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	07/22/2025

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 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** Based on interview and record review, the facility failed to complete a physician's order by documenting fluid intakes for a resident on restricted fluid intake for 1 of 4 residents reviewed for quality of care. (Resident E) Findings include:The clinical record for Resident E was reviewed on 7/22/24 at 10:43 a.m. Diagnoses included cirrhosis of the liver, diastolic congestive heart failure, and obesity. The resident was admitted [DATE].An acute care hospital physician's discharge note, dated 3/27/25, indicated the resident had hepatic cirrhosis and chronic diastolic heart failure and to continue plan of fluid restriction. A current physician's order, dated 3/27/25, indicated the resident was to have a regular diet with thin liquids with a 1500 ml (milliliter) fluid restriction. A review of the residents clinical record lacked fluid intake documentation or a care plan regarding the fluid restriction. During an interview on 7/22/25 at 1:34 p.m., the ADON indicated the fluid restriction was viewed as a dietary recommendation as the fluid restriction was in the directions of the order and not the order itself. The order was part of the resident's discharge orders from the hospital and was signed by the facility's physician, but was not tracked due to the placement of the fluid restriction in the order. A current facility policy, undated, titled, Fluid-Restriction Diet, provided by the Nurse Consultant on 7/22/25 at 3:08 p.m. , included the following: Definition: The fluid-restriction diet order limits an individual's daily fluid intake Counting Liquids and Foods for a Fluid Restriction Diet. A fluid is anything that is liquid or any foods that melt at room temperature. These foods and liquids must be counted as part of the daily food intake.The tag relates to Complaint 1669976.3.1-37(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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. Based on observation, interview, and record review, the facility failed to keep a resident's call light in reach and to apply ordered oxygen for 1 of 4 residents reviewed for neglect. (Resident D)Findings include:During an interview on 7/21/25 at 11:33 a.m., Resident D was observed seated on the side of her bed. An oxygen concentrator was observed on the opposite side of the bed, out of reach of the resident. The resident indicated she had recently gotten dressed with the assistance of staff and had forgotten to put her oxygen back on. She reached for her call light to get staff assistance and the light was observed coiled on the floor next to the bed, out of reach of the resident. During an observation on 7/21/25 at 11:46 a.m., accompanied by the Administrator, the oxygen concentrator with the resident's nasal cannula was observed out of reach on the opposite side of the bed where the resident was seated. The Administrator handed the tubing to the resident who applied the oxygen and indicated staff should have reapplied the oxygen following care. The call light tubing was observed coiled on the floor next to the resident's bed. The Administrator indicated this should have been placed so the resident can call staff for assistance. The clinical record for Resident D was reviewed on 7/21/25 at 12:38 p.m. Diagnoses included history of a stroke with left sided weakness, chronic obstructive pulmonary disease, diastolic congestive heart failure, and depression. A health care plan, dated 6/24/25, indicated the resident had activities of daily living performance deficits related to activity intolerance. Interventions included, the resident required assistance of one staff to dress and to move between surfaces (transfer).A current facility policy, revised 9/12/22, titled, Resident Call System, provided by the Administrator on 7/22/25 at 11:54 a.m., included the following: Procedure: 5. The call light should be positioned within reach of the resident .a) The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.A current facility policy, revised 4/8/25, titled, Oxygen Administration, provided by the Administrator on 7/22/25 at 11:54 a.m., included the following: Policy. To ensure that oxygen is administered and stored safely within the facility or in an outside storage area .Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia.The tag relates to Complaint 1669976.3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to maintain a clean, orderly shower room for resident use on 1 of 3 shower rooms observed for cleanliness. (100 hall) Findings include:During an observation of the 100 Hall shower room on 7/22/25 at 2:10 p.m., accompanied by the Assistant Director of Nursing (ADON), the following was observed: the floor had feces on the floor in three different areas outside the shower area. A used plastic bag, wet paper towels and a used nicotine patch were on the floor. The floor was visibly dirty throughout the room. There was a used nicotine patch stuck to the shower wall. Around the base of the shower area, where the wall and floor meet, there was a black substance. During an interview at the time of the observation, the ADON indicated the shower rooms should not be in this condition and was an unacceptable way to leave the shower room. During an interview on 7/22/25 at 2:21 p.m., the Lead Housekeeper indicated the room was unclean. The floors should be swept and mopped and all debris thrown away. The dark substance between the tiles on the floor and walls just remain when cleaned. She had tried to clean it and would try another product.The Administrator indicated there was not a specific policy or checklist that she was aware of, regarding cleaning of the bathrooms.This tag relates to Complaint 1669993. 3.1-18(b)