STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Retirement Village	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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 34129 Based on record review and interview, the facility failed to ensure adequate supervision, monitoring, and interventions were implemented for a resident who had a diagnosis of dementia (chronic condition that causes a decline in cognitive abilities, such as thinking, remembering, and reasoning, that interferes with daily life) and a history of aggressive behaviors for 1 of 6 residents reviewed for dementia (Resident BB), resulting in verbal and physical threats, and resident to resident altercations against his dementia diagnosed peers (Residents CC, F, DD, EE, and U). Findings include: The facility reported on the Indiana State Department of Health (ISDH) Survey Report System Resident BB being involved in 6 incidents: on 4/16/24 with Resident CC, on 5/4/24 with Resident F, on 5/30/24 with Resident CC, on 7/16/24 with Resident DD, on 9/8/24 with Resident EE, and on 11/4/24 with Resident U. Resident BB's medical record was reviewed on 11/6/24 at 1:06 p.m. The resident was admitted to the facility's memory care unit, on 11/10/23, with aggressive behaviors. Diagnoses included, but were not limited to, unspecified dementia of unspecified severity with psychotic disturbance and psychotic disorder with delusions, due to known physiological condition. An annual Minimum Data Set (MDS) assessment, dated 9/19/24, indicated the resident had a severe cognitive impairment. Resident BB exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) for 1 to 3 days of the 7-day assessment period, which significantly interfered with the resident's care, put the resident at significant risk for physical illness or injury, significantly interfered with the resident's participation in activities or social interactions, put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or living environment. Resident BB required setup or cleanup assistance for eating, oral hygiene, dressing and mobility, supervision or touching assistance for toileting, personal hygiene and bathing. (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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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Indiana State Department of Health Survey Report System report, dated 4/16/24 at 1:45 p.m., indicated Resident BB pushed Resident CC causing him to fall. Both residents resided on the memory care unit. Residents were immediately separated by staff and placed on safety monitoring. The police department, physician (MD), and the residents' families were informed. Social Services (SS) was to monitor for adverse psychosocial well-being. No injuries noted. Each resident would remain on safety monitoring until the interdisciplinary team (IDT) met to determine an alternative intervention, if warranted. Care plan reviewed and updated. Follow up of the investigation, dated 4/19/24, indicated both residents were not able to recall the alleged incident as they both reside on the memory care unit. SS to monitor for adverse psychosocial well-being with no mental anguish reported. IDT reviewed and safety monitoring for each resident was discontinued with no further incident noted. Residents' care plans reviewed and updated appropriately. Family and MD agreed to plan of care. A behavior progress note, dated 4/16/24 at 2:10 p.m., indicated Resident B had an incident of physical aggression on 4/16/24 at 2:00 p.m. Resident BB pushed another resident in the day room. The other resident was uninjured. Resident BB had no further aggression and went to his room A psychosocial progress note, dated 4/17/24 at 4:23 p.m., indicated Social Services (SS) visited with Resident BB. The resident showed no signs or symptoms of psychosocial distress. A psychosocial progress note, dated 4/18/24 at 4:23 p.m., indicated the SS had visited with Resident BB. The resident showed no signs or symptoms of psychosocial distress. A psychosocial progress note, dated 4/19/24 at 4:24 p.m., indicated SS had visited with Resident BB. The resident showed no signs or symptoms of psychosocial distress. An Indiana State Department of Health Survey Report System report, dated 5/4/24 at 1:01 a.m., indicated Resident BB and Resident F were in a physical altercation. Both residents reside on the memory care unit and were roommates. Residents were immediately separated by staff and placed on safety monitoring. Skin assessments were completed on each resident. Resident F noted with small skin tears to the left elbow and right knee. Resident BB noted with no skin concerns. The police department, MD and the residents' families were informed. Resident F received a room change. SS to monitor for signs or symptoms of adverse psychosocial well-being. Follow up of the investigation, dated 5/16/24, indicated Resident BB had successfully been moved to a different room and has not exhibited any change in mental status, no signs of distress. Psych services had also assisted with reviewing the resident's current behavioral care plan, as well as, medication regimen. The MD and family agreed with the revised plans. Resident F had not exhibited any change in mental status with no distress noted. Psych services also assisted with assessing Resident F's current status, medication regiment, and behavioral management plans. The MD and family agreed with the revised plans. The minor skin impairment areas were healed. A behavior progress note, dated 5/8/24 at 1:55 a.m., indicated the nurse was called to the memory unit related to Resident BB getting upset with his roommate. He stated his roommate was messing with the heating unit and Resident BB got upset and kicked his roommate. In doing so, the roommate lost his balance and fell to the floor. The nurse observed some blood to the roomate's left hand second digit, however, after cleaning site, no skin issue observed. Resident BB was immediately placed on one on one (1:1) care throughout the shift, and appeared calm at this time. The nurse notified family, Director of Nursing (DON), Administrator (ADM), and police. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care management progress note, dated 5/16/24 at 12:37 p.m., indicated both residents not able to recall the alleged incident as they both reside on the memory care unit. SS monitored for adverse psychosocial well being with no mental anguish reported. IDT reviewed and safety monitoring for each resident was discontinued with no further incident noted. Resident's care plan reviewed and updated appropriately. Family and MD agree to plan of care. A behavior progress note, dated 5/28/24 at 5:17 p.m., indicated Resident BB refused his medication and indicated to get out of his face. A behavior progress note, dated 5/28/24 at 5:19 p.m., indicated Resident BB was verbally aggressive with others and stated, you can get out of here. Staff redirected and would continue to monitor. A behavior progress note, dated 5/29/24 at 11:49 a.m., indicated Resident BB was yelling at other residents, You can't sit here with me, get away! While stating this, Resident BB pulled arm back like he was going to hit a resident. An Indiana State Department of Health Survey Report System report, dated 5/30/24 at 2:20 p.m., indicated Resident BB pushed Resident CC causing him to fall. Both residents resided on the memory care unit. Residents were immediately separated by staff and placed on safety monitoring. The police, MD and residents' families were informed. SS was to monitor for adverse psychosocial well-being. Resident BB received a new order for acute psych evaluation and treatment. Skin assessments completed with no injuries noted. Each resident was to remain on safety monitoring until IDT met to determine an alternative intervention if warranted. Care plans reviewed and updated. Follow-up added, on 6/7/24, of Resident BB continued to receive community based psych services. Upon his return, the IDT would review and determine any further changes in behavioral care planning. Resident CC had been assessed for any changes in psychosocial wellbeing with no noted changes. Resident CC did not have any noted injuries. The MD and family agreed with the current plan of care. An event progress note, dated 5/30/24 at 3:44 p.m., indicated Resident BB approached room door when another resident was noted standing in the doorway. Resident BB pushed the resident in the doorway to the ground. Staff were unable to approach the resident prior to the altercation occurring. The resident in the doorway was noted to be calm with no concerns prior to resident interaction. Staff immediately separated both residents. Resident BB noted to be redirected several times with minimal success. Other resident moved to another area and immediately assessed head to toe with no open areas or redness at this time. Resident BB placed on 1:1 safety monitoring. The MD, ADM, and family were informed. A behavior progress note, dated 6/29/24 at 9:17 a.m., indicated the nurse entered memory care unit and Resident BB noted in his room slamming doors and cursing loudly at staff. Staff tried to redirect and approach resident, resident noted slamming doors in room and attempting to hit staff. Resident was placed on 1:1 for safety and monitoring. Resident BB noted to continue to have escalated behaviors while on safety monitoring, unable to redirect after several attempts. Resident refused medications and stated, I will never take that! MD and DON notified with orders to call 911 for transport to the emergency room (ER) for psych evaluation and treatment. Report called to the ER nurse and all paperwork sent with the resident. The family was notified of the incident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Indiana State Department of Health Survey Report System report, dated 7/16/24 at 3:15 p.m., indicated Resident DD walked behind Resident BB's chair. Resident BB told Resident DD to get out from behind the chair. Resident BB stood up and pushed the chair towards Resident DD and Resident DD pushed it back. The residents were separated. SS monitoring for signs and symptoms of adverse psychosocial well-being. Families and MD were notified. MD ordered for evaluation and treatment for both residents at neuro-psych facility. IDT to meet and determine if alternative interventions were warranted and care plans reviewed and updated appropriately when they return to the facility. An event progress note, 7/16/24 at 3:31 p.m., indicated Resident BB informed a resident to get from behind his chair, then got up and pushed chair into other resident with skin assessments done with no open areas or redness noted and no complaints of pain or discomfort voiced. The residents were separated. Will continue to monitor resident. A health status progress note, dated 7/16/24 at 5:28 p.m., indicated Resident BB was discharged to a psychiatric unit for behaviors and the wife was called and informed. An Indiana State Department of Health Survey Report System report, dated 9/08/24 at 2:19 p.m., indicated Resident BB and Resident EE had a physical altercation. During the initial investigation the residents believed to have a disagreement over television. The residents were separated, Resident BB placed on 1:1 safety checks and Resident EE placed on 15-minute safety checks. Residents' head-to-toe assessments completed; families and MD notified. Investigation initiated. Resident EE noted to have laceration to the top of the head, next to left eye, and the top of the left hand with redness noted to chest. Resident BB had no noted injury noted and was referred to neuropsychic hospital. IDT was to review care plans and initiate further interventions as appropriate. A follow-up to the incident was added on 9/25/2024, which indicated the investigation was completed, with documentation, charts and care plans reviewed. No other residents were affected by the altercation. Laceration noted to Resident EE was healing with no adverse effects noted. Resident BB was discharged from a neuropsychic hospital for evaluation and review of medications. Resident EE has had no signs or symptoms of distress noted and removed from safety checks post 72 hours with no further issues. A behavior progress note, dated 9/8/24 at 2:34 p.m., indicated the nurse was walking down the hallway and heard yelling from Resident BB's room. Upon assessment, Resident BB had another resident in a headlock on the bed. The nurse immediately separated the residents and called for help. The other resident was taken out of the room and Resident BB was kept in the room to keep the residents separated. Resident BB vitals were within normal limits with no injuries noted. DON, SS, and family were notified of the incident and 1:1 initiated for safety of resident and others. A referral for a psychiatric hospital was placed. A care management progress note, dated 9/10/24 at 9:22 a.m., indicated resident reviewed related to resident to resident altercation. Resident BB was sent to neuropsychic for evaluation. Will assess resident upon return for implementation for new intervention and changes in plan of care as needed. A Social Service (SS) Assessment, dated 9/25/24, indicated Resident BB ambulated independently, required assistance with Activities of Daily Living (ADL) and had not exhibited any problem behaviors at the facility. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Indiana State Department of Health Survey Report System report, dated 11/4/24 at 12:01 p.m., indicated Resident U was attempting to enter Resident BB's room and Resident BB nudged Resident CC out causing her to lose her balance and fall to the floor. The residents were immediately separated. Resident U was sent to the ER for evaluation and treatment. Resident BB was placed on 1:1 monitoring. MD, psych services, and families were notified. SS monitored for signs and symptoms of psychosocial well-being and IDT to meet and determine an alternative intervention was warranted and care plans reviewed. A health status progress note, dated 11/4/24 at 2:39 p.m., indicated Resident BB told nurse, I didn't hit her, I just pushed her out. A health status progress note, dated 11/7/24 at 12:02 p.m., indicated Resident BB was discharged to another facility. Resident alert and oriented with intermittent confusion per normal resident condition stable, with skin intact, no psychosocial distress noted prior to leaving the facility. MD and family aware. An undated document, provided by the ADM, on 11/7/24 at 3:15 p.m., titled Get to Know [Resident BB's Name], listed Resident BB's family members; previous job; things the resident loved: trucks, watching TV - westerns, the news, movies, sports (football), bingo, and to take naps; and place the resident called home. A care plan, initiated on 5/9/24, indicated the resident had the potential to be physically aggressive, making physical contact with others, related to the diagnosis of dementia, with a care plan goal, dated 1/26/25, of the resident will not harm self or others throughout the review date. Interventions on the care plan all interventions but one care plan intervention were dated 5/9/24, which included, to administer medications as ordered; analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc.; observe and report as needed any signs or symptoms of resident posing a danger to self and others; referred to outside inpatient psych services for evaluation and treatment related to aggressive behavior with another resident; the one additional intervention, initiated on 11/7/24, of when the resident becomes agitated: intervene before agitation escalates; guide away from the source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away and approach later, and the resident was placed on 1:1 safety checks, dated on 11/4/24. The resident's care plan lacked resident specific interventions and lacked care plan interventions for each incident reported to ISDH. Resident BB's medical record lacked documentation to implement person-centered, individualized care to meet the behavioral health needs and resident specific interventions. On 11/6/24 at 3:50 p.m., the Director of Nursing (DON) indicated Resident BB has had multiple aggressive behaviors and the staff's immediate intervention for Resident BB was to get the residents separated, check them out from head to toe, notify the physician, administrator (ADM), and family of the incident. Resident BB would remain 1:1 with staff until he was discharged from the facility to a behavioral unit. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 3:15 p.m., ADM provided Resident BB's reportable incidents with the investigations for 4/16/24, 5/8/24, 5/30/24, 7/16/24, 9/8/24, and 11/4/24 incidents. ADM indicated he had started working as the facility Administrator and the Director of the Memory Unit in August 2024 and the incident dated 5/4/24 should have been 5/8/24 and the incident dated 5/30/24 had the incorrect resident's name and should have been Resident BB and Resident CC, not Resident BB and Resident F. ADM indicated Resident BB's care plan should have been revised with a new care plan intervention added for each of Resident BB's incidents. Resident BB had been discharged from the facility to a behavioral facility, this afternoon, on 11/7/24. On 11/7/24 at 3:15 p.m., the ADM provided and identified a document as a current facility policy, titled Care of the Cognitively Impaired (Dementia Care), dated 9/6/24. The policy indicated, .Policy: The facility will provide dementia treatment and services which may include but are not limited to the following: .1. Ensuring adequate medical care, diagnosis, and supports based on diagnosis; .2. Ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; and .3. Utilizing individualized, non-pharmacological approaches to care (e.g., purposeful and meaningful activities). Meaningful activities are those that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being .Procedure .1. Identify, address, and/or obtain necessary services for the dementia care needs of residents; .2. Develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment; .3. Develop individualized interventions related to the resident's symptomology and rate of progression (e.g., providing verbal, behavioral, or environmental prompts to assist a resident with dementia in the completion of specific tasks); .4. Review and revise care plans that have not been effective and/or when the resident has a change in condition; .5. Modify the environment to accommodate resident care needs; or .6. Achieve expected improvements or maintain the expected stable rate of decline 3.1-43(a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38767 Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were labeled, stored, and destroyed properly for 4 of 5 medication carts utilized for medication storage on the 100 and 300 hallways. Findings include: On 1/4/24 at 12:03 p.m., during an observation of the 100 hallway medication cart 3 with Registered Nurse (RN) 5, the following was observed, a. Resident J had an opened bottle of Alphagan P eye drops (used to treat glaucoma) labeled 1 drop in both eyes twice daily, and no opened date. b. Resident J had an opened bottle of Dorzolamide -Timolol eye drops (used to treat glaucoma) labeled 1 drop in both eyes twice daily, and no opened date. c. Resident J had an opened bottle of Rocklatan 0.02% - 0.005% eye drops (used to treat glaucoma) labeled 1 drop in both eyes at bedtime, and no opened date. d. Resident L an opened bottle of Geri-Tuss (used to treat cough and chest congestion)100 milligram (mg) per 5 milliliter (ml) labeled to give 20 ml as needed (prn) for cough, and no opened date. e. Resident K had an opened bottle of Fluticasone Propionate 50 micrograms (MCG) spray (used to treat seasonal allergies) labeled 1 spray in both nostrils daily, opened date 9/4/24, the bottle remained almost full. The medication administration record (MAR) indicated documentation of medication having been administered per physician's order daily. During an interview on 11/7/24 at 10:12 a.m., the Director of Nursing (DON) indicated Resident K's Fluticasone Propionate had been delivered from the pharmacy on 6/17/24, 7/9/24, 8/16/24, 9/13/24, and in her opinion by using manufacturer's instructions if all bottles were used there could have been enough medication to administer as ordered. Indicated the bottle delivered on 9/13 should have been opened and being used if the medication was administered as ordered daily, the bottle was not presented during the survey process. Observation of the 100 hallway medication cart 2 with RN 10, the following was observed, a. Resident M had an opened bottle of Fluticasone Propionate 50 MCG spray labeled 1 spray in both nostrils daily for allergies, opened date 7/18/24, bottle remained three fourths full. The MAR indicated documentation of the medication having been administered per physician's order daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident N had an over-the-counter bottle of Alpha Brain Memory and Focus daily cognitive support, 30 capsules per bottle, opened date 5/29. RN 10 counted 12 tablets remaining in the bottle. The label of the bottle was worn and faded. The MAR indicated documentation of the medication having been administered per physician's order daily. c. Resident P had an over-the-counter bottle of Simethicone 80 mg chewable, no opened date, and no instruction for administration on the bottle. The label indicated 100 chewable tablets per bottle, RN 10 counted 48 tablets remaining in the bottle. The MAR indicated documentation of the medication having been administered per physician's order daily. d. Resident P had an over-the-counter bottle of Simethicone 80 mg chewable, no opened date, and no instruction for administration on the bottle. The label indicated 100 chewable tablets per bottle, RN 10 counted 36 tablets remaining in the bottle. The MAR indicated documentation of the medication having been administered per physician's order daily. During an interview on 11/7/24 at 10:19 a.m., the DON indicated Resident P's Simethicone 80 mg had been delivered from the pharmacy on 4/2/24, 6/7/24, 7/1/24, and 11/6/24. Indicated by counting the number of delivered number of the medication from the pharmacy, with the number of documented doses having been administered, there would be a short fall of the medication. e. An opened tube of PeriGuard ointment skin protectant 7 ounce (oz), no open date, unbagged, laying in the medication cart drawer among oral medications. There was no pharmacy label or resident name on the tube. f. Two Albuterol Sulfate (bronchodilator) 0.5 mg/3 ml vials were laying in the medication cart drawer next to a tube of PeriGuard ointment, and on an unidentified sticky orange colored substance leaving the vials sticky also. The was no resident name on the vials or label with instructions for use. RN 10 was observed to put the 2 vials into 1 of 3 residents' opened box of Albuterol, and indicated they probably belonged to that resident. During an interview on 11/1/24 at 12:39 p.m., RN 10 indicated the night shift nurses were responsible for going through the medication carts at night to assure there were no expired medications, clean the carts, and order new medications as needed. PeriGuard ointment used on the buttocks was not supposed to be stored on the medication cart among oral medications, treatments were supposed to be stored in the treatment cart, but at times staff were ready to go home, and would just leave the treatments in the medication cart. Nebulizer vials should have been stored in the original box with a resident label. On 1/4/24 at 12:25 p.m., during an observation of the 300 hallway medication cart 2 with RN 15, the following was observed, a. Resident Q had an opened bottle of Dorzolamide - Timolol eye drops labeled instill 1 drop in both eyes twice daily for dry eye, opened date 8/8/24. RN 15 indicated, dependent on the eye drop medication, some could be opened for 28 days or 30 days, but if unsure the nurse should have called the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident R had an opened bottle of Fluticasone Prop 50 mcg spray labeled 1 spray in each nostril twice daily for an upper respiratory infection (URI) for 7 days. The medication was ordered for 9/4 - 9/11. c. Resident S had an opened bottle of Fluticasone Prop 50 mcg labeled 1 spray in each nostril daily allergies, sent from the pharmacy 3/9/24, no open date, remained almost full. The resident record indicated the medication was discontinued on 8/19/24. d. Resident S had an opened bottle of Simethicone 80 mg labeled 2 tabs three times daily for gas, opened date 4/1/24. The label indicated 100 chewable tablets per bottle, RN 15 counted 28 tablets remaining in the bottle. The resident record indicated the medication was discontinued on 8/19/24. Observation of the 300 hallway medication cart 1 with RN 15, the following was observed, a. Resident T had an opened bottle of Latanoprost 0.005% eye drops labeled 1 drop in both eyes, no opened date. During an interview on 11/4/24 at 12:03 p.m., RN 5 indicated eye medications were only good for 20 to 30 days depending on the medication, then had to be replaced and destroyed. During an interview on 11/6/24 at 12:12 p.m., the DON indicated medications including eye drops were supposed to be dated when opened. There was a chart at the nurse's desk to instruct staff on how long medications could be kept and used after they were opened. The nurse working the cart was responsible for reordering medications that were running low by calling the pharmacy or using the re-order button in the electronic medical record medication administration record (eMAR). When medication orders were discontinued, the nurse taking the order should have pulled the medications from the medication cart. Eye medications could have been left in the medication cart for per their policy for 28 days. Biologicals such as PeriGuard ointment and other tubes of topical treatments were supposed to have been stored in the treatment cart, not in the medication cart among oral medications. The PeriGuard was a house treatment, and each tube was shared among multiple residents. Residents were allowed to have a multi-dose bottle of over-the-counter medication provided by a family member. The bottle was required to have the resident's initials, drug name, and physician's order for use on the bottle. During an interview on 11/6/24 at 4:00 p.m., the DON indicated there was a contracted Registered Pharmacist (RPh) who audited the medication and treatment carts for compliance, she was not sure of the frequency. In addition, the DON, Assistant Director of Nursing (ADON), RN 10, and Infection Preventionist Nurse (IP) randomly performed cart audits. On 11/4/24 at 2:52 p.m., the Executive Director (ED) provided a Disposal/Destruction of Expired or Discontinued Medication policy, dated 10/30/23, and indicated the policy was the one currently being used by the facility. The policy indicated, .1. Facility staff should destroy and dispose of medications in accordance with facility policy and applicable law .2. Once an order to discontinue a medication is received, facility staff should remove this medication from the resident's medication supply .4. Facility should place all discontinued or outdated medications in a designated, secured location which is solely for discontinued medications .7. Facility should dispose of discontinued medication, outdated medication .no more than 90 days of the date the medication was discontinued . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Retirement Village	8616 W 10th St Indianapolis, IN 46234

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 3:03 p.m., the ED provided a Medication Storage Guidance chart from the pharmacy, dated 2021, and indicated the guidance was the one currently being used by the facility. The guidance indicated, . Ophthalmic products, dated when opened and discard unused portion after 28 days .Discard nasal products after 30 doses or 35 days .All internal and external products should be stored physically separated from one another . This citation relates to Complaint IN00446467. 3.1-25(j) 3.1-25(m) 3.1-25(o) 3.1-25(r)