STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00423770 and IN00428586 Complaint IN00423770- No deficiencies related to the allegations are cited. Complaint IN00428586- Federal/State deficiencies related to the allegations are cited at F0580 and F0690. Survey dates: February 22 and 23, 2024 Facility number: 000084 Provider number: 155167 AIM number: 100284600 Census Bed Type: SNF/NF: 122 Total: 122 Census Payor Type: Medicare: 11 Medicaid: 72 Other: 39 Total: 122 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 4, 2024	F 0000	March 15, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID Y4Y711 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during a Complaint Survey on 2/23/2024. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Shannon Harris Administrator	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Harris		03/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to timely notify a cognitively impaired resident's POA (Power of Attorney) of a new medication order for 1 of 3 residents reviewed for change in condition (Resident B). Findings include: The clinical record for Resident B was reviewed on 2/22/24 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, dementia with agitation and obstructive uropathy (retention of urine). He was admitted to the facility on 11/18/23 and was discharged from the facility on 12/24/23. A care plan, initiated 11/18/23, indicated Resident B had impaired cognition and thought processes related to dementia with severe agitation. The goal was for him to maintain his current level of cognitive function. The interventions included, but were not limited to, administer medications as ordered and to monitor for side effects and effectiveness, initiated 11/18/23, and to communicate with the resident, family, and caregivers regarding resident's capabilities and needs. A Physician's Progress Note, dated 11/20/23, indicated Resident B had dementia and did become agitated. When agitated, he would engage in activities such as pulling on his urinary catheter, which was detrimental for him. He was	F 0580	PROPOSED PLAN OF CORRECTION F580 1 – Resident B referenced in the 2567 discharged from our facility. 2 – The facility has determined that all residents have the potential to be affected. 3 – The DON, QA/In-Service Coordinator or ADON will educate appropriate nursing staff on our policy of notifying family when there is a change to orders received from the doctor. Furthermore, the documentation of the conversation needs to be verified in the electronic medical record. The DON, ADON, or QA/In-service Coordinator will provide education on the following: Notification of Family/Resident Representative of any change in condition and new orders from the physician. 4 – The DON/ADON or designee will conduct 5 weekly random	03/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	positive for agitation and behavioral problems, negative for dysphoric mood. He was not nervous and/or anxious. The plan indicated that he had severe dementia with agitation and Ativan (anti-anxiety medication) for his agitation as he had shown by his issues that his catheter, he was at risk for harming himself or others. A physician's order, dated 11/20/23, indicated he was to receive Lorazepam (generic for Ativan) 0.5 mg (milligram) tablet, 1 tablet every 4 hours, as needed, for anxiety/ agitation for 14 days. An Admission MDS (Minimum Data Set) Assessment, completed 11/24/23, indicated that he had impaired long and short-term memory, could recognize staff faces and/or names, understood he was in a nursing home, had moderately impaired decision-making skills (needing cues and supervision due to poor decision making). He required substantial assistance with toileting, had an indwelling urinary catheter, and received anti-anxiety medications. The Controlled Drug Use Record, dated 11/20/23, indicated that Resident B had received a Lorazepam 0.5 mg tablet on 11/22/23 at 6:00 p.m., 11/24/23 at 3:05 a.m., and 11/30/23 at 10:30 p.m. A Health Status Note, dated 11/22/23 at 9:59 p.m., indicated Resident B had become increasingly restless as the shift had progressed and was looking for his wife. Ativan was administered and was effective. An Order Administration Note, dated 11/24/23 at 3:05 a.m., indicated that Lorazepam (Ativan) 0.5 mg was administered due to Resident B wandering on the unit and into other rooms. The follow- up		audits for 6 weeks. These audits will assess for a change in conditions, notification of family/resident representatives and documentation of the notification in the EMR. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 3/14/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	Orders Administration Note, dated 11/24/23 at 5:28 a.m, indicated that the Lorazepam had been ineffective. A Health Status Note, dated 11/24/23 at 6:23 a.m., indicated Resident B was alert and oriented to person only. He was able to state his name and his birthdate. He had been attempting to get out of bed without assistance and was frequently pulling his pants up and down and adjusting his catheter. He had been given as needed Lorazepam (Ativan) for restlessness with no effect other than to making his gait more unstable. Resident B was under direct supervision due to increased unsteadiness after Lorazepam. A Nurse Practitioner Note, dated 11/29/23 at 4:58 p.m., indicated the Nurse Practitioner had spoken with Resident B's son about Resident B's plan of care. Resident B's son had requested that his Lorazepam be discontinued due Resident B's history of taking Lorazepam in the past with adverse side effects such as anxiety, aggression, and lethargy. During an interview on 2/22/24 at 3:18 p.m., FM (Family Member) 3 indicated that they had not been made aware of Resident B being started on Ativan. If FM 3 had known they would have immediately informed the facility that Resident B had a history of adverse side effects from Ativan, such as increased confusion, increased agitation and "making him worse". FM 3 had not been made aware that Resident B was receiving Ativan until after Resident B had already received at least 2 doses. During an interview on 2/23/24 at 11:23 a.m., UM 5 indicated when the physician gave a new order for a medication, the order was entered into the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	electronic health record. The electronic health record system would automatically inform the pharmacy of the new order. The family or representative of the Resident were to be informed of the new physician's order and the notification of the family or representative would be documented in the electronic health record. During an interview on 2/23/24 at 12:20 p.m., the DON (Director of Nursing Services) indicated there was no documentation in the electronic health record that Resident B's family and/ or Power of Attorney had been made aware of the 11/20/23 physician's order for Lorazepam. On 2/23/24 at 11:33 a.m., the DON provided the current Notification of Resident Change in Condition Policy which read "...A licensed nurse shall immediately inform the resident, consult with the resident's physician and if known, notify the resident's legal representative or an interested family member of...A need to alter treatment significantly i.e.[sic] a need to discontinue an existing form of treatment due to adverse consequences or to begin a new form of treatment...Resident representative[s] notifications and attempts will be made promptly and documented in the nurse's notes..." This Federal tag relates to Complaint IN00428586. 3.1-5(a)(3)			
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	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 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 record review, the facility failed to accurately monitor urinary output and urine characteristics for a resident with a indwelling urinary catheter resulting in hospitalization for acute urinary tract infection and urinary obstruction for 1 of 3 resident reviewed for change in condition. (Resident B).	F 0690	PROPOSED PLAN OF CORRECTION F690 1 –Resident B referenced in the 2567 discharged from our facility. 2 – The facility has determined that all residents with catheters have the potential to be affected.	03/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	Findings include: The clinical record for Resident B was reviewed on 2/22/24 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, dementia with agitation and obstructive uropathy (retention of urine). He was admitted to the facility on 11/18/23 and was discharged from the facility on 12/24/23. A care plan, initiated 11/18/23, indicated Resident B had impaired cognition and thought processes related to dementia with severe agitation. The goal was for him to maintain his current level of cognitive function. The interventions included, but were not limited to, administer medications as ordered and to monitor for side effects and effectiveness, initiated 11/18/23, and to communicate with the resident, family, and caregivers regarding resident's capabilities and needs. An Admission MDS (Minimum Data Set) Assessment, completed 11/24/23, indicated that he had impaired long and short-term memory, could recognize staff faces and/or names, understood he was in a nursing home, had moderately impaired decision-making skills (needing cues and supervision due to poor decision making). He required substantial assistance with toileting, had an indwelling urinary catheter, and received anti-anxiety medications. A care plan, initiated 11/24/23, indicated that Resident B had an indwelling catheter related to obstructive uropathy and gross hematuria (blood in urine). The goal was for him to remain free of catheter-related trauma and for him to show no signs or symptoms of a urinary tract infection. The interventions included, but were not limited		3 – The DON, QA/In-Service Coordinator or ADON will educate nursing staff on proper care of catheter bags and tubing and how to accurately monitor urinary output and urine characteristics with the goal of eliminating hospitalizations related to acute UTIs. 4 – The DON/ADON/Informatics Nurse or designee will conduct 5 weekly random audits for 6 weeks. These audits will assess whether the output has been documented appropriately and quiz nursing staff on what characteristics to look for with the urine that potentially could result in a possible UTI. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 3/14/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	to, administer medications as ordered, initiated 11/24/23, position catheter bag and tubing below the level of the bladder and away from entrance to room door, initiated 11/24/23, check tubing for kinks during care each shift, initiated 11/24/23, monitor and document intake and output as per facility policy, initiated 11/24/23, monitor for signs and symptoms of discomfort on urination and frequency, initiated 11/24/23, monitor, record, and report to physician for signs and symptoms of urinary tract infections, such as pain, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating patterns, initiated 11/24/23. A physician's order, dated 11/30/23, indicated to review the I &O (Intake and Output) administration record for the past 24 hours and enter totals. A physician's order, dated 11/30/23, indicated to empty Foley (urinary) catheter every shift. The December 2023 MAR (Medication Administration Record) indicated that Resident B's Foley (urinary) catheter was emptied, and urine output was recorded as the following: 12/20/23- day shift 500 ml(milter), evening shift 350 ml, and night shift 350 ml, 12/21/23- day shift 400 ml, evening shift 300 ml, night shift 700 ml, 12/22/23- day shift 500 ml, evening shift- no output recorded, night shift 400ml, 12/23/23- day shift 100 ml, evening shift- no output recorded, night shift 400 ml, and 12/24/23- day shift 300 ml.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	The December 2023 MAR indicated that Resident B's total intake and output were recorded as follows: 12/20/23- intake 1400 ml and output 1100 ml, 12/21/23- intake 860 ml and output not applicable, 12/22/23- intake 1060 ml and output not applicable, 12/23/24- intake not applicable and and output 1500 ml, and 12/24/24- intake 1160ml, and output 850ml. A Health Status Note, dated 12/23/23 at 10:13 p.m., indicated that Resident B had a "little" blood in his urine. He was not agitated. A Health Status Note, dated 1:48 p.m., indicated Resident B had received his morning medications at lunch time. His blood pressure before receiving his medications was 149/64 and his heart rate was 66. A Certified Nursing Assistant reported that Resident B had become lethargic and was not eating lunch. Resident B was not responding when staff called his name and sternal rub (firmly rubbing knuckles across the middle of the chest). Blood pressure was taken and was 70/46 and heart rate was not measured. Resident B was assisted to bed and did awaken during transfer, his legs were elevated. Blood pressure was rechecked and was 111/44 and heart rate was 44. At 1:42 p.m., Resident B's blood pressure was recorded as 104/53 and heart rate was 54. The physician was notified and gave a new order to hold Resident B's evening blood pressure medications. A Health Status Note, dated 12/24/23 at 4:43 p.m., indicated Resident B's family member had raised his voice and become aggressive, stating that Resident B's lips were blue. Resident B's family member had called 911. Resident B's lips were observed to be pink and red. Respirations were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	even and non-labored, lung sounds were clear. Resident B responded to a sternal rub and was able to tell me his name, his vital signs were temperature 98.2, heart rate 60, blood pressure 142/80 and blood oxygen saturations were 97%. A Health Status Note, dated 12/24/23 at 4:46 p.m., indicated Resident B was transferred to an acute care emergency room. The electronic health record for Resident B did not contain any further descriptions or assessment of Resident B's urine appearance from 12/23/23 until discharge on 12/24/23. During an interview on 2/22/24 at 3:18 p.m., FM (Family Member) 3 indicated that on 12/24/23, they had gone visited Resident B and found him laying in his bed and not responding. FM 3 could not wake Resident B and had thought his lips were turning blue. FM 3 was alarmed because they had seen him just a couple of days before, and he was acting normal. They had told the nurse on duty they wanted Resident B sent to the hospital and the nurse on duty had told them she would decide if Resident B needed to go the hospital, FM 3 could not demand that Resident B went to the hospital. FM 3 had called 911, because they were concerned for Resident B's well-being. Resident B was admitted to the hospital on 12/24/23 after being taken from the facility by emergency medical services. An ED (Emergency Department) note, dated 12/24/23 at 6:29 p.m., read "...This RN [Registered Nurse] noticed pts[sic] abd[sic] is distended, this RN bladder scanned pt[sic] which showed 919 ml in bladder, provider notified and ordered to inset a foley at this time, upon going to insert foley pt already had a foley in place with leg bag which			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING 00 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
	was full with over 500 ml in leg bag. Provider ordered to remove existing foley and replace with new one at this time. The Acute Care Hospital History and Physical, dated 12/24/23 at 7:58 p.m., read "...Altered mental status: Patent more drowsy and intermittently agitated per family...Dementia at baseline... WBC [White Blood Cells] 22.1...Complicated UTI: Patient with recurrent UTI's since being admitted for cystitis at the beginning of November. Foley was placed at that time for obstructive BPH [sic] and patient was following for urology. Continues to have foley. Retaining 1L [Liter], cloudy urine with sediment on admission due to obstructed foley..." On 2/23/24 at 11:33 a.m., the Director of Nursing provided the Catheter Care, Urinary Policy, last revised September 2014, which read "...The purpose of this procedure is to prevent catheter-associated urinary tract infections...Maintain an accurate record of the resident's daily output, per facility policy and procedure...Check the resident frequently to be sure he or she is not lying on catheter or to keep the catheter and tubing free of kinks..." This Federal tag relates to Complaint IN00428586.			