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	04/17/2024

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 the Investigation of Complaints IN00423668, IN00423918, IN00431047, IN00431148, IN00431307, and IN00432576. Complaint IN00423668 - No deficiencies related to the allegations are cited. Complaint IN00423918 - No deficiencies related to the allegations are cited. Complaint IN00431047 - No deficiencies related to the allegations are cited. Complaint IN00431148 - No deficiencies related to the allegations are cited. Complaint IN00431307 - No deficiencies related to the allegations are cited. Complaint IN00432576 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: April 15, 16, and 17, 2024 Facility number: 000497 Provider number: 155606 AIM number: 100291530 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Type: Medicare: 12 Medicaid: 81	F 0000	The creation of this letter of credible allegation constitutes Westside Village Health Center written allegation of compliance. Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an allegation admission of interest against the facility, the administrator, or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. This facility is respectfully requesting desk review:	

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

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	Other: 17 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 25, 2024.			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and	F 0657	**What corrective actions will be**	05/15/2024

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	interview, the facility failed to revise care plans for 2 of 6 residents reviewed for care plan revision (Residents GG and H). Findings include: 1. On 4/16/24 at 3:00 p.m., Resident GG was observed for wound care. The wound care nurse and wound care physician were completing wound rounds with the resident. Resident GG was observed to have an unstageable (full thickness tissue loss where the depth of the wound is completely obscured by eschar or dead tissue in the wound bed) pressure ulcer to her right ischium, a brief rash to her left buttock, and unstageable deep tissue injury (DTI -purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue) to her left and right heel. The left and right heel was observed for the first time during the wound rounds on 4/16/24. On 4/17/24 at 10:30 a.m., a comprehensive record review was completed for Resident GG. She had the following diagnoses which included but were not limited to heart failure, hypertension, type 2 diabetes, chronic kidney disease, cellulitis of the right lower limb, and age-related debility. A review of her care plan was completed. It indicated, "The resident has potential for pressure ulcer development related to decreased mobility, and diagnoses of diabetes mellitus (DM)." The goal indicated the resident would have intact skin, free of redness, blisters, or discoloration through the next review. The care plan did not address the resident's current skin integrity status of the right ischium. On 4/17/24 at 11:00 a.m., a current copy of		**accomplished for those residents found to have been affected by the deficient practice?** Resident GG has been reviewed by the Interdisciplinary Team (IDT) for wound care requirements and care planning needs. The care plan has been reviewed and/or revised as needed to reflect the current status of the resident. Resident H has been reassessed by the Interdisciplinary Team to ensure the area noted upon admission has been reviewed and assessed correctly, with appropriate treatment. There has been noted success in her wound healing process. The care plan has been updated to reflect the current status of the resident. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** A one-time audit of current resident population was conducted for those residents with wounds to validate current list of residents who have wounds and have had care plans audited to validate the skin integrity wound care plan has been initiated and updated to reflect the current status of the wound(s). The Interdisciplinary Team has been provided with re-education on the need for timely care planning updates for the	

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	resident's care plan was provided, and it included her current wound status.2. Resident H's record was reviewed on 4/15/24 at 1:43 p.m. Diagnoses upon admission on 4/5/24 included, but were not limited to, late onset Alzheimer's disease (a progressive disease that causes confusion, destroys memory and other important mental functions), and traumatic hemorrhage of the cerebrum (collection of blood within the skull usually caused by trauma or a blood vessel that bursts in the brain). Physician's orders, dated 4/5/24, administer Calmoseptine External Ointment (moisture barrier) 0.44-20.6 % (Menthol-Zinc Oxide) to coccyx topically every shift for wound, and a small amount every 12 hours as needed for skin irritation. An Admission/Readmission Collection Tool, dated 4/5/24, Registered Nurse (RN) 14 indicated skin available for inspection, resident confused as usual. Skin blanchable/redness (reperfusion and no skin damage), pink open lesion with no drainage at the level of the coccyx, skin color normal, temperature warm, moisture normal, and turgor was good. Documentation lacked description to include measurements or stage of the wound. A Wound Observation Tool signed by RN 6, on 4/15/24 effective 4/6/24, documented open area/split present on admission. Overall impression was the wound was worsening. Staff notified wound MD and power of attorney (POA) on 4/6/24. The wound had scant serous (a clear to yellow fluid that leaks out of a wound) drainage and measured 1.1 centimeters (cm) by (x) 1.0 cm x 0.1 cm. The Wound team was to continue to evaluate and treat. Treatment was calmoseptine.		comprehensive care planning process, as well as initiating care planning for those residents with impaired skin. **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 /designee will be responsible for auditing care plans 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 will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The 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	

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	A Mini Nutritional Assessment, signed by RN 6 on 4/15/24, effective date 4/11/24, indicated admission score of 10 out of 14 indicated at risk of malnutrition. Wound on coccyx upon admission on 4/5/24. Area/open/split was worsening. Staff notified wound MD and family on 4/6/24. Measurement of wound was 1.1 cm x 1.0 cm x 0.1cm with scant serous drainage. A care plan, dated 4/8/24, indicated resident was at risk for break in skin integrity. The goal was to maintain intact skin with no skin breaks through the next review. Interventions included clean and dry skin after each incontinence episode, pressure reducing mattress, treatment as ordered, weekly skin checks, and a wheelchair cushion. The care plans lacked documentation related to existing wounds. On 4/17/24 at 12:18 p.m., the Business Office Manager (BOM) provided a Comprehensive Care Plans and Revisions policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "Comprehensive care plans: reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments ...." 3.1-35(c)(1)		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- (i) A resident receives care, consistent with			

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	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 observation, record review, and interview, the facility failed to ensure effective wound management for a resident admitted with an open area on the coccyx that worsened resulting in a stage 3 pressure ulcer (full thickness tissue loss - subcutaneous fat may be visible, and slough may be present) to the coccyx for 1 of 3 residents reviewed for pressure ulcers (Resident H). Findings include: On 4/15/24 at 11:45 a.m., Resident H's responsible party indicated they were not happy with the care and services the resident was receiving after having recently been admitted to the facility for rehabilitative services related to a fall before admission at another facility. There had been a delay in starting rehabilitative services, Resident H was being left in the bed, and at times the resident's room smelled of urine. Last evening when the family arrived around 5:00 p.m., they found the resident still in a gown and lying flat in bed, and questioned how was she going to get better if left in bed. The resident representative indicated they were also upset due to being informed the prior evening Resident H had developed "a hole in her butt", as the resident had never had a sore in the past. The resident representative indicated they had taken their	F 0686	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident H has been reassessed by the Interdisciplinary Team to ensure the area noted upon admission has been reviewed and assessed correctly, with appropriate treatment. There has been noted success in her wound healing process. The care plan has been updated to reflect the current status of the resident. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** A one-time audit of current resident population was conducted for those residents with wounds to validate current list of residents who have wounds and are receiving wound care in the facility. Residents with wounds had their records/care plans audited to validate the skin	05/15/2024

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	concerns to SSD 4 last evening and had planned to speak with the ED on this date. On 4/15/24 at 2:00 p.m., the Director of Nursing (DON) provided an original wound tracking log, dated February - April 2024, and indicated the residents listed on the tracking log were the ones being followed by the wound nurse. The report lacked Resident H's name or documentation Resident H was being followed by the wound nurse. On 4/15/24 at 3:07 p.m., Resident H was observed lying flat on her back in bed with her eyes closed, and the covers were pulled up around her neck. No extra pillows or propping devices were observed in the room. On 4/16/24 at 10:17 a.m., Resident H was observed to be out of her room. Licensed Practical Nurse (LPN) 5 indicated Resident H was in the main dining room attending an activity. On 4/16/24 at 2:40 p.m., the resident was observed to be out of bed in a wheelchair. On 4/17/24 at 10:25 a.m., Resident H was observed lying on her back in the bed, lower body flat on the bed, upper body slightly turned towards right side. There was a low air mattress (LAM) on the bed setting on 2, and a specialty cushion in the wheelchair (wc). There were no devices such as extra pillows that could have been used to prop the resident off her back observed in the room. Resident H's record was reviewed on 4/15/24 at 1:43 p.m. Diagnoses upon admission on 4/5/24 included, but were not limited to, late onset Alzheimer's disease (a progressive disease that caused confusion, destroyed memory and other important mental functions), and traumatic		integrity wound care plan has been initiated and updated to reflect the current status of the wound(s). The Interdisciplinary Team has been provided with re-education on the need for timely skin inspections at time of admission to correctly identify skin impairment, care planning updates for the comprehensive care planning process, as well as identify interventions to promote wound healing, or prevent skin breakdown. The Nursing staff have been provided with re-education on use of repositioning aids for use in repositioning residents side to side and relieve pressure to bony prominences. **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 Director of Nursing /designee will be responsible for auditing new admits, readmits 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 skin integrity is assessed at time of admission, and validated for correct assessment of skin	

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	hemorrhage of the cerebrum (collection of blood within the skull usually caused by trauma or a blood vessel that bursts in the brain). An Admission/Readmission Collection Tool, dated 4/5/24, Registered Nurse (RN) 14 documented skin available for inspection, resident confused as usual. The document indicated skin blanchable/redness (reperfusion and no skin damage), pink open no drainage lesion at the level of the coccyx, skin color normal, temperature warm, moisture normal, and turgor good. Documentation lacked description to include measurements or stage of the wound. Physician's orders, dated 4/5/24, indicated to apply Calmoseptine External Ointment (moisture barrier) 0.44-20.6 % (Menthol-Zinc Oxide) to coccyx topically every shift for wound, and a small amount every 12 hours as needed for skin irritation. A Skilled Progress Note, dated 4/7/24 at 1:21 a.m., indicated the resident was confused and could be combative and or resistive to care. Resident was alert with confusion. Required frequent re-direction. Required total care from staff of one and transfer assist of 2 staff members. Her needs were anticipated by staff. Resident was incontinent of bladder and bowel (b/b). Locomotion via wheelchair (wc)and required staff to propel. A care plan, dated 4/8/24, indicated resident was at risk for break in skin integrity. The goal was to maintain intact skin with no skin breaks through the next review. Interventions included clean and dry skin after each incontinence episode, pressure reducing mattress, treatment as ordered, weekly skin checks, and a wc cushion.		impairment noted. Any issues identified will be immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Director of Nursing and/or Administrator. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The 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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	Physician's order, dated 4/14/23 at 11:00 p.m., indicated to apply Calmoseptine External Ointment 0.44-20.6 % (Menthol-Zinc Oxide) to coccyx topically every shift for wound. Physician's orders, dated 4/15/24 at 3:00 p.m., indicated to cleanse coccyx wound with wound cleanser, pat dry, then apply collagen matrix sheet, and secure with border gauze island every evening shift for healing and as needed for soilage or dislodgement. Physician's orders, dated 4/15/24 at 11:00 p.m., indicated: a. Wound Doctor to evaluate and treat. b. Extra cushion on wheelchair every shift for pressure reduction. c. Low Air Loss Mattress: Settings: alternate, comfort level 3. May adjust comfort settings according to resident preference as needed. Nurse to check settings every shift for pressure reduction. A Weekly Skin Integrity Data Collection tool, dated 4/14/24, LPN 5 documented, skin not intact, new finding, open area/wound. Contacted family and MD (medical doctor) on call waiting on call back. The documentation lacked a description of the wound or measurements. A Wound Observation Tool signed by RN 6, on 4/15/24 and effective 4/6/24, documented open area/split present on admission. Overall impression was wound was worsening. Notified wound MD and power of attorney (POA) on 4/6/24. The wound had scant serous (a clear to yellow fluid that leaks out of a wound) drainage and measured 1.1 centimeters (cm) by (x) 1.0 cm x 0.1 cm. Wound team were to continue to evaluate and treat. Treatment was calmoseptine.			

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	A Wound Observation Tool, effective 4/15/24, RN 6 documented Resident H admitted with wound on 4/5/24, pressure ulcer to coccyx, stage 3. Overall impression was the wound was worsening. Notified (wound MD name) and POA (power of attorney) on 4/15/24. The wound had scant amount of serous drainage. The wound measured 1.5 cm length (L) x 1.0 cm width (W) x 0.4 cm depth (D). Resident coccyx wound exacerbated, wound treatment changed, family notified. Treatment was collagen matrix border gauze island (an advanced wound care dressing that transforms into a soft gel sheet when in contact with wound exudate). A progress notes, dated 4/14/24 at 4:30 p.m., indicated LPN 5 was informed by a Certified Nursing Aide (CNA) while cleaning up resident noted an open area on resident coccyx area. The writer assessed the resident and applied barrier skin for immediate treatment until wound team assessed. The DON and family were made aware, attempted to call MD, and waiting on call back. A progress notes, dated 4/15/24 at 3:56 p.m., wound nurse assessed resident skin, resident present with pressure wound to coccyx area. Wound physician notified, treatment ordered and implemented, treatment administration record (TAR) updated. Pressure reduction mattress in place. Physical Therapy (PT) notified to evaluate resident for extra cushion to w/c. Care plan reviewed and updated. A Mini Nutritional Assessment signed by RN 6 on 4/15/24, effective date 4/11/24, indicated admission score 10/14 indicated at risk of malnutrition. Wound on coccyx found upon admission 4/5/24. Area/open/split was worsening.			

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	Notified wound MD and family on 4/6/24. Measurement of wound was 1.1 cm x 1.0 cm x 0.1 cm with scant serous drainage. A MDS note, dated 4/16/24 at 12:26 p.m., indicated resident admitted with pressure ulcer to coccyx. Interdisciplinary team (IDT) met to discuss risk factors and new interventions put into place to help current wound heal, and prevent new areas from forming. Family and MD aware of wound and its current stage. MDS was scheduled to capture wound status and new interventions. A late entry Cognitive Patterns/BIMS (brief interview for mental status) created on 4/16/24 at 2:24 p.m. by SSD 8, effective 4/12/24 2:20 p.m., indicated Resident H had a BIMS score of 3/15 indicating severe cognitive decline. Resident H did not know the year, month, or day of the week, and after 5 minutes resident was not able to recall 0/3 words. Resident H's record, dated from admission on 4/5/24 - 4/13/24, lacked documentation Resident H had a wound on her coccyx, preventative measures were implemented or utilized to prevent worsening of the coccyx wound, the wound MD was notified to see the resident's wound during his wound rounds on 4/9/24, new treatment orders were obtained, or the care plan was updated until documentation identified a coccyx wound being a new wound on 4/14/24. A (wound company name) report, dated 4/16/24, indicated patient presents with a wound on her coccyx. The report indicated the wound was a Stage 3 pressure wound coccyx wound full thickness, Etiology pressure, stage 3, duration over 7 days, wound size 1.0 cm L x 0.9 cm W x 0.3 cm D, and had light serous exudate.			

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	Recommendations were to include, off load wound, reposition per facility protocol, turn side to side in bed every 1-2 hours if able, group-2 mattress. Plan was to discuss patient's abnormal BMI (body mass index) with dietician. During an interview on 4/15/24 at 2:44 p.m., the ED indicated Resident H had been identified with a slit in the crack of her butt the prior evening, the family was notified, and the wound nurse was notified who was in the facility this date and would see the resident. During an interview on 4/16/24 at 10:18 a.m., LPN 5 indicated Resident H had a wound on her coccyx. Indicated the floor nurses were responsible for putting new wound documentation into the computer, but they were not allowed to stage the wound or put in a description. The wound MD had been notified, had been in the facility the day prior, and would be back again this date. The wound nurse and wound MD were responsible for documenting on wounds to include staging. When asked how the facility could prove a wound had not gotten worse from the time found until the wound nurse or wound MD observed and documented on it, LPN 5 indicated could not answer to that as it was not her responsibility. During an interview on 4/16/24 at 10:24 a.m., LPN 7 indicated if she had been informed of a new open area, she would have assessed the wound, contacted the MD, family, wound MD, and DON. She would then document in a skin assessment the location, size, and description. She would not stage the wound, that was the job of the wound nurse, RN 6. During an interview on 4/16/24 at 10:26 a.m., RN 6 indicated Resident H had a wound on her bottom			

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	155606	A. BUILDING 00 B. WING	04/17/2024

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	upon admission on 4/5/24, the wound on her coccyx identified on 4/14/24 was not new it had just gotten worse. During an interview on 4/16/24 at 10:30 a.m., RN 6 indicated when a new wound was found the resident's nurse would assess the wound, notify the MD for orders, notify the family, notify the wound MD to see during Tuesday rounds, open a risk management form, and document on a skin assessment. The nurse was to describe the wound(s), but not stage the wound(s), that was the responsibility of the wound nurse or the DON as they were certified wound nurses, or the wound MD. During an interview on 4/16/24 at 10:40 a.m., the DON indicated when a wound was found, the nurse was to assess and document the wound. Routinely the nurse described the wound and got treatment orders immediately. The nurse could stage the wound but was encouraged not to, the wound could not later be downstaged if documented incorrectly. RN 6 , the Wound MD who came on Tuesdays, or the DON would stage the wound promptly. During an interview on 4/16/24 at 10:45 a.m., the DON indicated Resident H had been admitted with what was described as a stage 2 pressure ulcer (partial thickness loss of skin presenting as a shallow open ulcer or blister without slough or bruising) on the coccyx, the recent documentation of a new wound was incorrect. A new skin sheet indicated a new wound on the coccyx, and failed to have a description to include stage or measurements. During an interview on 4/16/24 at 2:38 p.m. the Wound MD indicated when a resident admitted			

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	with a wound, or developed a new wound, the resident was added on the list to be assessed weekly during his Tuesday wound round visits, and he wanted to see all wounds big or small. The wound MD indicated he had not been asked during his visit the prior week on 4/9/24 to assess a wound on Resident H, and she had not been on the wound list. Resident H was up at this time, so she had been put on the end of the list for this date. During an interview on 4/17/24 at 9:45 a.m., the DON and RN 6 indicated the wound tracking log was the internal log of residents with wounds that RN 6 used to identify residents with wounds, and to assess and track residents' wound progress weekly. Both acknowledged Resident H's name was not on the original list. During an interview on 4/17/24 at 9:45 a.m., the DON provided an updated wound tracking log, dated February - April 2024, indicated Resident H had been on the original list, could not explain why the resident was not on the first list given to surveyor on 4/15/24. This report indicated resident admitted on 4/5/23, had a stage 3 pressure wound on the coccyx, measured 1.5 cm x 1.0 cm x 0.4 cm with serous drainage. During an interview on 4/17/24 at 9:45 a.m., the DON and RN 6 indicated there was no wound MD documentation available prior to 4/16/24, Resident H had not been seen by the wound MD until this week when the wound on the coccyx became worse. On 4/17/24 at 11:55 a.m., the DON provided a Documentation & Assessment of Wounds policy, undated, and indicated the policy was the one currently being used by the facility. The policy			

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	indicated, " ...(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 ...the facility must ensure residents receive treatment and care plan in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: i. Promote the prevention of pressure ulcer/injury development; ii. Promote the healing of existing ulcers/injuries ...." 3.1-40(a)(2)			