STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST LAFAYETTE ALF OPERATIONS	3575 SENIOR PLACE, WEST LAFAYETTE, , 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 470479. This visit was in conjunction with a Post Survey Revisit (PSR) to the Residential Licensure Survey and Investigation of Intake 467470 completed on May 4, 2026. Intake 470479-State deficiencies related to the allegations are cited at R349. Intake 467470-corrected. Unrelated deficiencies are cited. Survey dates: June 30 and July 1, 2026 Facility number: 014094 Residential Census: 61 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Allegation of Substantial Compliance West Lafayette Assited Living has or will have substantially corrected the alleged deficiencies and achieved substantial compliance on or before the date specified herein. The Plan of Correction constitutes West Lafayette Assisted Living's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before June 30, 2026.	

	Quality review was completed on July 13, 2026.		The statements made on this plan of correction are to correct the deficiencies continue to remain in substantial compliance with Indiana state requirements for health facilities found at 410 IAC 16.2, West Lafayette Assisted Living (herein after referred to as "community") has taken or will take the actions set forth in this plan of correction	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a	R 0217	Resident returned from the hospital on 7/16/2026. The Director of Nursing (DON) updated the resident's service plan on 7/17/2026 following the hospital discharge. The resident's sister-in-law was notified on 7/17/2026 of the resident's return to the community and that the resident had purchased BC Aspirin Powder. A Care Plan Meeting has been scheduled for 7/24/2026 at 1:00 p.m. The Long-Term Care Ombudsman has been invited to participate in the meeting. The purpose of the meeting is to discuss measures to prevent similar situations from occurring in the future and to identify an appropriate placement that can adequately meet the resident's care needs and ensure resident safety. The care planning team will focus on interventions	10/14/2026

	service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a service plan was reviewed and revised for 1 of 3 residents reviewed for service plans. (Resident C) Findings include: The clinical record for Resident C was reviewed on 7/1/26 at 1:07 p.m. The diagnoses included, but were not limited to, depression, anxiety disorder, polyneuropathy, and other toxic encephalopathy. A service plan, dated 1/4/26, indicated Resident C displayed no self-abusive behaviors or suicidal behaviors or		necessary to maintain the resident's health, welfare, and safety while appropriate placement options are being explored and secured. Due to having find placement with another community we are allotting ourselves 3 months to get this corrected as placement for this situation maybe difficult.	

tendencies. She required some direction and reminding from others. She required staff to administer medications.

An after-visit summary from an intensive care center, dated 1/9/26-1/13/26, indicated Resident C was seen for an admitting diagnosis of salicylate overdose (a poisoning caused by excessive amounts of salicylate compounds, most commonly aspirin).

A physician's order, dated 1/16/26, indicated a referral was sent for psychiatry to evaluate and treat for mood disorder, depression, and age-related cognitive decline.

A service plan, dated 4/1/26, indicated Resident C required staff to administer medications, displayed no suicidal behavior or tendencies, and was independent with shopping needs.

The service plan did not include Resident C having a medication overdose in January or any interventions which were in place.

A psychiatry progress note, dated 6/15/26, indicated the resident had reported a history of seeing and hearing things which were not there, specifically talking to deceased family members. She was noted

	to be talking to them in her sleep. More recently, when it was cold outside, she was witnessed talking to her deceased mother and father while sitting on an outside bench. She reported her mood as "pretty good" and denied suicidal ideation. She did acknowledge "feeling down" since the recent death of her brother within the last year. The psychiatry progress note did not include Resident C having a medication overdose in January. A facility observation note dated 6/25/26 at 12:45 p.m., indicated Resident C was having increased confusion, was wandering around barefoot and sleeping on the bench in the hallway. Resident C was sent to the emergency room for evaluation. A facility observation note dated 6/25/26 at 2:30 p.m., indicated the hospital called and indicated Resident C was being admitted for an aspirin overdose and would need dialysis. During an interview, on 7/1/26 at 2:20 p.m., the DON indicated she would complete room sweeps because Resident C would go out to the store and order several items off the internet including aspirin. The DON indicated she took it upon			

	herself to do the room sweeps to make sure the resident did not have medication in her room since she overdosed on the Bayer aspirin several months ago. Resident C did not show signs of depression. They took the resident's Bayer aspirin out of her apartment. Resident C was currently out at the hospital for the second time for taking too much of the aspirin. The DON indicated she reeducated Resident C, she could have the medication twice a day, the facility would have to keep the medication in the cart, and she could not buy anymore of the medication. The DON indicated she did not document any of these interventions on the resident's service plan and should have. A policy related to service plans was not provided before exit.			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on interview and record review, the facility failed to ensure a resident, who was deemed safe to self-administer	R 0295	The facility failed to ensure a resident, who was deemed safe to self-administer medications, was allowed to store medication, including narcotics, in their room for 1 of 1 resident reviewed for medication storage. A Self-Administration Assessment was completed on 7/23/2026. The resident already had all prescribed medications in her apartment and had been	07/23/2026

	medications, was allowed to store medication, including narcotics, in their room for 1 of 1 resident reviewed for medication storage. (Resident B) Findings include: During an interview, on 7/1/26 at 10:00 a.m., Resident B indicated she was unable to keep and self-administer her narcotic medications and would like to be able to do so. She was told it was a rule "coming down from the state". The clinical record for Resident B was reviewed on 6/30/26 at 1:24 p.m. The diagnoses included, but were not limited to, chronic pain, osteoarthritis, chronic obstructive pulmonary disease, hypertensive heart disease, and lymphedema. A medication self-administration assessment, dated 5/2/26, indicated Resident B was deemed able to safely self-administer "ALL medications". A service plan, dated 5/26/26, indicated Resident B controlled her own medications, could safely administer her own medications, and made her own decisions. During an interview, on 7/1/26 at 2:38 p.m., the Executive Director (ED) indicated it was		independently self-administering all medications except narcotics. Based on the assessment, the resident demonstrated the ability to safely self-administer all medications, including narcotics. All medications are maintained in a locked medication box within the resident's apartment. The resident verbalized understanding of medication management and safe storage requirements. The Director of Nursing (DON) will continue to complete quarterly Self-Administration Assessments to ensure ongoing compliance and safe medication administration practices.	

	the facility's policy to not allow residents to keep narcotics in their rooms due to incidents occurring several years ago where other residents had narcotics stolen. The ED indicated she understood residents' rights and knew they should be able to keep all their medications in their rooms if they were safely able to. A current facility policy, titled "Medication Administration Policy & Procedure", undated and received from the DON on 7/1/26 at 1:50 p.m., indicated " ...Resident Self-Administration...Residents may self-administer medications when assessment confirms safe ability and physician approval is documented...Ongoing safety monitoring occurs as needed...."			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview and record review, the facility failed to ensure staff did not document a medication was administered prior to administering the	R 0296	The facility failed to ensure staff did not document a medication was administered prior to administering the medication for 1 of 1 resident reviewed for medication administration. DON retrained and re-educated QMA of medication administration and the importance of ensuring that medication is prepared, administered and documented in accordance with MD orders. QMA was given a corrective	07/02/2026

	medication for 1 of 1 resident reviewed for medication administration. (Resident B) Findings include: During an interview, on 7/1/26 at 10:22 a.m., Resident B indicated she did not receive her lidocaine pain patches at 8:00 a.m., on the morning of 6/24/26. She reached out to the Director of Nursing (DON) to let her know and QMA 2 brought her patches to her at approximately 10:00 p.m. that night. The clinical record for Resident B was reviewed on 6/30/26 at 1:24 p.m. The diagnoses included, but were not limited to, chronic pain, osteoarthritis, chronic obstructive pulmonary disease, hypertensive heart disease, lymphedema, and multiple acute nondisplaced bilateral rib fractures. A physician's order, dated 6/22/26, indicated to administer two (2) Lidocaine 4% patches (a topical pain relief patch) topically once a day at 8 a.m. A medication administration record, dated June 2026, indicated the Lidocaine 4% patches were administered on 6/24/26 at 8:00 a.m., by Qualified Medication Aide (QMA) 2. A facility observation note dated		action form regarding the education of medication administration.	

	6/24/26 at 8:45 p.m., indicated Resident B stated she needed her pain patches, and she did not receive them. QMA 2 was notified and indicated she thought Resident B self-administered her patches. QMA 2 agreed to go back to the facility and apply the Lidocaine patches. During an interview, on 7/1/26 at 2:20 p.m., the DON indicated Resident B reached out to her by text to let her know she had never received her lidocaine patches. The DON contacted QMA 2 and she indicated she thought Resident B self-administered the Lidocaine patches which was why she did not administer them. The DON indicated she instructed QMA 2 to return to the facility and administer the patches to Resident B. Medications should not be documented as administered if they are not. A facility qualified medication aide job summary indicated to provide direct care to residents following an individual service plan, provide medication to residents in a timely manner, and accurately and safely prepare, administer, and document all medications used in the assisted living facility. A current facility policy, titled "Medication Administration			

	Policy & Procedure", undated and received from the DON on 7/1/26 at 1:50 p.m., indicated "...To ensure medications are prepared, administered, and documented safely and consistently in accordance with physician orders, pharmacy guidance, and state requirements, thereby protecting resident health and safety...Medication administered by the facility shall be given only by trained and authorized staff following physician orders...."			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure the clinical record contained an assessment following a fall by a licensed staff member for 1 of 3 residents reviewed for complete and	R 0349	The facility failed to ensure the clinical record contained an assessment following a fall by a licensed staff member for 1 of 3 residents reviewed for complete and accurate clinical records. August 3, 2026: All staff members are scheduled to be trained on the proper use of the bus lift, with emphasis on resident safety during transportation and lift operations. All staff members, including dietary, maintenance, activities, administration, housekeeping, and clinical personnel, were re-educated on the facility's 911 emergency response policy. Documentation of attendance and education was completed	08/04/2026

	accurate clinical records. (Resident B) Findings include: 1. During an interview, on 7/1/26 at 10:00 a.m., Resident B indicated she returned to the facility from an outing on 6/19/26 at 7:40 p.m. Resident B asked the Activity Director if she could get off the bus. Resident B thought she heard the Activity Directory say it was okay and proceeded to back her wheelchair onto what she thought was the lift. The resident backed the wheelchair off the bus and the wheelchair caught on the ramp. The resident fell backwards off the bus, landed on the ground, and hit her head. Resident B indicated she blacked out and laid on the ground for an undetermined amount of time. The resident was assisted off the ground by the Activity Director and (Certified Nursing Assistant) CNA 4. They placed her back in her wheelchair and CNA 4 took Resident B to the dining room to watch her for 30 minutes. CNA 4 then took the resident back to her room and the staff did not check on her until the scheduled dayshift (QMA 3) came into her room to administer her morning medication. Resident B was in pain and asked to go to the hospital. Resident B was told in		and maintained by the facility.	

the hospital she had a brain bleed.

The clinical record for Resident B was reviewed on 6/30/26 at 1:24 p.m. The diagnoses included, but were not limited to, chronic pain, osteoarthritis, chronic obstructive pulmonary disease, hypertensive heart disease, and lymphedema.

A signed service plan, dated 5/26/26, indicated Resident B was independent, could walk and ambulate independently, and used a wheelchair for longer distances.

A progress note, dated 6/19/26 at 8:30 p.m., indicated the Activity Director reported to the Director of Nursing (DON) Resident B had returned from an outing. Resident B started to back up on the ramp in her wheelchair before the ramp was lowered all the way down. This caused the wheelchair to flip and Resident B fell onto her back and hit her head. Resident B was checked over and assisted up into her wheelchair once the wheelchair was un-jammed from the ramp. Resident B refused several times to go to the emergency room (ER) and indicated she was fine.

A facility observation note dated 6/19/26 at 8:45 p.m., indicated CNA 4 notified the DON,

	Resident B fell off the bus's wheelchair ramp. Resident B did not wait for the Activity Director to tell her to get onto the ramp. The resident did hit her head but "swears to the CNA she was ok and did NOT want to go out, she just had a headache". A facility incident report, dated 6/19/26 at 8:10 p.m., indicated Resident B backed onto the facility wheelchair bus ramp. The ramp was not down, and the resident's wheelchair flipped off the bus, and she landed on her back on the ground. The resident's back hit the metal ramp, and her head hit the ground. A facility observation note dated 6/20/26 at 3:45 p.m., indicated Resident B was admitted to hospital for observation on 6/20/26. A hospital discharge note, dated 6/20/26, indicated Resident B's admitting diagnoses included, but were not limited to, bruised ribs and traumatic subarachnoid hemorrhage (occurs when head trauma causes bleeding into the space between the brain and skull).			

The clinical record did not contain a documented assessment of the resident after the fall or any neurological checks completed by a licensed staff member.

During an interview, on 7/1/26 at 2:00 p.m., the Director of Nursing (DON) indicated if she was in the building, she would assess a resident after a fall. A QMA could not complete assessments. If she was not in the building, the QMA would reach out to her, communicate the vital signs and what happened. She would "sometimes" complete a "FaceTime" assessment of the residents with the QMA. When Resident B fell and hit her head, she did not complete a physical assessment on the resident. She indicated she talked to Resident B. The DON indicated Resident B did not ask to go to the hospital until the next day. She should have instructed the staff to call 911 and had the emergency personnel decide whether the resident should go to the hospital. The DON indicated she did not document everything which had happened and she should have.

During an interview, on 7/1/26 at 2:20 p.m., the DON indicated she did not physically assess the resident when the resident fell off the bus. CNA 4 helped

Resident B off the ground with the assistance of the Activity Director. CNA 4 obtained Resident B's vital signs and assisted her back to her room. The DON indicated she notified the physician and left a message for Resident B's son, but she did not document it and she should have.

A current facility policy, titled "Fall Incident," undated and provided by the ED on 7/2/26 at 11:08 a.m., indicated " ...All residents who have fallen must be assessed by the nurse before they are moved from the position they are found ...assessing for injury are priority when arriving to fallen resident...Fall report must be filled out completely by the nurse on duty at the time of the fall ...A complete and detailed nurse's note must be done about the fall ...If resident is injured from a fall, provide immediate first aide then contact doctor or an on call physician for further instructions ...Nurse's clinical skills should be used to determine needs for transport to the ER ...Many residents who hit their head or receive minor injuries from a fall can be treated in our facility. Neuro checks and good clinical nursing judgement can be used to determine need for further evaluation ...."

	This citation relates to Intake 470479.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREKristie Cottrell	TITLEExecutive Director	(X6) DATE07/23/2026