA 16 placed the used lancet in the box on Accuchecks supplies and placed the used glucometer on top. The glucometer was not observed to be clean before or after the Accuchecks. During an interview on 11/30/23 at 12:14 p.m., QMA 16 indicated there was one glucometer per cart. The glucometer was cleaned at beginning of their shift and at the end of their shift. QMA 16		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The glucometers were cleaned on each unit per facility policy. Licensed Supervisory Nurses and QMAs were provided re-education on glucometer cleaning following the identification of improper procedures, the importance of not fanning the cleansed area when obtaining accucheck readings, of avoiding use of carry all container for accucheck supplies, of keeping accucheck equipment out of reach of residents, not to be left at bedside, hand hygiene when hands have been contaminated, and of discarding the used lancets in the sharps containers. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of Licensed Supervisory Nurses and QMAs to clean glucometers as per facility policy before using glucometer with another resident. The DON/Designee will be responsible for observing accucheck procedures for the machines following use 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. Any issues identified will be	

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	indicated they may clean the glucometer done checking residents' blood sugars. QMA 16 used the Sani wipes on the medication cart. QMA 16 indicated they would wipe the glucometer for 20 to 40 seconds. QMA 16 showed the wipes they used; Sani-cloth in the purple container. QMA 16 demonstrated cleaning the glucometer with the Sani wipe at 12:17 p.m. On 11/30/23 at 12:18 p.m., the Director of Nursing (DON) was notified of observation concerns and indicated the glucometer should be cleaned between residents. The policies for blood glucose monitoring and cleaning of glucometers policy were requested. On 11/30/23 at 12:21 p.m., Licensed Practical Nurse (LPN) 32 cleaned the glucometer with a Sani-cloth from the purple canister. At 12:22 p.m., LPN 32 dried the wet glucometer off with a paper towel. She donned gloves and entered Resident 94's room with the glucometer and supplies. She placed the Accuchecks supplies on the bedside table and went to the bathroom to dump his urinal that had been sitting on the bedside table. LPN 32 changed gloves but did not perform hand hygiene. LPN 32 cleaned the resident's finger with an alcohol swab and then fanned the finger. LPN 32 placed the used glucometer in Accuchecks supplies box. The glucometer was not observed to be cleaned. a. On 11/30/23 at 12:57 p.m. Resident 62's medical record was reviewed. The resident had a diagnosis of Diabetes Type 2. A physician order, dated 4/1/23, indicated to administer Humalog (insulin) per sliding scale: if blood sugar was 151 to 200 give 2 units (u); 201 to 250 give 4 u; 251 to 300 give 6 u; 301 to 350 give 8u; 351 to 400 give 10u; and 401 to 450 give 12u.		immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	b. On 11/30/23 at 2:20 p.m., Resident 67's medical record was reviewed. The resident had a diagnosis of Diabetes Type 2. A Physician order, dated 3/27/23, indicated to administer Novolog (insulin) per sliding scale: if 200 to 250 give 2 units; 251 to 300 give 4 units; and 301 to 350 give 6 units. c. On11/30/23 02:10 PM Resident 80's medical record was reviewed. The resident had a diagnosis of Diabetes Type 2. A Physician order, dated 11/28/23, indicated to give Insulin Aspart per sliding scale 350 give 8 Units; 351 to 400 give 10 Units ; and 401 to 450 give 12 Units d. On 11/30/23 at 12:48 p.m., Resident 94's record was reviewed. The resident had a diagnosis of Diabetes Type 2. A Physician order, dated 10/30/23, indicated to perform Accuchecks before meals and at bedtime. On 12/4/23 at 10:43 a.m., the Vice President (VP) of Operations provided a current policy titled, "Blood Glucose Monitoring," last revised 9/15/23. The policy indicated, " ...Associates who obtain capillary blood glucose specimens will do so in accordance with their scope of practice and in accordance with all applicable local, state, and federal guidelines. Specimens will be collected in a manner that adheres to current standards of practice and infection control standards ...This facility will utilize the Lippincott procedure ...." On 12/4/23 at 10:43 a.m., the Vice President (VP) of Operations provided a copy of the Lippincott procedure. The procedure indicated, " ...The Centers for Disease Control and Prevention recommends refraining from sharing blood glucose monitors among residents whenever			

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	possible. If one device must be used to monitor several residents, it must be cleaned and disinfected after every use ...Use an antiseptic pad to thoroughly clean the intended puncture site. Allow the site to dry completely before obtaining a blood sample ...." 3.1-18(b)			
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.			

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	§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to ensure residents had the opportunity to received influenza, pneumonia, and COVID-19 vaccinations for 5 of 5 residents reviewed for vaccinations (Resident Q, W, M, R, and N). Findings include: On 12/04/23 at 3:06 p.m., five residents were reviewed for their immunization status based on infection control standards. a. Resident Q's electronic chart indicated for her influenza vaccination; the immunization was	F 0883	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility was not provided with resident identifier information for Residents Q, W, M, R, N. Facility staff did assist with showing the surveyor the documentation of where vaccinations had been offered, declined or received depending on resident request,	01/04/2024

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	requested. Her pneumonia vaccination showed an undated refusal. Her Covid-19 indicated a consent was required. b. Resident W's electronic chart indicated for his influenza vaccination; the immunization was requested. c. Resident M's electronic chart indicated for her influenza vaccination; the immunization was requested. Her pneumonia vaccination showed an undated refusal. Her Covid-19 indicated a consent was required. d. Resident R's electronic chart indicated for her influenza vaccination; the immunization was requested. Her pneumonia vaccination showed an undated refusal. Her Covid-19 indicated a consent was required. e. Resident N's electronic chart indicated for her influenza vaccination; the immunization was requested. Her pneumonia vaccination showed an undated refusal. Her Covid-19 indicated a consent was required. On 12/4/23 at 11:24 a.m., the Director of Nursing (DON) indicated she would provide further information about the resident vaccinations. During the Exit Conference, on 12/4/23, the DON indicated she would provide further information via email regarding the resident's vaccination status. No email was received. The Centers for Disease Control and Prevention indicated, in part, to provide vaccination according to age, " ...> 65 years ...Covid-19 ...1 or more doses of updated (2023-2024 Formula) vaccine ...> 60 years ...Influenza ...one dose annually ...Age 65 years or older who have: not previously received a dose of PCV (Prevnar) 13, PVC 15, or PCV 20 or whose previous vaccination history is unknown: 1 dose of PCV 15 or 1 dose of		prior to exiting the survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of current resident population for offering residents vaccinations available has been completed. The IDT has been provided re-education on offering and documenting vaccinations available in the medical record, dating administration or declination of vaccines, and of obtaining consents as required timely. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the facility staff to offer and administer available vaccinations upon request and physician order. The DON/Designee will be responsible for auditing 10% current resident population for offering and administering of vaccines available as requested and ordered weekly for 12 weeks, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator.	

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	PCV 20. If PCV is used, administer 1 dose PPSV23 at least 1 year after the PCV 15 dose ...." 3.1-13(a)(1)		**How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	
F 0908 SS=F Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview, and record review, the facility failed to ensure essential kitchen equipment was maintained in good and working condition to prevent the potential for accidents. This deficient practice had the potential to effect 102 of 102 residents who were served from the kitchen. Findings include:	F 0908	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No specific residents were identified. **How other residents having the potential to be affected by the same deficient practice will be**	01/04/2024

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	1. On 11/27/23 Cook 55 arrived back from delivering breakfast trays at 9:55 a.m., and an initial kitchen tour was conducted. There was a two-compartment standing Hot-Box next to the stove. The box was observed on, and leaking water from the back. The water dripped down over electrical cords and coils and created a standing puddle of water in front and under the stove. Cook 55 indicated it been in use but broke over the weekend and she was not sure why it was leaking. On 11/27/23 at 10:10 a.m., Cook 4 arrived. When asked about the puddle of water underneath the stove, Cook 4 indicated it was from the leaking hot box. The hot box broke over the weekend and it needed to be fixed and he had put a maintenance request in the day before. A copy of the maintenance ticket was requested. On 12/01/23 at 3:38 p.m., the Vice President (VP) of Operations indicated the Executive Director (ED) told her the hot box had not worked for years so there was no current work order for the box. The VP of Operations requested for staff to remove the broken box from the kitchen so that kitchen staff would not accidently use it or believe that they broke the box. During an interview on 12/4/23 at 4:00 p.m., the ED indicated a copy of the maintenance ticket for the hot-box repair had been requested for 4 days, but there wasn't one because the hot-box had not been in use. 2. During the initial kitchen tour, the dishwasher was observed. The machine was dirty. Streaks of wet and dry food substances were stuck to the sides and bottom of the machine. The seals were		**identified and what corrective action will be taken:** The hotbox (also known as the oven) has been repaired. The dish machine, to include the seals, rubber strips, and rubber curtain of strips has been deep cleaned. The drying rack has been repaired to allow for draining water and avoid standing water. The cleaning schedule has been visibly posted for staff convenience. The dietary staff have been provided with re-education on Sanitation and Maintenance policy, cleaning and sanitation of equipment plus utensils, and routine dish machine cleaning. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** It is the responsibility of the dietary staff to follow the cleaning schedule and avoid use of broken equipment, or of equipment in need of repair. The Dietary Manager/Designee will be responsible for observing the dish machine, “hot box”, and kitchen equipment for cleanliness and good repair 3 times a week for 8 weeks, twice a month for 2 months, and then monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as	

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	built up with lime and/or hard water. There was a thick layer of debris on top of the machine with unidentified food particles and a dirty rag. There were blue rubber strips that hung down and draped across the dishes and they came out of the wash cycle. The rubber curtain strips were observed to have hard water built up, and macerated food particles stuck to the top, which had the potential to drop or fall onto the clean dishes as they slid out and between the curtains. The drying rack where the clean dishes were slid onto was not properly draining. Standing water with food particles was observed under the racks of clean dishes. Cook 4 indicated the rack was not tilted at a good angle to allow for proper drainage which needed to be fixed. Another problem was that the dish washer (DW) was loading the plate covers the wrong way. He indicated the plate covered needed to be turned the other way so that they did not scoop water out onto the clean table when they came out but should instead scoop water back towards and into the dishwasher and drain. The DW indicated he did not know that. When asked about how often the dishwasher needed to be cleaned, the DW indicated, he did not know if there was a scheduled day, but it should be cleaned when it needed it. When asked if he though it needed to be cleaned, he indicated yes. On 11/28/23 at 4:28 p.m., the ADON provided a copy of current facility policy titled, "Cleaning Schedule," reviewed 2/45/23. The policy indicated, "The Director of Food and Nutrition Services develops a cleaning schedule, with assistant form the Registered Dietician, to ensure that the Food		determined necessary by the Dietary Manager and/or Administrator. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator/designee will be responsible for reviewing the completed audits as per the schedule above. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction.	

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	and Nutrition Service department remains clean and sanitary at all times ... the cleaning schedule is posted in a location where it can be easily read ...." On 11/28/23 at 4:28 p.m., the ADON provided a copy of current facility policy titled, "Sanitation and Maintenance," revised 4/26/23. The policy indicated, "The Director of Food and Nutrition Services is responsible for ensuring that the department is maintained according to the standards of sanitation and in compliance with federal, state and local requirements ... Food and Nutrition Services associates are trained in the proper use, cleaning and sanitation of all equipment and utensils ... there is a facility process that includes reporting and follow up for all maintenance issues ... Equipment of the type and in the amount necessary for the proper preparation, serving and storing of food for proper dishwashing are provided and maintained in good working order ...the dish machine will be broken down and cleaned properly each day ...." 3.1-19(bb)			