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	01/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00449427, IN00447172, IN00451144, and IN00451289. Complaint IN00449427 - Deficiencies related to the allegations are cited at F561, F677, and F695. Complaint IN00447172 - Deficiencies related to the allegations are cited at F561. Complaint IN00451144 - Deficiencies related to the allegations are cited at F689. Complaint IN00451289 - No deficiencies related to the allegations are cited. Survey dates: January 8, 9, 10, 13, 14, and 15, 2025. Facility number: 000497 Provider number: 155606 AIM number: 100291530 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 3 Medicaid: 63 Other: 23 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 23, 2025.	F 0000	The preparation and/or execution of this plan of corrections does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State laws. Please free to contact Westside Village Retirement Center at 317-209-2800. We respectfully request a desk review for compliance review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maurice Woolfolk	Executive Director	02/06/2025

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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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity when a Certified Nurse Aide (CNA) spoke harshly to a resident and the resident's room had pictures with insturctions hanging in public view (Resident 1) and when a resident (Resident 40) was not assisted to the restroom in a timely manner by two staff members who were available for 2 of 2 residents reviewed for dignity. Findings include: 1. During a continuous observation on 1/14/25 at 9:11 a.m. until 10:47 a.m., the following was observed. At 9:11 a.m., Resident 40 was observed as she sat at a table and finished her breakfast. She drank all of her juice, a cup of coffee and requested a second cup of coffee. When she finished her breakfast, she was not offered an opportunity to toilet after the meal and was assisted to an activity. At 10:00 a.m., Activity Assistant 29 began to gather residents for an activity and assisted Resident 40 to another table. At 10:08 a.m., Resident 40 said out loud, "I have to go to the bathroom." Activity Assistant and a Speech Therapist who assisted with the activity, indicated to Resident 40 they would get someone to help her. Activity Assistant 29 approached the nurses station were Licensed Practical Nurse (LPN) 28	F 0550	F550 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident #40 has been re-evaluated for toileting needs with the care plan updated to reflect the current status of the resident. Resident #1s room has been reviewed to remove the posted sign(s). Res #1 has been re-evaluated for transfer status needs. Resident #1 has been assessed for changes in psychosocial status in relation to bouts of crying. The care plans have 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:** A one-time review of the current resident population on the secured unit was completed reviewing needs for transfer status. A one-time review of the current resident population has been completed validating resident transfer ability with the use of the sit 2 stand lift transfers. The facility staff including the LPN and RN will be re-educated on responding to resident requests,	02/17/2025

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	was seated and worked on the computer and told her Resident 40 needed to use the restroom. LPN 28 indicated, "I know, I head. Where are the aides?" Activity Assistant 29 indicated she did not know but needed to finish the activity. At 10:11 a.m., Resident 40 tapped the table in front of her and leaned toward Activity Assistant 29 and indicated, "honey, I've got to go to the bathroom now." Activity Assistant 29 patted her hand and indicated, "I know, you're aide will be here in just a minute to take you." At 10:13 a.m., Resident 40 indicated loudly, she needed to use the bathroom and "didn't want to have an accident." At 10:18 a.m. CNA 27 exited another resident's room with a bag of soiled linen and took it to the soiled closet. LPN 28 indicated to the aide, "do you know where CNA 26 is? [Resident 40] needs to go to the bathroom." CNA 27 indicated, "no, but I'll text her." At 10:20 a.m., CNA 26 returned to the unit and CNA 27 told her, Resident 40 needed to use the restroom. At 10:21 a.m., CNA 26 approached Resident 40 and leaned down to her ear and indicated, "I'm so sorry, lets get you to the bathroom," and assisted her to her room. During an interview on 1/14/25 at 10:47 a.m., CNA 26 indicated all staff were taught to answer call light or resident requests to go to the bathroom if they were certified to do so. CNA 26 indicated Resident 40 was a one person assist. When CNA 26 got her to the restroom the resident had been incontinent of urine, her brief was soaked, but the		Customer Service, Resident 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. The Administrator/designee will complete 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 Administrator and/or Director of Nursing. **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 Quality Assurance Committee meeting monthly for 3 months and the quarterly, for a total of 6 months.	

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	resident had been able to have a bowel movement on the toilet. On 1/14/25 at11:55 a.m., Resident 40's medical record was reviewed. She was a long-term care resident who resided on the secure memory care unit with diagnoses which included, but were not limited to, severe dementia with anxiety and the need for assistance with personal care. She had a comprehensive care plan, revised 12/28/23, which indicated, she had an activities of daily living (ADL) self-care performance deficit related to her diagnoses of dementia, anxiety, and need for assistance with personal care. Interventions for this plan of care included, but were not limited to, total assistance of 1 staff for toilet use, and to assist with toileting as needed. During an interview on 1/14/25 at 11:27 a.m., the Executive Director (ED) indicated if staff who are licensed or certified to assist residents with toileting were available, then they should assist a resident to the bathroom upon request, regardless if they were on that assignment or not. During an interview on 1/15/25 at 11:00 a.m., the Director of Nursing (DON) provided a copy of a LPN job description, and indicated, LPN 28 could assist within her job description of up to 35 pounds. The DON clarified with the Assistant DON, LPN 28 was not on restrictions. The DON indicated she would not want a resident to wait to go the bathroom for more than 20 minutes. The LPN Job Description was dated 11/10/16 and indicated, " ...The LPN nurse delivers quality of care to patients through interpersonal contact and provides care and services to assure patient safety and attain or maintain the highest		Re-education, frequency and/or duration of reviews will be increased 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. **Date of Compliance: 2/17/25**	

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	practicable physical, mental and psychosocial well-being of each patient in accordance with all applicable laws, regulations and Life Care standards... Essential Functions ... must exhibit excellent customer service and a positive attitude towards patients ... must be able to sit, stand, bend, lift, push, pull, stoop, walk, reach and move intermittently during working hours ...." 2a. On 1/8/25 at 11:09 a.m., Resident 1 was observed sitting on the toilet, she was crying and crying out while two staff members, Registered Nurse (RN) 6 and Certified Nursing Assistant (CNA) 7, were using a sit-to-stand lift to transfer her from the toilet to her wheelchair. Resident 1 was shouting without words, when RN 6 indicated to the resident, "it won't hurt your feet. Jesus!" On 1/8/25 at 11:15 a.m., Resident 1's facial grimace was visible, she was still crying after being transferred from the toilet to her wheelchair. RN 6 asked her if she was still in pain, Resident 1 indicated yes. RN 6 indicated she would tell her nurse, RN 35. During an interview, on 1/8/25 at 11:20 a.m., Resident 1 indicated it hurt her that much every time she was transferred via sit-to-sit transfers. During an interview, on 1/14/25 at 11:30 a.m., the Executive Director (ED) indicated staff members needed to be attentive to the residents' concerns. During an interview, on 1/15/25 at 11:27 a.m., the Director of Nursing (DON) indicated Registered Nurse (RN) 6 was helping to move Resident 1. She was pointing at the strap that goes around the resident's legs. She indicated she would have to hear the staff's actual comments before she could do anything about it, however, it was not ok to have an inappropriate tone with a resident.			

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	2b. On 1/8/25 at 1:06 p.m., Resident 1's record was reviewed. She was admitted to the facility on 4/7/22. Her diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) after a cerebral infarction (stroke) affecting her right dominant side, diabetes mellitus (blood sugar disorder), and immunodeficiency virus (HIV) disease. On 1/8/25 at 11:02 a.m., on Resident 1's free standing closet, photographs of her in her wheelchair were observed facing the room's door to the public hallway. Her first initial and all but the last letter of her name was visible in the photographs. The corner of the photograph indicated to, "make sure [resident's first name) looks like this picture everyday!!" On 1/10/25 at 9:22 a.m., two photographs of her in her wheelchair were still in view from the public hallway. Most of her name was still visible. During an interview, on 1/13/25 at 10:59 a.m., Resident 1 indicated through facial gestures, sounds, and facial expressions that she did not want photographs of herself in her wheelchair posted in her room to teach staff how she should be positioned in her wheelchair. During an interview, on 1/13/25 at 12:10 p.m., the Director of Nursing (DON) indicated the photographs of Resident 1 in her wheelchair should not have been posted in her room. All the photographs have been removed and would not be put back up again. During an interview, on 1/14/25 at 11:30 a.m., the			

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	Executive Director (ED) indicated it was inappropriate for Resident 1 wheelchair positioning photographs to be posted in her room. The facility staff should have been more attentive to the resident's concerns. A current policy, titled, "Resident Rights," dated 9/10/23, was provided by the ED, on 1/13/24 at 11:34 a.m. A review of the policy indicated, " ...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 ...." 3.1-3(a)			
F 0561 SS=E Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination Based on observation, interview, and record review, the facility failed to ensure residents who wanted to register to vote were registered and the residents who were registered to vote were able to vote for 5 of 5 residents who wanted to vote in the 2024 Presidential Election (Residents B, C, D, E, and F). Findings include: During an interview, on 1/10/25 at 9:28 a.m., Resident B indicated his democratic right was violated because he was not registered and wanted to vote. During an interview, on 1/10/25 at 8:47 a.m., Resident E indicated he wanted to vote but did not get his absentee ballot. During an interview, on 1/10/25 at 8:56 a.m., Resident F indicated she wanted to vote, but no	F 0561	F561 **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 identification information for Residents B, C, D, E, and F. **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 questionnaire has been completed for the current resident population on their status of being registered to vote, as well as their specific desire to vote in future elections. The Activities Director has been provided	02/17/2025

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	one got her up. During an interview, on 1/10/25 at 9:00 a.m., Resident D indicated she wanted to vote. They were supposed to come to the facility and did not. During an interview, on 1/10/25 at 9:01 a.m., Resident C indicated he wanted to vote. He signed the papers, but they did not come back or provide an absentee ballot. During an interview, on 1/10/25 at 9:02 a.m., the Activity Director (AD) indicated she contacted the voting board, they sent someone out to register the residents. Some were registered, some were not. She did not have a list of residents who wanted to be registered to vote. She indicated some residents were upset they could not vote. No absentee ballots were provided for the facility. On 1/10/25 at 10:33 a.m., the AD indicated two people from the Mobile Voting Board (MVB) came on 10/22/24 at 10:30 a.m. to register residents to vote. They talked with Resident C and Resident B. She believed they went throughout the building to ask residents if they wanted to vote. Afterward, she called them several times and left messages to get further information. They were supposed to come one day to register residents to vote and come back another day to provide and assist residents as needed to vote on absentee ballots. Resident B had told her he would call the MVB directly. On 1/10/25 at 10:54 a.m., the Executive Director (ED) provided the facility voting investigation with no date. It indicated, "All residents had the opportunity to vote on 10/22/24 at 10:30 a.m. [Resident B] was the only known resident that didn't get a chance to vote. The reason he didn't		education on assisting residents with their right to vote and completion of absentee ballot process and assisting residents to the voting location upon their request. **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 self-determination and exercise their right to vote. The Activity Director/designee will complete a voting questionnaire to ensure residents have the self determination to vote. This questionnaire will be done for every new admission and annually during scheduled Minimum Data Set assessment during the Assessment Reference Date (ARD) period 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 and/or Director of Nursing. **How the corrective action will be monitored to ensure the deficient practice will not recur:**	

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	vote was because he wasn't registered to vote that day. The inhouse [sic] voting committee went to [Resident B]'s room that day to talk with him. [Resident B] expressed that he would get registered, and the voting committee advised him to call when he was registered. [Resident B] was upset because the voting committee didn't get back with him." On 1/13/25 at 8:47 a.m., MVB person 36 indicated registration was available. If a resident needed to register to vote the traveling mobile board would go to them. They helped them complete the application, then they bring a team out to vote. They bring the forms. Some residents needed assistance with completing the absentee ballot. She understood some residents voted and some were upset they did not vote. She indicated the traveling mobile voting board did go to the facility. She indicated she would do some research and call back. The facility residents would need an "ABS" (absentee ballot) application to schedule the traveling voting board come back in for actual voting. On 1/13/25 at 12:05 p.m., voter registrations were reviewed online. a. Resident B was not registered to vote. b. Resident C was not registered to vote. c. Resident E was not registered to vote. d. Resident D was registered to vote, but did not vote. e. Resident F was not registered to vote. During an interview, on 1/13/25 at 2:49 p.m., the AD indicated the MVB called the facility to come for residents to vote. She indicated some of the residents did vote. The first resident to vote was Resident T. Further information was requested from the AD regarding her efforts to get residents		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 Quality Assurance Committee meeting monthly for 3 months and the quarterly, for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased 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. **Date of Compliance: 2/17/25**	

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	registered to vote and ensure the residents were able to vote. During an interview, on 1/13/25 at 2:58 p.m., MVB 36 indicated she would email to research report. She believed a gentleman turned in an application. His roommate wanted to vote, and another resident. They filled out applications for two other residents, but she could only find one now. Some residents, Resident B and Resident C, did not turn in their applications. One resident was not registered. She indicated the AD or the MVB personnel go around the facility and ask residents who wanted to vote. The MVB was at the facility on 1/9/24 and left applications for voters' registration and travel board voting. On 1/15/25 at 2:43 p.m., the Regional Director of Clinical Services (RDCS) provided a document, titled, "Ad Hoc Quality Assurance Performance Improvement," dated 1/15/25, for voting. It indicated, "Prior to election facility will provide education and reminder during resident council [sic] on registering to vote." On 1/15/25 at 2:45 p.m., the RDCS provided a document signed by the AD. It indicated, "I, [AD name], met with [MVB 36] on January 31, 2024 at 1:30 pm[sic] from the voting board. We made date for them to come back to register Residents to vote. They came back on October 28, 2024 to register resident n [sic] took voter registration application with them. They said they will be back on November 4th, 2024 to register other Residents. They said they came back late evenning [sic] could not get in the Building to Register. Thank You [AD name]" During an interview, on 1/13/25 at 12:12 p.m., the Director of Nursing (DON) indicated every			

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	resident had the right to vote. She was unaware of residents wanting to register to vote and was unaware of residents not having the opportunity to vote. A current policy, titled, "Resident Rights," dated 9/10/24, was provided by the Executive Director (ED), on 1/13/25 at 11:34 a.m. A review of the policy indicated, " ...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 ...." This citation relates to Complaints IN00447172 and IN00449427. 3.1-3(u)(3)			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on observation, interview, and record reviews, the facility failed to ensure a timely and appropriate response to grievances related to answering call lights in a timely manner. This deficient practice had the potential to affect 11 of 11 residents who spoke on behalf of the facility during a resident council meeting. Findings include: On 1/13/25 at 11:05 a.m., copies of the resident council meeting minutes from July 2024 to November 2024 were reviewed. A resident council meeting minutes form, dated 7/24/24 at 2:00 p.m., indicated residents had to wait 1 to 2 hours sometimes for their call light to be answered and it was worse at night.	F 0565	F565 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The residents who participated in the Resident Council meeting were not provided to the facility. **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 specially called resident council meeting has been completed, discussing call light issues with the current resident population. The facility staff have	02/17/2025

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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
	A resident council follow-up form, dated 7/25/24, indicated all staff were reeducated on the call light policy and procedure. A resident council meeting minutes form, dated 10/18/24 at 1:30 p.m., indicated call light response times were getting better but sometimes call lights were still not answered within a reasonable time frame especially on night shift and weekend shifts. A resident council follow-up form, dated 10/18/24, indicated all staff were educated on timely call light responses. A resident council meeting minutes form, dated 11/18/24, indicated sometimes staff would answer call lights 45 minutes to 1 hour after the resident turned the call light on. A resident council follow-up form, dated 11/19/24, indicated education continued in monthly in-services on call lights. On 1/13/25 at 1:41 p.m., a resident council meeting was held. Eleven residents were in attendance for a resident council meeting. During that meeting all residents that were present indicated, it took a long time for call lights to be answered. The residents indicated, it came up almost every month in resident council and they had filed many grievances about the issue. They indicated it would get a little better for a month but then it would go back to taking a long time for the nursing staff to answer the call lights. On 1/14/25 at 9:23 a.m., resident grievance logs from February 2024 to September 2024 were reviewed.		been provided with re-education on answering call lights timely during their tour of duty. The interdisciplinary team will be provided with re-education on the review and completion of resident grievances and determining if other actions or interventions will be required to address continued concerns. **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 assist with call light response times. 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 immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the	

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	155606	A. BUILDING 00 B. WING	01/15/2025

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	A grievance, dated 2/3/24, indicated a resident who wrote the grievance had to keep calling out to go to the bathroom. The resolution to this grievance indicated there had been a meeting with staff about call light times. A grievance, dated 3/1/24, indicated a resident's husband had to call the unit from his home for her call light to be answered. The resolution to this grievance indicated staff had been coached to ensure toileting prior to meals. A grievance, dated 3/14/24, indicated the resident council felt call lights were not being answered in a timely manner. The resolution to this grievance indicated staff audited call lights and addressed staff. A grievance, dated 4/1/24, indicated a resident had nursing concerns. The resolution to this grievance indicated an unknown staff member spoke to staff about timeliness and care. A grievance, dated 4/16/24, indicated a resident had nursing concerns. The resolution to this grievance indicated an unknown staff member spoke to staff about call light response times. A grievance, dated 4/24/24, indicated a resident had nursing concerns. The resolution to this grievance indicated an unknown staff member spoke to staff regarding call light response times. A grievance, dated 5/7/24, indicated a resident had nursing concerns. The resolution to this grievance stated, "call light response." . A grievance, dated 5/31/24, indicated a resident had concerns with call light response times. The resolution to this grievance indicated, an		Administrator and/or Director of Nursing. **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 Quality Assurance Committee meeting monthly for 3 months and the quarterly, for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased 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. **Date of Compliance: 2/17/25**	

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	unknown staff member reviewed the call light policy and procedures with staff. A grievance, dated 6/2/24, indicated a resident had concerns with their call light was turned off or it took too long to respond. The resolution to this grievance indicated, an unknown staff member spoke to staff about quicker call light responses. A grievance, dated 9/3/24, indicated there were call light concerns. The resolution to this grievance indicated an unknown staff member spoke with staff about answering call lights sooner. In an interview on 1/14/25 at 11:34 a.m., with the Executive Director (ED) indicated they had some in-services for call lights and he was going to look to see if they had done anything else to resolve these call light issue. In an interview on 1/15/25 at 1:10 p.m., with the Director of Nursing (DON), the Regional Director of Clinical Services (RDCS) and the ED present, the DON indicated, the only thing they had done to try and improve call light times were monthly in-services and reeducation. At this time copies of education and in-services that had been provided to staff and sign-in sheets for who attended these in-services were requested. At the time of exit these documents were not provided. On 1/15/25 at 3:05p.m., the DON provided a copy of a current facility policy titled, "Resident Call System", dated 1/4/23. The policy indicated that, " ...1. Facility associates should always be aware of call lights. 2. Facility associates should answer call lights whether they are assigned to provide care to that resident ...".			

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F 0578 SS=D Bldg. 00	3.1-3(g) 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on record review and interview, the facility failed to ensure residents had advanced directives or code statuses for 3 of 4 reviewed for advanced directives (Residents 250, 45, and B) . Findings include: 1. A record review was completed on 1/8/25 at 1:45 p.m. Resident 250 admitted to the facility on 1/3/25. She had the following diagnosis which included but not limited to gastro-esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), age-related osteoporosis, and schizoaffective disorder. Upon initial review, her medical record lacked an order and a care plan to address her advanced directive wishes. Later, the Director of Nursing (DON) provided a copy of the resident's care plan indicating she had a care plan, and an order were entered for her advanced directive. The care plan was dated 1/5/25. The DON indicated the advanced directive was not present until the documents were requested. The care plan, dated 1/5/25, indicated Resident had advanced directives cardio-pulmonary resuscitation (CPR). On 1/14/25 at 1:45 p.m., during an interview, the DON indicated advanced directives should be obtained upon admission.2. On 1/9/25 at 1:06 p.m., Resident 48's record was reviewed. She was a long-term care resident whose	F 0578	**F 578** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Facility staff were not given resident B's identifying information, The clinical record including order, care plan and POST for residents #250 and #48 were updated to reflect the resident's preferred code status. **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 records completed by the nurse management team and/or designee to ensure the clinical record accurately reflects their preferred advanced directives. Any deficiencies noted will be corrected. The Administrator/DON will reeducate the Social Service Director and licensed nursing staff on the facility policy titled Do Not Resuscitate and the Indiana Physicians Orders for Scope of Treatment (POST). Staff who are non-compliant with the policy will receive additional education and/or progressive discipline as	02/17/2025

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	diagnoses included but were not limited to cerebral infarction (stroke), type two diabetes, hypertension (high blood pressure) and major depressive disorder. There was an active physician order, dated 1/27/24, for full code status. A physician progress note, dated 12/31/24 at 12:00 a.m., indicated Resident 48 had her daughter as a surrogate decision maker on file and an advanced care plan listed as a full code. Resident 48's care plan, dated 3/31/22, indicated Resident 48 had an advance directive of Do Not Resuscitate (DNR) comfort measures only. A care plan, dated 3/31/22, indicated the Resident's code status will be reviewed on a quarterly basis and as needed. A care plan, dated 3/31/22, indicated the Residents advanced directives will be honored. A care plan, dated 3/31/22, indicated the Resident had signed DNR.3. On 1/9/25 at 11:38 p.m., Resident B's medical record was reviewed. He was admitted on 5/23/24. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (lung disease), diabetes mellitus (blood sugar disorder) with chronic kidney disease, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (causes breathing to stop or be reduced during sleep). There was no physician's order or care plan for his advance directive status.		appropriate. The code status of residents will be reviewed upon admission/re-admission by the charge nurse. **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 Director and/or Social Service Assistant to ensure code status and POST forms are obtained upon admission/readmission. The SSD/SSA and/or designee will complete advance directive audits 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 residents have accurate advanced directives and care plans. Any negative findings will be addressed at the time of observation. **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	

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	During an interview, on 1/8/25 at 12:12 p.m., Resident B indicated after he arrived, no one asked him about creating an advance directive. He did not know how long he had been in the facility without one. Finally, someone came in to talk with him about getting his advanced directive in place. On 1/11/25 at 1:35 p.m., the Director of Nursing (DON) provided a copy of Resident B's physician orders. The orders indicated a verbal advanced directive order was given on 5/31/24. A written advanced directive order was created and entered into the resident's electronic health record (EHR) on 1/10/25 at 6:06 a.m. The DON also provided his advance directive care plan, it was created and initiated on 1/10/25. During an interview, on 1/13/25 at 12:13 p.m., the DON indicated if a resident did not have an advance directive in place, then would be a full code. It is preferable to have an advanced directive for the resident's desired code status in place within the first 24 hours of the resident's stay in the facility. During an interview, on 1/15/25 at 11:31 a.m., the DON indicated the facility had problems creating resident's advance directive status. The admissions nurse tried to do it, then the Social Services Director (SSD) should be following up. They had someone who used to do it 4 or 5 months ago but was no longer at the facility. Now, it was everyone's duty to see that it was completed. On 1/15/25 at 2:43 p.m., the Regional Director of Clinical Services (RDCS) provided a document, titled, "Ad Hoc Quality Assurance Performance Improvement," dated 1/15/25, for code status. It		increased 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. **Date of Compliance: 2/17/25**	

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	indicated, "Code status concern brought forth during survey. Audit completed and corrections made." A current policy, titled, "Advance Directives and Advance Care Planning," dated 3/28/22, was provided by the Executive Director (ED), on 1/10/25 at 9:30 a.m. A review of the policy indicated, " ...Residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including the right to execute or refuse to execute an advance directive ...." A policy titled, "Advanced Directives and Advanced Care Planning" was provided by the Regional Director of Nursing Services on 1/14/25 at 2:03 p.m. It indicated, " ...The resident and/or family upon admission to determine the need and knowledge relative to advanced directive and advanced care planning ...Each time the resident is admitted to the facility, quarterly, and when a change in condition is noted in the resident condition, the facility should review the advanced directive and advance care planning information ...." 3.1-4(d) 3.1-4(f)(5)			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment was maintained in the main dining room of the memory care unit when remnants of feces were not cleaned up after a resident's incontinent episode, which had the	F 0584	F584 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?**	02/17/2025

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	potential to effect 22 of 22 residents who resided on the memory care unit , and the facility failed to ensure the floors for 2 of 22 residents' rooms (Residents 193 and 6) were free from large areas of staining due to resident incontinent episodes. Findings include: 1. During an initial tour of the memory care unit on 1/8/25 at 10:26 a.m., an irregular shaped dried clump of brown debris was observed in the corner of the dining room near the double glass door to the patio. There was a small brown streak on the baseboard near the stain as well. There was a large irregular puddle-shaped stain on the floor in the same corner, it was a yellow color. On 1/10/25 at 9:41 a.m., the Floor Tech entered the unit with an industrial carpet cleaner and began to clean the dining room carpet. On 1/14/25 at 11:37 a.m., stains and debris remained in the corner of the dining room. At that time Houskeeper (HK) 30 was observed as she spot swept the dininr room before lunch. She swept over the dried brown clump of the carpet but it did not come up. She indicated the clump looked to, "poop." During an interview on 1/14/24 at 11:45 a.m., Certified Nursing Aide (CNA) 26 observed the stains in the corner of the dining room. She put her hand over her mouth and indicated, "oh no, I think that's from [Resident 81] he uses the bathroom in the wrong places, and this is a usual spot." On 1/14/25 at 12:02 p.m., the stains were observed with the Floor tech and the Regional Director of Clinical Services (RDCS). The floor tech indicated		Resident #193 has been successfully discharged from the facility. The room has been fully cleaned. Resident #6's room has been fully deep cleaned. The area of feces was immediately cleaned. **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 will be completed checking all occupied resident rooms and common areas for cleanliness. The facility staff will be provided with re-education on reporting cleanliness of rooms and common areas and immediately cleaning areas with body fluids or waste. **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 Housekeeping manager will be responsible for completing 10% of resident rooms and common area cleanliness checks 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks and the monthly for 3 months. Any issues identified will be immediately corrected, 1:1 re-education completed with staff	

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	he had been asked to clean the memory care dining room carpet because a resident had an accident. The Floor Tech indicated, the spot must not have been gotten by the floor machine when he cleaned the other day because the large rounded front of the machine did not fit into the square corner. It needed to be spot cleaned. He did not know why it had not been cleaned up yet. On 1/10/25 at 9:52 a.m., Resident 81's medical record was reviewed. He was a long-term care resident who resided on the secure memory are unit with diagnoses which included but were not limited to, bipolar disorder and dementia. A nursing progress note, dated 1/5/25 at 3:39 p.m., indicated, "resident has the brief on and defecate in the corner of dining room this shift and then lay down in the bed in his room." During an interview on 1/14/25 at 12:36 p.m., Registered Nurse (RN) 25 indicated she put the progress note in about his accident in the dining room and indicated the corner she referred to was by the cabinets and the double glass doors. RN 25 indicated a CNA cleaned up the majority of the accident, but she let the Floor Tech know it needed to be cleaned. 2. On 1/9/25 at 9:13 a.m., Resident 6 was observed as he was assisted out of his room by Certified Nursing Aide (CNA) 27. CNA 27 indicated, she had just finished getting him cleaned up and dressed for the day. A crumpled pile of linens was observed on his bed, with a large yellow/brown stain, and the room smell strongly of urine. There was a fall mat on the floor beside the right side of his bed, and the tiles underneath were visible at the edges, deeply discolored and brownish/orange color.		personnel as identified, with disciplinary action completed as determined necessary by the Administrator and/or Director of Nursing. **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 Quality Assurance Committee meeting monthly for 3 months and the quarterly, for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased 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. **Date of Compliance: 2/17/25**	

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	During an interview on 1/9/25 at 9:15 a.m. CNA 27 indicated the tiles were stained from urine because Resident 6 would sometimes roll to the side of his bed and urinate on the floor, it would seep under the edges of the fall mat and over time had permanently discolored the tiles. On 1/9/25 at 9:21 a.m., Resident 193's room was observed. There was a large rectangular stain on the floor beside her bed. Very similar to Resident 6's floor, the tiles were deeply discolored with a brownish/orange color. During an interview on 1/10/25 at 9:12 a.m., CNA 26 indicated, a male resident used to live in what was now Resident 193's room. Like Resident 6, that resident had also often urinated on the floor where a fall mat had been and had over time permanently discolored the tiles. On 1/14/25 at 12:10 p.m., Resident 6 and 193's floors were observed with the Floor Tech and the RDCS. The Floor Tech indicated, he had been back at the facility as the Floor Tech for 4 months and even though the room and been cleaned and the floor had been buffed, the stains remained. The Floor Tech indicated the tiles probably needed to be hand scrubbed with special chemicals, but he had not done that or arranged for it to be completed by anyone else because they were presently discolored. The Floor Tech indicated, he had not put in a request for work on the tiles or to have them replaced. On 1/14/25 at 12:03 p.m., the RDCS provided a copy of current facility policy titled, "Resident Belonging and Homelike Environment," reviewed 6/12/24. The policy indicated, "The facility will provide a safe, clean, comfortable and homelike			

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	environment ... it is the responsibility of all facility staff to create a "homelike" environment and promptly address and cleaning needs ...." 3.1-19(f)(5)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments were coded accurately for 2 of 18 residents reviewed for MDS (Residents 193 and 81). Findings include: 1. On 1/9/25 at 1:13 p.m., Resident 193 was observed on the secured memory care unit. She paced and wandered without purpose throughout the unit. She entered several other rooms that were not hers but walked back out. Staff attempted to redirect her, but Resident 193 continued to wander through the unit. On 1/10/25 at 9:07 a.m., Resident 193 was observed as she wandered, unnoticed, into another resident's room. The resident in her room, chased Resident 193 out and yelled, "get out of my room! This is not your room, you don't belong in here!" She raised her arm with a magazine in hand with a "shooing" gesture. Resident 193 walked back to the dining room and sat at a table. She indicated to a tablemate, "she got mad at me." On 1/13/25 at 2:35 p.m., Resident 193 was observed as she wandered, without purpose, through the memory care unit. Staff attempted to redirect her to the TV lounge where a movie was playing, but after Resident 193 was seated, she	F 0641	**F641** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Staff have completed a modified MDS to reflect Resident #81 and #193's exhibited behaviors or diagnosis. **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 current resident population who exhibit behaviors or have diagnosis associated with mental health diagnoses the MDS accurately reflects their diagnosis and behaviors. The interdisciplinary Team has been re-educated on completing items required on the MDS and coding accurately. **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	02/17/2025

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	would promptly stand back up and continue wandering through the unit. She entered other resident's rooms without notice. She walked herself back out after a few minutes and continued to wander through the unit. On 1/9/25 at 1:37 p.m., Resident 193's medical record was reviewed. She had diagnoses which included, but were not limited to, unspecified dementia (an irreversible degenerative brain disease which affects cognitive function and memory). She was admitted on 12/26/24, and her admission MDS, dated 12/31/24, indicated she had no wandering behaviors in the 7-day look back period for the assessment. A nursing progress note ,dated 12/26/24 at 7:44 p.m., indicated, "Resident is confused and wandering. resident trying to search her roommate drawer and went to 100 unit room. Resident is on 15 minutes check and will continue to monitor," A nursing progress note, dated 12/29/24 at 7:45 a.m., indicated, "Resident awake most of night shift. wandered on hall way an going other res rooms. unable to redirected." A nursing progress note dated 12/29/24 at 1:23 p.m., indicated, "Resident continues on safety monitoring this shift. Resident noted frequent attempting to wander in hall and resident rooms and requires constant redirection, resident is not easily redirected and becomes agitated with redirection by staff at times. Resident unable to tell staff her direction and attempt, resident noted walking at a steady fast pace. Resident is a Extensive assist with ADLs and requires assistant with meals and toileting. Resident alert to self with		MDS/MDSA and/or designee to complete and ensure accurate information is placed in MDS including but not limited to diagnosis and behaviors. The MDS/MDSA and/or designee will be responsible to audit MDS accuracy 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 information is accurately documented in the MDS assessment. 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 and/or Director of Nursing. **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 if any areas of noncompliance are identified during the auditing process until compliance has been reached.	

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	155606	A. BUILDING 00 B. WING	01/15/2025

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	confusion. Ambulates with a steady gait." A nursing progress note dated 12/31/24 at 11:06 a.m., indicated, " ...Resident to wander aimless this shift requiring frequent redirection and safety monitoring." 2. On 1/10/25 at 9:52 a.m., Resident 81's medical record was reviewed. He was a long-term care resident who resided on the secured memory care unit and had diagnoses which included, but were not limited to, vascular dementia (a type of dementia that often has a more rapid progression and sometimes manifests more drastic personality changes). On 10/24/24 Resident 81 received a new diagnoses of bipolar disorder with manic and psychotic features. Resident 81 had a Pre-Admission Screen and Record Review (PASRR) Level II which was dated 3/14/24. The PASRR indicated Resident 81 was considered to have a major mental illness and was approved for long-term care. A significant change MDS assessment, dated 7/30/24, did not code Resident 81's mental health diagnosis on Section A for PASRR. During an interview on 1/10/25 at 11:00 a.m. the Social Service Director (SSD) indicated, wandering should have been coded for Resident 193 and PASRR should have been coded for Resident 81.		The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. **Date of Compliance: 2/17/25**	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID Based on observation, interview and record review, the facility failed to ensure that accurate	F 0645	**F645** **What corrective action will be**	02/17/2025

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	information was submitted on a Pre-Admission Screen and Record Review (PASRR) Level I for 1 of 6 residents reviewed for PASRR, (Resident 68), and the facility failed to complete a new level I for a resident who admitted to the facility on a 30 day exclusion for pre-admission screening and resident review (PASARR) for 1 of 2 residents reviewed for PASARR (Resident 90). Findings include: 1. On 1/8/25 at 10:00 a.m., Resident 68 was observed in the secured memory care unit. She was pleasantly confused and engaged in a table activity. On 1/9/25 at 1:08 p.m., Resident 68's medical record was reviewed. She was a long-term care resident who resided on the secured memory care unit and had diagnoses which included, but were not limited to, psychotic disorder with delusions and unspecified dementia. A PASRR Level I, dated 10/24/22, indicated Resident 68 did not require a level II screen because she did not have a major mental illness and/or intellectual disability. The level I also indicated she did not have a neurocognitive or dementia diagnoses. During an interview on 1/10/25 at 11:00 a.m., the Social Service Director (SSD) indicated, Resident 68's Level I should have included her diagnoses of dementia and psychotic order should have been listed on her Level I to accurately determine if a Levell II would have been required. 2. On 1/9/25 at 1:42 p.m., a record review was completed for Resident 90. She had the following diagnoses which included but were not limited to schizophrenia, arthritis, hypertension (HTN),		**accomplished for those residents found to have been affected by the alleged deficient practice?** The Social Service Staff reinitiated the PASARR screening for the applicable residents. Residents 90 and 68 PASRR level 2 have been resubmitted to reflect Diagnosis. **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 current resident population associated with mental health diagnoses to validate the PASSR has been completed and updated as applicable. The interdisciplinary Team has been re-educated on completion of items required on the level 2 PASRR accurately. Social Service Staff or designee was re-educated on the completion of PASRR screening prior to admission. **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 SSD/SSA and/or designee to complete and ensure accurate information is placed in PASRRs Section A for mental health diagnosis. The SSD/SSA and/or designee will be responsible for audit PASRR accuracy 5 times a	

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	depression, anxiety, and heart failure. Resident 90 admitted to the facility on 12/9/24. She had a level I that was completed on 12/5/24 indicating she was approved to stay at the facility for 30 days. The 30 days expired on 1/4/25. A new level I could not be located in her medical records and it was not received upon request. During an interview with the Social Service Assistant (SSA) on 1/14/25 at 12:10 p.m., she indicated she did not know why a new level I was not completed. During an interview with the Director of Nursing on 1/14/25 at 1:45 p.m., she indicated she did not know why a new level I was not created. A policy titled, "Pre-admission Screening and Resident Review (PASARR) was provided by the Executive Director (ED) on 1/10/25 at 9:30 a.m., " ...Ensure Level I PASSAR screening has been completed on potential admissions prior to admission. A record of the pre-screening should be retained in the resident's medical record ...." 3.1-16(d)		week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months validating information is accurately documented in the level 2 PASRR assessment. 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 and/or Director of Nursing. **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 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. **Date of Compliance: 2/17/25**	
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

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Bldg. 00	Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were reviewed and revised as needed with resident's updated interventions for 1 of 18 residents reviewed for care plan revisions, (Resident 14). Findings include: On 1/9/25 at 10:17 a.m., Resident 14's room was observed. There was a picture hung to the wall above her bed, which depicted the resident's left arms with a black splint in place. The picture had instructions to keep brace on at all times. Throughout the survey week, Resident 14 was not observed to wear any brace or splint. On 1/9/25 at 2:04 p.m., Resident 14's medical record was reviewed. She was a long-term care resident who resided on the secured memory care unit with a diagnosis of dementia. She had a comprehensive care plan 1/2/24 which indicated, she had an activities of daily living (ADL) self-care performance deficit related to her diagnoses. Interventions for her plan of care included but were not limited to, "wear L [left] edema glove and L wrist orthotic at all times. Cover with bandage during bathing." During an interview on 1/14/25 at 11:17 a.m., the Director of Therapy (DOT) indicated, Resident 14's brace had been used more than a year ago after she fractured her wrist, but she no longer required the brace or edema glove and the care plan should have been revised as well as the	F 0657	**F657** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident # 14's care plan and interventions reviewed and updated to ensure accurate to resident's needs and orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The DOR and/or Designee completed a one-time 30 day look back of current population using adaptive devices to ensure care plans are current and accurate. Any deficiencies noted will be corrected. The interdisciplinary Team has been re-educated reviewing and updating care plans timely with changes at time of change. **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 DOR and/or Designee for reviewing and updating care plans timely with changes at time of change to therapy care plans to ensure accuracy. Administrator/DON re-educated IDT on reviewing and updating care plans timely with	02/17/2025

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	picture in her room removed.		changes at time of change to therapy care plans to ensure accuracy. Staff who are non-compliant will receive additional education and/or progressive discipline as appropriate. The DOR and/or Designee will be responsible to audit therapy care plans for accuracy 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 care plans are completed and accurate. 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 and/or Director of Nursing. **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 if any areas of noncompliance are identified	

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			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. **Date of Compliance: 2/17/25**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to ensure a resident's activities of daily living were completed for 1 of 8 residents reviewed for completed ADLs (Resident B). Findings include: On 1/9/25 at 11:38 p.m., Resident B's medical record was reviewed. He was admitted on 5/23/24. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (lung disease), diabetes mellitus (blood sugar disorder) with chronic kidney disease, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (causes breathing to stop or be reduced during sleep). A care plan, dated 6/6/24, indicated Resident B was dependent on staff for meeting emotional, intellectual, physical, and social needs. A care plan, dated 5/24/24, indicated Resident B needed assistance with mobility and activities of daily living (ADL)s. On 1/08/25 at 12:10 p.m., Resident B's toenails	F 0677	**F677** **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 with information on resident B'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 toenails for current resident populations to ensure they are trimmed and groomed properly and added to the Podiatry list if needed. Any deficiencies noted will be corrected. The interdisciplinary Team has been re-educated on nail care, notification and podiatry visit procedures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	02/17/2025

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	were observed outside of his blanket. They were extremely long; the left toenail was jagged. He indicated he was unable to put them under the blanket due to pressure and coarseness. On 1/13/25 at 9:53 a.m., the Executive Director (ED) provided documentation of a podiatry visits on 12/21/24, Resident B was not seen. On 1/9/25, Resident B saw the podiatrist and was added to the 60-recall list. On 1/13/25 at 11:43 a.m., the ED provided further information regarding Resident B seeing the podiatrist. On 6/25/24 and 10/4/25, Resident B was not seen. During an interview, on 1/13/25 at 12:17 p.m., the Director of Nursing (DON) indicated the residents should be seen routinely when the podiatry doctor comes in. The nurses notify the Social Services Director (SSD), then the SSD makes out the list of residents to be seen. A current policy, titled, "Resident Rights," dated 9/10/24, was provided by the Executive Director (ED), on 1/13/24 at 11:34 a.m. A review of the policy indicated, " ...The resident has the right to reside and receive services in the facility with reasonable accommodation of resident and preferences ...." This citation relates to Complaint IN00449427. 3.1-38(a)(3)(E)		It is the responsibility of the nursing staff /designee to ensure ADL care, including but not limited to, toenail care is completed to meet the resident's needs. Nursing Staff were re-educated by the Nursing Administrative staff/designee on ADL's to include but not limited to feet/toenail care to meet the needs of residents in facility, ADON/ designee will monitor 10 residents 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 feet/toenail care. 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 and/or Director of Nursing. **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 if any areas of noncompliance are identified	

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			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. **Date of Compliance: 2/17/25**	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices A. Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident H) who had a history of falls received interventions to prevent a fall in which he sustained a nasal fracture for 1 of 8 residents reviewed for accidents. B. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when a resident, (Resident 193) who had exhibited behaviors of intrusive wandering, continued to intrusively wander into other residents' rooms and upset them for 1 of 8 residents reviewed for accidents. C. Based on observation, interview, and record review, the facility failed to ensure the Elopement binder was up to date that included four current residents (Residents 193, 89, 74 and 73) who were at risk for elopement for 4 of 8 residents reviewed for accidents. D. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when medications were left at bedside for two residents (Residents 1 and 13) for 2 of 8 residents reviewed for accidents. Findings include:	F 0689	**F 689** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The facility was not provided identifying information for Resident H. Resident #193 has been successfully discharged from the facility. The Elopement book has been updated to include Residents 89, 74, and 73. Resident 193 has been discharged from the facility. Resident #13 has had self-medication assessment completed with revised orders for med to be kept at bedside as Resident is fully capable of administering cough drops to self. There is no provided information regarding resident #1 listed in the facility report. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	02/17/2025

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	A. On 1/8/25 at 10:11 a.m., Resident H was observed as he sat on the side of his bed. The Resident had nonskid socks on his feet, his bed was in the lowest position with a regular mattress on the frame, his call light was not within reach and his side rails were not padded. On 1/10/25 at 9:35 a.m., Resident H was observed as he laid in his bed on his back and rested with his eyes closed. His call light was not within reach, there was a regular mattress on the bed frame and his side rails were not padded. During an interview on 1/13/25 at 9:33 a.m., Licensed Practical Nurse (LPN) 15 indicated Resident H went out to the hospital on 1/11/25 early in the morning on night shift after a fall. On 1/13/25 at 10:20 a.m., Resident H's medical record was reviewed. He was a long-term care resident whose diagnoses included, but were not limited to, abnormalities of gait and mobility, lack of coordination, muscle weakness, difficulty in walking and history of falling. He had a comprehensive care plan, dated 10/8/18, which indicated he had an Activities of Daily Living (ADL) self-care performance deficit due to left sided weakness. Interventions for this plan of care included, but were not limited to, he required a scoop mattress. He had a comprehensive care plan, dated 1/3/24, which indicated he was at risk for falls due to a history of falls. Interventions for this plan of care included, but were not limited to, his side rails should have been padded to prevent injury. A nursing progress note, dated 11/21/2024 at 8:00 a.m., indicated nursing staff noticed new		**action will be taken:** A one-time review of residents with fall history in the past 30 days, from January 5, 2025 – February 5, 2025, has been completed validating fall interventions listed in resident care plans are in place. A one-time review of current resident population has been completed for the past 30 days, 1/5/25 – 2/5/25, to identify residents with wandering behaviors who have the potential to be involved with negative behaviors from others. A one-time review of the Elopement book has been completed to validate the book is up to date with current residents at risk for elopement. A one-time audit has been completed of resident rooms to validate the facility has no medications at bedside without the appropriate self-medication assessment and MD order. The facility staff have been provided re-education on fall prevention and implementation of care plan interventions, wandering behaviors and how the resident could be affected with negative behaviors from others, and licensed nurses – Qualified Medication Aides have been re-educated on only leaving medications at bedside with appropriate order and assessment. The IDT has been provided re-education in reviewing and updating the elopement book for current information at a	

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	discoloration to Resident H's upper right arm and inner right leg. Resident H told the staff he had fallen out of bed. An interdisciplinary team (IDT) note, dated 11/22/2024 at 9:22 a.m., indicated when nursing staff asked about the bruising to his arm and leg, Resident H reported he fell from bed. A head-to-toe assessment was completed with bruising noted to the Residents right inner arm and right leg. Upon review of Resident H's room and chart it was noted that resident utilizes side rails for help with movement. IDT completed a side rail assessment to ensure side rails were still appropriate and it was determined that they were. Resident Hs care plan was reviewed and updated to include padding to side rails to prevent injury. A nursing progress note, dated 1/11/2025 at 4:37 a.m., indicated LPN 33 observed Resident H awake in his bed with new bruises to both his eyes. Resident H indicated he may have fallen but was not sure. Resident H was sent to a local hospital for further treatment. A history and physical from a local hospital, dated 1/11/25 at 1:57 p.m., indicated Resident H arrived to the hospital as a trauma 1 patient after being found in his bed with periorbital ecchymosis (bruising around the eyes that appears as dark purple or blue discoloration.) and nasal bone fracture. In an interview on 1/14/25 at 12:36 p.m, CNA 32 indicated she worked the night shift (11:00 p.m. to 7:00 a.m.) on the evening of Resident H's accident. She indicated, she did not know she had been assigned to Resident Hs room, and had not seen him until she was asked by the nurse to help clean him up.		minimum of monthly, or with census changes requiring revisions. **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the responsibility of the IDT and/or Licensed Nurses to validate new fall interventions that are implemented as per care plan. It is the responsibility of the IDT to monitor residents with increased wandering behaviors and the effects of such to others. It is the responsibility of the Social Services Department staff to review and revise the elopement book routinely and update information. It is the responsibility of the Licensed Nursing and QMA staff to safely pass medications and not leave medications at bedside without resident assessment and order to do so. The DON/Designee will be responsible for reviewing and validating fall interventions that are in place upon identification by IDT 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. The Social Services staff/designee will be responsible for reviewing for increases in wandering behavior 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months,	

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	155606	A. BUILDING 00 B. WING	01/15/2025

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	In an interview on 1/14/25 at 1:42 p.m., LPN 33 indicated, when he arrived for his shift, he had been asked by the outgoing nurse to check on Resident H's roommate's bed. When LPN 33 went to check on the bed as requested, he noticed the new bruises to Resident H's face. He asked the Resident what happened, but Resident H was confused and had a few different stories. On 1/15/25 at 3:05 p.m., the Director of Nursing (DON) provided a copy of a current facility policy titled, "Fall Management" dated 9/25/24. The policy indicated, " ...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, if not, reduce the risk of an accident ...." This citation relates to Complaint IN00451144.B. On 1/9/25 at 1:13 p.m., Resident 193 was observed on the secured memory care unit. She paced and wandered without purpose throughout the unit. She entered several other rooms that were not hers but walked back out. Staff attempted to redirect her, but Resident 193 continued to wander through the unit. On 1/10/25 at 9:07 a.m., Resident 193 was observed as she wandered, unnoticed, into another resident's room. The resident in her room, chased Resident 193 out and yelled, "get out of my room! This is not your room, you don't belong in here!" She raised her arm with a magazine in hand with a "shooing" gesture. Resident 193 walked back to the dining room and sat at a table. She indicated to a tablemate, "she got mad at me."		and reviewing the elopement book to validate the book is updated 5 times a week for 2 weeks, 3 times a week for 6 weeks, weekly for 4 weeks, and then monthly for 3 months. The DON/Designee will be responsible for monitoring 10% of resident rooms for medications in rooms without assessment or order 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 and/or Director of Nursing. **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 if any areas of noncompliance are identified during the auditing process until compliance has been reached. The Health Facility Administrator	

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	On 1/13/25 at 10:06 a.m., Resident 193 followed another resident, they both entered a room that was not theirs and were chased out by the occupant who yelled at them, "get out of here, you don't belong here!" On 1/13/25 at 2:35 p.m., Resident 193 was observed as she wandered, without purpose, through the memory care unit. Staff attempted to redirect her to the TV lounge where a movie was playing, but after Resident 193 was seated, she would promptly stand back up and continue wandering through the unit. She entered other residents' rooms without notice. She walked back out after a few minutes and continued to wander through the unit. On 1/9/25 at 1:37 p.m., Resident 193's medical record was reviewed. She had diagnoses which included, but were not limited to, unspecified dementia (an irreversible degenerative brain disease which affects cognitive function and memory). She was admitted on 12/26/24, and her admission MDS, dated 12/31/24, indicated she had no wandering behaviors in the 7-day look back period for the assessment. A nursing progress note, dated 12/26/24 at 7:44 p.m., indicated, "Resident is confused and wandering. resident trying to search her roommate drawer and went to 100 unit room. resident is on 15 minutes check and will continue to monitor..." A nursing progress note, dated 12/29/24 at 7:45 a.m., indicated the resident was awake most of night shift, wandered on hallway, and was going into other residents' rooms. Staff were unable to redirect the resident.		at Westside Village is responsible for ensuring compliance with this plan of correction. **Date of Compliance: 2/17/25**	

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	A nursing progress note, dated 12/29/24 at 1:23 p.m., indicated, "Resident continues on safety monitoring this shift. Resident noted frequent attempting to wander in hall and resident rooms and requires constant redirection, resident is not easily redirected and becomes agitated with redirection by staff at times. Resident unable to tell staff her direction and attempt, resident noted walking at a steady fast pace. Resident is a extensive assist with ADLs and requires assistant with meals and toileting. Resident alert to self with confusion. Ambulates with a steady gait." A nursing progress note dated 12/31/24 at 11:06 a.m., indicated, " ...Resident to wander aimless this shift requiring frequent redirection and safety monitoring." During an interview on 1/13/25 at 2:32 p.m., Activity Assistant 29 indicated Resident 193 and a couple other residents did wander and were not easily engaged or redirected to activities. Staff were usually able to get Resident 193 out of other rooms, but when she was brought to the activity, she would get up moments later and begin wandering again. During an interview on 1/13/24 at 2:38 p.m., Certified Nursing Assistant (CNA) 26 indicated Resident 193 was new to the unit but had not stopped intrusively wandering. She knew where her room was, but was a friendly resident and liked to go into other Residents room out of curiosity and confusion. Staff tired to keep an eye on her but often both CNAs would be busy with other residents and were not always able to catch her before she wandered into others rooms. It did make some residents angry.			

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	On 1/10/24 at 11:05 a.m. the Executive Director (ED) provided a copy of current facility policy titled, "Unsafe Wandering and Elopement," reviewed 9/13/23. The policy indicated, " ...the facility must ensure that ... each resident receives adequate supervision and assistance devices to prevent accidents ... unsafe wandering- it can be associated with an increased risk for falls and injuries ... Entering into another resident's room may lead to an altercation or contact with hazardous items ...." C. On 1/10/25 at 10:00 a.m., the facility's Elopement Binder was located in a cabinet at the front entrance reception desk. The Receptionist indicated she did not know if it was up to date, or how often it was reviewed. On 1/10/25 at 10:15 a.m., the Binder was reviewed and revealed, five residents' information was still in the book, although they no longer resided in the facility, and four residents who were still in the facility and had been assessed at risk for elopement, had not been included in the binder. 1. Resident 193 resided on the secured memory care unit and had a diagnosis of dementia. An admission nursing progress note, dated 12/26/24 at 3:57 p.m., indicated, Resident 193, " ... may exit seek and [is] at risk for fall due to history of falls and exit seeking ...." An Elopement Risk Evaluation, dated 12/26/24, indicated Resident 193 was at risk for Elopement. She had a comprehensive care plan, initiated 12/26/24 which indicated she was at risk for elopement with an intervention which included, but was not limited to, "Add resident to the			

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	Elopement Book." 2. Resident 89 was a long-term care resident who resided on the secured memory care unit with a diagnoses of dementia. A nursing progress note, dated 12/4/24 at 6:12 a.m., indicated, " ...wandered on hallway. Going [in] other [resident] rooms. Redirected but [resident] forgetful ...." An Elopement Risk Evaluation, dated 1/5/25, indicated Resident 89 was at risk for Elopement. She had a comprehensive care plan, initiated 12/7/24 which indicated she was at risk for elopement with an intervention which included, but was not limited to, "Add resident to the Elopement Book." 3. Resident 74 was a long-term care resident who resided on the secured memory care unit with a diagnosis of dementia. A nursing progress note, dated 11/8/24 at 2:56 p.m., indicated, " ... Resident noted to aimless wander and require constant redirection ...." An Elopement Risk Evaluation, dated 11/13/24, indicated, " ...Resident at risk for elopement r/t [related to] above risk assessment and frequent wandering. MD [Medical Doctor] notified with new orders to admit to secure unit for safety ...." She had a comprehensive care plan, initiated 11/13/24, which indicated she was at risk for elopement with an intervention which included, but was not limited to, "Add resident to the Elopement Book."			

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	4. Resident 75 was a long-term care resident who resided on the secured memory care unit with a diagnosis of dementia. An Elopement Risk Evaluation, dated 11/19/24, indicated, " ... Resident wandering and exit seeking, not easily redirectable, admitted to secure Unit ...." She had a comprehensive care plan, initiated 11/19/24, which indicated she was at risk for elopement with an intervention which included, but was not limited to, "Add resident to the Elopement Book." Residents 193, 89, 74 and 75 were not included in the Elopement Binder. On 1/10/24 at 11:05 a.m. the Executive Director (ED) provided a copy of current facility policy titled, "Unsafe Wandering and Elopement," reviewed 9/13/23. The policy indicated, " ...A system of identification for Residents identified with potential for unsafe wandering and elopement will be in place, including but not limited to: a. current photographs of residents. b. current responsible party contact information ...."D. On 1/9/25 at 11:38 p.m., Resident B's medical record was reviewed. He was admitted on 5/23/24. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (lung disease), diabetes mellitus (blood sugar disorder) with chronic kidney disease, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (causes breathing to stop or be reduced during sleep). There was no order for the miconazole 2% cream,			

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	and no order to allow the fluticasone furoate/vilanterol inhaler or the to be kept in the resident's room. On 1/8/25 at 1:06 p.m., medications were observed in Resident B's room. On his over-the-bed table was a bottle of gum wash (mouth wash) and fluticasone furoate/vilanterol inhaler (corticosteroid to reduce inflammation in the lung and bronchodilator). There was no open date on the inhaler. On his dresser, was a tube of miconazole 2% (antifungal cream). During an interview, on 1/13/25 at 12:20 p.m., the Director of Nursing (DON) indicated Resident B did not have an order or assessment to have medications in his room. On 1/10/25 at 12:33 p.m., Resident 13's record was reviewed. She was admitted on 6/21/21. Her diagnoses included, but were not limited to, idiopathic peripheral autonomic neuropathy (nerve pain), diabetes mellitus (blood sugar disorder), edema (swelling) in both lower extremities, and another diagnosis, dated 1/7/25, of pneumonia. On 1/9/25 at 8:56 a.m., Resident 13 was observed to have sore throat medication in her room, the ingredient inside the bottle was phenol. She also had menthol spray (treats joint pain), over-the-counter antacid, and diclophenac sodium gel (treats joint pain) on her over the bed table, she indicated she got it from the hospital yesterday. On 1/10/25 at 8:47 a.m., Resident 13's room was observed again with the sore throat medicine, menthol spray, antacids, and diclophenac sodium			

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	gel still in her room. On 1/13/25 at 9:45 a.m., Resident 13's January MAR/TAR (medication administration record and treatment administration record) were reviewed. Resident 13 did not have orders for sore throat medicine, menthol spray, antacids, and diclophenac sodium gel in her room. During an interview, on 1/13/25 at 12:19 p.m., the DON indicated Resident 13 only had an order and assessment to have honey cough drops in her room. There was no self-administration assessment for the sore throat medicine, menthol spray, antacids, and diclophenac sodium gel in her room. A current policy, titled, "Self-Administration of Medication," dated 9/16/24, was provided by the Executive Director (ED), on 1/10/25 at 9:30 a.m. A review of the policy indicated, " ...The facility will ensure that each resident who requests to self-administer medications is assessed by the interdisciplinary team (IDT) to determine if the resident is safe to self-administer medications ...." 3.1-45(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure a resident with a gastrointestional tube had appropriate services and documentation for medications and nutrition for 1 of 1 residents reviewed for gastrointestinal tube (G-tube) (Resident 295). Findings include:	F 0693	**F 693** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident #295 has had medication administration orders for route clarified, indicating medications	02/17/2025

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	On 1/9/25 at 9:35 a.m., Resident 295 was observed to have a G-tube, but the Resident indicated that the nurses do not use it for anything. During an interview on 1/9/25 at 10:16 a.m., Licensed Practical Nurse (LPN) 8 indicated nursing staff did not use Resident 295's G-tube for medications or feeding supplements. During an interview on 1/10/25 at 10:46 a.m., LPN 17 indicated she did not care for the Resident often, but she knew nursing staff did not use the G-tube for anything, and only followed orders to flush it. During an interview on 1/10/25 at 11:55 a.m., LPN 15 indicated she was newer to that hall but she had never had to use the Resident's G-tube for medications or feeding supplements. LPN 15 indicated nursing staff only administered Glucerna (a high calorie supplemental shake) if the Resident had consumed 50% or less of her meal and she had never had to give it because the Resident regularly ate over 50% of her meal. On 1/10/25 at 9:30 a.m., Resident 295's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, cerebral infarction (stroke), type two diabetes and obesity. She had physician's orders to receive 8 out of 20 medications by Gtube, a regular diet and for Glucerna as needed if Resident ate 50% or less of her meals. Resident 295 was weighed upon admission at 167.4 pounds. A second weight recorded on 1/1/25 documented Resident 295's weight		are to be given orally. The supplemental nutritional drink has been clarified for use. The resident's current weight status has been reviewed to validate there has not been an excessive weight gain. The care plans have been reviewed/revised 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 current resident population has been completed for those residents with gastrostomy tubes to validate medication administration route, weight status, as well as supplement nutritional needs. The Licensed Nurses and IDT have been provided re-education on medication administration for residents with a gastrostomy tube, following medication – supplement orders as written, and correctly weighing a resident at the time of admission at facility vs taking previous weight from other sources. **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 Nurses to administer medications as per MD order, obtain weights at facility vs using	

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	increased to 218.0 pounds and a third weight recorded on 1/8/25 documented Resident 295's weight increased to 220.6 pounds. Resident 295's MAR was reviewed for 1/1/25 - 1/10/25 and indicated check marks for the administration of Glucerna for 8 of 28 observations. A general progress note, dated 12/14/24 at 11:41 p.m., indicated Resident 295 was to receive a bolus (pushing an ordered amount of liquid nutrition through a G-tube all at once) of Glucerna if she orally consumed less than 50% of her meals three times a day. The note indicated, the G-tube was placed on 11/5/24 to keep up nutrition after a cerebrovascular accident (stroke). A health status progress note, dated 1/3/25 at 9:43 p.m., indicated Resident 295 was able to feed herself with set up assistance and she consumed 75% to 100% of her meals. A dietary note, dated 1/9/25 at 9:30 a.m., indicated Resident 295 had a weight warning trigger and a re-weight was needed. During an interview on 1/13/25 at 12:04 p.m., with the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) present, the DON indicated, the nurses did not use Resident 295's G-tube for medications or feeding supplements. They indicated the Glucerna should only be given as needed if the resident eats less than 50% of her meal. They agreed in her medical record it did look like she had a weight gain of approximately 50 pounds in one month. They indicated the Interdisciplinary Team (IDT) managed the Residents' weight.		weights from other sources, and to administer nutritional supplements as per MD order. The DON/Designee will be responsible for validating gastrostomy tube medication administration is completed as per order, weights are obtained at time of admission, and nutritional supplements are administered as per MD order 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 and/or Director of Nursing. **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 if any areas of noncompliance are identified during the auditing process until compliance has been reached.	

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	On 1/13/25 at 2:00 p.m., the DON provided documentation the 8 medications ordered to be given by G-tube had been corrected, and that the orders to give medications via G-tube had been incorrect. On 1/14/25 at 10:22 a.m., the DON provided a document from a previous health care provider which recorded her weight before admission on 12/1/24 was 224.7, which meant she had not gained more than 50 pounds. On 1/15/25 at 3:05 p.m., the DON provided a copy of a current facility policy titled, "Weights and Heights" dated 9/20/24. The policy indicated "All residents are weighed within 24 hours of admission and weekly for 4 weeks..." 3.1-44(a) 3.1-44 (1)		The Health Facility Administrator at Westside Village is responsible for ensuring compliance with this plan of correction. **Date of Compliance: 2/17/25**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure oxygen (O2) levels were set correctly for 2 of 2 residents using nasal cannulas (NC) (Resident Z and B), and the facility failed to ensure humidifier bottles for oxygen administration were changed at 7 day interval, and a bipap mask and tubing were protected from contamination for 1 of 2 residents reviewed for contamination of bipap masks and tubing when not in use (Resident B). Findings include: 1. On 1/10/25 at 12:33 p.m., Resident Z's record was reviewed. Her diagnoses included, but were not limited to, idiopathic peripheral autonomic	F 0695	**F 695** **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 information on the identity of Residents Z and B. **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 the current resident population has been	02/17/2025

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	01/15/2025

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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	neuropathy (nerve pain), diabetes mellitus (blood sugar disorder), edema (swelling) in both lower extremities, and another diagnosis, dated 1/7/25, of pneumonia. A new physician's order, dated 1/10/25, indicated 2 liters of oxygen per minute (lpm) as needed for shortness of breath. Staff may titrate (change) to keep oxygen saturations above 90%. A respiratory care plan, dated 12/19/24, indicated Resident Z would have no signs or symptoms of poor oxygen absorption. The approaches included giving medications as ordered by the physician. Her oxygen via nasal prongs (NC) at 3L per minute. On 1/9/24 at 9:09 a.m., Resident Z was observed eating her breakfast feeling short of breath (SOB). Her O2 concentrator was set to 1 liter per minute (lpm). She indicated it should be at 2 lpm. Her NC was not dated and the O2 humidity bottle was dated 12/31/24. She was wearing her O2 cannula upside down. During an interview, on 1/9/24 at 9:16 a.m., Licensed Practical Nurse (LPN) 8 indicated Resident Z was on 1L of O2 and her O2 blood saturation was 87%. LPN 8 changed the O2 concentrator to 2L and after a few deep breaths. Resident Z indicated she still felt SOB and needed a breathing treatment. LPN 8 indicated she was not Resident Z's nurse and wasn't sure where her nurse was at this time. LPN 8 did not auscultate her chest to listen to lung sounds. She indicated she would contact the Physician's Assistant (PA) 9. For an evaluation and orders. On 1/8/24 at 9:26 a.m., LPN 8 provided an albuterol nebulizer treatment.		completed validating oxygen needs and orders. A one-time audit of the current resident population with bipap/cpap mask devices with tubing has been completed validating appropriate storage of devices when not in use. The Licensed Nurses have been re-educated on cleaning and storage of devices not in use. **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 Nurses to clean and store unused mask devices with tubing. The DON/Designee will validate the cleaning and storage of mask devices/tubing when not in 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 immediately corrected, 1:1 re-education completed with staff personnel as identified, with disciplinary action completed as determined necessary by the Administrator and/or Director of Nursing. **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	

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	155606	A. BUILDING 00 B. WING	01/15/2025

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	During an interview, on 1/9/25 at 9:28 a.m., LPN 37 indicated Resident Z came back from the hospital yesterday and the facility staff put her on 1L of O2. She indicated Resident Z was coughing last night. No one was supposed to be on 1L of oxygen. The resident had not been back to the facility for 24 hours yet and she had not had a chance to look at her chart. She provided a print-out of her medications including the new hospital medications. LPN 37 indicated Resident Z's O2 saturation kept dropping below 90% during her nebulizer treatment. During an interview, on 1/9/25 at 9:42 a.m., LPN 37 indicated, as Resident Z was finishing the nebulizer treatment, that her O2 saturation at 88%. Resident Z indicated she was feeling dizzy. On 1/9/25 at 9:44 a.m., Resident Z's O2 saturation was observed at 87%. No nurses were in the resident's room at this time. On 1/9/25 at 9:46 a.m., LPN 37 brought in a stethoscope. She indicated her heard wheezing in her left, upper posterior chest and her O2 saturations were all over the place. On 1/9/25 at 9:50 a.m., the PA 9 was observed assessing Resident Z. LPN 37 told her the albuterol nebulizer was a new order from the hospital. Resident Z told her she was coughing up phlegm (mucus from the chest) and wanted to get more pain medications for her feet. The PA had her dangle her legs over the side of the bed, the effort brought her O2 saturation down to 82%, then it jumped up to 99%. During an interview, on 1/9/25 at 10:01 a.m., LPN 37 indicated Resident Z had a new hospital order		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 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. **Date of Compliance: 2/17/25**	

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	for tiotropium (opens the airways) as rescue inhaler. PA indicated she needed a pulmonary (lung) doctor. On 1/9/25 at 10:04 a.m., LPN 37 left to see if the new inhaler was here. Resident Z indicated she wanted to use it. On 1/9/25 at 10:06 a.m., with the PA near her, Resident Z indicated she was dizzy. On 1/9/25 at 10:08 a.m., LPN 37 indicated the rescue inhaler was in the medication cart. 2a. On 1/9/25 at 11:38 p.m., Resident B's medical record was reviewed. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (lung disease), diabetes mellitus (blood sugar disorder) with chronic kidney disease, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (causes breathing to stop or be reduced during sleep). His physician orders indicated O2 at 2L per minute continuously per nasal cannula related to acute and chronic respiratory failure with hypoxia (low oxygen levels) and hypercapnia (increased carbon dioxide levels). His bi-pap care plan, dated 5/24/24, indicated the resident was at risk for alteration in breathing patterns related to chronic obstructive pulmonary disease (COPD) with hypoxia (low oxygen levels) and obstructive sleep apnea and requires the use of a bi-pap during sleeping hours. An approach was to recognize he was at risk for respiratory illness. He would be free of signs and symptoms of respiratory infections.			

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	On 1/8/25 at 12:14 p.m., Resident B's oxygen concentrator was set at 3 LPM, he indicated it should have been on 2 lpm. His bipap tubing was observed disconnected and laying on the floor. His uncovered bipap mask was observed laying in the corner of the windowsill with his bipap machine. Dust, dirt, hair, and caulking debris were noted on the windowsill. Dust and possibly water spots were noted on the bipap mask. During an interview, on 1/8/25 at 12:17 a.m., Resident B indicated he liked to go to sleep between 11:00 to 12:00 p.m. He would use his call light and wait until 2:00 to 3:00 a.m. sometimes before the bi-pap mask would be put on him. Sometimes, he would have to sleep without it. He would like to have it put on at 11:00 p.m. each night. He indicated the bipap mask had been dropped on the floor and not cleaned or replaced. He preferred the mask to be covered during the day. On 1/10/25 at 9:07 a.m., Resident B's uncovered bipap mask was observed laying in the corner of the windowsill with his bipap machine. Dust, dirt, hair, and caulking debris were noted on the windowsill. Dust and possibly water spots were noted on the bipap mask. On 1/13/25 at 12:24 p.m., the Director of Nursing (DON) indicated a bipap mask when not in used should be covered and tubing should not be on the floor. A current policy, titled, "Oxygen Administration (Safety, Storage, Maintenance)," dated 10/11/24, was provided by the Regional Director of Clinical Services (RDCS), on 1/13/25 at 3:57 p.m. A review of the policy indicated, " ...Respiratory care ...consistent with professional standards of			

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	practice ...Humidifier/Aerosol bottles should be dated and replaced every 7 days regardless of H2O (water) level ...Store oxygen and respiratory supplies in bag labeled with resident's name when not in use ...." This citation relates to Complaint IN00449427. 3.1-19(bb)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to obtain a blood pressure as indicated in an order prior to administration of a blood pressure medication for 1 of 4 residents reviewed (Resident 250). Findings include: On 1/10/25 at 12:36 p.m., a record review was completed for Resident 250. She had the following diagnosis which included but not limited to gastro-esophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), age-related osteoporosis, and schizoaffective disorder. She had an order for prazosin HCL capsule 1 milligram (mg) by mouth at bedtime for prophylaxis. Hold if systolic blood pressure (SBP) was less than 100 or pulse less than 60. The order lacked instructions to obtain a blood pressure prior to administering the medication. During an interview with the Director of Nursing (DON) on 1/14/25 at 1:45 p.m., she indicated there should have been a blood pressure added to the order.	F 0757	**F757** **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident #250's blood pressure medication order reviewed for supplemental documentation to include BP results prior to holding medication per parameters updated and accurate. **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 residents on Blood pressure medications reviewed to ensure there is supplemental documentation in place for blood pressure reading prior if there is a hold order. The interdisciplinary Team has been re-educated on order entry for supplemental documentation and parameters.	02/17/2025

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	01/15/2025

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	A policy titled "Administration of Medications" was provided by the Regional Director of Clinical Services (RDCS) on 1/14/25 at 2:03 p.m. It indicated, " ...Right Assessment. Note the resident's history and any parameters around drug administration ...". 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)		**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 Administrative Staff/designee to ensure orders are inputted accurately with parameters and supplemental documentation if needed. Nursing Staff were re-educated by the Nursing Administrative Staff on order for supplemental documentation and parameters. ADON/designee will monitor new/readmitting and 10 residents 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 accurately entering orders with parameters and supplemental documentation. 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 and/or Director of Nursing. **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	

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

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			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 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. **Date of Compliance: 2/17/25**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to remove expired drugs from the population for 2 of 2 medication rooms observed (medication rooms 100 and 300). Findings include: On 1/13/25 at 9:52 a.m., medication room 100 was observed to have a bottle of lorazepam belonging to Resident 28 in the refrigerator. The bottle had his name written on it. The bottle was opened and there was no date to indicate when it was opened. In the 100-medication room, an opened bottle of aplisol (used to test for tuberculosis) was in the refrigerator. It had a date opened of 12/26/24. It had expired. In the 300-medication room, an opened bottle of chlorpactin 2mg/liter belonging to Resident 27. It was sent by the pharmacy on 12/26/24. In the	F 0761	F761 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No resident were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** A one-time review of medication/treatment carts and medication refrigerates on each unit has been completed to validate there were no other expired medications and medication/treatments were labeled with open and EXP dates. The Nursing Staff were	02/17/2025

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	155606	A. BUILDING 00 B. WING	01/15/2025

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	expiration space 12/30/24 was written in. RN 5 brought the bottle in and stated the date opened was 12/30/24 and that it was not expired. The medication was good for 10 days in the refrigerator. That time had expired. A policy titled "Storage and Expiration Dating of Medications, Biologicals" was provided by the Regional Director of Clinical Services (RDCS) on 1/14/25 at 2:03 p.m. It indicated, " ...Facility should ensure that medications and biologicals that; (1) have an expired date on the label; (2) have been retained longer than recommended by the manufacturer or supplies guidelines; (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier ...If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		re-educated by the Nursing Administrative staff 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 medication upon opening and to remove expired medication. ADON/designee will be responsible for auditing medication carts and medication refrigerators 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 open dates are correct and medication(s) are removed from the carts and refrigerators at time of expatriation. 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 and/or Director of Nursing. **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	

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

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			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 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. **Date of Compliance: 2/17/25**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observations and interviews, the facility failed to provide hand hygiene between residents and wear gloves when administering an ear drop to a resident (Resident 19) for 1 of 1 Qualified Medication Aide (QMA 21) observed. Findings include: On 1/14/25 at 8:25 a.m., medication administration observation was completed with QMA 21. She had already had a resident's medications in a cup and ready to administer. She went to administer the medications and came back to her medication cart. She did not perform hand hygiene before going to the next resident (Resident 20). She prepared his medications and administered his medications to him, came back to the medication cart and did not perform hand hygiene. She went to the next resident, Resident 25 and prepared his medications. She administered his medications and returned to the cart. She did not perform hand hygiene after administering his medications.	F 0880	F880 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** No identifiers for residents #19 and #20 were provided on the Resident Identifier List. Resident cited on 2567 was #25 resident has been assessed by clinical and do not have any abnormalities or ill effects. The QMA was removed from cart and completed re-education on hand Hygiene during medication pass prior to returning to medication pass. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	02/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Lastly, she prepared Resident 19's medications. She went to resident's room and administered the medications. She had ear drops to administer to the resident's left ear. She pushed the resident's ear down with an ungloved hand and administered the drops without a glove on the other hand. The QMA was asked about performing hand hygiene and she pulled out a box of individual wipes. On 1/14/25 at 1:48 p.m., the Director of Nursing (DON) indicated the QMA was removed from the floor until she could be provided with additional education. A policy titled, "Ear Drop Instillation" was provided by the Regional Director of Clinical Services (RDCS) on 1/14/25 at 10:56 a.m. It indicated " ...put on gloves, as needed, to comply with standard precautions ....". 3.1-18(a)		A one-time hand hygiene competency assessment completed for all QMAs. The Nursing Staff were re-educated by the Nursing Admin/Designee on proper hand hygiene during medication pass. Any deficiencies noted will be corrected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be educated relative to infection control policy and procedure, including but not limited to, on proper hand hygiene (handwashing and ABHS), specifically with regards to when to use wash hands with soap and water and when it is appropriate to use ABHS. The IP nurse/Designee will complete visual rounding audits 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 staff are practicing appropriate Infection Control Practices, including but not limited to hand hygiene. 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 and/or Director of Nursing. **How the corrective action will be monitored to ensure the**	

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			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 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. **Date of Compliance: 2/17/25**	
F 0908 SS=D Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair (WC) (Resident 14) was maintained in a safe operating condition with a broken brake and brake handle and a resident's WC's left arm did not slide inappropriately forward and back (Resident 1) for 2 of 16 wheelchair reviewed for proper working order Findings include: 1. On 1/8/25 at 11:02 a.m., Resident 1's wheelchair's left arm was observed to be broken. It was freely moving forward and backward.	F 0908	F908 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident 1's wheelchair's arm was repaired. Resident 14's wheelchair was repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	02/17/2025

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

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	On 1/8/25 at 11:02 a.m., Resident 1 indicated the staff knew the wheelchair was broken. On 1/14/25 at 12"16 p.m., Resident 1's wheelchair was observed to still be broken with the left arm moving too freely forward and backward. During an interview, on 1/14/25 at 12:16 p.m., the Regional Director of Clinical Services (RDCS) indicated Resident 1's wheelchair was already fixed. During an interview, on 1/14/25 at 12:17 p.m., Certified Occupational Therapy Assistant (COTA) 38 indicated the bolt under her wheelchair was completely broken in half. She indicated she emailed the wheelchair company last week for a replacement part, it had not arrived yet. During an interview. On 1/14/25 at 12:18 p.m., the Maintenance Director (MM) if someone could find another wheelchair for her to use, he had ¼" bolts and could have it fixed in an hour. During an interview, on 1/14/25 at 12:20 p.m., COTA 38 indicated the facility had another wheelchair for her to use but her feet would be dangling and would not be able to propel herself. Resident 1 chose it sit on the bed while the repair was made. During an interview, on 1/14/25 at 11:27 a.m., the Director of Nursing (DON) indicated the Certified Nursing Aides (CNA) or the therapy staff should have reported her broken WC to the Maintenance Director (MM). 2. On 1/9/25 at 10:20 a.m., Resident 14 was observed. She was seated in a wheelchair (WC) which had extended handles for the brakes. The right brake handle was missing so that a		A one-time audit of current wheelchairs has been completed to validate wheelchairs are in good repair. The Maintenance Director has been provided education on ensuring all wheelchair equipment are in good repair. **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 Maintenance Director to make sure Essential Equipment including wheelchairs are in good repair. The Maintenance Director will be responsible for performing audits monthly times 6 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 and/or Director of Nursing. **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 Quality Assurance Committee meeting monthly for 3 months and the quarterly, for a total of 6 months.	

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	hollow metal bar with no cap. Throughout the survey week, the WC brake handle remained broken. On 1/13/25 at 1:46 p.m., Resident 14 was observed. She was seated in her WC, and the brake handle remained broken/missing. Licensed Practical Nurse (LPN) 28 was notified, and she indicated, the brake handle was broken which could be a safety concern since the lock would not engage on the right wheel. LPN 28 indicated she would notify the Director of Therapy (DOT). On 1/14/25 at 9:09 a.m., Resident 14 was observed. A WC extension bar had been placed replaced, but the bar was uncapped and the open edges of the bar were exposed. During an interview on 1/14/25 at 10:00 a.m., the DOT indicated, Resident 14's brake handle had been replaced so that the brake would engage on the wheel. He did not know the handle was uncapped. He indicated it could cause a skin tear if she reached across and snagged her arm. On 1/14/25 at 11:25 a.m., the Executive Director (ED) indicated he did not have a policy related to WC maintenance but provided a copy of a WC inspection checklist. The WC inspection checklist was dated for the year 2024 and indicated, " ...inspect the wheelchair for damaged or missing components ... check wheelchairs for the following: hand grips, brakes ...." A current policy, titled, "Preventative Maintenance - Wheelchair," dated 1/22/24, was provided by the DON, on 1/14/25 at 10:25 a.m. A review of the policy indicated, " ...To ensure that all wheelchairs used in this facility are inspected		Re-education, frequency and/or duration of reviews will be increased 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. **Date of Compliance: 2/17/25**	

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	upon arrival to the facility. Quarterly cleaning and inspection of all chairs will be scheduled for proper operations thereafter ...chairs which are found to have broken or missing parts or are in need of repair will be taken out of use immediately and reported to the maintenance department or rehab services for repair ...." 3.1-19(bb)			
F 9999 Bldg. 00	3.1-13 ADMINSTRATION AND MANAGEMENT (b) The licensee shall provide the number of staff as required to carry out all the functions of the facility, including the following: (1) Initial orientation of all employees. (2) A continuing in-service education and training program for all employees. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure Qualified Medication Aides (QMA) received required education for 9 of 9 QMA employees reviewed for education (QMAs 39, 40, 41, 42, 43, 44, 45, 46, and 47). Findings include: On 1/12/25 at 11:41 a.m., QMA 39's 12-month education form titled, "Qualified Medication Aide (QMA) Record of Annual Inservice Training," was requested from the Executive Director (ED). On 1/14/25 at 10:40 a.m., QMA 40, 41, 42, 43, 44,	F 9999	No state findings.	02/17/2025

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	45, 46, and 47's annual education was requested. During an interview, on 1/14/25 at 11:15 a.m., the ED indicated QMA 43 was a new QMA and did not have any facility education. He provided documentation she was licensed on 6/12/24. He indicated the facility had not had a Staff Development Coordinator (SDC) for a year. During an interview, on 1/14/24 at 1:14 p.m., the ED indicated the facility did not have any education for QMA 39. He indicated she did her education yesterday and provided her annual record of in-service training, dated 1/13/25. During an interview, on 1/15/24 at 11:23 p.m., the Director of Nursing (DON) indicated the corporation staff did annual roll-overs for education bundles for the employee healthcare providers, but they did not do it for the QMAs. During an interview, on 1/15/25 at 2:50 p.m., the ED indicated the facility did not have any education for all QMAs. They have been scheduled to complete the education. On 1/15/25 at 3:20 p.m., the ED provided a document, titled, "Enrolling Students in Courses." A review of the documents indicated nine QMA's were enrolled in 11 educational courses. On 1/15/25 at 3:20 p.m., the ED provided a document, titled, "PC Unit Certified Medication Aide (PC Unit CMA) Job Description Primary", dated 7/8/2016. A review of this job description indicated, " ...Attends and participates in continuing education programs ...." 3.1-13 ADMINSTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5			

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	to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. (x) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards.			

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	This state rule was not met as evidenced by: Based on observation and interview, the facility failed to ensure a Alzheimer's/Dementia Special Care Disclosure Form was completed and submitted as required annually in December. This deficient practice had the potential to effect 22 of 22 residents who resided on the secured memory care unit. Findings include: During the survey entrance conference on 1/8/25 at 9:50 a.m., the Executive Director (ED) indicated, the facility did have a specialized, secured memory care unit (MC). A copy of the most recent Alzheimer's/Dementia Special Care Disclosure Form was requested. On 1/8/2025 at 12:00 p.m., an initial tour of the Secured Special Memory Care unit was conducted. There were 22 Residents who resided in the unit and were in various stages of preparing for and being assisted to lunch. During an interview on 1/14/25 at 1:17 p.m., the ED indicated, he had not been able to find an updated Disclosure form and the facility's Cooperate offices usually completed and submitted the form, but had not done so for the most current year. The ED indicated there was no policy or disclosure form for review, but the facility should follow all state rules. 3.1-13(w)			