STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	02/27/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00393493 and IN00396911. Complaint IN00393493- Unsubstantiated due to lack of evidence Complaint IN00396911 - Substantiated. Federal/State deficiencies related to the allegations are cited at F0677 and F0689. Survey dates: February 21, 22, 23, 24, and 27, 2023 Facility number: 000473 Provider number: 155389 AIM number: 100290410 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicare: 6 Medicaid: 23 Other: 6 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 1, 2023	F 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations. The facility requests a desk review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kesha LaGrone		03/15/2023

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

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	defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document that self administration of medications and treatments were clinically appropriate for 1 of 1 residents randomly observed for medications at bedside. (Resident 10) Findings include: A random observation of Resident 10's room was conducted on 2/21/23 at 11:21 a.m. Resident 10 was lying in bed with her eyes closed and her bedside table across her lap. On the bedside table, were two clear, plastic medication cups. One cup had several unidentified pills in it and the other contained a red liquid. An interview and observation with DNS (Director of Nursing Services) was conducted with Resident 10 on 2/21/23 at 11:44 a.m. DNS woke Resident 10 and asked her why she had not taken her medications which were on her bedside table. Resident 10 indicated, she had fallen asleep and stated she did not want to take the medications right now. DNS removed the medication cups from Resident 10's room. DNS indicated, medications should not be left at bedside. The facility was unable to locate a completed self-administration of medication assessment for Resident 10. Resident 10's clinical record was reviewed on 2/22/23 at 10:53 a.m. Resident 10's diagnoses included, but not limited to, hypertension, heart failure, and paranoid schizophrenia. Resident 10's clinical record did not contain a completed	F 0554	F554 It is the practice of this facility to administer medications in accordance with physicians' orders and consistent with professional standards of practice. Medications were removed from resident 10's room immediately. A self-administration of medication assessment was completed for resident 10 on 3/13/23 by DON/Designee and it was determined resident 10 shall not be permitted to self-administer medications for herself. All residents who receive medication have the potential to be affected by the alleged deficient practice. Room sweeps were conducted during daily angel rounds to ensure no other residents had medication at bedside without a physicians' order on or before 3/10/23. Licensed nursing staff will be educated on policy/procedure for medication self-administration and not leaving medications at the bedside on or before 3/19/23, by DON/Designee. Any employee who fails to comply with the points of the in-service will be further educated. Random room sweeps during angel rounds will be conducted by DON/designee to ensure medications are not at	03/20/2023

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	self-administration of medication assessment, a physician's order to self-administer certain medications, nor was "May keep at bedside" documented on the medication record per the facility's policy. A Medication Self-Administration policy and procedure was received on 2/21/23 @ 2:57 p.m. from DNS. The policy indicated, "Policy: 1. Residents who request to self-administer drugs will be assessed at the time of admission or thereafter to determine if the practice is safe, based on the results of the 'Resident Assessment-Self-administration Tool'. 2. The assessment results will be discussed with the attending physician and an order obtained to self-administer if appropriate...Personnel authorized to administer medications are responsible for documenting resident's understanding of the use of emergency and routine drugs, signs and symptoms and response to use, and based on observation of resident self-administration...8. Prescription medications stored in the resident's room should be written on the medication record 'May keep at bedside'. 9. Residents who self-administer shall be monitored at least semi-annually be licensed nursing personnel." 3.1-11		bedside without a physicians' order and medication self-administration assessment. Audits will be completed three days a week for four weeks, one day a week for four weeks, and monthly for four months. Any concerns noted will be immediately addressed and corrected. Any conclusions from the audit will be discussed in QAPI meeting. The DON and/or designee will be responsible for completion of audits. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. Date of Compliance: 3/20/2023	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care			

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	and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and			

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	advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged			

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	violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to assure a resident was informed of a grievance resolution for 1 of 3 residents reviewed for grievances (Resident 139). Findings include: The clinical record for Resident 139 was reviewed on 2/21/23 at 2:08 p.m. The Resident's diagnosis included, but were not limited to, anxiety and diabetes. An Admission MDS (Minimum Data Set) Assessment, completed 2/8/23, indicated she was cognitively intact and needed extensive assist of 1 staff member for bed mobility and toilet use. During an interview on 2/21/23 at 2:08 p.m., Resident 139 indicated she had reported 2 staff members for being rude and cursing while they were caring for her the night she returned from the hospital. She had not been informed of what happened after she had reported the staff members. On 2/21/23 at 3:08 p.m., the ED (Executive Director) provided an I Would Like To Know form and indicated it was the grievance form for the	F 0585	F585 It is the practice of this facility to ensure grievances are resolved in a timely manner. Resident 139's grievance was addressed and resolved by the facility administrator on or before 2/27/2023 and Resident 139 was satisfied with the outcome. All residents with grievances have the potential to be affected by the alleged deficient practice. All resident grievances in the months of February and March 2023 have been audited on 3/13/2023 and no concerns have been left unaddressed. Also, the facility followed its policy/procedure by addressing the concerns timely and with the appropriate signatures. The facility administrator was in-serviced on 3/9/23 by the BOM/Designee on the facility policy/procedure regarding grievances. All staff will be educated on policy/procedure for grievances on or before 3/19/23, by Administrator/Designee. Any	03/20/2023

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	concern that Resident 139 had reported. The form was dated 2/3/23, and indicated that on 2/2/23, 2 CNAs (Certified Nursing Assistance) had been rude and were cursing when they had assisted with changing Resident 139. The actions taken indicated that an investigation had been initiated. The CNA who had cared for Resident 139 on the night in question had resigned without notice and was unable to be interviewed. The Results/ Answer to the question was that in-servicing and skills validation would be completed with the staff. The form did not have a date of when the results were discussed with Resident 139, whether she understood the answer, or how she was notified of the results of the actions taken. It was signed by the ED on 2/6/23. During an interview on 2/23/23 at 10:35 a.m., the ED indicated the I Would Like to Know form should include the date the resident was informed of the results of the investigation. On 2/23/23 at 9:31 a.m., the Regional Director of Operations provided the I Would Like to Know policy, updated 2/9/2016, which read "...Purpose: To provide a 'process' by which a resident or a resident's representative can have their questions/ concerns brought to the proper source to be answered/ addressed and resolved as much as possible to the satisfaction of the resident or their representative and to have this activity documented including: A. Question and Details B. Action Taken [and by whom] C. Dates/ Times D. Response back to resident/ representative E. Documentation complete F. Filing in 'I Would Like To Know...' Binder..." 3.1-7(a)(2)		employee who fails to comply with the points of the in-service will be further educated. The BOM/Designee shall audit the facility's grievances to ensure they are completed properly and addressed accordingly. Audits will be completed 1x a week for four weeks, and monthly for five months. Any concerns noted will be immediately addressed and corrected. Any conclusions from the audit will be discussed in QAPI meeting. The Administrator and/or designee will be responsible for completion of audits. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. Date of compliance: 3/20/2023	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for a resident who was unable to carry out activities of daily living by not ensuring twice weekly showers/complete bed baths for 1 of 2 residents reviewed for activities of daily living (ADLs). (Resident 19) Findings include: An observation of Resident 19 was conducted on 2/21/23 at 11:52 a.m. Resident 19 was lying in bed wearing a hospital gown, her hair was messy, and her face was visibly dry with flaky skin. A physician's order dated 5/3/22 indicated, to apply Eucerin Lotion to face topically in the morning for dry skin. The clinical record for Resident 19 was reviewed on 2/23/23 at 2:19 p.m. Resident 19's diagnoses included, but not limited to, dementia, expressive language disorder, seizures, and aphasia (difficulty with communicating and/or understanding communication). Resident 19's quarterly MDS (minimum data set) dated 1/27/23 indicated, she required extensive assistance of one person for bed mobility, toileting, personal hygiene and physical help in part with assistance of one person for bathing.	F 0677	F677 It is the policy of the facility to provide bathing per residents' choice.Resident 19 was immediately offered a shower and accepted.All residents have the potential to be affected by the alleged deficient practice. Shower sheets and ADL/shower documentation review by DON/Designee on 2/28/23 and DON/Designee ensured all residents received baths/showers within 48 hours prior of the review.DON/designee will educate nursing staff on facility bathing policy/procedure on or before 3/19/23. Any employee who fails to comply with points of the in-service will be further educated. DON/Designee will complete audits five days a week for four weeks, three days a week for four weeks, and monthly for four months. Any concerns noted will be immediately addressed and corrected. Any conclusions from the audit will be discussed in QAPI meeting. The DON and/or designee will be responsible for completion of audits.Any deficiencies will be corrected immediately, and the findings of	03/20/2023

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	Resident 19's care plan dated 8/31/20 indicated, she required staff assistance with ADL's related to her seizure disorder. Interventions included, but not limited to, set up and assist the resident with a shower twice per week and as needed. A preferences care plan dated 4/12/17 indicated, she would like to shower twice weekly. A review of Resident 19's bath/shower task tab in the EHR (electronic health record) was reviewed on 2/23/23 at 2:15 p.m. It indicated, Resident 19 received a shower/complete bed bath on the following days for the month of February: 2/2/22 - shower 2/6/22 - complete bed bath February's shower sheets for the facility were received on 2/23/23 at 3:13 p.m. from ED (Executive Director). The following shower sheets were identified as Resident 19's: 2/2/23 - shower received 2/6/23 - resident refused shower/complete bed bath 2/20/23 - resident refused shower/complete bed bath An interview with DNS (Director of Nursing Services) conducted on 2/23/23 at 3:31 p.m. indicated, showers should be offered twice weekly. A Bathing policy was received on 2/23/23 at 3:35 p.m. from ED. The policy indicated, "To cleanse the skin and to promote circulation...Procedure: 1. Verify bath schedule or need...4. Introduce self and explain procedure and provide privacy, encouraging as much self care as possible...COMPLETE BATH-Involves washing resident's entire body...tub bath or shower with supervision...never leave resident in tub or		the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. Date of Compliance: 3/20/2023	

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	shower room unattended...10. Use deodorant under arms and apply body lotion to dry skin areas...21. Document in ADL worksheet of PCC [sic, point click care, charting system]." This Federal tag relates to complaint IN00396911. 3.1-38(a)(3) 3.1-38(b)(2) 3.1- 38(b)(4)			
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 implementation of fall interventions per the resident's plan of care for 1 of 3 residents reviewed for accidents. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 2/21/23 at 2:00 p.m. The diagnosis included, but was not limited to: repeated falls. A fall care plan for Resident 7 dated 10/12/22 indicated "...At risk for falls with potential for injury...fall mat at bedside,...keep bed in low position when staff is not providing care,...Sign on wall to use call light and wait for staff to	F 0689	F689 It is the practice of this facility to ensure interventions are in place to prevent accidents. Resident 7 was assessed by nursing services on or before 2/27/23 and no abnormal findings were detected. Resident 7's care plan was reviewed with Resident 7 and interventions were updated accordingly to ensure Resident 7 is free from accidentsAll residents who fall have the potential to be affected by the alleged deficient practice. All resident fall care plans were reviewed and updated by DON/Designee on or before	03/20/2023

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	assist..." An Interdisciplinary team (IDT) note dated 9/20/22 indicated Resident 7 had an unwitnessed fall in her room on 9/19/22. She had attempted to transfer herself without assistance at bedside. At that time, "There is a fall mat at the bedside." An observation was made of Resident 7 on 2/21/23 at 2:10 p.m. The resident's room did not have a mat or a reminder sign hanging to remind resident to use her call light for assistance per the plan of care. Observations were made of Resident 7 on 2/22/23 at 2:34 p.m., and 2:59 p.m., Resident 7 was observed in her bed with the bed raised and not in the lowest position. A mat was not observed at the bedside nor a reminder sign hanging on the wall to utilize her call light and wait for staff to assist. An interview was conducted with Certified Nursing Aide 15 on 2/22/23 at 3:00 p.m. She indicated she had not seen a mat at Resident 7's bedside nor signage on the wall as a reminder to use the call light and ask for assistance. An observation was made of Resident 7 in her bed with Nurse Consultant (NC) 1 on 2/22/23 at 3:02 p.m. The bed was not observed in the lowest position. There was no mat at the bedside or signage on the wall reminding resident to utilize her call light per the plan of care. During that time, NC 1 had confirmed with the resident that her preference was for the bed not to be in the lowest position. Resident 7 indicated to NC 1, she knows the staff prefer the bed to be low due to her falling, but she does not want it to be in the lowest position.		2/27/2023. Accordingly, all resident interventions were verified to be in place by DON/Designee on or before 2/27/2023.All staff will be educated on policy/procedure for incidents/accidents and fall interventions on or before 3/19/23, by DON/Designee. Any employee who fails to comply with the points of the in-service will be further educated. Random room sweeps during angel rounds will be conducted by DON/designee to ensure fall interventions are in place based on each residents' fall care plan. Audits will be completed three days a week for four weeks, one day a week for four weeks, and monthly for four months. Any concerns noted will be immediately addressed and corrected. Any conclusions from the audit will be discussed in QAPI meeting. The DON and/or designee will be responsible for completion of audits.Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved.Date of Compliance: 3/20/2023	

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	A fall policy was provided by the Regional Director of Operations (RDO) on 2/24/23 at 9:15 a.m. It indicated, "...Purpose: To ensure that accidents and incidents that occur with residents are identified, reported, investigated, and resolved. To provide a database to study the cause of accidents/incidents and to provide assistance in implementing corrective actions to prevent reoccurrences when possible...14. Based on the results of the investigation, the residents care plan is revised as necessary to prevent or minimize further accidents/incidents when possible..." This Federal tag relates to Complaint IN00396911. 3.1-45			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review, the facility failed to timely obtain laboratory test, as ordered by the physician, for 1 of 5 residents review for unnecessary medications (Resident 26). Findings include: The clinical record for Resident 26 was reviewed on 2/22/23 at 9:19 a.m. The Resident's diagnosis	F 0770	F770 It is the practice of this facility that residents receive timely lab services. Resident 26 was assessed by nursing services on or before 2/27/2023 and no abnormal findings were detected. Resident 26 received her ordered lab draws on 2/27/23 and results were sent to MD for review and	03/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	02/27/2023

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

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	included, but were not limited to, bipolar disorder and anxiety. A physician's order, dated 2/8/23, indicated that a Depakote level and an ammonia level were to be drawn on every 6 months on the 13th day of the month. During an interview on 2/23/23 at 3:05 p.m., the Executive Director indicated that the Depakote level and an ammonia level had not been drawn on 2/13/23. The requisition had been faxed to the lab, but the specimen had not been obtained. She was unsure why it had not been drawn. On 2/24/23 at 9:15 a.m., the Regional Director of Operation provided the current Lab Scheduling/ Tracking policy which read "... 5. When the lab is obtained, the phlebotomist or lab representative will indicated this within the system. Additionally, the lab phlebotomist or lab representative will leave a written report of the residents from whom specimens were obtained...7. Any omitted labs will be researched, and the lab will be contacted for an explanation as to the delay..." 3.1-49(a)		orders.All residents who have orders for labs have the potential to be affected by the alleged deficient practice. All resident lab orders were reviewed and updated by Regional Nurse Consultant on or before 2/27/2023 and orders were updated accordingly.All licensed staff will be educated on policy/procedure for lab services on or before 3/19/23, by DON/Designee. Any employee who fails to comply with the points of the in-service will be further educated. Labs services will be reviewed in the morning daily clinical meeting M-F by nursing services. Audits will be completed three days a week for four weeks, one day a week for four weeks, and monthly for four months. Any concerns noted will be immediately addressed and corrected. Any conclusions from the audit will be discussed in QAPI meeting. The DON and/or designee will be responsible for completion of audits.Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved.Date of Compliance: 3/20/2023	