STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30344 Based on interview and record review, the facility failed to immediately notify the Administrator of an allegation of abuse for 2 of 2 residents reviewed for abuse. (Resident 1 and 28) Findings include: 1. The clinical record for Resident 1 was reviewed on 4/2/24 at 1:30 p.m. His diagnoses included, but were not limited to: anxiety, major depressive disorder, insomnia, and type 2 diabetes. An interview was conducted with Resident 1 on 4/2/24 at 1:33 p.m. He indicated Resident 6 grabbed him and kicked him in the back of his wheel chair last week, in the dining room. He told staff about it and they followed up with him. Now, he stayed away from Resident 6. The 3/30/24 Nursing Progress Note for Resident 1 read, Unwitnessed incident the resident was kicked by another resident in the back of his w/c [wheel chair] and pinched on his left upper arm and back, no apparent injuries, statement was taken from the resident whom was hit, head to toe assessment done on this resident who was stuck, he had no apparent injuries, NP [Nurse Practitioner,] DON [Director of Nursing,] and Family notified. An interview was conducted with the ED (Executive Director) on 4/2/24 at 1:45 p.m. She indicated she knew about the altercation between Resident 1 and Resident 6. It happened on Saturday, 3/30/24. She didn't find out about it until Monday, 4/1/24, at Monday Morning Meeting through a progress note and risk management entry. The nurse who created the progress note entered the altercation into a risk management entry for both residents. The nurse thought the ED would find out about the altercation through risk management. The nurse should have reported it to her immediately. An interview was conducted with Resident 1 on 4/4/24 at 10:30 a.m. He indicated the pinch hurt, but not too much, and didn't leave a bruise or anything. It hurt his feelings at the time, but he was okay now. 41129 2. The clinical record for Resident 28 was reviewed on 4/2/24 at 1:13 p.m. Resident 28's diagnoses included, but not limited to, borderline personality disorder, bipolar disorder, Lupus, anxiety disorder, major depressive disorder, and fibromyalgia. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 12/15/23 at 8:26 a.m. indicated, Resident 28 had told the writer of the nursing note of an incident that happened during the evening shift on 12/14/23. Resident 28 indicated, she was verbally abused by her roommate and wanted staff to be aware but did not want to move rooms. An interview with Resident 28 conducted on 4/2/23 at 2:36 p.m. indicated, when she was roommates with Resident 13, Resident 13 would yell at her to get off the phone, say that she is good for nothing, and that she needed mental help. An interview with ED (Executive Director) conducted on 4/2/24 at 3:17 p.m. indicated, the alleged verbal abuse between Resident 28 and Resident 13 on 12/14/23 had not been reported to her or the management staff. ED further indicated, the alleged verbal abuse had not been reported to the Indiana State Department of Health as of yet, but she was going to report it immediately and an investigation into the incident was to begin. The investigation file for the alleged verbal abuse was received on 4/4/24 at 1:20 p.m. It contained, but not limited to, an Indiana State Department of Health incident report dated 4/2/24 at 3:39 p.m. The incident report indicated, the actual identified date of the incident being reported had occurred on 12/15/23 at 8:26 a.m. The alleged verbal abuse incident was not reported timely. An Abuse Prevention Program policy received on 4/3/24 at 2:14 p.m. from ED indicated, . Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, or mistreatment they observe, hear about of suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator. The Administrator is the Abuse Coordinator .Supervisors shall immediately inform the Administrator or in the absence of the Administrator, the person in charge of the facility of all reports of incidents, allegations, or suspicion of potential mistreatment. Upon learning of the report, the Administrator or in the absence of the Administrator, the person in charge of the facility shall indicate an incident investigation .The Administrator or designee utilizing the ISDH [sic, Indiana State Department of Health] Incident Report form will immediately notify the ISDH by email or fax .Verbal Abuse: Any use of oral, written, or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. 3.1-28(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40287 Based on interview and record review, the facility failed to provide showers, as care planned and preferred, for 1 of 3 residents reviewed for ADL (Activities of Daily Living) care (Resident 35). Findings include: The clinical record for Resident 35 was reviewed on 4/2/24 at 1:17 p.m. The Resident's diagnosis included, but were not limited to, parkinsonism and tremors. A care plan, initiated on 8/1/23, indicated Resident 35 needed assistants with adl care related to his impaired mobility and tremors. The goal was for him to have all adl needs met by staff. The interventions included, but were not limited to, bathe per resident preference 2 x weekly and as needed, initiated 8/1/23. An Activity Resident Interview, completed 1/12/24, indicated it was very important to Resident 35 to choose between a tub bath, shower, bed bath or sponge bath. A Quarterly MDS (Minimum Data Set) Assessment, completed 2/5/24, indicated he was cognitively intact. During an interview on 4/2/24 at 1:17 p.m., Resident 35 indicated he did not always get his showers. He thought his shower day was on Fridays. He did not always get showers twice a week and that he preferred showers, not bed baths. During an interview on 4/3/24 at 1:44 p.m., the DON (Director of Nursing) indicated his showers were scheduled for Wednesday and Sunday evenings. During an interview on 4/3/24 at 3:15 p.m., CNA (Certified Nursing Assistant) 20 indicated Resident 35 normally did not refuse his showers. March and April showers should have been performed on 3/3, 3/6, 3/10, 3/13, 3/17, 3/20, 3/24, 3/27, 3/31, 4/3. On 4/3/34 at 3:30 p.m., the RNC (Regional Nurse Consultant) 1 provided shower sheets for Resident 35 for March 2024, which indicated that he had received the following: 3/6/24- shower, 3/9/24- shower, 3/16/24- bed bath, 3/20/24- he had refused, 3/23/24- shower, 3/27/24- shower, and 3/30/24- shower. On 4/4/24 at 10:06 a.m., the RNC 1 provided the current Activities of Daily Living policy which read .ADL care is provided throughout the day, evening and night as care planned and / or as needed. ADL care is coordinated between the resident and the care giver with emphasis on resident preferences as much as possible . 3.1-38(3)(b)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility failed to clarify and administer a resident's medication, as ordered; to ensure physician orders were followed, as ordered, for a resident with elevated blood sugars; and to monitor blood pressure, as ordered, prior to administering a medication for 3 of 5 residents reviewed for unnecessary medications. (Resident 10, 11, and 21) Findings include: 1. The clinical record for Resident 10 was reviewed on 4/3/24 at 1:49 p.m. His diagnoses included, but were not limited to paranoid schizophrenia. The paranoid schizophrenia care plan, revised 2/21/23, indicated he was at risk for the behavioral expressions of paranoia, delusions, and making false accusations at times. Interventions were to GDR (gradual dose reduction) per schedule and provide medications as ordered. The 3/18/23 Note To Attending Physician/Prescriber read, This resident is due for a trial reduction of Haloperidol 5 mg three times a day for schizophrenia. Please consider a gradual dose reduction, while monitoring for re-emergence and/or withdrawal symptoms .Recommend to change to: Haloperidol 5 mg twice daily and 4 mg in the afternoon for schizophrenia. The Physician/Prescriber Response section of the note, completed by the facility's Psyche NP (Nurse Practitioner) on 3/22/24, indicated she agreed with the recommendation and to change the order to the recommended Haloperidol 5 mg twice daily and 4 mg in the afternoon. The 3/22/24 psychiatry progress note, written by the facility Psyche NP, read, [Name of Resident 10] is assessed today in his room, he is resting in his bed underneath the blanket. Addressed his name, he barely responded that he wants to sleep. He appears without any distress. Staff reported resident is doing same and no concerns with sleep, appetite, anxiety or depression or any mood or behavior symptoms. So, reduced his haloperidol slightly as per GDR today. Continue psychiatric services to monitor resident's mood, behaviors, diagnoses, and medications, making appropriate adjustments when clinically indicated Paranoid schizophrenia Mod [moderately] stable - 1. REDUCE Haloperidol Lactate concentrate 5 mg [2.5 ml] BID [twice daily,] and haloperidol 4 mg daily in the afternoon. The March and April, 2024 MARs (medication administration records) indicated he received 2.5 ml of Haloperidol Lactate Oral Concentrate 2 mg/ml by mouth at bedtime only from 3/24/24 through 4/3/24, which was not in accordance with the facility Psyche NP's 3/22/24 pharmacy recommendation response or 3/22/24 psychiatry progress note. An interview was conducted with the DON (Director of Nursing) on 4/4/24 at 10:36 a.m. She indicated on 3/22/24 the Psyche NP put the Haloperidol order in for intramuscularly, the wrong route. Then the evening shift nurse, LPN (Licensed Practical Nurse) 5, noticed it, so she switched the order to 2.5 ml, but didn't have an order to do so. LPN 5 took it upon herself to change the order. Resident 10 should have been administered his Haloperidol, as ordered, in accordance with the 3/22/24 Psyche NP note and 3/22/24 pharmacy recommendation response. 34850 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The clinical record for Resident 21 was reviewed on 4/3/24 at 9:03 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. A physician order dated 1/31/24 indicated Resident 21 was to receive novolog insulin with meals utilizing a sliding scale. The scale was the following: blood sugars 0 - 150 = 0 units of insulin, blood sugars 151 - 200 = 2 units of insulin, blood sugars 201 - 250 = 4 units of insulin, blood sugars 251 - 300 = 6 units of insulin, blood sugars 301 - 350 = 8 units of insulin, and blood sugars 351 - 400 = 10 units of insulin The staff were to call the medical provider if the resident's blood sugar was greater than 425. The March 2024 Medication Administration Record (MAR) indicated Resident 21's blood sugar reading was 486 on 3/6/24 at 11:00 a.m., and 497 on 3/7/24 at 5:00 p.m. A MAR nursing note dated 3/6/24 indicated Writer notified of resident's elevated BG [blood glucose] level; 486. Notified NP [Nurse Practitioner]. Order to give sliding scale per [DATE] units plus additional 2 units. Recheck after 1-2 hours. Will continue with plan of care. The resident's clinical record did not indicated the resident's blood sugar was rechecked in 1-2 hours as ordered. A MAR nursing note dated 3/7/24 indicated the resident's BS [blood sugar] is 497, Nurse notify And 13 units given and to be checked back in 1 hr [hour]. The resident's clinical record did not indicate the resident's blood sugar was rechecked 1 hour as ordered. An interview was conducted with Regional Nurse Consultant 1 on 4/4/24 at 2:08 p.m. She indicated she was unable to find any notations that Resident 21's blood sugars were rechecked as ordered after treating elevated blood sugars of greater than 425 on 3/6/24 and 3/7/24. 40287 3. The clinical record for Resident 11 was reviewed on 4/2/24 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, hypertension and congestive heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, initiated 10/5/2019, indicated Resident 11 had a diagnosis of hypertension. The goal was for her to have no complications with blood pressure. The interventions, initiated 10/5/2019, were to administer medication as ordered, monitor blood pressure per physician order or facility policy, and to notify the physician and family as needed. A physician's order, dated 2/24/24, indicated Resident 11 was to received metoprolol 75 mg (milligram) tablet twice daily. Hold if systolic blood pressure is less than 100. The March and April 2024 MAR (Medication Administration Record) indicated the metoprolol 75 mg had been administered twice daily. There were no blood pressure recorded on the MAR to indicate what the systolic blood pressure was at the time of administration. The blood pressures recorded in the vital signs section of the electronic health record were 3/15/24 -109/69, 4/2/24- 105/ 65, and 4/3/24- 110/76. On 4/3/24 at 3:40 p.m., the DON (Director of Nursing) indicated that the blood pressures should have been completed prior to administering the metoprolol. The Verbal Orders/Admission/Readmission Orders policy was provided by (Regional Nurse Consultant) 2 on 4/4/24 at 11:22 a.m. It read, Question the authorized prescriber if there is any uncertainty regarding the order. The following physician orders policy was provided by the Director of Nursing on 4/4/24 at 2:10 p.m. It indicated .Policy: It is the policy of the facility to follow the orders of the physician. At the time of admission the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission .4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on interview and record review, the facility failed to ensure vision services was provided for 1 of 1 residents reviewed for vision services. (Resident 38) Findings include: The clinical record for Resident 38 was reviewed on 4/2/24 at 10:30 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. The resident was admitted to the facility on [DATE]. A eye consultant consent dated 12/6/23 indicated Resident 38 would like vision services. An interview was conducted with Resident 38 on 4/2/24 at 10:39 a.m. He indicated he was having trouble with his vision and would like to see an eye doctor. The eye visits were provided by the Regional Nurse Consultant 2 on 4/4/24 at 2:00 p.m. It indicated eye services was provided in the facility on 3/27/24. Resident 38 had not been seen. An interview was conducted with Social Services Director on 4/5/24 at 9:12 a.m. She indicated Resident 38 had signed a consent to receive vision services. She was unsure why the resident had not been seen. There have been some concerns with delays on vision services with the vision company the facility current uses. A vision services policy was provided by Regional Nurse Consultant 3 on 4/5/24 at 10:47 a.m. It indicated . The vision and hearing services standard has been to assist with achieving compliance standards found within the State Operations Manual pertaining to proper treatment to maintain vision and hearing abilities. Purpose: To promote, comply, and ensure compliance with state and federal regulations pertaining to vision and hearing services .Policy: It is the standard of the organization to ensure that residents receive the proper treatment and assistive devices to maintain hearing and vision abilities . 3.1-39(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on observation, interview and record review, the facility failed to ensure dental services were provided for 2 of 2 residents reviewed for dental (Resident 25 and Resident 38) Findings include: 1. The clinical record for Resident 38 was reviewed on 4/2/24 at 10:30 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. The resident was admitted to the facility on [DATE]. The dental consultant consent dated 12/6/23 indicated Resident 38 would like dental services. An observation was made of Resident 38 on 4/2/24 at 10:39 a.m. The resident's oral cavity was observed with missing and broken teeth. The resident indicated at that time he was having trouble with some of his teeth. He had several teeth missing and cavities. He had not seen a dentist since he had been in the facility. 2. The clinical record for Resident 25 was reviewed on 4/2/24 at 10:30 a.m. The diagnosis included, but was not limited to: type 2 diabetes mellitus. The resident was admitted to the facility on [DATE]. The dental consultant consent dated 8/9/23 indicated Resident 25 would like dental services. An observation was made of Resident 25 on 4/2/24 at 10:24 a.m. The resident was observed with a dark rotten front tooth. He indicated he would like to be seen by a dentist, but haven't seen one. The dental visits were provided by the Regional Nurse Consultant 2 on 4/4/24 at 2:00 p.m. It indicated the dental provider had been in the facility providing services on 3/22/24 and 4/3/24. Resident 25 nor Resident 38 had been seen on those dates. An interview was conducted with Social Services Director (SSD) on 4/5/24 at 9:12 a.m. She indicated Resident 38 and Resident 25 had signed consents to receive dental services. It should take approximately a month to set up for routine dental services. She was unsure why the residents had not been seen. She was unaware Resident 38 had been having trouble with his teeth until the care plan meeting that had been conducted on 4/2/24. She had received a dental report dated 12/18/23 indicating Resident 25's payer source was still pending. She had not followed up with the dental provider. A dental services policy was provided by Regional Nurse Consultant on 4/5/24 at 9:02 a.m. It indicated . Policy: It is is the policy of the facility to provide medically related social services to attain or maintained the highest practicable physical, mental and psychosocial well-being of each resident. This includes meeting any need for dental/denture care to include routine as well as emergency indicated services . 3.1-24(a)(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34850 Based on observation, interview and record review, the facility failed to ensure food items were stored closed and labeled with open dates. This had a potential to effect 38 of 39 residents that eat food prepared in the kitchen. Findings include: An observation was made of the kitchen with Cook 5 on 4/2/24 at 8:06 a.m. During the tour, the refrigerators and freezers were observed with the following food items opened and/or not labeled with open dates: One freezer had 1 half full container of orange sherbet and 1 cardboard box that contained 5 lime sherbet containers individual size with no open dates. A 2nd freezer was observed with a bag of french fries opened to air with no open date and 1 bag of chicken tied shut, but no open date. The refrigerator was observed with 1 half full bag of spring salad mix closed with no open date. An interview was conducted with Cook 5 on 4/2/24 at 8:30 a.m. She indicated all food items should be labeled with open dates and sealed shut. The food storage policy was provided by the Regional Director of Operations on 4/3/24 at 11:22 a.m. It indicated .Policy: Food shall be stored on shelves in a clean, dry area, from containments. Food shall be stored at appropriate temperatures and using appropriate methods to ensure highest level of food safety. Procedure: I. General storage guidelines to be followed: Label all food items. The label must include the name of the food and the date by which it should be sold, consumed or discarded . The date marking policy was provided by the Regional Director of Operations on 4/3/24 at 11:22 a.m. It indicated .Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date . 3.1-21(i)(1) 3.1-21(i)(2) 3.1-21(i)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40287 Based on observation and interview, the facility failed to maintain the floors in good repair with the potential to affect 39 of 39 residents residing at the facility. Findings include: On 4/4/24 at 10:55 a.m., an environmental tour of the facility was conducted with the DOM (Director of Maintenance), RDO (Regional Director of Operations), and the ED (Executive Director). The following areas of concern were noted: 1. The flooring in the hallway outside of room [ROOM NUMBER] had a crack in the floor tiles approximately 4 ft long. 2. The flooring in the hallway outside of room [ROOM NUMBER] had cracks in the tiles which was approximately 25 ft long and 3 inches at the widest part. 3. the flooring outside of room [ROOM NUMBER] had a crack in the tiles which was the width of the hallway and 11/2 inch at the widest part. 4. The metal threshold between the new and older part of the building had a divot that was approximately 2 inches x 2 inches and 1/4 inch deep. There were 4 broken tiles present at the threshold. 5. The hallway flooring outside of room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] had a broken tiles present. 6. The tiles outside of room [ROOM NUMBER] had a stained and dirty appearance. 7. The hallway flooring outside of room [ROOM NUMBER] had stained tyles. 8. The vinyl flooring by the janitors' closet was buckled and pulled from the floor. 9. The vinyl flooring in the hallway by room [ROOM NUMBER] was pulled up from the floor by the cove base. 10. The vinyl flooring at the thresholds of room [ROOM NUMBER] and 12 were pulling away from the floor. 11. The vinyl flooring in the hallway outside of room [ROOM NUMBER] had divots in the floor and cracks in the vinyl. During an interview on 4/4/24 at 11:10 a.m., Resident 94 indicated the floors were like a roller coaster in some parts of the building. The hallway flooring could use some work. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave 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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/4/24 at 11:12 a.m., Resident 1 indicated the flooring in the facility was bumpy in places. During an interview on 4/4/24 at 11:15 a.m., the ED, RDO, and DOM indicated the building floors had settled and caused the cracks in the tiles. The tiles were cleansed and waxed regularly, however due to the age of the flooring, some of the tiles were permanently stained. The vinyl flooring had been installed improperly causing a bumpy, unevenness to the floor. 3.1-19(a)(4)