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	01/15/2025

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 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. 38768 Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were reviewed and revised as needed with resident's updated interventions for 1 of 18 residents reviewed for care plan revisions, (Resident 14). Findings include: On 1/9/25 at 10:17 a.m., Resident 14's room was observed. There was a picture hung to the wall above her bed, which depicted the resident's left arms with a black splint in place. The picture had instructions to keep brace on at all times. Throughout the survey week, Resident 14 was not observed to wear any brace or splint. On 1/9/25 at 2:04 p.m., Resident 14's medical record was reviewed. She was a long-term care resident who resided on the secured memory care unit with a diagnosis of dementia. She had a comprehensive care plan 1/2/24 which indicated, she had an activities of daily living (ADL) self-care performance deficit related to her diagnoses. Interventions for her plan of care included but were not limited to, wear L [left] edema glove and L wrist orthotic at all times. Cover with bandage during bathing. During an interview on 1/14/25 at 11:17 a.m., the Director of Therapy (DOT) indicated, Resident 14's brace had been used more than a year ago after she fractured her wrist, but she no longer required the brace or edema glove and the care plan should have been revised as well as the picture in her room removed.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 Based on observation, interview, and record review, the facility failed to ensure a resident's activities of daily living were completed for 1 of 8 residents reviewed for completed ADLs (Resident B). Findings include: On 1/9/25 at 11:38 p.m., Resident B's medical record was reviewed. He was admitted on [DATE]. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (lung disease), diabetes mellitus (blood sugar disorder) with chronic kidney disease, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (causes breathing to stop or be reduced during sleep). A care plan, dated 6/6/24, indicated Resident B was dependent on staff for meeting emotional, intellectual, physical, and social needs. A care plan, dated 5/24/24, indicated Resident B needed assistance with mobility and activities of daily living (ADL)s. On 1/08/25 at 12:10 p.m., Resident B's toenails were observed outside of his blanket. They were extremely long; the left toenail was jagged. He indicated he was unable to put them under the blanket due to pressure and coarseness. On 1/13/25 at 9:53 a.m., the Executive Director (ED) provided documentation of a podiatry visits on 12/21/24, Resident B was not seen. On 1/9/25, Resident B saw the podiatrist and was added to the 60-recall list. On 1/13/25 at 11:43 a.m., the ED provided further information regarding Resident B seeing the podiatrist. On 6/25/24 and 10/4/25, Resident B was not seen. During an interview, on 1/13/25 at 12:17 p.m., the Director of Nursing (DON) indicated the residents should be seen routinely when the podiatry doctor comes in. The nurses notify the Social Services Director (SSD), then the SSD makes out the list of residents to be seen. A current policy, titled, Resident Rights, dated 9/10/24, was provided by the Executive Director (ED), on 1/13/24 at 11:34 a.m. A review of the policy indicated, .The resident has the right to reside and receive services in the facility with reasonable accommodation of resident and preferences This citation relates to Complaint IN00449427. 3.1-38(a)(3)(E)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37981 Based on observation, interview, and record review, the facility failed to ensure oxygen (O2) levels were set correctly for 2 of 2 residents using nasal cannulas (NC) (Resident Z and B), and the facility failed to ensure humidifier bottles for oxygen administration were changed at 7 day interval, and a bipap mask and tubing were protected from contamination for 1 of 2 residents reviewed for contamination of bipap masks and tubing when not in use (Resident B). Findings include: 1. On 1/10/25 at 12:33 p.m., Resident Z's record was reviewed. Her diagnoses included, but were not limited to, idiopathic peripheral autonomic neuropathy (nerve pain), diabetes mellitus (blood sugar disorder), edema (swelling) in both lower extremities, and another diagnosis, dated 1/7/25, of pneumonia. A new physician's order, dated 1/10/25, indicated 2 liters of oxygen per minute (lpm) as needed for shortness of breath. Staff may titrate (change) to keep oxygen saturations above 90%. A respiratory care plan, dated 12/19/24, indicated Resident Z would have no signs or symptoms of poor oxygen absorption. The approaches included giving medications as ordered by the physician. Her oxygen via nasal prongs (NC) at 3L per minute. On 1/9/24 at 9:09 a.m., Resident Z was observed eating her breakfast feeling short of breath (SOB). Her O2 concentrator was set to 1 liter per minute (lpm). She indicated it should be at 2 lpm. Her NC was not dated and the O2 humidity bottle was dated 12/31/24. She was wearing her O2 cannula upside down. During an interview, on 1/9/24 at 9:16 a.m., Licensed Practical Nurse (LPN) 8 indicated Resident Z was on 1L of O2 and her O2 blood saturation was 87%. LPN 8 changed the O2 concentrator to 2L and after a few deep breaths. Resident Z indicated she still felt SOB and needed a breathing treatment. LPN 8 indicated she was not Resident Z's nurse and wasn't sure where her nurse was at this time. LPN 8 did not auscultate her chest to listen to lung sounds. She indicated she would contact the Physician's Assistant (PA) 9. For an evaluation and orders. On 1/8/24 at 9:26 a.m., LPN 8 provided an albuterol nebulizer treatment. During an interview, on 1/9/25 at 9:28 a.m., LPN 37 indicated Resident Z came back from the hospital yesterday and the facility staff put her on 1L of O2. She indicated Resident Z was coughing last night. No one was supposed to be on 1L of oxygen. The resident had not been back to the facility for 24 hours yet and she had not had a chance to look at her chart. She provided a print-out of her medications including the new hospital medications. LPN 37 indicated Resident Z's O2 saturation kept dropping below 90% during her nebulizer treatment. During an interview, on 1/9/25 at 9:42 a.m., LPN 37 indicated, as Resident Z was finishing the nebulizer treatment, that her O2 saturation at 88%. Resident Z indicated she was feeling dizzy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 9:44 a.m., Resident Z's O2 saturation was observed at 87%. No nurses were in the resident's room at this time. On 1/9/25 at 9:46 a.m., LPN 37 brought in a stethoscope. She indicated her heard wheezing in her left, upper posterior chest and her O2 saturations were all over the place. On 1/9/25 at 9:50 a.m., the PA 9 was observed assessing Resident Z. LPN 37 told her the albuterol nebulizer was a new order from the hospital. Resident Z told her she was coughing up phlegm (mucus from the chest) and wanted to get more pain medications for her feet. The PA had her dangle her legs over the side of the bed, the effort brought her O2 saturation down to 82%, then it jumped up to 99%. During an interview, on 1/9/25 at 10:01 a.m., LPN 37 indicated Resident Z had a new hospital order for tiotropium (opens the airways) as rescue inhaler. PA indicated she needed a pulmonary (lung) doctor. On 1/9/25 at 10:04 a.m., LPN 37 left to see if the new inhaler was here. Resident Z indicated she wanted to use it. On 1/9/25 at 10:06 a.m., with the PA near her, Resident Z indicated she was dizzy. On 1/9/25 at 10:08 a.m., LPN 37 indicated the rescue inhaler was in the medication cart. 2a. On 1/9/25 at 11:38 p.m., Resident B's medical record was reviewed. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (lung disease), diabetes mellitus (blood sugar disorder) with chronic kidney disease, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (causes breathing to stop or be reduced during sleep). His physician orders indicated O2 at 2L per minute continuously per nasal cannula related to acute and chronic respiratory failure with hypoxia (low oxygen levels) and hypercapnia (increased carbon dioxide levels). His bi-pap care plan, dated 5/24/24, indicated the resident was at risk for alteration in breathing patterns related to chronic obstructive pulmonary disease (COPD) with hypoxia (low oxygen levels) and obstructive sleep apnea and requires the use of a bi-pap during sleeping hours. An approach was to recognize he was at risk for respiratory illness. He would be free of signs and symptoms of respiratory infections. On 1/8/25 at 12:14 p.m., Resident B's oxygen concentrator was set at 3 LPM, he indicated it should have been on 2 lpm. His bipap tubing was observed disconnected and laying on the floor. His uncovered bipap mask was observed laying in the corner of the windowsill with his bipap machine. Dust, dirt, hair, and caulking debris were noted on the windowsill. Dust and possibly water spots were noted on the bipap mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/8/25 at 12:17 a.m., Resident B indicated he liked to go to sleep between 11:00 to 12:00 p.m. He would use his call light and wait until 2:00 to 3:00 a.m. sometimes before the bi-pap mask would be put on him. Sometimes, he would have to sleep without it. He would like to have it put on at 11:00 p. m. each night. He indicated the bipap mask had been dropped on the floor and not cleaned or replaced. He preferred the mask to be covered during the day. On 1/10/25 at 9:07 a.m., Resident B's uncovered bipap mask was observed laying in the corner of the windowsill with his bipap machine. Dust, dirt, hair, and caulking debris were noted on the windowsill. Dust and possibly water spots were noted on the bipap mask. On 1/13/25 at 12:24 p.m., the Director of Nursing (DON) indicated a bipap mask when not in used should be covered and tubing should not be on the floor. A current policy, titled, Oxygen Administration (Safety, Storage, Maintenance), dated 10/11/24, was provided by the Regional Director of Clinical Services (RDCS), on 1/13/25 at 3:57 p.m. A review of the policy indicated, .Respiratory care .consistent with professional standards of practice .Humidifier/Aerosol bottles should be dated and replaced every 7 days regardless of H2O (water) level .Store oxygen and respiratory supplies in bag labeled with resident's name when not in use This citation relates to Complaint IN00449427. 3.1-19(bb)