STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/19/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00453023, IN00447130, IN00454689 and IN00445504. Complaint IN00453023-State deficiencies related to the allegations are cited at R296. Complaint IN00447130-State deficiencies related to the allegations are cited at R144. Complaint IN00454689-No deficiencies related to the allegations are cited. Complaint IN0045504-State deficiencies related to the allegations are cited at R144. Survey dates: March 13, 14, 17, 18 and 19, 2025. Facility number: 014094 Residential Census: 47 These State Residential	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 May 30, 2025. 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	

	Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on March 25, 2025.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and	R 0117	**What corrective actions will be accomplished for those residents found to have been affected by our deficient practice.** All residents are at risk of being affected by this citing. A minimum of 1 awake staff person, with CPR certificates shall be onsite at all times**.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** The DON and BOM will be responsible for verifying that compliance is met. March 24th we contacted Randy Keen, independent CPR/First Aid instructor to see when the first opening for CPR training was available. Randy will come to the building to train all our	05/30/2025

	interview, the facility failed to ensure the staff on duty met the requirements of Cardiopulmonary Resuscitation (CPR) hands on training certification for 4 full shifts and 4 half shifts reviewed for CPR certification. (4 full and 4 half shifts of 21 shifts) Findings include: A record review of the employee as worked schedule indicated, during the week of 3/2/25 through 3/8/25, the facility had 4 full shifts, and 4 half shifts out of 21 shifts without a certified staff member with CPR hands on training. During an interview, on 3/17/25 at 4:28 p.m., the Executive Director indicated CPR online training had been completed but she was not aware CPR training required hands on demonstrations to certified staff members. A current facility policy, titled "Policy: CPR," not dated and received from the Executive Director on 3/18/25 at 12:24 p.m., indicated "...A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times...." Based on record review and interview, the facility failed to ensure the staff on duty met the requirements of		management team and clinical team on CPR. We have collected his credentials as an independent contractor. Our staff will be taken off the schedule if they cannot make the three classes we have scheduled. The schedule will be: Wednesday April 16th at 11am-1pm, next class is April 16th at 6pm-8pm, last will be April 17th 1pm-3pm. If a staff member cannot attend they will remain off the schedule until they are certified. We will be in compliance by April 17, 2025. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur.** Business Office Manager and ED will meet to audit files with this schedule: Weekly for 30 days Bi-weekly for 30 days Monthly for 90 days	

	Cardiopulmonary Resuscitation (CPR) hands on training certification for 4 full shifts and 4 half shifts reviewed for CPR certification. (4 full and 4 half shifts of 21 shifts) Findings include: A record review of the employee as worked schedule indicated, during the week of 3/2/25 through 3/8/25, the facility had 4 full shifts, and 4 half shifts out of 21 shifts without a certified staff member with CPR hands on training. During an interview, on 3/17/25 at 4:28 p.m., the Executive Director indicated CPR online training had been completed but she was not aware CPR training required hands on demonstrations to certified staff members. A current facility policy, titled "Policy: CPR," not dated and received from the Executive Director on 3/18/25 at 12:24 p.m., indicated "...A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times...."		This is to ensure staff is qualified to administer CPR to any resident.	
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a	R 0121	**What corrective action(s) will be accomplished for those residents found to have been affected**	05/30/2025

	facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or		**by the deficient practice** All residents have the potential to be affected by this alleged deficient practice. All new employees will have 1st step administered on initial employment or prior. HR/designee to monitor & issue reminders to new hires to ensure 2nd step of TB testing is administered within 14 days of hire. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 04/17/2025. The Director of Nursing will also in-serviced the Executive Director, Business Office Manager and Nursing Managers on the TB requirements. The Director of Nursing audited all current employee health records to ensure compliance. Any concerns were promptly addressed.	

	signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure personnel were screened for tuberculosis (TB) using the two-step skin test for 6 of 10 employees reviewed for tuberculosis screening. (Staff Member 7, 12, 13, 8, 14 and 15) Findings include: 1. During a review of Staff Member 7's health record, on 3/18/25 at 11:15 a.m., no first step and second step TB skin test was completed. 2. During a review of Staff Member 12's health record, on 3/18/25 at 11:30 a.m., no first step and second step TB skin test was completed. 3. During a review of Staff Member 13's health record, on 3/18/25 at 11:38 a.m., no first step and second step TB skin test was completed. 4. During a review of Staff Member 8's health record, on 3/18/25 at 11:40 a.m., no first step and second step TB skin test was completed. 5. During a review of Staff Member 14's health record, on		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Business Office Manager, as coordinator of employee hiring & training processes, will ensure all new hires and current employees remain compliant with this regulation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Business Office Manager/designee will audit/review all new hire personnel files and current employees with the following schedule: Weekly for 30 days, Bi-Weekly for 30 days, and Monthly for 90 days. Monitoring will be ongoing	

	3/18/25 at 11:43 a.m., no first step and second step TB skin test was completed. 6. During a review of Staff Member 15's health record, on 3/18/25 at 11:47 a.m., no first step and second step TB skin test was completed. During an interview, on 3/18/25 at 11:50 a.m., the Director of Nursing indicated the employees were missing the two-step process for TB testing. A current facility policy, titled "Tuberculosis Exposure Control Plan Policy- Associates -OM-6," not dated and received from the Executive Director on 3/18/25 at 3:00 p.m., indicated "...The initial screening should be completed using the two-step Mantoux skin test...." Based on record review and interview, the facility failed to ensure personnel were screened for tuberculosis (TB) using the two-step skin test for 6 of 10 employees reviewed for tuberculosis screening. (Staff Member 7, 12, 13, 8, 14 and 15) Findings include: 1. During a review of Staff Member 7's health record, on 3/18/25 at 11:15 a.m., no first step and second step TB skin test was completed. 2. During a review of Staff		**By what date the systemic changes will be completed.** Systemic changes will be completed by May 30, 2025	

	Member 12's health record, on 3/18/25 at 11:30 a.m., no first step and second step TB skin test was completed. 3. During a review of Staff Member 13's health record, on 3/18/25 at 11:38 a.m., no first step and second step TB skin test was completed. 4. During a review of Staff Member 8's health record, on 3/18/25 at 11:40 a.m., no first step and second step TB skin test was completed. 5. During a review of Staff Member 14's health record, on 3/18/25 at 11:43 a.m., no first step and second step TB skin test was completed. 6. During a review of Staff Member 15's health record, on 3/18/25 at 11:47 a.m., no first step and second step TB skin test was completed. During an interview, on 3/18/25 at 11:50 a.m., the Director of Nursing indicated the employees were missing the two-step process for TB testing.			

	A current facility policy, titled "Tuberculosis Exposure Control Plan Policy- Associates -OM-6," not dated and received from the Executive Director on 3/18/25 at 3:00 p.m., indicated "...The initial screening should be completed using the two-step Mantoux skin test...."			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on interview and record review, the facility failed to ensure housekeeping services were provided to residents according to the service plan for 37 of 52 rooms reviewed for scheduled weekly cleaning. (the week of 3/8/25 through 3/14/25) Findings include: The housekeeping schedule, for 3/8/25 through 3/14/25, indicated 15 rooms were cleaned for the week. 52 rooms should have been cleaned. During an interview, on 3/14/25 at 3:04 p.m., the Executive Director (ED) indicated there was only one housekeeper on staff at the time of the survey.	R 0144	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** All residents have the potential to be affected by the deficient practice. We have identified 38 residents affected by the deficient practice. **How the facility will identify other residents having the potential to be affected by same deficient practice.** On April 17, 2025 at all staff meeting there will be an in-service for housekeeping and Night Staff. Maintenance Director, housekeeper, and ED met and have planned to use our PRN housekeeper on the weekends to ensure rooms are	05/30/2025

	She indicated the rooms should have been cleaned. During an interview, on 3/17/25 at 3:51 p.m., Housekeeping Staff 17 indicated she could only complete what she could. She could not complete 52 rooms in a week. The facility would need to hire additional staff. She had discussed the issue with the ED. A current facility residency agreement policy, not titled, not dated and received from the Executive Director on 3/18/25 at 12:30 p.m., indicated "...Weekly housekeeping services provided consisting of vacuuming, dusting cleared surfaces, cleaning bathroom and kitchenette areas, and changing bed linens...." This citation relates to Complaints IN00447130 and IN00445504. Based on interview and record review, the facility failed to ensure housekeeping services were provided to residents according to the service plan for 37 of 52 rooms reviewed for scheduled weekly cleaning. (the week of 3/8/25 through 3/14/25) Findings include: The housekeeping schedule, for 3/8/25 through 3/14/25, indicated 15 rooms were cleaned for the week. 52 rooms		being cleaned. CNA's have a task sheet that have night time cleaning around the building, including public bathrooms, dining area, vacuuming all common area's, and cleaning windows around the building. Housekeeping will focus on resident rooms only. **What measures will be put into place or what changes the facility will make to ensure the deficient practice does not reoccur** Housekeeping Audits are as follows: Each department leader will have 2 daily apartment checks, 5 days a week for 30 days. Each department leader will have 1 daily apartment checks 5 days a week for 30 days. Each department leader will have 1 apartment check a week for 30 days.	

	should have been cleaned. During an interview, on 3/14/25 at 3:04 p.m., the Executive Director (ED) indicated there was only one housekeeper on staff at the time of the survey. She indicated the rooms should have been cleaned. During an interview, on 3/17/25 at 3:51 p.m., Housekeeping Staff 17 indicated she could only complete what she could. She could not complete 52 rooms in a week. The facility would need to hire additional staff. She had discussed the issue with the ED. A current facility residency agreement policy, not titled, not dated and received from the Executive Director on 3/18/25 at 12:30 p.m., indicated "...Weekly housekeeping services provided consisting of vacuuming, dusting cleared surfaces, cleaning bathroom and kitchenette areas, and changing bed linens...." This citation relates to Complaints IN00447130 and IN00445504.		Each department leader will have 2 apartment checks a month for 60 days.	

R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure evaluations were completed and updated semi-annually for 6 of 7 residents reviewed for semi-annual evaluations. (Resident B, D, E, F, G and H) Findings include: 1. A record for Resident B indicated an evaluation was not completed and updated semi-annually. 2. A record for Resident D indicated an evaluation was not completed and updated semi-annually. 3. A record for Resident E indicated an evaluation was not completed and updated semi-annually. 4. A record for Resident F indicated an evaluation was not completed and updated	R 0214	**1.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	05/30/2025

	semi-annually. 5. A record for Resident G indicated an evaluation was not completed and updated semi-annually. 6. A record for Resident H indicated an evaluation was not completed and updated semi-annually. During an interview, on 3/19/25 at 4:38 p.m., the Director of Nursing indicated the residents were missing their semi-annual evaluations. The facility did not have a policy or procedure addressing semi-annual evaluations. Based on record review and interview, the facility failed to ensure evaluations were completed and updated semi-annually for 6 of 7 residents reviewed for semi-annual evaluations. (Resident B, D, E, F, G and H) Findings include: 1. A record for Resident B indicated an evaluation was not completed and updated semi-annually. 2. A record for Resident D indicated an evaluation was not completed and updated semi-annually. 3. A record for Resident E indicated an evaluation was not		**The facility will follow all service plan and review all accidents appropriately. All residents have the potential to be affected by this deficient practice.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?** **All residents have the potential to be affected · All service plans will be audited and updated by May 30, 2025.** **3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** **A service tool form has been created to ensure service plans have been updated has been put into place. DON will be re-educated on when to update the service plan.** **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into practice** The DON and ED will audit semi annual evaluations with the following schedule: All resident's weekly for 30 days, bi-weekly for 30 days, and monthly for 90 days.	

	completed and updated semi-annually. 4. A record for Resident F indicated an evaluation was not completed and updated semi-annually. 5. A record for Resident G indicated an evaluation was not completed and updated semi-annually. 6. A record for Resident H indicated an evaluation was not completed and updated semi-annually. During an interview, on 3/19/25 at 4:38 p.m., the Director of Nursing indicated the residents were missing their semi-annual evaluations. The facility did not have a policy or procedure addressing semi-annual evaluations.			
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;	R 0217	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **All residents have the potential to be affected by the deficient practice.** **How the facility will identify other residents having the potential to be affected by the same**	05/30/2025

	(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 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 residents' service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans. (Resident B, C, D, E, F, G and H)		**deficient practice** **and what corrective action will be taken, all residents have the potential to** **be affected by this deficiency.**An audit of resident service plans will be completed by 05/30/2025. **What** **measures will be put into place or what systemic changes the facility will make** **to ensure that the deficient practice does not recur;** **Education** **for Health and Wellness Director on the Service Plan policy will be given April 1, 2025** **How** **the corrective action(s) will be monitored to ensure the deficient practice** **will not recur, i.e., what quality assurance program will be put into place;** **The** **Director of Wellness or designee will conduct an audit of 5 resident service** **plans weekly x 4 weeks then monthly x 3 months.** **By** **what date the systemic changes will be completed.** May 30, 2025 and continuation of monitoring.	

Findings include:

1. The record for Resident B was reviewed on 3/19/25 at 1:05 p.m. A service plan was not signed by the resident or representative for 2024.

2. The record for Resident C was reviewed on 3/19/25 at 1:15 p.m. A service plan was not signed by the resident or representative for 2024.

3. The record for Resident D was reviewed on 3/19/25 at 1:25 p.m. A service plan was not signed by the resident or representative for 2024.

4. The record for Resident E was reviewed on 3/19/25 at 1:30 p.m. A service plan was not signed by the resident or representative for 2024.

5. The record for Resident F was reviewed on 3/19/25 at 1:35 p.m. A service plan was not signed by the resident or representative for 2024.

6. The record for Resident G was reviewed on 3/19/25 at 1:40 p.m. A service plan was not signed by the resident or representative for 2024.

7. The record for Resident D was reviewed on 3/19/25 at 1:45 p.m. A service plan was not signed by the resident or representative for 2024.

During an interview, on 3/19/25 at 3:15 p.m., the Director of Nursing indicated the residents did have a service plan, but it was not signed. The resident or representative should have signed the service plan when it was discussed with him and his family. The facility did not have a current policy related to signing service plans.

Based on interview and record review, the facility failed to ensure residents' service plans were signed by the resident or the resident's representative for 7 of 7 residents reviewed for service plans. (Resident B, C, D, E, F, G and H)

Findings include:

1. The record for Resident B was reviewed on 3/19/25 at 1:05 p.m. A service plan was not signed by the resident or representative for 2024.

2. The record for Resident C was reviewed on 3/19/25 at 1:15 p.m. A service plan was not signed by the resident or representative for 2024.

3. The record for Resident D was reviewed on 3/19/25 at 1:25 p.m. A service plan was not signed by the resident or representative for 2024.

4. The record for Resident E was reviewed on 3/19/25 at 1:30 p.m. A service plan was

	not signed by the resident or representative for 2024. 5. The record for Resident F was reviewed on 3/19/25 at 1:35 p.m. A service plan was not signed by the resident or representative for 2024. 6. The record for Resident G was reviewed on 3/19/25 at 1:40 p.m. A service plan was not signed by the resident or representative for 2024. 7. The record for Resident D was reviewed on 3/19/25 at 1:45 p.m. A service plan was not signed by the resident or representative for 2024. During an interview, on 3/19/25 at 3:15 p.m., the Director of Nursing indicated the residents did have a service plan, but it was not signed. The resident or representative should have signed the service plan when it was discussed with him and his family. The facility did not have a current policy related to signing service plans.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **West Lafayette will follow established safe food**	05/30/2025

	standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food was labeled and dated in the refrigerator, freezer, and dry storage area, to ensure food temperatures were checked prior to serving meals, refrigerator, freezer, and dishwasher temperatures were monitored and recorded in 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 47 of 47 residents who received food from the kitchen. Findings include: During the tour of the kitchen, on 3/17/25 at 3:15 p.m., the following observations were made: 1. The dry storage area was observed to have the following opened and not dated items: a. one bin of flour. b. one bin of sugar. c. one bag of onion ring crisps. d. two bags of cereal. e. one bag of rice. 2. The freezer area was observed to have the following opened and not dated items:		**handing guidelines including recording of food temperatures prior to service.** **All residents have the potential to be affected by this alleged deficiency.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **Food temperatures at point of service will be recorded by dietary servers using the established tracking form. Any variances will be addressed to ensure safe serving of food. All dietary staff will be re-educated on April 17, 2025 at mandatory staff meeting on appropriate food temps & procedures for recording such and how to address any variances to resolve temperature concern.** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** **Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee and Dietary Director will conduct this audit as follows: Daily for 30 days; weekly for 30 days and monthly for 90 days and monitored thereafter.** **How the corrective action(s) will be**	

	a. one large bag of potato wedges. b. one large box of potato patties. c. one large box of hamburger steaks. d. one large bag of onion rings. 3. Additional observations for the kitchen included the following: a. The stove backsplash was dirty. b. The storage bins were dirty with debris on the lids of the storage bins. c. The rolling serving cart was dirty with debris. d. The loading cart for food items was rusty and had debris. 4. During a record review, on 3/17/25 at 2:48 p.m., the serving temperature logs for the facility meals were missing between the dates of 9/30/24 through and including 2/23/25. During a dining observation, on 3/18/25 at 11:45 a.m., the sausage was served on top of iced sauerkraut.		**monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. By what date the systemic changes will be completed. May 30, 2025**	

	5. During a record review, on 3/17/25 at 2:55 p.m., the refrigerator temperature logs indicated the following: a. The facility kitchen refrigerator log was missing the temperatures between 12/28/24 and 2/23/25. b. The serving area refrigerator log was missing the temperatures between 12/31/24 and 3/17/25. 6. During a record review, on 3/17/25 at 3:10 p.m., the freezer temperature logs indicated the following: a. The freezer temperature log was missing the temperatures for 1/29, 1/30, 1/31, 2/1, 2/2, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22 and 2/23/2025. 7. During a record review, on 3/17/25 at 3:25 p.m., the dishwasher temperature logs indicated the following: a. The dishwasher temperature log was missing the temperatures for 8/23/24 through and including 9/19/24, 10/10, 10/11, 10/12, 10/13, and 10/14/24 and 12/18/24 through and including 2/23/25. During an interview, on 3/18/25 at 2:50 p.m., the Dietary Manager indicated the open items should have been sealed and dated. The equipment			

	should have been cleaned. The missing temperatures for the serving area were because he did not complete them. He was told the nursing staff did those recordings. He did not know where the other missing logs were located. He did not review the temperature logs for accuracy and completeness. During an interview, on 3/17/25 at 5:10 p.m., the Executive Director indicated all kitchen items should be dated and sealed once opened. The transport equipment and storage bins should be clean and free of dust and debris. The temperature logs should have been completed prior to serving the meals. The kitchen refrigerator, freezer, and dishwasher logs should have been completed daily. The facility did not have a policy for temperature documentation or sealing and dating open food. Based on observation, interview and record review, the facility failed to ensure food was labeled and dated in the refrigerator, freezer, and dry storage area, to ensure food temperatures were checked prior to serving meals, refrigerator, freezer, and dishwasher temperatures were monitored and recorded in 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 47 of 47			

residents who received food from the kitchen.

Findings include:

During the tour of the kitchen, on 3/17/25 at 3:15 p.m., the following observations were made:

1. The dry storage area was observed to have the following opened and not dated items:

a. one bin of flour.

b. one bin of sugar.

c. one bag of onion ring crisps.

d. two bags of cereal.

e. one bag of rice.

2. The freezer area was observed to have the following opened and not dated items:

a. one large bag of potato wedges.

b. one large box of potato patties.

c. one large box of hamburger steaks.

d. one large bag of onion rings.

3. Additional observations for the kitchen included the following:

	a. The stove backsplash was dirty. b. The storage bins were dirty with debris on the lids of the storage bins. c. The rolling serving cart was dirty with debris. d. The loading cart for food items was rusty and had debris. 4. During a record review, on 3/17/25 at 2:48 p.m., the serving temperature logs for the facility meals were missing between the dates of 9/30/24 through and including 2/23/25. During a dining observation, on 3/18/25 at 11:45 a.m., the sausage was served on top of iced sauerkraut. 5. During a record review, on 3/17/25 at 2:55 p.m., the refrigerator temperature logs indicated the following: a. The facility kitchen refrigerator log was missing the temperatures between 12/28/24 and 2/23/25. b. The serving area refrigerator log was missing the temperatures between 12/31/24 and 3/17/25.			

	6. During a record review, on 3/17/25 at 3:10 p.m., the freezer temperature logs indicated the following: a. The freezer temperature log was missing the temperatures for 1/29, 1/30, 1/31, 2/1, 2/2, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22 and 2/23/2025. 7. During a record review, on 3/17/25 at 3:25 p.m., the dishwasher temperature logs indicated the following: a. The dishwasher temperature log was missing the temperatures for 8/23/24 through and including 9/19/24, 10/10, 10/11, 10/12, 10/13, and 10/14/24 and 12/18/24 through and including 2/23/25. During an interview, on 3/18/25 at 2:50 p.m., the Dietary Manager indicated the open items should have been sealed and dated. The equipment should have been cleaned. The missing temperatures for the serving area were because he did not complete them. He was told the nursing staff did those recordings. He did not know where the other missing logs were located. He did not review the temperature logs for accuracy and completeness. During an interview, on 3/17/25 at 5:10 p.m., the Executive Director indicated all kitchen items should be dated and			

	sealed once opened. The transport equipment and storage bins should be clean and free of dust and debris. The temperature logs should have been completed prior to serving the meals. The kitchen refrigerator, freezer, and dishwasher logs should have been completed daily. The facility did not have a policy for temperature documentation or sealing and dating open food.			
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 the competence of medication staff when a resident received the incorrect medication for 1 of 6 residents reviewed for medication administration. (Resident B) Findings include: A facility document indicated QMA 17 administered the wrong medication to Resident B during a medication pass on 2/4/25. During an interview, on 3/13/25	R 0296	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **All residents have the potential to be affected by the deficient practice. It is the intention of West Lafayette Assisted Living to comply with the policy and procedures of medication management. April 17, 2025 all QMA's will be in-serviced on the scope of practice and the policy and procedure of the company. A corrective action form was given to QMA who administered wrong medication to a resident.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action**	05/30/2025

	at 3:38 p.m., QMA 17 indicated she had preset up her medication pass for Resident J, on 2/4/25, and then she left the facility. She returned to the facility and gave Resident B the medications she had preset up for Resident J. Resident B recognized the wrong medications and the cup of medications had another room number listed on it. He returned the medications to QMA 17 and advised her he had taken 2 of the medications. The medications he had taken were a multivitamin capsule and a vitamin D tablet. QMA 17 did not notify the Director of Nursing (DON) or the physician of her error. She indicated "they were just vitamins". The resident reported the medication error to the DON, on 2/6/25, two days after the error occurred. QMA 17 indicated she had made the error. She had preset medications, not reported her error, and did not call the resident's doctor. The clinical record for Resident B was reviewed on 3/13/25 at 12:50 p.m. The diagnoses included, but were not limited to, cellulitis, type 2 diabetes mellitus and vitamin deficiency. The clinical record for Resident B indicated the resident was cognitively intact. The clinical record did not		**will be taken;** **An audit tool form will be used for The Director of Nursing to audit/review a med pass. This will be conducted with the following schedule.** **Daily for 30 days** **Weekly for 30 days** **Monthly for 90 days**	

	indicate the resident was monitored, until 2/8/25, when the notes indicated the resident's vital signs, blood sugar, and behaviors were observed. During an interview, on 3/13/25 at 3:58 p.m., Resident B indicated he had been given the wrong medication cup, and he had taken a couple of the medications before he realized the mistake. He told the nurse, and she told him it was just vitamins, and he would be okay. He told the DON, on 2/6/25, he received the wrong medication, and he wanted to make sure he was okay. During an interview, on 3/17/25 at 4:10 p.m., the DON indicated the resident told her, on 2/6/25, about the medication error. She interviewed QMA 17 regarding the error and not reporting it. She called the resident's doctor and received a verbal order to monitor the resident's vital signs, blood sugar, and behavior for 48 hours. During an interview, on 3/18/25 at 12:20 p.m., the DON indicated she had forgotten to write the verbal order from the resident's doctor regarding the need for the vital signs, blood sugar, and behaviors to be monitored for 48 hours on 2/7 and 2/8/25.			

	A current facility policy, titled "Medication Management," dated 11/1/2019 and received from the Executive Director on 3/18/25 at 3:00 p.m., indicated "...All Medications shall be given only to the individual resident for whom they are prescribed, given in accordance with the directions on the prescription...." This citation relates to Complaint IN00453023. Based on interview and record review, the facility failed to ensure the competence of medication staff when a resident received the incorrect medication for 1 of 6 residents reviewed for medication administration. (Resident B) Findings include: A facility document indicated QMA 17 administered the wrong medication to Resident B during a medication pass on 2/4/25. During an interview, on 3/13/25 at 3:38 p.m., QMA 17 indicated she had preset up her medication pass for Resident J, on 2/4/25, and then she left the facility. She returned to the facility and gave Resident B the medications she had preset up for Resident J. Resident B recognized the wrong medications and the cup of medications had another room number listed on it. He returned the medications to QMA 17 and			

advised her he had taken 2 of the medications. The medications he had taken were a multivitamin capsule and a vitamin D tablet. QMA 17 did not notify the Director of Nursing (DON) or the physician of her error. She indicated "they were just vitamins". The resident reported the medication error to the DON, on 2/6/25, two days after the error occurred. QMA 17 indicated she had made the error. She had preset medications, not reported her error, and did not call the resident's doctor.

The clinical record for Resident B was reviewed on 3/13/25 at 12:50 p.m. The diagnoses included, but were not limited to, cellulitis, type 2 diabetes mellitus and vitamin deficiency.

The clinical record for Resident B indicated the resident was cognitively intact.

The clinical record did not indicate the resident was monitored, until 2/8/25, when the notes indicated the resident's vital signs, blood sugar, and behaviors were observed.

During an interview, on 3/13/25 at 3:58 p.m., Resident B indicated he had been given the wrong medication cup, and he had taken a couple of the medications before he realized

the mistake. He told the nurse, and she told him it was just vitamins, and he would be okay. He told the DON, on 2/6/25, he received the wrong medication, and he wanted to make sure he was okay.

During an interview, on 3/17/25 at 4:10 p.m., the DON indicated the resident told her, on 2/6/25, about the medication error. She interviewed QMA 17 regarding the error and not reporting it. She called the resident's doctor and received a verbal order to monitor the resident's vital signs, blood sugar, and behavior for 48 hours.

During an interview, on 3/18/25 at 12:20 p.m., the DON indicated she had forgotten to write the verbal order from the resident's doctor regarding the need for the vital signs, blood sugar, and behaviors to be monitored for 48 hours on 2/7 and 2/8/25.

A current facility policy, titled "Medication Management," dated 11/1/2019 and received from the Executive Director on 3/18/25 at 3:00 p.m., indicated "...All Medications shall be given only to the individual resident for whom they are prescribed, given in accordance with the directions on the prescription...."

This citation relates to Complaint IN00453023.

R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure the pharmacist reviewed a resident's drug regimen at least every 60 days for 1 of 7 residents reviewed for pharmacy reviews. (Resident D) Findings include:	R 0298	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **All residents have the potential to be affected by the deficient practice. It is the intention of West Lafayette Assisted Living to comply with the policy and procedures of medication pharmacy reviews.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** **The facility failed to ensure pharmacist reviewed all residents drug regimen per state regulations. Pharmacist apologized and explained she had a new system change in PCC and there had to have been a glitch in the system. Pharmacist is conducting a retro-review for the 1 resident and has sent us the review to upload.The DON and ED will audit/review as follows:** **April 2025, June 2025, August 2025, October 2025, December**	05/30/2025

	The clinical record for Resident D was reviewed on 3/13/25 at 2:50 p.m. The record did not indicate Resident D had a pharmacist drug review every 60 days. During an interview, on 3/19/25 at 4:02 p.m., the Executive Director indicated Resident D did not have a pharmacy review every 60 days for his medication regimen. The facility did not have a policy related to pharmacy regimen reviews every 60 days. Based on record review and interview, the facility failed to ensure the pharmacist reviewed a resident's drug regimen at least every 60 days for 1 of 7 residents reviewed for pharmacy reviews. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/13/25 at 2:50 p.m. The record did not indicate Resident D had a pharmacist drug review every 60 days. During an interview, on 3/19/25 at 4:02 p.m., the Executive Director indicated Resident D did not have a pharmacy review every 60 days for his medication regimen. The facility did not have a policy related to pharmacy regimen reviews		**2025** **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; May 30, 2025**	

	every 60 days.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure an infection control program was established which analyzed patterns of infectious symptoms in the facility for 9 of 12 months reviewed for infection tracking and trending. (April, May, June, July, August, September, October, November and December 2024) Findings include: During a review of the facility infection control records, on 3/17/25 at 11:30 a.m., the	R 0407	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **All residents have the potential to be affected by the deficient practice. It is the intention of West Lafayette Assisted Living to comply with the policy and procedures of infection control.**	05/30/2025

	facility did not have documentation to show tracking and trending or monitoring of infections throughout the facility was completed for April, May, June, July, August, September, October, November and December 2024 During an interview, on 3/17/25 at 11:38 a.m., the Director of Nursing indicated there were no records found for the infection control monitoring of residents from 4/24 through 12/24. The facility should have had a system to track and monitor infections as they occurred throughout the facility. The facility did not have a policy on infection control monitoring. Based on record review and interview, the facility failed to ensure an infection control program was established which analyzed patterns of infectious symptoms in the facility for 9 of 12 months reviewed for infection tracking and trending. (April, May, June, July, August, September, October, November and December 2024) Findings include: During a review of the facility infection control records, on 3/17/25 at 11:30 a.m., the facility did not have documentation to show tracking and trending or monitoring of infections throughout the facility			

	was completed for April, May, June, July, August, September, October, November and December 2024 During an interview, on 3/17/25 at 11:38 a.m., the Director of Nursing indicated there were no records found for the infection control monitoring of residents from 4/24 through 12/24. The facility should have had a system to track and monitor infections as they occurred throughout the facility. The facility did not have a policy on infection control monitoring.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents had an annual statement to indicate the resident showed no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter for 7 of 7 residents reviewed for the annual health statement. (Resident B, C, D, E, F, G and	R 0409	**What corrective actions will be accomplished for those residents found to have been affected by the finding:** **No negative outcome identified for those residents affected. All resident have the potential to be affected.** **How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No resident was adversely affected.** **What measures will be put in place or what systemic changes the facility will make**	05/30/2025

	H) Findings include: 1. The clinical record for Resident B did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 2. The clinical record for Resident C did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 3. The clinical record for Resident D did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 4. The clinical record for Resident E did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 5. The clinical record for Resident F did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.		**to ensure that the deficient practice does not recur:** **Resident** **medical records will be audited for annual tuberculin skin test or risk** **assessments. Any medical record found out of compliance will be corrected immediately.** **How** **the corrective action(s) will be monitored to ensure the finding will not** **recur:** **Wellness** **Director or designee will monitor annual tuberculin skin tests or risk** **assessments Weekly for 2 months Bi-weekly for 2 months and monthly thereafter** **Systemic** **Change will occur by May 30, 2025**	

	6. The clinical record for Resident G did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 7. The clinical record for Resident H did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. During an interview, on 3/19/25 at 4:30 p.m., the Director of Nursing indicated the residents were missing the annual health statement. The facility did not have a policy addressing annual health statements. Based on record review and interview, the facility failed to ensure residents had an annual statement to indicate the resident showed no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter for 7 of 7 residents reviewed for the annual health statement. (Resident B, C, D, E, F, G and H) Findings include: 1. The clinical record for Resident B did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious			

	stage as verified upon admission and yearly thereafter. 2. The clinical record for Resident C did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 3. The clinical record for Resident D did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 4. The clinical record for Resident E did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 5. The clinical record for Resident F did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 6. The clinical record for Resident G did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. 7. The clinical record for			

	Resident H did not indicate an annual statement was obtained to show no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. During an interview, on 3/19/25 at 4:30 p.m., the Director of Nursing indicated the residents were missing the annual health statement. The facility did not have a policy addressing annual health statements.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have	R 0410	**What corrective actions will be accomplished for those residents found to have been affected by the finding:** **No negative outcome identified for those residents affected. All resident have the potential to be affected.How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No resident was adversely affected.What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:Resident medical records will be audited for annual tuberculin skin test or risk assessments. Any medical record found out of compliance will be corrected immediately.How the corrective action(s) will be monitored to ensure the finding will not**	05/30/2025

	a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure residents were screened for tuberculosis (TB) using the two-step skin test upon admission for 6 of 7 residents reviewed for tuberculosis screening. (Resident C, D, E, F, G and H) Findings include: 1. The clinical record for Resident C did not have documentation to indicate a TB skin test or screening was completed upon admission. 2. The clinical record for Resident D did not have documentation to indicate a TB skin test or screening was completed upon admission. 3. The clinical record for Resident E did not have documentation to indicate a TB skin test or screening was completed upon admission. 4. The clinical record for Resident F did not have documentation to indicate a TB skin test or screening was completed upon admission. 5. The clinical record for Resident G did not have documentation to indicate a TB skin test or screening was		**recur:Wellness Director or designee will monitor annual tuberculin skin tests or risk assessments Weekly for 2 months Bi-weekly for 2 months and monthly thereafterSystemic Change will occur by May 30, 2025**	

completed upon admission.

6. The clinical record for Resident H did not have documentation to indicate a TB skin test or screening was completed upon admission.

During an interview, on 3/19/25 at 4:30 p.m., the Director of Nursing indicated the residents were missing the TB skin testing.

A current facility policy, titled "Tuberculosis Screening/ testing policy - Residents -IC-2," not dated and received from the Executive Director on 3/19/25 at 4:30 p.m., indicated "...Testing should be performed on each new resident within three months prior to admission, or within one week of admission or per state regulations. Testing methods may include: Mantoux skin testing-using the two-step method...."

Based on record review and interview, the facility failed to ensure residents were screened for tuberculosis (TB) using the two-step skin test upon admission for 6 of 7 residents reviewed for tuberculosis screening. (Resident C, D, E, F, G and H)

Findings include:

1. The clinical record for Resident C did not have documentation to indicate a TB

skin test or screening was completed upon admission.

2. The clinical record for Resident D did not have documentation to indicate a TB skin test or screening was completed upon admission.

3. The clinical record for Resident E did not have documentation to indicate a TB skin test or screening was completed upon admission.

4. The clinical record for Resident F did not have documentation to indicate a TB skin test or screening was completed upon admission.

5. The clinical record for Resident G did not have documentation to indicate a TB skin test or screening was completed upon admission.

6. The clinical record for Resident H did not have documentation to indicate a TB skin test or screening was completed upon admission.

During an interview, on 3/19/25 at 4:30 p.m., the Director of Nursing indicated the residents were missing the TB skin testing.

A current facility policy, titled "Tuberculosis Screening/ testing policy - Residents -IC-2," not dated and received from the Executive Director on 3/19/25 at

	4:30 p.m., indicated "...Testing should be performed on each new resident within three months prior to admission, or within one week of admission or per state regulations. Testing methods may include: Mantoux skin testing-using the two-step method...."			

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 SIGNATURE	TITLE	(X6) DATE