| 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 03/20/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westside Retirement Village | 8616 W 10th St<br>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) |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to be informed of and choose her treatment when the facility transferred a resident to a psychiatric facility against her will for 1 of 3 residents reviewed for abuse and neglect (Resident C). Findings include:The clinical record review for Resident B was completed on 3/18/26 at 10:51 a.m. Diagnoses included bipolar disorder, anxiety disorder, and mild cognitive impairment. The resident was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 2/11/26, indicated the resident was cognitively intact. She was independent with all activities of daily living. She had no behaviors or rejection of care during the assessment period. An Application for Emergency Detention of Mentally Ill and Dangerous and/or Gravely Disabled Person document, dated 1/21/26 at 10:02 a.m., indicated [Resident B] has a psyshitric [SIC] condition that impairs her judgement and reasoning and is unwilling to accept treatment voluntaryly [SIC] with in her skilled nursing facility as driected [SIC] by attending geriatric psychaitry [SIC] provider. For more than 14 days. [Resident B] has demonstrated impaired judgement and has the physical capityy [SIC] to induce grave harm to herslef [SIC] and other [SIC]. She has been verbily [SIC] aggressive and has threatned [SIC] residents and staff verbally and with spraying chemicals. The order provided that law enforcement was to take the individual into custody and transport to the psychiatric facility listed on the order. A care management progress note, dated 1/21/26 at 4:16 p.m., indicated Resident B had been taken to a psychiatric (pysch) hospital. The resident had refused to go. A court order had been obtained, and the resident was escorted by police to the psych provider facility. A readmission Nurse Practitioner (NP) progress note, dated 2/1/26, included Resident B was irritable during examination and indicated she was going to sue the pants off of this place for sending me to another facility without my permission. During an interview on 3/20/26 at 9:54 a.m., the Director of Nursing (DON) indicated the reason that Resident B was transferred by court order to a psych facility was that she had become manic and was pacing up and down the hallways and refusing her medications. The DON had told the resident she wanted her to go to the hospital to get her medications under control. The resident was okay with going to the hospital but refused when she realized it was for a psych hospital. She had not displayed any aggressive behaviors. The DON indicated the documentation of the refused medication and manic behaviors was documented in the Court order. A progress note from the psychiatric facility, dated 1/21/26, indicated the facility had reported Resident B was displaying the following behaviors: physical and verbal aggression over the last 72 hours per staff. The resident had been cursing and yelling at her new roommate. The resident had also refused to clean up all of her items from her roommate's side of the room. It was reported Resident B had sprayed a staff member in the face with chemicals after her roommate had a bowel movement in the bathroom to cover up the smell. Resident B had indicated she was unclear why she had been sent to the facility, sharing that she knows she has problems. She indicated she planned to contact her legal attorney and guardian to file a lawsuit against the facility for sending her to another facility because she was unaware exactly why she was sent and the reason was never explained to her. During an interview on 3/20/26 at 12:39 p.m., the Social Service Director (SSD) indicated she had given a verbal report regarding Resident B's<br>(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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| 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 03/20/2026 |
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | behaviors to the psychiatric facility. This information had been provided to her by staff and not specifically documented in the clinical record. She was unable to say who reported being sprayed in the face with air freshener, but she recalled being informed about it. If she documented something in a note that was said to her, it must have happened. She could not remember specifics regarding Resident B's comment of making her roommate's life miserable, but she must have said it, because she documented it. During an interview on 3/20/26 at 1:18 p.m., the Nurse Practitioner (NP) indicated she completed the Emergency Detention form at the request of the SSD. There had to be certain verbiage included in order to qualify for eligibility to initiate an emergency detention. She felt Resident B was the most capable resident to cause another harm given her independence. The information she was provided by the SSD regarding her behaviors was used to document on the Emergency Detention Order (EDO). In her clinical documentation the term verbally abusive to residents was not a good choice of words. She could be uninhibited, coarse, direct, and rude. They use an Artificial Intelligence software program to document her visits. During the visits Resident B would swear and sound aggressive, but she was not personally aware of resident incidents of behaviors with others. During an interview on 3/20/26 at 3:15 p.m., the DON indicated upon reviewing the Resident B's medication administration record and progress notes, there had been no documented refusal of medications. Refusal of medications had been documented by the SSD, but not by nursing staff. She was unsure why the resident had been sent out to a psychiatric hospital. She had overhead the previous Administrator and SSD talking about behaviors Resident B had displayed but had not been brought in the loop about her behaviors. She had been notified of a conflict over a phone, but no specifics regarding threats or aggression. She was not notified of any type of abuse. This citation relates to Intake 2800757. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(n)(2) 410 IAC (Indiana Administrative Code) 16.2-3.1-3(n)(3) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse for 1 of 3 residents reviewed for abuse and neglect (Resident B). Findings include:An Adult Protective Services (APS), Elder Abuse online report, dated 2/3/26, indicated Resident C as an endangered adult, Resident B was the perpetrator, and the allegation was battery. The narrative/description of the incident indicated Resident C had arrived at the facility and moved into Resident B's room. Resident B was sent out to a psychiatric (pysch) facility that day. Resident C was in the room by herself for a week. The night Resident B returned from her psych hospital stay, she started to threaten to physically harm Resident C. Resident C's sister was on the phone and overhead the entire conversation between Resident B and Resident C. Resident C was moved within hours of the threats to a new room. The clinical record review for Resident C was completed on 3/18/26 at 11:17 a.m. Diagnoses included history of malignant brain neoplasm (tumor), need for assistance with personal care, muscle weakness, and depression. An admission Minimum Data Set (MDS) assessment, dated 1/26/26, indicated the resident was cognitively intact. She required staff assistance for bed mobility, dressing, showering, transfers, and personal hygiene. During an interview on 3/18/26 at 1:38 p.m., Resident C indicated she was admitted to the facility on [DATE]. She used her cell phone to talk with her sister throughout the day and night. The following day, on 1/21/26, her phone stopped working and her charger would not charge her phone. Her roommate, Resident B, had been sent out to a hospital and the staff had switched the landline phone for her so she could contact her sister. When Resident B returned to the facility on 1/28/26, she became very upset that Resident C was using her landline phone and told Resident C, if anyone touches my stuff, I'm going to kill you. Then she told Resident C's sister on the phone that she was gonna kill her too. She told the aids what had happened. She had not reported the threats to a nurse, but the aide said she would tell the nurse. Resident C was moved out of her room that evening to another room. She stayed in her room and did not attend activities because of her fear of Resident B. Now, when Resident B walked by her door, she looked at her and pointed her fingers like a gun at her. She used to go to activities in her old facility (Bingo, church, etc.) but does not go to activities here because of her fear of Resident B. She had spoken to the Social Services Director (SSD) regarding finding another facility because of not feeling safe with Resident B in the facility. Resident C indicated she had not met the Director of Nursing (DON) or spoken with her. The Administrator had visited her in her room and spoke to her and her sister, on the phone, during the visit. During a telephone interview on 3/20/26 at 3:00 p.m., Resident C's sister indicated during the incident on 1/28/26, Resident B had told her that if she called the phone again, she would kill her. She heard Resident B say to Resident C, If you touch my things, I will kill you. I will kill anyone who touches my things. A care management progress note, dated 1/29/26 at 10:30 a.m., indicated Resident C had spoken to the SSD about the night before. She had been moved out of her room to a new room due to difficulties with her roommate (Resident B). Resident C was happy about the move but was still upset with her former roommate. A care management progress note, dated 1/29/26 at 12:27 p.m., included that Resident C had a room move on 1/28/26 due to roommate incompatibility. Resident C was not showing any psychosocial or concerns with new roommate. A nurse practitioner's progress note, dated 1/17/26 at 6:19 p.m., indicated Resident B had bipolar disorder and had a two-week escalation of behaviors that was now putting others at risk of harm. She had been non-compliant and belligerent at times with staff and her treatment plan. She had multiple episodes of verbal aggression, treatment refusal, verbal abuse of her roommate and spraying a substance at a CNA. An SSD progress note, dated 1/19/26 at 10:54 a.m., indicated Resident B had been informed she would be getting a roommate. The resident indicated she would not be nice to the roommate. A health status progress note, dated 1/28/26 at 11:20 a.m., (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated Resident B had been readmitted from her stay at the psychiatric facility. The resident was in her room re-arranging her personal belongings. A care management progress note, dated 1/29/26 at 11:02 a.m., indicated the SSD and DON had met with Resident B in her room. The resident argued about the incident that happened with her roommate the night before. The resident had been spoken to regarding her treatment of residents and staff at the facility. During an interview on 3/18/26 at 2:22 p.m., Resident B was observed in her room, seated on her bed. She was well groomed and had a steady gate. She indicated she had been looking into going to an Assisted Living facility with the help of the SSD. She had no current issues with any other residents. She had some issues from time to time, but everyone does; she chose not to answer as to an example of an issue with another resident. She indicated she did not have any concerns regarding her time at this facility even though she had some tough times but did not want to talk about them. During an interview on 3/19/26 at 9:58 a.m., the SSD indicated on 1/28/26, she was called after hours at home by a CNA and told that Resident B was threatening Resident C and being verbally aggressive towards her. She could not recall who had called her. She instructed staff to move Resident C as far away as possible depending on room availability. The room Resident C was moved to had the nurse's station in between them so the residents would have had to cross in front of staff and could be monitored. She also instructed them to call the police to file a report. She reported the incident the following day to Adult Protective Services (APS). She followed up with Resident C the following day and she seemed to be doing well. Resident C had not told her that she did not feel safe. Resident B attended most activities, so that may be why Resident C did not go to activities. Resident C had told her once that Resident B would walk by her room and make a finger gun gesture at her. She had not observed Resident B walk by Resident C's room or had not observed her make that gesture. She had not interviewed any staff regarding Resident B making that gesture. She was sure staff would have reported it to her if they had witnessed something like that. She talked to Resident C about every couple of days when she called her into her room. Resident C had reported yesterday (3/18/26) during a care plan meeting about Resident B making finger gun gestures. Resident C usually kept her door shut. The facility staff were aware of avoiding interaction between the two residents. The SSD had witnessed Resident B behave verbally aggressive with other residents, but she had not known her to threaten to kill anyone. She cannot recall what other residents had been involved in the verbal aggressions. As far as she knew, no one had talked with Resident B about any of these behaviors, but she would deny them anyway, even if true. The reason she was called about the incident was because it required a room move and that was something she would handle. The investigation of the incident would be completed by the DON. She was unsure if the DON was called or informed. During an interview on 3/19/26 at 10:46 a.m., the DON indicated the only thing reported to her was that Resident C's sister was told by Resident B on the phone not to call her phone again, in not nice terms but did not know what was said. The SSD notified her that she wanted to move Resident C out of the room because Resident B had an altercation with Resident C's sister on the phone. She could not recall how she was notified by the SSD and was unsure if she had spoken to her on the phone or received a text, or how the contact occurred. To her knowledge, the sister talked with the SSD and had not felt safe for Resident C to remain in the room. She had no further knowledge regarding the incident. There was not an investigation because the incident was between Resident B and Resident C's sister, not with the resident. She had spoken to Resident C sometime after the room move and as far as she recalled, Resident C was fine. As far as Resident B performing the shooting gesture, Resident C was four doors down from her office and she had not observed Resident B going down the hall. When she had observed her going down the hall, it had been to attend an activity. She had not spoken with the SSD any further regarding the incident. She had not been aware an Adult Protective Service report had been filed or that the police had been contacted. She had not known Resident C had not felt safe until yesterday's (3/18/26) care plan meeting with Resident C. If Resident B had threatened to kill Resident C, this would definitely have been reported to the state agency within two hours and (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | investigated. This was not done because she had no idea there were threats, police involvement or an APS report. During an interview on 3/19/26 at 1:50 p.m., the DON indicated she had spoken with someone (unable to identify staff member) who reported that Resident B had returned and Resident C had kept calling her sister. Resident B had answered the phone and told the sister she was going to whoop her ass. She had spoken to the SSD as to why she had filed the APS report, and she had indicated it was requested by the family and Resident C's case manager. The DON indicated she had not done staff or resident interviews because there had been no resident abuse. During an interview on 3/19/26 at 2:19 p.m., the Unit Manager (UM) indicated she recalled an argument in Resident B and Resident C's room over a phone on the morning on 1/28/26. On 1/21/26, when Resident B had been sent to a psych facility, there had been an issue with Resident C calling her sister. She was passing by the room during her shift and Resident C indicated her cellphone was not working and her charger was not charging. She asked about her room's landline phone. She went to the SSD and reported that Resident C's phone charger was not working. The SSD said she had a charger she could use and would help Resident C. When Resident B returned to the facility, she overheard an argument regarding the landline phone. Later in the evening, around 6 to7:00 p.m., she received a call from the DON. She told her to move Resident C to another room immediately. The staff pulled together and moved her in about 15 minutes. Resident C indicated to her she just wanted to leave the room. She had not explained her reason. She asked if there was another concern beside the phone and she said no, I just want to move. She had not heard Resident B say anything threatening. During an interview on 3/20/26 at 10:36 a.m., the DON indicated that she felt with Resident B not having a prior history of resident agitation/concerns, it was appropriate to place a new resident as her roommate while arranging for police transport to a psych facility. She wanted Resident C transferred out of the room with Resident B so that the altercation with Resident C's sister did not spill over on to Resident C. She had checked in with Resident C the following day and she had indicated she was fine. During an interview on 3/20/26 at 11:03 a.m., CNA 5 indicated Resident B and Resident C's call light was on in the late afternoon on 1/28/26. When she answered the call light, Resident B indicated to her she was fine. Resident C indicated I need to get out of this room, it's upsetting [Resident B] and she's being mean. At the time, Resident C was on the phone with her sister, and indicated, She keeps threatening me. CNA 5 got on the phone with Resident C's sister, who indicated Resident B kept threatening her sister. CNA 5 indicated she would report this to the nurse. Resident B had left the room, so CNA 5 left and reported the allegation to the Unit Manager (UM). Regarding Resident B, she had not known her to have issues with other residents. Resident B had issues with roommates because she was very independent and clean. She had a hard time with incontinent residents or residents who required staff help. During an interview on 3/20/26 at 12:01 p.m., the DON indicated she called the non-emergency number for Indianapolis Metropolitan Police Department (IMPD) to obtain a copy of the police report that the SSD had indicated was made. She gave the dates of 1/28/26 to 2/2/26 and IMPD reported there had been no reports that had been filed from the facility. During an interview on 3/20/26 at 12:13 p.m., the Activity Director indicated Resident C had come to her, maybe the second week she was at the facility, and spoke with her about a church she was familiar with that had done volunteer activities with facilities. She was going to reach out to them to see if they would be willing to come to the facility in the future. Resident C contracted COVID 19 shortly after their conversation and stayed in her room after that. She offers her activities, but she declined to come out of her room. She felt Resident C might have had some depression. During an interview on 3/20/26 at 1:51 p.m., the Activities Assistant indicated Resident C had come to the main dining room a couple times the first week she was a resident. The following week she said she preferred to eat in her room and had not returned since to the dining room. She had declined to attend activities since her arrival at the facility. She reapproached her frequently, but she always declined to attend. A current facility policy, reviewed 5/6/25, titled, Abuse-Identification of Types, provided by the Administrator on 3/20/26 at 3:18 p.m., included the following: .Definition Abuse - is defined as the willful infliction of injury, (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Mental or Verbal Abuse Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, [NAME], agitation, or degradation. Involuntary seclusion occurs when separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident representative. This citation relates to Intake 2800757.<br>410 IAC (Indiana Administrative Code) 16.2-3.1-27(b) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff reported an allegation of resident-to-resident verbal abuse for 1 of 3 residents reviewed for abuse and neglect. (Resident C)Findings include:During an interview on 3/18/26 at 1:38 p.m., Resident C indicated she was admitted to the facility on [DATE]. She used her cell phone to talk with her sister throughout the day and night. The following day, her phone stopped working and her charger would not charge her phone. Her roommate, Resident B, had been sent out to a hospital and the staff had switched the landline phone for her so she could contact her sister. When Resident B returned to the facility on 1/28/26, she became very upset that Resident C was using her landline phone and told Resident C if anyone touches my stuff, I'm going to kill you. Then she told her sister on the phone that she was gonna kill her too. She told the aids what had happened. She had not reported the threats to a nurse, but the aide said she would tell the nurse. She was moved out of her room that evening to another room. She does not feel safe in the facility. Now, when Resident B walked by her door, she looked at her and pointed her fingers like a gun at her. She had not met the Director of Nursing (DON) or spoken with her. The Administrator had visited her in her room and spoke to her and her sister, on the phone, during the visit. During a telephone interview on 3/20/26 at 3:00 p.m., Resident C's sister indicated during the incident on 1/28/26, Resident B had told her that if she called the phone again, she would kill her. She heard Resident B say to Resident C, If you touch my things, I will kill you. I will kill anyone who touches my things.The clinical record review for Resident C was completed on 3/18/26 at 11:17 a.m. Diagnoses included history of malignant brain neoplasm (tumor), need for assistance with personal care, muscle weakness, and depression.An admission Minimum Data Set (MDS) assessment, dated 1/26/26, indicated the resident was cognitively intact. She required staff assistance for bed mobility, dressing, showering, transfers, and personal hygiene.An Adult Protective Services (APS), Elder Abuse online report, dated 2/3/26, indicated Resident C as an endangered adult, and Resident B as the perpetrator, and the allegation as battery. The narrative/description of the incident indicated Resident C had arrived at the facility and moved into Resident B's room. Resident B was sent out to a psychiatric (pysch) facility that day. Resident C was in the room by herself for a week. The night Resident B returned from her psych hospital stay, she started to threaten to physically harm Resident C. Resident C's sister was on the phone and overhead the entire conversation between Resident B and Resident C. Resident C was moved within hours of the threats to a new room. The confirmation email indicated the form was received and was addressed to the Social Services Director.During an interview on 3/19/26 at 9:58 a.m., the SSD indicated on 1/28/26, she was called after hours at home by a Certified Nursing Aide (CNA) and told that Resident B was threatening Resident C and being verbally aggressive towards her. She could not recall who had called her. She instructed staff to move Resident C as far away as possible depending on room availability. The room Resident C was moved to had the nurse's station in between them so the residents would have had to cross in front of staff and could be monitored. She also instructed them to call the police to file a report. She reported the incident the following day to Adult Protective Services (APS). She followed up with Resident C the following day and she seemed to be doing well. Resident C had not told her that she did not feel safe. Resident C had told her once that Resident B would walk by her room and make a finger gun gesture at her. She had not observed Resident B walk by Resident C's room or had not observed her make that gesture. She had not interviewed any staff regarding Resident B making that gesture. She was sure staff would have reported it to her if they had witnessed something like that. She talked to Resident C about every couple days when she called her into her room. Resident C had reported yesterday (3/18/26) during a care plan meeting about Resident B making finger gun gestures. Resident C usually kept her door shut. The facility staff were<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | aware of avoiding interaction between the two residents. The SSD had witnessed Resident B behave verbally aggressive with other residents, but she had not known her to threaten to kill anyone. She cannot recall what other residents had been involved in the verbal aggression. As far as she knew, no one had talked with Resident B about any of these behaviors, but she would deny them anyway, even if true. The reason she was called about the incident was because it required a room move and that was something she would handle. The investigation of the incident would be completed by the DON. She was unsure if the DON was called or informed.During an interview on 3/19/26 at 10:46 a.m., the DON indicated the only thing reported to her was that Resident C's sister was told by Resident B on the phone not to call her phone again, in not nice terms but does not know what was said. The SSD notified her that she wanted to move Resident C out of the room because Resident B had an altercation with Resident C's sister on the phone. She could not recall how she was notified by the SSD and was unsure if she had spoken to her on the phone or received a text, or how the contact occurred. To her knowledge, the sister talked with the SSD and had not felt safe for Resident C to remain in the room. She had no further knowledge regarding the incident. There was not an investigation because the incident was between Resident B and Resident C's sister, not with the resident. She had spoken to Resident C sometime after the room move and as far as she recalled, Resident C was fine. As far as Resident B performing the shooting gesture, Resident C was four doors down from her office and she had not observed Resident B going down the hall. When she had observed Resident B going down the hall, it had been to attend an activity. She had not spoken with the SSD any further regarding the incident. She had not been aware an Adult Protective Service report had been filed or that the police had been contacted. She had not known Resident C had not felt safe until yesterday's (3/18/26) care plan meeting with Resident C. If Resident B had threatened to kill Resident C, this would definitely have been reported to the state agency within two hours and investigated. This was not done because she had no idea there were threats, police involvement or an APS report. During an interview on 3/19/26 at 2:19 p.m., the Unit Manager (UM) indicated she recalled an argument in Resident B and Resident C's room over a phone on the morning on 1/28/26. On 1/21/26, when Resident B had been sent to a psych facility, there had been an issue with Resident C calling her sister. She was passing by the room during her shift and Resident C indicated her cellphone was not working and her charger was not charging. She asked about her room's landline phone. She went to the SSD and reported that Resident C's phone charger was not working. The SSD said she had a charger she could use and would help Resident C. When Resident B returned to the facility, she overheard an argument regarding the landline phone. Later in the evening, around 6-7:00 p.m., she received a call from the DON. She told her to move Resident C immediately. The staff pulled together and moved her in about 15 minutes. Resident C indicated to her she just wanted to leave the room. She had not explained her reason. She asked if there was another concern beside the phone and she said no, I just want to move. She had not heard Resident B say anything threatening. During an interview on 3/20/26 at 10:36 a.m., the DON indicated she wanted Resident C transferred out of the room with Resident B so that the altercation with Resident C's sister did not spill over on to Resident C. She had checked in with Resident C the following day and she had indicated she was fine. During an interview on 3/20/26 at 11:03 a.m., CNA 5 indicated the resident's call light was on in the late afternoon. When she answered the call light, Resident B indicated to her she was fine. Resident C indicated I need to get out of this room, it's upsetting [Resident B] and she's being mean. At the time she was on the phone with her sister, and indicated, She keeps threatening me. CNA 5 got on the phone with Resident C's sister, who indicated Resident B kept threatening her sister. CNA 5 indicated she would report this to the nurse. Resident B had left the room, so she left and reported the allegation to the UM. Regarding Resident B, she had not known her to have issues with other residents. Resident B had issues with roommates because she was very independent and clean. She had a hard time with incontinent residents or residents who require staff help. During an interview on 3/19/26 at 1:50 p.m., the DON indicated she had spoken with someone (unable to identify<br>(continued on next page) |

| 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 03/20/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westside Retirement Village | 8616 W 10th St<br>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.

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | person/position) who reported that Resident B had returned and Resident C had kept calling her sister on the landline phone. Resident B had answered the phone and told the sister she was going to whoop her ass. She had spoken to the SSD as to why she had filed the APS report, and she had indicated it was requested by the family and Resident C's case manager. The DON indicated she had not done staff or resident interviews because there had been no resident abuse.During an interview on 3/20/26 at 12:01 p.m., the DON indicated she called the non-emergency number for Indianapolis Metropolitan Police Department (IMPD) to obtain a copy of the police report that the SSD had indicated was made. She gave the dates of 1/28/26 to 2/2/26 and IMPD reported there had been no reports that had been filed from the facility. A current facility policy, reviewed 5/7/25, titled, Abuse-Reporting and Response-Suspicion of a Crime, provided by the Administrator on 3/20/26 at 3:18 p.m., included the following: .Reporting Procedures 1. Once an associate or other covered individual at the facility (e.g., medical director) forms a reasonable suspicion that a crime has been committed against a resident or other individual receiving services at the facility, he or she must immediately notify the Executive Director of their suspicion. Cross reference F600.This citation relates to Intake 2800757.410 IAC (Indiana Administrative Code) 16.2-3.1-27(b) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document, report, or conduct a thorough investigation of an allegation of resident-to-resident verbal abuse for 1 of 3 residents reviewed for abuse and neglect. (Resident C)Findings include:During an interview on 3/18/26 at 1:38 p.m., Resident C indicated she was admitted to the facility on [DATE]. She used her cell phone to talk with her sister throughout the day and night. The following day, her phone stopped working and her charger would not charge her phone. Her roommate, Resident B, had been sent out to a hospital and the staff had switched the landline phone for her so she could contact her sister. When Resident B returned to the facility on 1/28/26, she became very upset that Resident C was using her landline phone and told Resident C if anyone touches my stuff, I'm going to kill you. Then she told her sister on the phone that she was gonna kill her too. She told the aids what had happened. She had not reported the threats to a nurse, but the aide said she would tell the nurse. She was moved out of her room that evening to another room. Now, when Resident B walked by her door, she looked at her and pointed her fingers like a gun at her. She has spoken to the Social Services Director (SSD) regarding finding another facility because of not feeling safe with Resident B here. She had not met the Director of Nursing (DON) or spoken with her. The Administrator had visited her in her room and spoke to her and her sister, on the phone, during the visit. During a telephone interview on 3/20/26 at 3:00 p.m., Resident C's sister indicated during the incident on 1/28/26, Resident B had told her that if she called the phone again, she would kill her. She heard Resident B say to Resident C, If you touch my things, I will kill you. I will kill anyone who touches my things.The clinical record review for Resident C was completed on 3/18/26 at 11:17 a.m. Diagnoses included history of malignant brain neoplasm (tumor), need for assistance with personal care, muscle weakness, and depression.An admission Minimum Data Set (MDS) assessment, dated 1/26/26, indicated the resident was cognitively intact. She required staff assistance for bed mobility, dressing, showering, transfers, and personal hygiene.An Adult Protective Services (APS), Elder Abuse online report, dated 2/3/26, indicated Resident C as an endangered adult, and Resident B as the perpetrator, and the allegation as battery. The narrative/description of the incident indicated Resident C had arrived at the facility and moved into Resident B's room. Resident B was sent out to a psych facility that day. Resident C was in the room by herself for a week. The night Resident B returned from her psych hospital stay, she started to threaten to physically harm Resident C. Resident C's sister was on the phone and overhead the entire conversation between Resident B and Resident C. Resident C was moved within hours of the threats to a new room. The confirmation email indicated the form was received and was addressed to the Social Services Director.During an interview on 3/19/26 at 9:58 a.m., the SSD indicated on 1/28/26, she was called after hours at home by a Certified Nursing Assistant (CNA) and told that Resident B was threatening Resident C and being verbally aggressive towards her. She could not recall who had called her. She instructed staff to move Resident C as far away as possible depending on room availability. The room Resident C was moved to had the nurse's station in between them so the residents would have had to cross in front of staff and could be monitored. She also instructed them to call the police to file a report. She reported the incident the following day to Adult Protective Services (APS). She followed up with Resident C the following day and she seemed to be doing well. Resident C had not told her that she did not feel safe. Resident B attended most activities, so that may be why Resident C did not go to activities. Resident C had told her once that Resident B would walk by her room and make a finger gun gesture at her. She had not observed Resident B walk by Resident C's room or had not observed her make that gesture. She had not interviewed any staff regarding Resident B making that gesture. She was sure staff would have reported it to her if they had witnessed something like that. She talked to Resident C about every couple days when she called her into her room. Resident C had reported yesterday (3/18/26) during a care plan meeting about<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident B making finger gun gestures. Resident C usually kept her door shut. The facility staff were aware of avoiding interaction between the two residents. The SSD had witnessed Resident B behave verbally aggressive with other residents, but she had not known her to threaten to kill anyone. She cannot recall what other residents had been involved in the verbal aggression. As far as she knew, no one had talked with Resident B about any of these behaviors, but she would deny them anyway, even if true. The reason she was called about the incident was because it required a room move and that was something she would handle. The investigation of the incident would be completed by the DON. She was unsure if the DON was called or informed.During an interview on 3/19/26 at 10:46 a.m., the DON indicated the only thing reported to her was that Resident C's sister was told by Resident B on the phone not to call her phone again, in not nice terms but does not know what was said. The SSD notified her that she wanted to move Resident C out of the room because Resident B had an altercation with Resident C's sister on the phone. She could not recall how she was notified by the SSD and was unsure if she had spoken to her on the phone or received a text, or how the contact occurred. To her knowledge, the sister talked with the SSD and had not felt safe for Resident C to remain in the room. She had no further knowledge regarding the incident. There was not an investigation because the incident was between Resident B and Resident C's sister, not with the resident. She had spoken to Resident C sometime after the room move and as far as she recalls, Resident C was fine. As far as Resident B performing the shooting gesture, Resident C was four doors down from her office and she had not observed Resident B going down the hall. When she had observed Resident B going down the hall, it had been to attend an activity. She had not spoken with the SSD any further regarding the incident. She had not been aware an Adult Protective Service report had been filed or that the police had been contacted. She had not known Resident C had not felt safe until yesterday's (3/18/26) care plan meeting with Resident C. If Resident B had threatened to kill Resident C, this would definitely have been reported to the state agency within two hours and investigated. This was not done because she had no idea there were threats, police involvement, or an APS report. During an interview on 3/19/26 at 1:50 p.m., the DON indicated she had spoken with someone (unable to identify person/position) who reported that Resident B had returned and Resident C had kept calling her sister on the landline phone. Resident B had answered the phone and told the sister she was going to whoop her ass. She had spoken to the SSD as to why she had filed the APS report, and she had indicated it was requested by the family and Resident C's case manager. The DON indicated she had not done staff or resident interviews because there had been no resident abuse. During an interview on 3/20/26 at 12:01 p.m., the DON indicated she called the non-emergency number for Indianapolis Metropolitan Police Department (IMPD) to obtain a copy of the police report that the SSD had indicated was made. She gave the dates of 1/28/26 to 2/2/26 and IMPD reported there had been no reports that had been filed from the facility. A current facility policy, reviewed 5/7/25, titled, Abuse-Reporting and Response-Suspicion of a Crime, provided by the Administrator on 3/20/26 at 3:18 p.m., included the following: .Reporting Procedures 1. Once an associate or other covered individual at the facility (e.g., medical director) forms a reasonable suspicion that a crime has been committed against a resident or other individual receiving services at the facility, he or she must immediately notify the Executive Director of their suspicion. Cross reference F600. Cross reference F609. This citation relates to Intake 2800757. 410 IAC (Indiana Administrative Code) 16.2-3.1-27(b) |