STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave Indianapolis, IN 46222

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40287 Based on interview and record review, the facility failed to ensure a baseline care plan was completed for a resident that had been admitted to the facility for 1 of 3 residents reviewed for pain management (Resident Y) and timely develop baseline care plans for 1 resident reviewed for Respiratory Services, and 1of 6 resident reviewed for unnecessary medications (Resident 195 and 196). Findings include: 1. The clinical record for Resident 195 was reviewed on 3/22/22 at 1:52 p.m. The Resident's diagnosis included, but were not limited to, acute and chronic respiratory failure. He was admitted to the facility on [DATE]. A social services note, dated 3/14/22 at 4:43 p.m., indicated that he was adjusting well to his stay. A social services note, dated 3/15/22 at 12:51 p.m., indicated he was adjusting well to his stay and had no complaints. The clinical record did not contain a baseline care plan, addressing the minimum health care information necessary for care to be provided. 2. The clinical record for Resident 196 was reviewed on 3/22/22 at 11:10 a.m. The Resident's diagnosis included, but were not limited to, acute pain due to trauma and displaced fracture of the left lower leg. She was admitted to the facility on [DATE]. A nursing progress noted, dated 3/20/22 at 7:46 a.m., indicated that she was alert and oriented to person, place, and time. She was able to make her needs and wants known. The clinical record did not contain a baseline care plan, addressing the minimum health care information necessary for care to be provided. During an interview on 3/31/22 at 10:31 a.m., the DON (Director of Nursing) indicated there were no baseline care plans present in Resident 195 and Resident 196's clinical records. 34850 (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The clinical record for Resident Y was reviewed on 3/23/22 at 9:30 a.m. The Resident's diagnoses included, but were not limited to, Sickle-Cell Disorder, chronic pain, heart failure and diabetes mellitus. The resident was admitted to the facility on [DATE] and discharged on [DATE]. An Admission MDS (Minimum Data Set) Assessment, completed on 1/28/22, indicated that he was cognitively intact. Hospital discharge paperwork dated 1/21/22 indicated a pain assessment was completed. Resident Y was in constant pain to right wrist, right ankle, and back. As of 1/17/22, .Patient [Resident Y] currently in sickle cell crisis Patient has no complaints besides a generalized/joint achiness . The resident has current prescriptions of oxycodone and was to resume for pain control. The clinical record for Resident Y did not have a completed baseline care plan for the resident's 1/22/22 admission. A care plan dated 2/2/22 indicated Resident Y had potential for pain Interventions meds a as ordered. notify MD [medical doctor] of uncontrolled pain. observe for effectiveness of intervention. observe for s/s [signs and symptoms] of pain. pain assessment upon admit, quarterly and prn [as needed]. A care plan dated 2/2/22 indicated At risk for adverse effects from opiod use .Interventions give medications as ordered . An interview was conducted with License Practical Nurse (LPN) 23 on 3/30/22 at 10:24 a.m. She indicated the facility has a checklist for new admissions. The checklist includes: vitals, assessments which include skin and pain, and verifying medications with the discharge orders. The baseline care plan should be completed in 48-72 hours. An interview was conducted with the Director of Nursing (DON) on 3/31/22 at 11:18 a.m. She indicated baseline care plans should be completed 24-48 hours of a resident's admission. A baseline care plan policy was provided by the DON on 3/24/22 at 9:47 a.m. It indicated Policy: It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of admission. The Baseline Care Plan is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission .Procedure: 1. Upon admission to the facility, the admitting nurse will initiate the Baseline Care Plan assessment to establish an initial plan of care to identify potential problems and to initiate appropriate goals and interventions. The Baseline Care Plan will be completed within 48 hours of admission and will address areas of imminent concern .c. In the event that the resident is admitted over the weekend (Friday Admissions after 5:00 p.m.) and the IDT [interdisciplinary] Team is not available to participate in the completion and implementation of the Baseline Care Plan, it will be the responsibility of the admitting nursing staff and the scheduled in-house weekend manager to ensure that the Baseline Care Plan is completed and implemented within 48 hours .

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on interview and record review, the facility failed to ensure a resident had a discharge summary that included a recap of his stay and a summary of the resident's condition on discharge for 1 of 1 residents reviewed for discharge. (Resident Y) Findings include: The clinical record for Resident Y was reviewed on 3/23/22 at 9:30 a.m. The Resident's diagnoses included, but were not limited to, Sickle-Cell Disorder, chronic pain, heart failure and diabetes mellitus. The resident was admitted to the facility on [DATE] and discharged on [DATE]. An Admission MDS (Minimum Data Set) Assessment, completed on 1/28/22, indicated that he was cognitively intact. Hospital discharge paperwork dated 1/21/22 indicated Resident Y had an ulceration wound on his left ankle. The clinical record for Resident Y did not have a completed baseline care plan for the resident's 1/22/22 admission. A nursing progress note dated 2/6/22 indicated resident (Y) was discharged from facility at 4:20 pm (sic) with his belongings. He was picked up by his [name of family member] and education was given to resident regarding his care and medication regimen. The resident's clinical record did not include a discharge summary nor discharge forms. An interview was conducted with the Director of Nursing (DON) on 3/31/22 at 11:44 a.m. She indicated she would have to look into, but she believed Resident Y had discharged AMA [Against Medical Advice] on 2/6/22. The DON as of 4/1/22 had not provided any additional information or missing documents in the resident's clinical record regarding discharge summary and/or post discharge forms for Resident Y. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Transfer and Discharge Policy and Procedure was provided by the Director of Nursing on 3/29/22 at 1:30 p.m. It indicated .Discharge to home or lower level of care where resident or family will be administering the resident's medications: 1. Explain discharge procedure .2. The attending physician is required to write a discharge order .3. When calling the attending physician for a discharge order, inquire whether or not the resident's medication is to be sent with the resident .4. If medications are to be included, write this in the order. Complete the Post Discharge Instruction form. a. Include list of medications with instructions in simple terms. b. Include instructions for post discharge care and explain to the resident and/or representative. c. Have resident and/or representative or person responsible for care sign the Post discharge instruction form . e. Place the signed copy of form in the health record .6. Complete a discharge summary .Discharge Against Medical Advice: 1. When the resident wishes to go home or the resident's family/Responsible party wishes to take the resident home and the attending physician refuses to give a discharge order, a 'Discharge Against Medical Advice' form must be signed by the resident or the resident's representative and placed in the health record. 2. No transfer form is completed 3.1-36(a)(1)(2)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 30344 Based on interview and record review, the facility failed to provide ongoing assessment to a cognitively impaired resident after an unwitnessed fall and administer their seizure medication, as ordered, resulting in a hospitalization with break through seizure for 1 of 3 residents reviewed for hospitalization . (Resident T) Findings include: The clinical record for Resident T was reviewed on 3/22/22 at 1:33 p.m. The diagnoses included, but were not limited to: seizure disorder, convulsions, and dementia. The 1/20/22 Quarterly MDS (Minimum Data Set) assessment indicated she was severely cognitively impaired. The seizures and at risk for injury related to tremors and/or seizure activity care plan, revised 8/31/20, indicated an intervention was to provide medications as ordered. The physician's orders indicated to administer two 300 mg tablets of oxcarbazepine (anticonvulsant medication used to treat seizures) twice daily, effective 9/24/21. The January, 2022 MAR (medication administration record) indicated the oxcarbazepine was not administered the evening of 1/28/22 or the morning of 1/29/22 with entry codes indicating to see the nurse's notes for the reasons the medication was not administered. The 1/28/22, 4:36 p.m. electronic MAR note indicated the medication was not given, because it was on order. The note read, OXcarbazepine Tablet 300 MG Give 2 tablet by mouth every 12 hours related to OTHER SEIZURES (G40.89) on order. The 1/29/22 at 11:52 a.m. electronic MAR note indicated the medication was not given, because it needed to be reordered. The note read, OXcarbazepine Tablet 300 MG Give 2 tablet by mouth every 12 hours related to OTHER SEIZURES (G40.89) NEED TO BE REORDER. The 1/29/22, 7:07 a.m. nurse's note, written by RN (Registered Nurse) 18, indicated Resident T had an unwitnessed fall that occurred between the 2 missed administrations of Oxcarbazepine. The note read, Resident found lying on ground between bathroom and room door laying on side, resident able to move extremities WNL [within normal limits,] resident unable to state what happened, vitals WNL, resident placed back into bed, bed placed in lowest position call light with in reach, condition currently stable, husband and MD notified will continue to monitor and update as needed. RN 18 was agency staff who was unavailable for interview. There was no verification in the clinical record that neurological checks or follow up assessments were conducted after Resident T's fall. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the DON (Director of Nursing) on 3/30/22 at 2:25 p.m. She indicated she looked into Resident T's 1/29/22 fall to see if there was anymore information about it, but she was unable to locate any. There was no accident report, no verification of neurological checks, and no 72 hour follow up. All of those things should have been done after her fall. The 1/29/22, 3:56 p.m. nurse's note read, Patient was sent out per nurse due to health issues steaming [sic] from possible seizures. The 1/29/22, 7:34 p.m. nurses note, written by RN 17, read, Resident had kept displaying an altered mental mind state according to staff members that are familiar with her. When this writer accessed [sic] he had noticed that resident was constantly shaking and her BP [blood pressure] and Pulse were elevated 169/107 [BP]-114 [pulse]-97.5 [temperature]-20-97% R/A [oxygen saturation on room air.] NP [Nurse practitioner] notified and orders were given to send to [name of hospital] ER [emergency room] for Eval [evaluation] and treatment. 911 was called and they took her to the ER around 3pm, DON and family notified. RN 17 was agency staff who was unavailable for interview. The 1/29/22 to 1/30/22 hospital notes read, Chief Complaint with Duration: Altered mental status and fall . Apparently patient fee [sic] in the morning at ECF [extended care facility] and later in the day staff concerned her mental status was altered so sent to the hospital. Unfortunately tried called ECF to get more info [information] but no one picked up, patient unable to provide any hx [history] fu [follow up] to baseline aphasia. In the ED [emergency department] noted to be hypoxic requiring 2-3 liters 02, also concerns for focal seizures by ED so loaded with Keppra and received 1 mg IV [intravenous] ativan Assessment/Plan: . Seizure disorder Break through seizure. Neurology consulted. Keppra load. Continue with trileptal [oxcarbazepine] and keppra. The Incidents/Accidents/Falls policy was provided by the DON on 3/29/22 at 1:30 p.m. It read, After the resident has had immediate attention and their safety is established, a written report will be entered into Risk Management (usually Risk Management section of electronic health record). The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated, and resolved. Procedure: .Further, residents who have an unwitnessed fall must have neuro checks started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed fall. 3 The nurse responsible for the oversight and care of the resident will complete an incident/accident report. When possible, a descriptive statement(s) will be obtained from the resident and/or any witnesses 6. The incident/accident report will be completed as soon as information is obtained. The report should be finished as much as possible before the nurse ends the shift. The nurse who completes the report is the nurse who signs the report. An exact description of the circumstances (not opinion or conjecture) surrounding the incident/accident are to be documented 9. Documentation of the physical and mental status of the resident(s) involved will be completed each shift (every 8 hours minimally) over the next 72 hours or until the resident(s)'s condition improves. Neuro checks will be completed after any head trauma as well as after any unwitnessed fall (even if the resident states they did not hit their head) as per policy 11. All falls will have a site investigation by appropriate staff in an effort to define the root cause of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Medication Administration policy was provided by the DON on 3/29/22 at 12:15 p.m. It read, Purpose: To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration. Policy: Unless otherwise specified by the physician, medications will be administered within 60 minutes before or after the facility's dosing schedule, except before or after meal orders and non-routine time ordered medications. This Federal tag relates to Complaint IN00375439. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on interview and record review, the facility failed to timely identify and provide wound treatment to a resident's ankle wound for 1 of 1 residents reviewed for pressure ulcers. (Resident Y) Findings include: The clinical record for Resident Y was reviewed on 3/23/22 at 9:30 a.m. The Resident's diagnoses included, but were not limited to, Sickle-Cell Disorder, chronic pain, heart failure and diabetes mellitus. The resident was admitted to the facility on [DATE] and discharged on [DATE]. An Admission MDS (Minimum Data Set) Assessment, completed on 1/28/22, indicated that he was cognitively intact. Hospital discharge paperwork dated 1/21/22 indicated Resident Y had an ulceration wound on his left ankle. The clinical record for Resident Y did not have a completed baseline care plan for the resident's 1/22/22 admission. A care plan dated 2/2/22 indicated Potential for skin breakdown DT [due to] impaired mobility .Interventions. Record skin assessment upon admission and weekly . A weekly skin check form was provided by the Director of Nursing (DON) on 3/23/22 at 11:53 a.m. It indicated on 2/2/22 a skin assessment was conducted. It was identified at that time, the resident had a wound on left lower ankle. A Weekly wound evaluation dated 2/2/22 indicated Resident Y had a stage 3 pressure on his left inner ankle on 1/22/22 admission. It measured 2 centimeters in length, 4 centimeters in width, 0 .1 centimeters in depth. The pressure ulcer was identified at the facility on 2/2/22. An medical provider dated on 2/2/22 indicated .Details: CHIEF COMPLAINT Wound [Resident Y] newly admitted to facility 1/22/22 post tricuspid valve replacement. Nursing staff noted today wound on his medial lower leg/ankle area that resident has been caring for himself since admission. Staff was not aware of wound until today. He has been using ABD [abdominal] pad and curlex (sic), no signs of infection, but wound is open with mild drainage, approx [approximate] size of a quarter Skin: Notes: open area to LLE lower leg/ankle area, no redness, granulated tissue .- Start calcium alginate and cover with xeroform dressing . A physician order dated 2/3/22 indicated a dressing change lower left inner ankle, cleanse with saline pat dry, apply calcium alginate, xeroform, abd pad and kerlix, secure with tape. One time a day for dressing change LLE [left lower extremity] until healed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident Y on 3/29/22 at 2:20 p.m. He indicated he was admitted to the facility with a wound on his left ankle. The staff was delayed on providing any treatments to his left ankle wound. He had provided his own care to the wound until the staff recognized he had one. An interview was conducted with License Practical Nurse (LPN) 23 on 3/30/22 at 10:24 a.m. She indicated the facility has a checklist for new admissions. The checklist includes: vitals, assessments which include skin and pain, and verifying medications with the discharge orders. The baseline care plan should be completed in 48-72 hours. An interview was conducted with the Director of Nursing (DON) on 3/31/22 at 11:18 a.m. She indicated the resident's ankle wound should have been identified on admission. A skin/pressure ulcer policy was provided by the DON on 3/29/22 at 1:31 p.m. It indicated .Policy: .Further, that a resident who enters the facility with pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Procedure: Risk Assessment. 1) A Risk Assessment for skin issues will be performed by qualified staff who have received training to recognize risk factors for skin breakdown. This Risk Assessment will be performed upon admission, re-admission and at the time of a significant change in condition as appropriate, as well as a weekly skin assessment .Procedure: Pressure Ulcer Assessment. 1) Pressure Ulcer Assessments will be performed on all pressure ulcers at least weekly .Procedure: Skin Assessment 1) A complete skin assessment is to be done weekly as part of the Skin Breakdown Prevention . A baseline care plan policy was provided by the DON on 3/24/22 at 9:47 a.m. It indicated Policy: It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of admission. The Baseline Care Plan is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission .Procedure: 1. Upon admission to the facility, the admitting nurse will initiate the Baseline Care Plan assessment to establish an initial plan of care to identify potential problems and to initiate appropriate goals and interventions. The Baseline Care Plan will be completed within 48 hours of admission and will address areas of imminent concern .c. In the event that the resident is admitted over the weekend (Friday Admissions after 5:00 p.m.) and the IDT [interdisciplinary] Team is not available to participate in the completion and implementation of the Baseline Care Plan, it will be the responsibility of the admitting nursing staff and the scheduled in-house weekend manager to ensure that the Baseline Care Plan is completed and implemented within 48 hours . This Federal tag relates to complaint IN00372908. 3.1-40

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34850 Based on interview and record review, the facility failed to conduct comprehensive pain assessments and address a resident's pain for 2 of 3 residents reviewed for pain management. This resulted in a resident's pain that was uncontrolled and had become severe. (Resident W and Y) Findings include: 1. The clinical record for Resident Y was reviewed on 3/23/22 at 9:30 a.m. The Resident's diagnoses included, but were not limited to, Sickle-Cell Disorder, chronic pain, heart failure and diabetes mellitus. The resident was admitted to the facility on [DATE] and discharged on [DATE]. An Admission MDS (Minimum Data Set) Assessment, completed on 1/28/22, indicated that he was cognitively intact. Hospital discharge paperwork dated 1/21/22 indicated a pain assessment was completed. Resident Y was in constant pain to right wrist, right ankle, and back. As of 1/17/22, .Patient [Resident Y] currently in sickle cell crisis Patient has no complaints besides a generalized/joint achiness . The resident has current prescriptions of oxycodone and was to resume for pain control. The clinical record for Resident Y did not have a completed baseline careplan that includes a pain assessment for the resident's 1/22/22 admission. A care plan dated 2/2/22 indicated Resident Y had potential for pain Interventions meds a as ordered. notify MD [medical doctor] of uncontrolled pain. observe for effectiveness of intervention. observe for s/s [signs and symptoms] of pain. pain assessment upon admit, quarterly and prn [as needed]. A care plan dated 2/2/22 indicated At risk for adverse effects from opiod use .Interventions give medications as ordered . The vitals tab in the the resident's clinical record did no include recorded pain assessments on 1/22/22 and 1/23/22. A progress note dated 1/23/22 at 7:59 a.m., indicated Resident Y had no complaints of pain at that time. A physician order dated 1/23/22 indicated Resident Y was to receive 20 milligrams of oxycodone extended release twice a day for moderate to severe pain. A physician order dated 1/23/22 indicated Resident Y was to receive 20 milligrams of oxycodone every 4 hours PRN for pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A medical provider note dated 1/24/22 indicated Resident Y was admitted on [DATE] and has complaints of pain.He has a PMH [past medical history] of sickle cell and takes oxycontin 20mg (sic) BID [twice a day] + oxycodone 20mg q4h [every 4 hours] prn for sickle cell pain. He has been without his pain medication since he was admitted to the facility. He is currently having withdrawals, including shaking, sweats, and irritation . RX [prescription] sent for oxycontin and oxycodone . The clinical record did not indicate non-pharmacological interventions were attempted for pain control. The 1/24/22 Controlled Drug Receipt/Record/Disposition Form indicated Resident Y received his first dose of his scheduled 20 milligrams of oxycodone on 1/25/22 at 12:05 a.m. The EDK (Emergency Drug Kit) transaction form was provided by the Director of Nursing (DON) on 3/30/22 at 2:00 p.m. It indicated on 2/2/22 at 7:04 p.m., the staff had obtained 5 milligram tablet(s) of oxycodone for Resident Y. An interview was conducted with Resident Y on 3/29/22 at 2:20 p.m. He indicated he was in constant pain his whole life. He normally stays around a 3 in a pain scale of 1 being the least and 10 being the most. There was a delay in getting pain medications when he was admitted in the facility. By the time, the staff provided pain medications his pain had reached a severe level. An interview was conducted with License Practical Nurse (LPN) 23 on 3/30/22 at 10:24 a.m. She indicated the facility has a checklist for new admissions. The checklist includes: vitals, assessments which include skin and pain, and verifying medications with the discharge orders. If the nurse does not have a hard script to send to the pharmacy for the resident's narcotics; the staff should call the provider, and he or she will send them over electronically to the pharmacy. The staff should pull from the EDK if the resident's pain medication was not available. The baseline care plan should be completed in 48-72 hours, and it does include a pain assessment that should be completed on admission to assess the resident's pain. An interview was conducted with the DON on 3/31/22 at 11:18 a.m. She indicated she was unable to provide any additional dosages of 20 milligrams of oxycodone that was pulled from the EDK prior to the 2/2/22, administration for Resident Y. 2. The clinical record for Resident W was reviewed on 3/22/22 at 10:30 a.m. The Resident's diagnoses included, but were not limited to, pain left lower leg and anoxic [without oxygen] brain damage. An Admission MDS (Minimum Data Set) Assessment, completed on 2/15/22, indicated that the resident was moderately cognitive impaired. A care plan dated 9/2/21 indicated Potential for alteration in comfort r/t [related to] decreased mobility neuropathic pain left lower extremity, anoxic brain damage .Interventions: .pain assessment on admission, with each MDS, and at least quarterly . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Westpark A Waters Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N Tibbs Ave Indianapolis, IN 46222	

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A pain assessment for Resident W was completed on 11/12/21 indicated .C. Pain Interview. 1. Ask resident: 'Have you had pain or hurting at any time in the last 5 days?' [marked on form resident responded as yes] 2. Ask resident: 'How much of the time have you experienced pain or hurting over the last 5 days?' [marked on form resident responded as frequently] Pain assessment indicated the resident was a 4 using a pain scale of 1 being the least and 10 being the most in the last 5 days. The intensity of her pain in the last 5 days was moderate. A medical provider progress note dated 2/24/22 indicated .the staff reports that the patient is pale and her blood pressure is 90/65. We will obtain some baseline labs to see how the patient is doing .PICC [Peripherally inserted central catheter] placement for hydration status dehydration. A nursing progress note dated 2/25/22 indicated Resident W was to be sent to hospital. The clinical record did not include a comprehensive pain assessment that was conducted for Resident W when she had a change of condition nor readmission from the hospital. A physician order dated 9/1/21 indicated Resident W was to receive 2 tablets of 325 milligrams of Tylenol as needed for pain. An interview was conducted with Resident W on 3/22/22 at 10:44 a.m. She indicated her pain was always a 7-8 using a pain scale of 1 being the least and 10 being the most. An interview was conducted with the Director of Nursing (DON) on 4/1/22 at 8:50 a.m. She indicated a pain assessment should be done on admission, change of condition, readmission. She was unable to provide any additional comprehensive pain assessments that were conducted for Resident W when she had a change of condition nor readmission from the hospital. A pain assessment policy was provided on 3/24/22 at 10:15 a.m. It indicated Policy. Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and lift involvement A standard format for assessing, monitoring and documenting pain in both cognitively intact and cognitively impaired residents will be utilized. As part of a comprehensive approach to pain assessment and management, pain will be considered the 'fifth' vital sign at the facility, .For the purpose of this policy, pain is defined as 'whatever the experiencing person says it is, existing whenever person says it does'. Procedure . 3. Nursing involvement A. Pain assessment - completed upon admission, readmission, each MDS assessment and change of resident condition. The Comprehensive Pain assessment measures the impact of pain on the resident's function assessing the resident's physical condition, history, mental status and ADLS's [activities of daily living] . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A baseline care plan policy was provided by the DON on 3/24/22 at 9:47 a.m. It indicated Policy: It is the policy of the facility to ensure that every resident has a Baseline Care Plan completed and implemented within 48 hours of admission. The Baseline Care Plan is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission .Procedure: 1. Upon admission to the facility, the admitting nurse will initiate the Baseline Care Plan assessment to establish an initial plan of care to identify potential problems and to initiate appropriate goals and interventions. The Baseline Care Plan will be completed within 48 hours of admission and will address areas of imminent concern .c. In the event that the resident is admitted over the weekend (Friday Admissions after 5:00 p.m.) and the IDT [interdisciplinary] Team is not available to participate in the completion and implementation of the Baseline Care Plan, it will be the responsibility of the admitting nursing staff and the scheduled in-house weekend manager to ensure that the Baseline Care Plan is completed and implemented within 48 hours . This Federal tag relates to complaint IN00372908. 3.1-37(a)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility failed to ensure a residents anticonvulsant medication was available for administration for 1 of 3 residents reviewed for hospitalization (Resident T); the availability of pain medication for 1 of 3 residents reviewed for pain (Resident Y); and the availability of anti-anxiety medication for 1 of 6 residents reviewed for unnecessary medications (Resident P). Findings include: 1. The clinical record for Resident T was reviewed on 3/22/22 at 1:33 p.m. The diagnoses included, but were not limited to: seizure disorder and convulsions. The seizures and at risk for injury related to tremors and/or seizure activity care plan, revised 8/31/20, indicated an intervention was to provide medications as ordered. The physician's orders indicated to administer two 300 mg tablets of oxcarbazepine (anticonvulsant medication used to treat seizures) twice daily, effective 9/24/21. The January, 2022 MAR (medication administration record) indicated the oxcarbazepine was not administered the evening of 1/28/22 or the morning of 1/29/22 with entry codes indicating to see the nurse's notes for the reasons the medication was not administered. The 1/28/22, 4:36 p.m. electronic MAR note indicated the medication was not given, because it was on order. The note read, OXcarbazepine Tablet 300 MG Give 2 tablet by mouth every 12 hours related to OTHER SEIZURES (G40.89) on order. The 1/29/22 at 11:52 a.m. electronic MAR note indicated the medication was not given, because it needed to be reordered. The note read, OXcarbazepine Tablet 300 MG Give 2 tablet by mouth every 12 hours related to OTHER SEIZURES (G40.89) NEED TO BE REORDER. 34850 2. The clinical record for Resident Y was reviewed on 3/23/22 at 9:30 a.m. The Resident's diagnoses included, but were not limited to, Sickle-Cell Disorder, chronic pain, heart failure and diabetes mellitus. The resident was admitted to the facility on [DATE] and discharged on [DATE]. An Admission MDS (Minimum Data Set) Assessment, completed on 1/28/22, indicated that he was cognitively intact. Hospital discharge paperwork dated 1/21/22 indicated a pain assessment was completed. Resident Y was in constant pain to right wrist, right ankle, and back. As of 1/17/22, .Patient [Resident Y] currently in sickle cell crisis Patient has no complaints besides a generalized/joint achiness . The resident has current prescriptions of oxycodone and was to resume for pain control. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 2/2/22 indicated Resident Y had potential for pain Interventions meds a as ordered. notify MD [medical doctor] of uncontrolled pain. observe for effectiveness of intervention. observe for s/s [signs and symptoms] of pain. pain assessment upon admit, quarterly and prn [as needed]. A physician order dated 1/23/22 indicated Resident Y was to receive 20 milligrams of oxycodone extended release twice a day for moderate to severe pain. A physician order dated 1/23/22 indicated Resident Y was to receive 20 milligrams of oxycodone every 4 hours PRN for pain. A Medication Administration Record note dated 1/23/22 indicated 20 milligrams of oxycodone was not available to administer to Resident Y. A medical provider note dated 1/24/22 indicated Resident Y was admitted on [DATE] and has complaints of pain.He has a PMH [past medical history] of sickle cell and takes oxycontin 20mg (sic) BID [twice a day] + oxycodone 20mg q4h [every 4 hours] prn for sickle cell pain. He has been without his pain medication since he was admitted to the facility. He is currently having withdrawals, including shaking, sweats, and irritation . RX [prescription] sent for oxycontin and oxycodone . The 1/24/22 Controlled Drug Receipt/Record/Disposition Form indicated Resident Y received his first dose of his scheduled 20 milligrams of oxycodone on 1/25/22 at 12:05 a.m. The EDK (Emergency Drug Kit) transaction form was provided by the Director of Nursing (DON) on 3/30/22 at 2:00 p.m. It indicated on 2/2/22 at 7:04 p.m., the staff had obtained 5 milligram tablet(s) of oxycodone for Resident Y. An interview was conducted with Resident Y on 3/29/22 at 2:20 p.m. He indicated he was in constant pain his whole life. He normally stays around a 3 in a pain scale of 1 being the least and 10 being the most. There was a delay in getting pain medications when he was admitted in the facility. By the time, the staff provided pain medications his pain had reached a severe level. An interview was conducted with License Practical Nurse (LPN) 23 on 3/30/22 at 10:24 a.m. She indicated the facility has a checklist for new admissions. The checklist includes: vitals, assessments which include skin and pain, and verifying medications with the discharge orders. If the nurse does not have a hard script to send to the pharmacy for the resident's narcotics; the staff should call the provider, and he or she will send them over electronically to the pharmacy. The staff should pull from the EDK if the resident's pain medication was not available. An interview was conducted with the DON on 3/31/22 at 11:18 a.m. She indicated she was unable to provide any additional dosages of 20 milligrams of oxycodone that was pulled from the EDK prior to the 2/2/22, administration for Resident Y. 41129 3. The clinical record for Resident P was reviewed on 3/28/22 at 11:30 a.m. Resident P's diagnoses included, but not limited to, major depressive disorder, generalized anxiety, and bipolar disorder. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident P's quarterly Minimum Data Set (MDS) dated [DATE] indicated, Resident P was cognitively intact. A physician's order dated 12/8/21 indicated, give one 0.25 mg(milligram) tablet of clonazepam by mouth, two times a day. An interview with Resident P was conducted on 3/22/22 at 1:12 p.m. Resident P indicated, the facility had run out of his clonazepam last week and had gone several days without it. A copy of Resident P's March MAR (Medication Administration Report) was provided by DON (Director of Nursing) on 3/31/22 at 4:14 p.m. The March MAR indicated the clonazepam was not administered on the following days and times with corresponding codes: 3/11/22 at 9 a.m.- coded as 5 3/11/22 at 9 p.m. - coded as 11 3/12/22 at 9 a.m. - coded as 5 3/12/22 at 9 p.m. - coded as 9 3/13/22 at 9 a.m. - coded as 5 3/15/22 at 9 a.m. - coded as 9 3/16/22 at 9 p.m. - coded as 9 3/18/22 at 9 a.m. - coded as 9 According to the MAR chart codes, 5 was Hold/See Nurse Notes; 9 was Other/See Nurse Notes; and 11 was Out on Pass A medication administration note dated, 3/11/2022 at 10:07 a.m. indicated, the clonazepam was on order. A medication administration note dated, 3/12/2022 at 12:51 p.m. indicated, the clonazepam medication to be delivered. A medication administration note dated, 3/12/2022 at 9:07 p.m. indicated, the clonazepam was on order from pharmacy. A medication administration note dated, 3/13/2022 at 10:11 a.m. indicated, the clonazepam medication reordered. A medication administration note dated, 3/15/2022 at 9:06 a.m. indicated, the facility was out of med in regards to the clonazepam. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medication administration note dated, 3/18/2022 at 8:13 a.m. indicated, the clonazepam was on order. An interview with the facility's contracted pharmacy was conducted on 3/30/22 at 10:21 a.m. The pharmacist indicated, they had sent Resident P's clonazepam on the following dates and number of medication: -On 1/5/22, they sent 60 tabs of clonazepam. -On 1/28/22, they sent another 60 tabs of clonazepam -On 3/18/22, they sent 60 tabs of clonazepam The pharmacy further indicated, they had no requests for or communication about the facility being out of the clonazepam tablets until the 3/18/22 message to refill the medication. No additional deliveries of clonazepam tablets occurred between 1/28/22 and 3/18/22. A copy of the Controlled Drug sheets for Resident P's clonazepam were received on 3/31/22 at 4:14 p.m. from DON. The Controlled Drug sheets for the 1/28/22 delivery indicated, the facility ran out of the clonazepam on 3/10/22. No other Controlled Drug sheets were located for any possible administrations of clonazepam from 3/10/22 to 3/18/22. An unavailable medication policy was provided by the DON on 3/30/22 at 3:27 p.m. It indicated .Purpose: To ensure that an adequate supply of medications is available for each residents as has been ordered by the resident's primary care physician. Upon discovery of an inadequate supply of medication, the nurse will immediately initiate action to obtain the medication from the pharmacy. Policy: Medication Shortage During Normal Pharmacy hours. If the medication shortage is discovered during normal pharmacy hours: 1. Facility nurse will call the pharmacy to determine the status of the order. If the medication has not bee ordered, facility nurse will place the order/reorder for the next scheduled delivery. 2. If the next available delivery causes a delay or a missed dose, the nurse should obtain medication from the emergency medication supply. 3. If the medication is not available in the emergency medication supply, the facility nurse should notify the pharmacy and attempt to arrange for an emergency delivery. 4. If the next scheduled dose has been missed the nurse will notify the physician of the missed dosed medication. 5. If the medication is not available the facility nurse will notify the Director of Nursing so that an emergency delivery of medication can be arranged. Medication Shortage After normal Pharmacy hours. If medication shortage is discovered after normal pharmacy hours: 1. Facility nurse should obtain the medication from the emergency supply. 2. If the medication is not available in the emergency supply, the nurse should call pharmacy and speak with the after hours pharmacy to request emergency/STAT [urgent] delivery. 3. If the next scheduled dose of medication has been missed the nurse will notify the physician of the missed dose of medication. 4. If the medication is not available the facility nurse will notify the Director of Nursing and the emergency delivery of medication can be arranged. If the emergency delivery is unavailable, the nurse should contact the Director of Nursing and the attending physician to obtain further orders . This Federal tag relates to complaint IN00372908 and IN00375439. 3.1-(a)(b)