STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WICKSHIRE WEST LAFAYETTE	3575 SENIOR PLACE WEST LAFAYETTE, IN 47906

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00416527, IN00417451, IN00417516 and IN00417573. Complaint IN00416527 - No deficiencies related to the allegations are cited. Complaint IN00417451 - No deficiencies related to the allegations are cited. Complaint IN00417516 - State deficiencies related to the allegations are cited at R0044 Complaint IN00417573 - State deficiencies related to the allegations are cited at R0144 Survey dates: September 14 and 15, 2023 Facility number: 014094 Residential Census: 59 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 22, 2023.	R 0000	Allegation of Substantial Compliance Wickshire West Lafayette 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 Wickshire West Lafayette's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before November 30, 2023 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with Indiana state requirements for health facilities found at 410 IAC 16.2, Whickshire West Lafayette (herein after referred to as "community") has taken or will take the actions set forth in this plan of correction.	
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility.			

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

May Ehresman | Executive Director | 11/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	(2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: (A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or (F) the facility ceases to operate. (5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following: (A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B). (B) Any physician when transfer or discharge is necessary under subdivision (4)(D).			
	Based on interview and record review, the facility failed to provide a required document to the	R 0044	Plan of Correction: ="" p="">1. The immediate action	11/30/2023

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	resident or family after the facility initiated an involuntary transfer or discharge for 3 of 3 residents reviewed for discharge. (Residents D, F, and G) Finding includes: 1. The Residency Agreement record for Resident D was reviewed on 09/15/2023 at 1:27 p.m. A document, dated 09/11/2023, regarding the termination of a residency agreement from the facility to the resident indicated the facility was terminating Resident D's residency agreement 30 days from the date on the letter due to non-payment. No document regarding termination of agreement was sent to the Ombudsman, a family member, resident's legal representative or the resident's physician. No state form document 49669 or 49831 was sent to the resident, Ombudsman, a family member, resident's legal representative or resident's physician. 2. The Residency Agreement record for Resident F was reviewed on 09/15/2023 at 1:30 p.m. A document, dated 09/11/2023, regarding the termination of a residency agreement from the facility to the resident indicated the facility was terminating Resident F's residency agreement 30 days from the date on the letter due to non-payment. No document regarding termination of agreement was sent to the Ombudsman, a family member, resident's legal representative or resident's		which was taken for the residents affected: ="" p="">All of the discharge planning paperwork was redrafted per regulations and sent certified mail to required parties for 2 of the 3 residents. The third resident worked out a payment plan with the community and will not be discharged. ="" p="">2. The facility identified other residents which could be affected. ="" p="">All residents could be affected, however residents with past due balances, behaviors or other issues that could subject them to discharge are more immediately affected. ="" p="">3. The measures that were put into place/system changes made to ensure the deficient practice does not recur; Business Office Manager, Nursing Directors and Executive Director were trained on proper discharge procedures. ="" p="">4. The corrective actions will be completed by 11/30/2023. ="" p="">5. Discharges will be monitored by; Executive Director will monitor and approved all discharges and associated paperwork for next six months to assure all parties doing discharge paperwork are correctly following required discharge procedures. ="" p="">	

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	physician. No state form document 49669 or 49831 was sent to the resident, Ombudsman, a family member, resident's legal representative or resident's physician. 3. The Residency Agreement record for Resident G was reviewed on 09/15/2023 at 1:37 p.m. A document, dated 09/11/2023, regarding the termination of a residency agreement from the facility to the resident indicated the facility was terminating Resident G's residency agreement 30 days from the date on the letter due to non-payment. No document regarding termination of agreement was sent to the Ombudsman, a family member, resident's legal representative or resident's physician. No state form document 49669 or 49831 was sent to the resident, Ombudsman, a family member, resident's legal representative or resident's physician. During a phone interview, on 9/15/2023 at 1:39 p.m., the Ombudsman indicated the facility must use the prescribed form from the Department of Health, which was SF (state form) 49669. She indicated she never received the form. This form was also not provided to the resident. The state regulations for discharge or transfer rights indicate "...For health facilities, the written notice...must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged.			

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	(D) A statement...that reads, you have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you...If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health...." She indicted the resident did not receive form 49831 regarding appeal process. During an interview, on 09/15/2023 at 4:45 p.m., the Executive Director indicated she was not aware of forms 49831 and 49669. She did not send notification of discharge to the Ombudsman, a family member, resident's legal representative or resident's physician. She was not aware she needed to send notification to the Ombudsman, a family member, resident's legal representative or resident's physician. The Indiana Administrative Code section 16.2-3.1-12 (6) (A) Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following: the resident, a family member, the resident's legal representative, the local long term care ombudsman and the resident's physician.			

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	This State Residential finding relates to Complaint IN00417516.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (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 observation, interview and record review, the facility failed to follow their policy and procedure for the spread of bed bugs within the facility. This deficient practice had the potential to affect 59 of 59 residents at the facility. Finding include: A document, dated 9/13/2023, indicated the Executive Director (ED) received a call at 7:47 a.m., Resident N living in apartment 302 was in the dining room and bed bugs were found on her. The ED instructed the resident and her breakfast be taken back to her apartment. The resident was showered in her apartment. The resident put on clean clothes after her shower. The resident's clothes and all bedding were washed and dried on high heat. The pest treatment company was called to treat the apartment on 9/13/2023. The company could not come until 9/14/2023 to treat the apartment. Resident N's family was notified. Resident N slept in her room on 9/13/2023. A document, dated 9/14/2023, indicated the resident received a shower in her room and put on clean clothes. Resident N was sent out of her room and room 302 was treated by the pest company. The pest company inspected room 301 and no bed bugs were found. The bedding was removed from the resident's bed and was dried on	R 0144	=" " p=" ">1. The immediate action which was taken for the residents affected: =" " p=" ">Resident was showered and given clean clothes and moved to another room. Per policy Orkin was called and policy followed step by step =" " p=" ">2. The facility identified other residents which could be affected =" " p=" ">All residents could be affected. =" " p=" ">3. The measures that were put into place/system changes made to ensure the deficient practice does not recur; Executive Director will be immediately informed and take responsibly for ensuring policy will be followed. All staff will be in-serviced on correct procedures by 11/30/2023 =" " p=" ">4. The corrective actions will be monitored by; Executive Director will monitor each time there is a report. Bed Bug dog was contracted and will inspect/sniff the entire community to ensure procedures followed	11/30/2023

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	high heat. During an observation, on 9/14/2023 at 11:30 a.m., Resident N was roaming the facility throughout the first floor. During an observation, on 9/14/2023 at 12:00 p.m., the residents of the facility were eating their lunch meal in the dining room where bed bugs were found on a resident, on 9/13/2023. During an interview, on 9/14/2023 at 3:30 p.m., Resident O indicated he was aware Resident N had bed bugs found on her in the dining room, on 9/13/2023, at breakfast. He was afraid to have dinner in the dining room since the room had not been treated for bed bugs. During an observation, on 9/14/2023 at 5:10 p.m., the residents of the facility were eating their dinner meal in the dining room where bed bugs were found on a resident, on 9/13/2023. The dining room had not been treated. During an interview, on 9/14/2023 at 4:10 p.m., the Director of Nursing indicted she was aware of the bed bugs in room 302 and on Resident N. The resident was showered, and clean clothes were placed on the resident. The resident was left in her room overnight and the room had not been treated until today. She was not aware of the policy and procedure of the facility. The ED oversaw the bed bug issue, and she did what she was instructed to do regarding the bed bugs. During an interview, on 9/14/2023 at 4:41 p.m., QMA 4 indicated he was called to the dining room at breakfast time, on 9/13/2023, by Resident G. Resident G was picking bed bugs off Resident N. QMA 4 notified the ED and Resident N was		have been effective at eradicating the bed bugs. ="" p="">	

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	transported to her room for a shower. He indicated he did see bed bugs on the resident and 3 small bites on her right arm. The resident was not transferred to another room and the resident was left inside room 302. The dining room was not cleared, and the residents continued with the breakfast meal. During an interview, on 9/14/2023 at 4:49 p.m., the Assistant Director of Nursing (ADON) indicated he was notified of the bed bug situation, on 9/13/2023. He was not aware of the facility bed bug policy and procedure. The DON and the ED were notified. The resident was transported to her room for a shower. The resident was not transferred to another room and was left inside room 302. The dining room was not cleared, and the residents continued with the breakfast, lunch, and dinner meals. He indicated he was not aware if the dining room had been treated for bed bugs. During an interview, on 9/14/2023 at 5:15 p.m., the ED indicated the pest company had treated room 302 for bed bugs. She did not notify the state of the bed bugs in the facility. She did not notify the surveyor during the entrance conference about the facility having a bed bug issue. She followed the pest company advisement on how to treat the bed bug spread. She did not follow the policy and procedure of the facility. She would locate the current policy and procedure for review. Only room 302 was treated for bed bugs. The resident was only out of her room during the treatment process. The resident was not moved to another room during the process. The rooms around the treated room were not treated nor inspected. The dining room was still in use by the residents and had not been treated nor inspected. The resident (Resident G) who found the bed bugs on Resident N had not been showered or inspected for bed			

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	bugs. A review of the policy and procedure, on 9/15/2023 at 11:20 a.m., received from the ED on 9/15/2023 at 11:10 a.m., indicated "The Environmental Services Director will utilize the Bed Bugs Signs and Symptoms form to walk each apartment to document if there are any signs of bed bugs and document the findings on the form. The Health & Wellness Director is responsible for determining appropriate control measures, as well as Treatment and management actions. The Bed Bugs Signs and Symptoms form will be completed, documenting any residents or associates that have any signs of bites." These procedures were not followed by the staff. A review of the policy and procedure, on 9/15/2023 at 11:20 a.m., received from the ED on 9/15/2023 at 11:10 a.m., indicated "The resident will be moved to another apartment, if available, taking care not to bring other belongings from the affected apartment." This procedure was not followed by the staff. A review of the policy and procedure, on 9/15/2023 at 11:20 a.m., received from the ED on 9/15/2023 at 11:10 a.m., indicated "Pest control vendor should inspect all apartments, and common areas that are adjacent, above and below, to the known infested area." This procedure was not followed by the facility staff. A review of the policy and procedure, on 9/15/2023 at 11:20 a.m., received from the ED on 9/15/2023 at 11:10 a.m., indicated "Documentation The following procedures will be implemented by the Health Services Director or designee following a confirmed bed bug incident: Fill out an incident report. Utilize the Bed Bugs Signs and Symptoms			

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	form to track any residents or associates that may have bed bug bites, and to track apartments or common areas where there are signs of bugs present. During an interview, on 9/15/2023 at 11:38 a.m., the ED discussed the policy and procedure for bed bugs, effective 12/22/2020, she indicated she had not followed the policy and procedure. This State Residential finding relates to Complaint IN00417573.			