STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Westside Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10th St Indianapolis, IN 46234	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46414 Based on observation, record review, and interview, the facility failed to revise care plans for 2 of 6 residents reviewed for care plan revision (Residents GG and H). Findings include: 1. On 4/16/24 at 3:00 p.m., Resident GG was observed for wound care. The wound care nurse and wound care physician were completing wound rounds with the resident. Resident GG was observed to have an unstageable (full thickness tissue loss where the depth of the wound is completely obscured by eschar or dead tissue in the wound bed) pressure ulcer to her right ischium, a brief rash to her left buttock, and unstageable deep tissue injury (DTI -purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue) to her left and right heel. The left and right heel was observed for the first time during the wound rounds on 4/16/24. On 4/17/24 at 10:30 a.m., a comprehensive record review was completed for Resident GG. She had the following diagnoses which included but were not limited to heart failure, hypertension, type 2 diabetes, chronic kidney disease, cellulitis of the right lower limb, and age-related debility. A review of her care plan was completed. It indicated, The resident has potential for pressure ulcer development related to decreased mobility, and diagnoses of diabetes mellitus (DM). The goal indicated the resident would have intact skin, free of redness, blisters, or discoloration through the next review. The care plan did not address the resident's current skin integrity status of the right ischium. On 4/17/24 at 11:00 a.m., a current copy of resident's care plan was provided, and it included her current wound status. 38767 2. Resident H's record was reviewed on 4/15/24 at 1:43 p.m. Diagnoses upon admission on 4/5/24 included, but were not limited to, late onset Alzheimer's disease (a progressive disease that causes confusion, destroys memory and other important mental functions), and traumatic hemorrhage of the cerebrum (collection of blood within the skull usually caused by trauma or a blood vessel that bursts in the brain). (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's orders, dated 4/5/24, administer Calmoseptine External Ointment (moisture barrier) 0.44-20.6 % (Menthol-Zinc Oxide) to coccyx topically every shift for wound, and a small amount every 12 hours as needed for skin irritation. An Admission/Readmission Collection Tool, dated 4/5/24, Registered Nurse (RN) 14 indicated skin available for inspection, resident confused as usual. Skin blanchable/redness (reperfusion and no skin damage), pink open lesion with no drainage at the level of the coccyx, skin color normal, temperature warm, moisture normal, and turgor was good. Documentation lacked description to include measurements or stage of the wound. A Wound Observation Tool signed by RN 6, on 4/15/24 effective 4/6/24, documented open area/split present on admission. Overall impression was the wound was worsening. Staff notified wound MD and power of attorney (POA) on 4/6/24. The wound had scant serous (a clear to yellow fluid that leaks out of a wound) drainage and measured 1.1 centimeters (cm) by (x) 1.0 cm x 0.1 cm. The Wound team was to continue to evaluate and treat. Treatment was calmoseptine. A Mini Nutritional Assessment, signed by RN 6 on 4/15/24, effective date 4/11/24, indicated admission score of 10 out of 14 indicated at risk of malnutrition. Wound on coccyx upon admission on 4/5/24. Area/open/split was worsening. Staff notified wound MD and family on 4/6/24. Measurement of wound was 1.1 cm x 1.0 cm x 0.1cm with scant serous drainage. A care plan, dated 4/8/24, indicated resident was at risk for break in skin integrity. The goal was to maintain intact skin with no skin breaks through the next review. Interventions included clean and dry skin after each incontinence episode, pressure reducing mattress, treatment as ordered, weekly skin checks, and a wheelchair cushion. The care plans lacked documentation related to existing wounds. On 4/17/24 at 12:18 p.m., the Business Office Manager (BOM) provided a Comprehensive Care Plans and Revisions policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, Comprehensive care plans: reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments 3.1-35(c)(1)

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38767

Based on observation, record review, and interview, the facility failed to ensure effective wound management for a resident admitted with an open area on the coccyx that worsened resulting in a stage 3 pressure ulcer (full thickness tissue loss - subcutaneous fat may be visible, and slough may be present) to the coccyx for 1 of 3 residents reviewed for pressure ulcers (Resident H).

Findings include:

On 4/15/24 at 11:45 a.m., Resident H's responsible party indicated they were not happy with the care and services the resident was receiving after having recently been admitted to the facility for rehabilitative services related to a fall before admission at another facility. There had been a delay in starting rehabilitative services, Resident H was being left in the bed, and at times the resident's room smelled of urine. Last evening when the family arrived around 5:00 p.m., they found the resident still in a gown and lying flat in bed, and questioned how was she going to get better if left in bed. The resident representative indicated they were also upset due to being informed the prior evening Resident H had developed a hole in her butt, as the resident had never had a sore in the past. The resident representative indicated they had taken their concerns to SSD 4 last evening and had planned to speak with the ED on this date.

On 4/15/24 at 2:00 p.m., the Director of Nursing (DON) provided an original wound tracking log, dated February - April 2024, and indicated the residents listed on the tracking log were the ones being followed by the wound nurse. The report lacked Resident H's name or documentation Resident H was being followed by the wound nurse.

On 4/15/24 at 3:07 p.m., Resident H was observed lying flat on her back in bed with her eyes closed, and the covers were pulled up around her neck. No extra pillows or propping devices were observed in the room.

On 4/16/24 at 10:17 a.m., Resident H was observed to be out of her room. Licensed Practical Nurse (LPN) 5 indicated Resident H was in the main dining room attending an activity. On 4/16/24 at 2:40 p.m., the resident was observed to be out of bed in a wheelchair.

On 4/17/24 at 10:25 a.m., Resident H was observed lying on her back in the bed, lower body flat on the bed, upper body slightly turned towards right side. There was a low air mattress (LAM) on the bed setting on 2, and a specialty cushion in the wheelchair (wc). There were no devices such as extra pillows that could have been used to prop the resident off her back observed in the room.

Resident H's record was reviewed on 4/15/24 at 1:43 p.m. Diagnoses upon admission on 4/5/24 included, but were not limited to, late onset Alzheimer's disease (a progressive disease that caused confusion, destroyed memory and other important mental functions), and traumatic hemorrhage of the cerebrum (collection of blood within the skull usually caused by trauma or a blood vessel that bursts in the brain).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Admission/Readmission Collection Tool, dated 4/5/24, Registered Nurse (RN) 14 documented skin available for inspection, resident confused as usual. The document indicated skin blanchable/redness (reperfusion and no skin damage), pink open no drainage lesion at the level of the coccyx, skin color normal, temperature warm, moisture normal, and turgor good. Documentation lacked description to include measurements or stage of the wound. Physician's orders, dated 4/5/24, indicated to apply Calmoseptine External Ointment (moisture barrier) 0. 44-20.6 % (Menthol-Zinc Oxide) to coccyx topically every shift for wound, and a small amount every 12 hours as needed for skin irritation. A Skilled Progress Note, dated 4/7/24 at 1:21 a.m., indicated the resident was confused and could be combative and or resistive to care. Resident was alert with confusion. Required frequent re-direction. Required total care from staff of one and transfer assist of 2 staff members. Her needs were anticipated by staff. Resident was incontinent of bladder and bowel (b/b). Locomotion via wheelchair (wc)and required staff to propel. A care plan, dated 4/8/24, indicated resident was at risk for break in skin integrity. The goal was to maintain intact skin with no skin breaks through the next review. Interventions included clean and dry skin after each incontinence episode, pressure reducing mattress, treatment as ordered, weekly skin checks, and a wc cushion. Physician's order, dated 4/14/23 at 11:00 p.m., indicated to apply Calmoseptine External Ointment 0.44-20.6 % (Menthol-Zinc Oxide) to coccyx topically every shift for wound. Physician's orders, dated 4/15/24 at 3:00 p.m., indicated to cleanse coccyx wound with wound cleanser, pat dry, then apply collagen matrix sheet, and secure with border gauze island every evening shift for healing and as needed for soilage or dislodgement. Physician's orders, dated 4/15/24 at 11:00 p.m., indicated: a. Wound Doctor to evaluate and treat. b. Extra cushion on wheelchair every shift for pressure reduction. c. Low Air Loss Mattress: Settings: alternate, comfort level 3. May adjust comfort settings according to resident preference as needed. Nurse to check settings every shift for pressure reduction. A Weekly Skin Integrity Data Collection tool, dated 4/14/24, LPN 5 documented, skin not intact, new finding, open area/wound. Contacted family and MD (medical doctor) on call waiting on call back. The documentation lacked a description of the wound or measurements. A Wound Observation Tool signed by RN 6, on 4/15/24 and effective 4/6/24, documented open area/split present on admission. Overall impression was wound was worsening. Notified wound MD and power of attorney (POA) on 4/6/24. The wound had scant serous (a clear to yellow fluid that leaks out of a wound) drainage and measured 1.1 centimeters (cm) by (x) 1.0 cm x 0.1 cm. Wound team were to continue to evaluate and treat. Treatment was calmoseptine. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Wound Observation Tool, effective 4/15/24, RN 6 documented Resident H admitted with wound on 4/5/24, pressure ulcer to coccyx, stage 3. Overall impression was the wound was worsening. Notified (wound MD name) and POA (power of attorney) on 4/15/24. The wound had scant amount of serous drainage. The wound measured 1.5 cm length (L) x 1.0 cm width (W) x 0.4 cm depth (D). Resident coccyx wound exacerbated, wound treatment changed, family notified. Treatment was collagen matrix border gauze island (an advanced wound care dressing that transforms into a soft gel sheet when in contact with wound exudate). A progress notes, dated 4/14/24 at 4:30 p.m., indicated LPN 5 was informed by a Certified Nursing Aide (CNA) while cleaning up resident noted an open area on resident coccyx area. The writer assessed the resident and applied barrier skin for immediate treatment until wound team assessed. The DON and family were made aware, attempted to call MD, and waiting on call back. A progress notes, dated 4/15/24 at 3:56 p.m., wound nurse assessed resident skin, resident present with pressure wound to coccyx area. Wound physician notified, treatment ordered and implemented, treatment administration record (TAR) updated. Pressure reduction mattress in place. Physical Therapy (PT) notified to evaluate resident for extra cushion to w/c. Care plan reviewed and updated. A Mini Nutritional Assessment signed by RN 6 on 4/15/24, effective date 4/11/24, indicated admission score 10/14 indicated at risk of malnutrition. Wound on coccyx found upon admission 4/5/24. Area/open/split was worsening. Notified wound MD and family on 4/6/24. Measurement of wound was 1.1 cm x 1.0 cm x 0.1 cm with scant serous drainage. A MDS note, dated 4/16/24 at 12:26 p.m., indicated resident admitted with pressure ulcer to coccyx. Interdisciplinary team (IDT) met to discuss risk factors and new interventions put into place to help current wound heal, and prevent new areas from forming. Family and MD aware of wound and its current stage. MDS was scheduled to capture wound status and new interventions. A late entry Cognitive Patterns/BIMS (brief interview for mental status) created on 4/16/24 at 2:24 p.m. by SSD 8, effective 4/12/24 2:20 p.m., indicated Resident H had a BIMS score of 3/15 indicating severe cognitive decline. Resident H did not know the year, month, or day of the week, and after 5 minutes resident was not able to recall 0/3 words. Resident H's record, dated from admission on 4/5/24 - 4/13/24, lacked documentation Resident H had a wound on her coccyx, preventative measures were implemented or utilized to prevent worsening of the coccyx wound, the wound MD was notified to see the resident's wound during his wound rounds on 4/9/24, new treatment orders were obtained, or the care plan was updated until documentation identified a coccyx wound being a new wound on 4/14/24. A (wound company name) report, dated 4/16/24, indicated patient presents with a wound on her coccyx. The report indicated the wound was a Stage 3 pressure wound coccyx wound full thickness, Etiology pressure, stage 3, duration over 7 days, wound size 1.0 cm L x 0.9 cm W x 0.3 cm D, and had light serous exudate. Recommendations were to include, off load wound, reposition per facility protocol, turn side to side in bed every 1-2 hours if able, group-2 mattress. Plan was to discuss patient's abnormal BMI (body mass index) with dietician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/24 at 2:44 p.m., the ED indicated Resident H had been identified with a slit in the crack of her butt the prior evening, the family was notified, and the wound nurse was notified who was in the facility this date and would see the resident. During an interview on 4/16/24 at 10:18 a.m., LPN 5 indicated Resident H had a wound on her coccyx. Indicated the floor nurses were responsible for putting new wound documentation into the computer, but they were not allowed to stage the wound or put in a description. The wound MD had been notified, had been in the facility the day prior, and would be back again this date. The wound nurse and wound MD were responsible for documenting on wounds to include staging. When asked how the facility could prove a wound had not gotten worse from the time found until the wound nurse or wound MD observed and documented on it, LPN 5 indicated could not answer to that as it was not her responsibility. During an interview on 4/16/24 at 10:24 a.m., LPN 7 indicated if she had been informed of a new open area, she would have assessed the wound, contacted the MD, family, wound MD, and DON. She would then document in a skin assessment the location, size, and description. She would not stage the wound, that was the job of the wound nurse, RN 6. During an interview on 4/16/24 at 10:26 a.m., RN 6 indicated Resident H had a wound on her bottom upon admission on 4/5/24, the wound on her coccyx identified on 4/14/24 was not new it had just gotten worse. During an interview on 4/16/24 at 10:30 a.m., RN 6 indicated when a new wound was found the resident's nurse would assess the wound, notify the MD for orders, notify the family, notify the wound MD to see during Tuesday rounds, open a risk management form, and document on a skin assessment. The nurse was to describe the wound(s), but not stage the wound(s), that was the responsibility of the wound nurse or the DON as they were certified wound nurses, or the wound MD. During an interview on 4/16/24 at 10:40 a.m., the DON indicated when a wound was found, the nurse was to assess and document the wound. Routinely the nurse described the wound and got treatment orders immediately. The nurse could stage the wound but was encouraged not to, the wound could not later be downstaged if documented incorrectly. RN 6 , the Wound MD who came on Tuesdays, or the DON would stage the wound promptly. During an interview on 4/16/24 at 10:45 a.m., the DON indicated Resident H had been admitted with what was described as a stage 2 pressure ulcer (partial thickness loss of skin presenting as a shallow open ulcer or blister without slough or bruising) on the coccyx, the recent documentation of a new wound was incorrect. A new skin sheet indicated a new wound on the coccyx, and failed to have a description to include stage or measurements. During an interview on 4/16/24 at 2:38 p.m. the Wound MD indicated when a resident admitted with a wound, or developed a new wound, the resident was added on the list to be assessed weekly during his Tuesday wound round visits, and he wanted to see all wounds big or small. The wound MD indicated he had not been asked during his visit the prior week on 4/9/24 to assess a wound on Resident H, and she had not been on the wound list. Resident H was up at this time, so she had been put on the end of the list for this date. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 9:45 a.m., the DON and RN 6 indicated the wound tracking log was the internal log of residents with wounds that RN 6 used to identify residents with wounds, and to assess and track residents' wound progress weekly. Both acknowledged Resident H's name was not on the original list. During an interview on 4/17/24 at 9:45 a.m., the DON provided an updated wound tracking log, dated February - April 2024, indicated Resident H had been on the original list, could not explain why the resident was not on the first list given to surveyor on 4/15/24. This report indicated resident admitted on [DATE], had a stage 3 pressure wound on the coccyx, measured 1.5 cm x 1.0 cm x 0.4 cm with serous drainage. During an interview on 4/17/24 at 9:45 a.m., the DON and RN 6 indicated there was no wound MD documentation available prior to 4/16/24, Resident H had not been seen by the wound MD until this week when the wound on the coccyx became worse. On 4/17/24 at 11:55 a.m., the DON provided a Documentation & Assessment of Wounds policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, .(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing .the facility must ensure residents receive treatment and care plan in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: i. Promote the prevention of pressure ulcer/injury development; ii. Promote the healing of existing ulcers/injuries 3.1-40(a)(2)