| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155389 | A. Building<br>B. Wing | 10/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westpark A Waters Community | 1316 N Tibbs Ave<br>Indianapolis, IN 46222 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>Based on observation, interview and record review, the facility failed to have the interdisciplinary team determine and document that a resident was capable to safely self-administer medications for 1 of 1 resident randomly observed. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/10/25 at 11:00 a.m. The diagnoses included, but were not limited to, gastro-esophageal reflux disease (GERD). A physician's order, dated 7/8/25, indicated Resident C was to receive 500 milligrams of a chewable calcium carbonate tablet three times a day. An observation was conducted of Resident C's room on 10/10/25 at 11:27 a.m. The resident's room was observed with the door open. A medication cup with a pink tablet was observed on a bedside table. The resident nor staff member was present in the room at that time. An observation was conducted of Resident C's room with the Director of Nursing on 10/10/25 at 11:53 a.m. The resident's door was observed open with a medication cup that contained a pink tablet on a bedside table. The resident nor a staff member was present. The Director of Nursing indicated at that time, the medication was a chewable calcium carbonate tablet (TUMS). An interview was conducted with the Director of Nursing on 10/10/25 at 1:45 p.m. She indicated Resident C did not have a self-administration of medication assessment that had been conducted. She should not have medications left at bedside. A Medication Self-Administration policy was provided by the Director of Nursing 10/10/25 2:12 p.m. It indicated Purpose: To provide procedures for determining if the resident can safely self-administer and store medications in their room. Policy: 1. Residents who request to self-administer drugs will be assessed at the time of admission or thereafter to determine if the practice is safe, based on the results of the 'Resident Assessment-Self-administration Tool'. 2. The assessment results will be discussed with the attending physician and an order obtained to self-administer if appropriate.8. Prescription medications stored in the resident's room should be written on the medication record 'May keep at bedside'. 3.1-11(a) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure controlled medications were obtained timely from the pharmacy for 3 of 3 residents reviewed for availability of medications. (Residents B, C, and D) Findings include: 1. The clinical record for Resident C was reviewed on [DATE] at 11:00 a.m. The diagnoses included, but were not limited to, gastro-esophageal reflux disease (GERD).<br><br>An Annual [DATE] Minimum Data Set (MDS) assessment indicated Resident C was moderately cognitively impaired.<br><br>A physician's order, dated [DATE], indicated Resident C was to receive two tablets of 5-325 milligrams (mg) of hydrocodone-acetaminophen three times a day. The medication was to be administered at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The two tablets of hydrocodone-acetaminophen medication was discontinued and changed, on [DATE], to one tablet.<br><br>A physician's order, dated [DATE], indicated Resident C was to receive one tablet of 5-325 milligrams of hydrocodone-acetaminophen three times a day. The medication was to be administered at 6:00 a.m., 2:00 p.m., and 10:00 p.m.<br><br>The [DATE] Medication Administration Record (MAR) for Resident C indicated the following days the 5-325 milligrams of hydrocodone-acetaminophen medication was not available to administer:<br><br>Two tablets of 5-325 milligrams of hydrocodone-acetaminophen: [DATE] at 10:00 p.m., and [DATE] at 6:00 a.m.<br><br>One tablet of 5-325 milligrams of hydrocodone-acetaminophen: [DATE] at 2:00 p.m. and 10:00 p.m., [DATE] at 6:00 a.m. and 2:00 p.m.<br><br>An interview was conducted with Resident C on [DATE] at 11:28 a.m. She indicated she takes pain medication for the pain in her legs. Resident C had fallen and broken both of her legs. She had to go without her hydrocodone-acetaminophen medication, because the facility often runs out of the supply of medication.<br><br>An interview was conducted with the Director of Nursing on [DATE] at 2:26 p.m. She indicated if a script expired, the staff were not able to pull the medication out of the Emergency Drug Kit. The staff should be reordering medications from the pharmacy when the residents' medications were down to six to eight days left of their medication supply.<br><br>2. The clinical record for Resident B was reviewed on [DATE] at 10:20 a.m. The diagnoses included, but were not limited to, migraine and sciatica.<br><br>An admission MDS assessment, completed [DATE], indicated she was cognitively intact and had experienced pain almost constantly. The pain had limited her ability to sleep and perform day to day activities almost constantly. She described her pain as moderate.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A care plan, last revised on [DATE], indicated she had the potential for pain related to chronic pain and impaired mobility. The goal was for her to be free of pain with interventions as needed. The interventions included, but were not limited to, medication as ordered, notify the physician of uncontrolled pain, and observe for effectiveness of interventions.<br><br>A physician's order, dated [DATE], indicated she was to receive oxycodone (narcotic pain medication) 10 mg; one tablet every four hours for pain. The order was discontinued on [DATE].<br><br>A physician's order, dated [DATE], indicated she was to receive oxycodone 10 mg; one tablet every four hours for pain while awake. The scheduled times were listed as midnight, 8:00 a.m., noon, 4:00 p.m., and 8:00 p.m. It did not include a 4:00 a.m. dose.<br><br>The [DATE] Medication Administration Record (MAR) indicated she had not received her scheduled dose of oxycodone 10 mg on [DATE] at midnight, [DATE] at 4:00 a.m., [DATE] at noon, [DATE] at 8:00 a.m., [DATE] at noon, and [DATE] at 4:00 p.m.<br><br>During an interview on [DATE] at 11:30 a.m., Resident D indicated the facility had not ordered her scheduled pain medication timely and that she had missed several doses. When she began receiving her scheduled oxycodone again, the nursing staff had stopped bringing it to her at 4:00 a.m. Resident B did not know why the times had been changed. Resident B indicated her pain was severe when she was not getting her scheduled oxycodone.<br><br>During an interview on [DATE] at 2:40 p.m., the Corporate Nurse Consultant (CNC) indicated Resident B should have received her pain medication as ordered. The physician's order for oxycodone 10 mg, received on [DATE], should have included an administration at 4:00 a.m.<br><br>3. The clinical record for Resident D was reviewed on [DATE] at 11:00 a.m. The diagnoses included, but were not limited to, anxiety, schizoaffective disorder, and mood disorder.<br><br>A care plan, last revised on [DATE], indicated she received psychotropic medications related to schizoaffective disorder, anxiety, and mood disorder. The goal was for her to be free of drug related complications. The interventions included to administer medications as ordered.<br><br>A physician's order, dated [DATE], indicated she was to receive clonazepam (anti-anxiety medication) 1 mg three times a day. The order was discontinued on [DATE].<br><br>A physician's order, dated [DATE], indicated she was to receive clonazepam 1 mg three times a day.<br><br>The [DATE] MAR indicated Resident D had not received her scheduled dose of clonazepam on the following days: [DATE] at 4:00 p.m., and 10:00 p.m., [DATE] at 4:00 p.m., and 10:00 p.m.<br><br>During an interview on [DATE] at 1:45 p.m., the Director of Nursing indicated Resident D's scheduled clonazepam had not been reordered timely. The pharmacy was waiting for a new prescription to refill the medication.<br><br>On [DATE] at 1:45 p.m., the Director of Nursing provided the current Ordering Medications policy, that read . Narcotics are ordered from the pharmacy after the pharmacy has received a valid prescription from the prescriber .<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This citation relates to Intake 2636594.<br><br>3.1-25(a) |