PRINTED: 03/25/2025

DEPARTMEN CENTERS FOI		OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155177		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP	SURVEY LETED 5/2025
	PROVIDER OR SUPPLIEI NSTER VILLAGE -	R WEST LAFAYETTE	2741 N	ADDRESS, CITY, STATE, ZIP COD N SALISBURY ST LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
F 0000 Bldg. 00	Licensure Survey. Residential Licensus the Investigation of IN00443524, IN00 Complaint IN00444 the allegations are of Complaint IN00445 the allegations are of Complaint IN00445 the allegations are of Complaint IN00446 the allegations are of Complaint IN00446 the allegations are of Complaint IN00446 the allegations are of Survey dates: February Facility number: 10 Provider number: 11 AIM number: 2012 Census Bed Type: SNF: 11 SNF/NF: 53 Residential: 62 Total: 126 Census Payor Type Medicare: 11 Other: 53 Total: 64	as 24 - No deficiencies related to cited. 1342 - Federal/state deficiencies ations are cited at F744. 0547- No deficiencies related to cited. uary 19, 20, 21, 24 and 25, 2025 00093 55177 271750	F 0000	Preparation, submission, an implementation of this Plan Correction does not constit admission or agreement wi facts and conclusions set for the survey report by Westm Village West Lafayette. Our of Correction is prepared an executed as a means to continuously improve the quare and to comply with all applicable state and federal regulatory requirements. We respectfully request a correview of this POC and a subsequent paper compliant revisit.	of ute an th the orth on ninster r Plan nd uality of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Quality review was completed on March 6, 2025.

TITLE

(X6) DATE

Kristen Patz Administrator 03/20/2025

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155177	B. W	ING	<u> </u>	02/25	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			SALISBURY ST		
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE		WEST LAFAYETTE, IN 47906			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0684	483.25						
SS=D	Quality of Care						
Bldg. 00							
		and record review, the facility	F 0	584	F684 Quality of Care		03/20/2025
	failed to ensure staff followed the physician's				S=D	_	
		parameters were followed for 2			I Residents #45 a	ınd	
		wed for quality of care.			#33 had no negative		
	(Residents 45 and 3	3)			consequences from the allege		
	Findings 1 1 1				deficient practice. The physic	ıan	
	Findings include:				orders were reviewed by the		
	1 The distant				physician, for both residents,		
	1. The clinical record for Resident 45 was reviewed on 2/24/25 at 11:46 a.m. The diagnoses included, but were not limited to, end stage renal disease,				the determination was made	Ю	
					maintain the current order.		
		lure, pulmonary edema and			III All residents who		
	atrial fibrillation.	iure, pulmonary edema and			have doctor orders with medi		
	atriai mormation.				parameters have the potentia		
	Δ care plan dated 7	7/17/24, indicated Resident 45			be affected.	110	
	-	congestive heart failure and			be anected.		
	-	enal failure. Interventions			l III		
	-	not limited to, give medications			Nursing management staff ha	N/e	
	as ordered.				audited all current orders for	.,,	
					parameters for accuracy and		
	A physician's order.	, dated 7/22/24, indicated to			updated orders to include wo	rdina	
		plood pressure medication) 12.5			of "less than", "equal to", "gre	_	
		ice daily with instructions to			than" for clarity.		
	,	for a systolic blood pressure			ĺ		
	of less than 100 or a	a heart rate of less than 60.			All nurses and QMA's to be		
					educated on policies and		
	The Medication Ad	ministration Record (MAR),			procedures for order paramet	ers	
		gh 11/30/24, indicated			and holding of medications.		
	metoprolol was adn						
	a. On 11/7/24, in the	e morning with a heart rate of			Director of Nursing Services ((DON)	
	56.				and/or designee will:		
		he evening with a systolic			Audit a random sample of a		
	blood pressure of 9'	7.			minimum of 20% of residents		
					Physician Orders and medica	ition	
		2/1/24 through 12/31/24,			administration records to ens	ure	
	-	ol was administered:			compliance with medication		
a. On 12/2/24, with a heart rate of 58.				administration parameters; A	udits		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155177	B. W	ING		02/25/	/2025
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R			SALISBURY ST		
WESTM	INSTER VII I AGF -	WEST LAFAYETTE			LAFAYETTE, IN 47906		
	T		_		I		Т
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	b. On 12/5/24, with				will have a goal of 100%		
	· ·	th a heart rate of 50 and a			compliance; Audits will be		
	systolic blood press	sure of 90.			completed weekly until 100%		
	TI MAD 4-4-4 1	/1/25 45			compliance is achieved for 3		
		/1/25 through 1/31/25, indicated			consecutive evaluations, then		
	metoprolol was administered:				every other week until 100%		
	a. On 1/18/25, in the morning with a systolic blood				compliance is achieved for 3	thon	
	pressure of 91.				consecutive evaluations, and monthly until 100% compliance		
	A MAR, dated 2/1/25 through 2/28/25, indicated				achieved for 3 consecutive	DC 19	
	metoprolol was administered:				evaluations. Additional audits	will	
	a. On 2/14/25, in the evening with a systolic blood				be completed as needed base		
	pressure of 90.				upon the level of compliance.	Ju	
	pressure of 70.				apon the level of compliance.		
	During an interview, on 2/25/25 at 4:20 p.m., the				Results of all audits will be		
	_	g (DON) indicated Resident 45's			brought to QAPI for review ar	nd	
		not have been given outside of			revision as needed. The audi		
	_	e indicated a "H" in parenthesis			be reviewed by the Quality		
	meant the medicati	on was held. 2. The clinical			Assurance Committee until su	ıch	
	record for Resident	33 was reviewed on 2/20/25 at			time consistent substantial		
	11:15 a.m. The diag	gnoses included, but were not			compliance has been achieve	ed as	
	limited to, orthosta	tic hypotension (low blood			determined by the committee	. The	
	pressure), Parkinso	n's disease, depression,			Administrator and DON will be	е	
	dementia, and anxi-	ety disorder.			responsible for sustained		
					compliance. This will be		
		, dated 2/20/24, indicated to			submitted to QAPI monthly fo	r	
		ed to treat low blood pressure)			review.		
		mes a day if the systolic blood					
	pressure (SBP) was	s less than 130.			IV The facility will be		
					and remain in compliance by:		
		Iministration Record (MAR),			March 20, 2025		
		25, indicated the 9:00 a.m. dose					
	was given the following dates:						
		drine was given when the					
	systolic blood pressure was 142.						
	b. On 2/2/25, midodrine was given when the						
	systolic blood pressure was 142. c. On 2/6/25, midodrine was given when the						
	· ·	2					
	systolic blood press						
	a. On 2/8/25, mido	drine was given when the	ı		1		I

	OF CORRECTION	IDENTIFICATION NUMBER 155177	A. BUILDING B. WING	00	COMP	E SURVEY PLETED 5/2025
	PROVIDER OR SUPPLIER NSTER VILLAGE -	WEST LAFAYETTE	2741 N	ADDRESS, CITY, STATE, ZIP COD SALISBURY ST LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
IAU	systolic blood press e. On 2/9/25, midod systolic blood press f. On 2/12/25, midod systolic blood press g. On 2/13/25, midod systolic blood press h. On 2/16/25, midod systolic blood press i. On 2/18/25, midod systolic blood press j. On 2/21/25, midod systolic blood press k. On 2/23/25, midod systolic blood press l. On 2/25/25, midod systolic blood press l. On 2/25/25, midod systolic blood press b. On 2/1/25, midod systolic blood press b. On 2/1/25, midod systolic blood press b. On 2/9/25, midod systolic blood press c. On 2/12/25, midod systolic blood press d. On 2/13/25, midod systolic blood press d. On 2/13/25, midod systolic blood press g. On 2/16/25, midod systolic blood press f. On 2/19/25, midod systolic blood press g. On 2/23/25, midod systolic blood press g. On 2/23/25, midod systolic blood press The MAR, for 2/1/2 p.m. dose was giver a. On 2/8/25, midod systolic blood press g. On 2/23/25, midod systolic blood press blood press g. On 2/23/25, midod systolic blood press g. On 2/23/25, midod systolic blood press	ure was 146. Irine was given when the ure was 149. drine was given when the ure was 194. odrine was given when the ure was 146. odrine was given when the ure was 159. drine was given when the ure was 142. drine was given when the ure was 142. odrine was given when the ure was 143. drine was given when the ure was 144. 25 to 2/28/25, indicated the 1:00 of the following dates: Irine was given when the ure was 153. Irine was given when the ure was 143. odrine was given when the ure was 143. odrine was given when the ure was 143. odrine was given when the ure was 144. odrine was given when the ure was 147. drine was given when the ure was 151. odrine was given when the ure was 159. 25 to 2/28/25, indicated the 5:00 of the following dates: Irine was given when the ure was 159.	IAU			DATE

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155177		A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155177	B. WING		02/25/2025	
	ROVIDER OR SUPPLIEF	WEST LAFAYETTE	2741	T ADDRESS, CITY, STATE, ZIP COD N SALISBURY ST T LAFAYETTE, IN 47906		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
	systolic blood press	odrine was given when the sure was 167. odrine was given when the				
	indicated if the residence or greater the medicated in the medicates are the medicated at the medicates are the medicated at	v, on 2/25/25 at 8:47 a.m., LPN 4 dent's blood pressure was 130 cation should not have been ician should have been called.				
	DON indicated then	y, on 2/25/25 at 4:36 p.m., the re were several midodrine he was not sure why they were				
	Medication," dated received from the C 2/25/25 at 11:45 p.1 administered in a sa prescribedMedica	olicy, titled "Administering as revised on 4/2019 and Clinical Executive Director on m., indicated "Medications are afe and timely manner, and as ations are administered in escriber orders, including any es"				
	Documentation," da received from the C 2/24/25 at 2:06 p.m					
F 0688 SS=D	483.25(c)(1)-(3)	Decrease in ROM/Mobility				
Bldg. 00	Based on observation	on, interview and record	F 0688	F688 Increase/Prevent	03/20/2025	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155177	B. W	NG		02/25	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	0	
NAME OF P	ROVIDER OR SUPPLIER	L Comment			SALISBURY ST		
VALCEVAL	NOTED VIII ACE	MEST LAFAVETTE					
WESTIMI	NSTER VILLAGE -	WEST LAFAYETTE		WEST	LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
	review, the facility	failed to ensure physician's			Decrease in ROM/Mobility		
	orders were followe	ed and therapy evaluations			S=D		
	were completed in a	a timely manner for 2 of 4			I Residents #51 ar	nd	
	_	position and mobility.			#9 had no negative consequer	nces	
	(Resident 51 and 9)	-			from the alleged deficient prac		
	()				Resident #51 has been evalua		
	Findings include:				by therapy for wheelchair		
	i manigo metade.				positioning. A wheelchair cush	ion	
	During an observati	ion, on 2/19/25 at 12:09 p.m.,			has been provided to assist wi		
	_	the dining room with her			wheelchair positioning. The	uı	
		away from the table. The					
	-	-			resident care plan has been		
		g forward with her left arm			reviewed and updated to ensu		
	dangling below the	wheelchair seat.			interventions to maintain range		
		0/10/07 0.00			motion and mobility at the high	est	
	_	on, on 2/19/25 at 3:08 p.m., the			possible level of functioning.		
	_	next to the nurse's station			Resident #9 has been evaluate		
	_	d. The resident was leaning			for therapy related to a diagno		
	forward and sitting	crooked in her wheelchair.			of contractures. The treatment		
					plan has been updated by the		
		on, on 2/20/25 at 10:27 a.m.,			therapy team to provide treatm	nent	
		ing next to the nurse's office			interventions. The resident car	e	
	in her wheelchair.	The resident was leaning			plan has been reviewed and		
		uch her left shoe. The nurse			updated to ensure intervention	is to	
	was sitting at the de	sk in the nurse's office with			maintain range of motion and		
	her back facing the	resident and the Certified			mobility at the highest possible)	
	Nursing Assistant (CNA) was assisting residents			level of functioning.		
	out of the dining roo	om.			-		
	-				II All healthcare		
	During an observati	ion, on 2/21/25 at 10:49 a.m.,			residents who require therapy		
		ing in her wheelchair, leaning			evaluations and services have	the	
	to the left and touch				potential to be affected.		
	During an observati	ion, on 2/21/25 at 12:30 p.m.,					
		served with several staff			I III An audit has been		
		ng the resident in the common			conducted of all residents with		
		fell out of her wheelchair and	conducted of all residents with current therapy evaluation orders				
		or. The resident was on her			to ensure they have been	013	
	left side.	or. The resident was off field				No	
	icit side.				evaluated in a timely manner.		
			I		concerns were noted during th	IS	I

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During an observation, on 2/24/25 at 9:11 a.m., the

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audit.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155177	B. W	ING		02/25/	/2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			SALISBURY ST		
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE			LAFAYETTE, IN 47906		
	Г		1		, 		OVE)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION s at a table with a visitor. The	+	TAG	Education will be provided to		DATE
	_	g to the left side with her head			nursing staff to alert the thera	2)/	
		had her left wrist wrapped			department of all new therapy	-	
	with a brown elastic				orders, via fax, during their		
	with a brown clastic	c wrap.			scheduled shift.		
	During an observat	ion, on 2/24/25 at 11:55 a.m.,			Director of Rehab Services of	r	
	the resident was in the dining room eating her				designee will: Perform an aud		
	lunch. The resident had a white pillow propped				100% of therapy referral order		
	under her left arm. The pillow was pushed down				ensure timely implementation		
		and helping the resident sit up			the order; Audits will have a g		
	straight.	1 0			of 100% compliance; Audits w		
					be completed weekly until 100		
	The clinical record for Resident 51 was reviewed				compliance is achieved for 3		
	on 2/20/25 at 11:29 a.m. The diagnoses included,				consecutive evaluations, then		
	but were not limited	d to, left wrist fracture,			every other week until 100%		
	hypertension, diabe	etes mellitus, dementia, and			compliance is achieved for 3		
	anxiety disorder.				consecutive evaluations, and	then	
					monthly until 100% complianc	e is	
	_	3/25/24, indicated the resident			achieved for 3 consecutive		
	1	ry related to falls. Interventions			evaluations. Additional audits	will	
		not limited to, therapy to			be completed as needed base	ed	
	screen and treat as a	needed.			upon the level of compliance.		
					Results of all audits will be		
	_	3/25/24, indicated the resident			brought to QAPI for review an		
		eased activities of daily living			revision as needed. The audit	s will	
	1 '	ons included, but were not			be reviewed by the Quality		
	ilmited to, therapy	to screen and treat as needed.			Assurance Committee until su	icn	
	A physician's and-	dated 2/4/25 indicated			time consistent substantial	d 00	
		r, dated 2/4/25, indicated T) to evaluate and treat.			compliance has been achieve		
	physical merapy (P	1) to evaluate and fieat.			determined by the committee. Administrator and DON will be		
	A physician's order	, dated 2/24/25, indicated			responsible for sustained	•	
	1	by (OT) to treat three times a			compliance. This will be		
					submitted to QAPI monthly for	r	
	week for eight weeks. Treatment may include self-care, therapy, and wheelchair management to				review.		
		nce in ADL's and facilitate					
	optimal alignment				IV The facility will be	in	
	1				and remain in compliance by:		
	The electronic heal	th record did not have any			March 20, 2025.		
		documentation to indicate why it took the therapy					

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· · · · · · · · · · · · · · · · · · ·		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155177	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIER	WEST LAFAYETTE	•	2741 N	ADDRESS, CITY, STATE, ZIP COD SALISBURY ST LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	department 17 days evaluation and treat	to complete a therapy rement.					
	6 indicated the residual staff propped the rehier straight. She had	dent leaned to the left and the sident up on a pillow to keep d noticed the resident leaning times and would assist her with					
	Therapy Director in receiving therapy. 2/21/25 after the res She did not know if leaning in her whee was ordered to assis Therapy Director di was not seen on 2/4 was written for the treated by physical were seen within 48	or, on 2/24/25 at 12:24 p.m., the idicated the resident was The resident was seen on sident fell out of her wheelchair. If the resident had a history of lichair. A wheelchair cushion is ther with positioning. The id not know why the resident if yellow when a physician's order resident to be evaluated and therapy. Normally, residents is hours after the physician's not have taken days before aduated.					
	Resident 9's family ask the staff to repo was sitting in her w on their own. The rebuttocks in the past, 9 would usually lay get up at 3:00 p.m. The clinical record 2/20/25 at 11:29 a.r. were not limited to,	ew, on 2/20/25 at 11:11 a.m., the member indicated he had to sition the resident while she heelchair as they did not do it esident had wounds on her , but they are healed. Resident down after lunch and would for Resident 9 was reviewed on m. The diagnoses included, but atrial fibrillation, age-related imer's disease, dementia, nxiety disorder.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155177	A. BUILDIN B. WING	∖G	00	COMPL 02/25/	
		100177		_	_	02/25/	2020
NAME OF I	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD SALISBURY ST		
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE			AFAYETTE, IN 47906		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 8/12/16, indicated the resident	TAG	j	DEFICIENCE!		DATE
	_	function. Interventions					
	•	not limited to, therapy to					
	screen and treat as	needed.					
	A care plan, dated	12/29/23, indicated the resident					
	was at risk for further contractures. Interventions						
		not limited to, notify the nurse					
	of any decline in co	ontractures or if any new					
	contractures noted.						
		hone order, dated 2/4/25,					
	indicated physical therapy (PT) and occupational						
		valuation and treatment with a ctures. The order was signed					
	_	Nursing (DON) and a LPN. The					
	_	signed the order on 2/9/25.					
		y (PT) evaluation and plan of					
		ed 2/20/25, indicated the					
	4/18/25, 3 times a v	e therapy from 2/20/25 to					
		th record did not have any					
		ndicate why it took the therapy					
	and treatment.	s to complete a PT evaluation					
	and treatment.						
	_	v, on 2/24/25 at 4:30 p.m., the					
		did not know why the resident					
	was not evaluated of	on 2/4/25.					
	_	v, on 2/25/25 at 9:08 a.m., LPN 4					
	_	hysician gave a telephone					
		write it on a form, the white					
		physician's folder and the nthe Unit Manager folder. The					
		the order to the morning					
		was reviewed in the meeting					
		ned off on the order. A					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155177		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/25/2025	
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD SALISBURY ST	•
WESTMI	INSTER VILLAGE -	WEST LAFAYETTE	WEST	LAFAYETTE, IN 47906	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	
PREFIX	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE
TAG		would be given to the therapy	TAG	DETERMINET?	DATE
		erapy department was not			
	_	nger than 72 hours to do their			
	evaluation on the re	esident. The resident was			
	supposed to be seen	n for contractures.			
	A current facility no	olicy, titled "Therapy			
	• •	& Referral," dated as revised			
	_	d by the Unit Manager on			
	2/25/25 at 10:54 a.r	n., indicated "For each			
	_	management of ordered			
	_	nts or therapy services, the			
		epare and include in the care			
		ferral for therapy based on			
		Referral Criteria includes			
		e referred for therapy when following criteria are			
		nction: Observable decline in			
	physical, cognitive.				
		Concerns: Issues with			
		on, or risk of fallsReferral			
		tion of Need: Any healthcare			
	provideror IDT T	eam who identifies a potential			
		ould promptly assess the			
	_	determine if therapy is			
	appropriateObser				
		ng with family or caregiver			
		formal referral is initiated once y is recognizedThe referral			
		ers is submitted to the therapy			
		receiving the referral, a			
		conducts a comprehensive			
	assessment to evalu	-			
		olicy, titled "Charting and			
		ated as revised 7/2019 and			
		nical Executive Director on			
		, indicated "The following documental in the resident			
	medical recordMe				

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155177	B. W	ING		02/25/	/2025
	PROVIDER OR SUPPLIER	WEST LAFAYETTE	•	STREET ADDRESS, CITY, STATE, ZIP COD 2741 N SALISBURY ST WEST LAFAYETTE, IN 47906			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0744	involving the reside procedures and trea refused the procedu family, physicians of 3.1-42(a)(2) 483.40(b)(3)	es in the resident's incidents or accidents entDocumentation of tmentswhether the resident are/treatmentnotification of or other staff"					
SS=D	Treatment/Service	e for Dementia					
Bldg. 00	review, the facility new person-centere for residents with w check wanderguard	on, interview and record failed to ensure staff initiated d dementia care interventions randering behaviors and to placement for 2 of 5 residents tria care. (Resident B and C)	F 0	744	F744 Treatment/Services for Dementia S=D I Residents B and had no negative consequence from the alleged deficient practile. II All residents with	C es ctice.	03/20/2025
	1. During an observ	ration, on 2/19/25 at 1:35 p.m., lking in the common area near			wandering behaviors and wanderguards have the poten be affected.		
	_	ion, on 2/20/25 at 12:15 p.m., abulating down the hall ors.			III A 100% audit of a residents with behavior care p for person-centered interventi was conducted. Care plans	lans	
		ion, on 2/21/25 at 1:54 p.m., the ating back from the exit door			updated to reflect current level care. A 100% audit of all residents wanderguards has been		
	resident was sitting	ion, on 2/24/25 at 9:06 a.m., the on the couch in the common main entrance doors.			completed to ensure documentation of wanderguar checks every shift and documentation regarding the	⁻ d	
		ion, on 2/25/25 at 12:15 p.m., lking near the front entrance			monitoring of behaviors every No new concerns were identif		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155177	B. W	ING		02/25	/2025
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			SALISBURY ST		
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE			LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	frequently looking	at the doors.			as a result of this audit.		
	During an observat	ion, on 2/25/25 at 2:05 p.m., the			Education to all nursing staff		
	-	he alarm on an exit door			members regarding the		
		e staff were redirecting her away			requirement to complete		
	-	she returned to the door within			wanderguard checks every sh	sift	
	minutes.	she returned to the door within			and to complete behavior	iiit	
	minuco.				monitoring documentation each	ch	
	The clinical record	for Resident B was reviewed			shift.	J. I	
		p.m. The diagnoses included,			J. Srint.		
	but were not limited to, dementia, history of				Facility will implement a mont	hlv	
	falling, and insomnia.				IDT behavioral monitoring me	-	
	idinig, did insomina.				to: Review previous month's r	-	
	A care plan, dated 10/9/24, indicated the resident				behaviors, current psychotrop		
	-	ing the facility by herself due to			medications, status and frequ		
		ntions included, but were not			of GDR's, current person-cen	-	
	-	rguard was placed on her left			interventions of residents with		
		we her from potentially harmful			noted behaviors in the previou		
	situations.				month.		
	A T (1' ' 1'	1 1 1 1 1 1 1 1 0 / 2 4 4 5 4 7			DOM 1	00/	
		y note, dated 11/19/24 at 5:47			DON or designee will audit: 2		
	-	resident was wandering			of all Residents with wanderg	uards	
		and was at the exit door in the			to ensure documentation of	.:f4	
	administration halls	way.			wanderguard checks every sh		
	An Interdissiplinam	y note, dated 12/26/24 at 3:24			and documentation regarding		
		resident was restless, pacing,			monitoring of behaviors every		
		the door to the main building			Audits will have a goal of 100	/0	
		gain around 3:20 p.m.			compliance; Audits will be completed weekly until 100%		
	uns morning and ag	gam around 3.20 p.m.			compliance is achieved for 3		
	A monthly summar	ry report, dated 1/1/25 at 1:40			consecutive evaluations, then		
	-	resident was confused with			every other week until 100%		
	-	n memory problems, had			compliance is achieved for 3		
		ed decision making, and was			consecutive evaluations, and	then	
		y on her own. The report			monthly until 100% compliand		
		e no alarms present and no			achieved for 3 consecutive		
	recorded behaviors	-			evaluations. Additional audits	will	
		-			be completed as needed base		
	The monthly summ	nary report did not indicate the			upon the level of compliance.		
	The monthly summary report did not indicate the				aport the lever of compliance.		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		155177	B. W	ING		02/25	/2025	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					SALISBURY ST			
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE		WEST	LAFAYETTE, IN 47906			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	had known wander	ing behaviors.			Social Services Director or			
					designee will audit: Behavior	care		
	An Interdisciplinar	y note, dated 1/3/25 at 1:19			plans with every MDS or with			
	a.m., indicated the	resident wandered the unit			changes of behavior.			
	continuously and w	vas exit-seeking when awake.			_			
					Results of all audits will be			
	An Interdisciplinar	y note, dated 1/6/25 at 12:40			brought to QAPI for review an	d		
		resident was confused,			revision as needed. The audit			
		l, and was exit-seeking. The			be reviewed by the Quality			
	-	ne combative with care during			Assurance Committee until su	ıch		
	the night.	2			time consistent substantial			
					compliance has been achieve	d as		
	An Interdisciplinar	y note, dated 1/6/25 at 12:31			determined by the committee.			
	_	resident had severely impaired			Administrator and DON will be			
	_	nd cognitive abilities. The			responsible for sustained	,		
	_	derguard in place due to			compliance. This will be			
		ring and exit-seeking".			submitted to QAPI monthly for	r		
	Continuous wande	ing and exit-seeking.			review.			
	An alanament riels	assessment, dated 1/6/25 at			l review.			
	_	d the resident was at risk for						
	_	n her wandering and pushing			DV The feetlife will be	:		
	_	n her wandering and pushing			IV The facility will be			
	on exit doors.				and remain in compliance by:			
	A. T. T. 11	v note detail 1/7/25 -4 0 20			March 20, 2025.			
	_	y note, dated 1/7/25 at 9:29						
		ident B wandered daily and						
		g with 5 minutes after						
	redirection.							
	A monthly summer	ry report, dated 2/3/25 at 6:20						
	I	resident was confused with						
	-	n memory problems, had						
		ed decision making, and was						
		——————————————————————————————————————						
		ly on her own. The report ent had a bracelet alarm and no						
	behaviors were rec	oraea.						
	The monthly summary report did not indicate the							
		wandering behaviors.						
	A signed facility st	atement, dated 2/24/25,						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		NSTRUCTION	(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLE	
		155177	B. WIN	NG		02/25/2	2025
NAME OF P	PROVIDER OR SUPPLIER	<u>. </u>	.		ADDRESS, CITY, STATE, ZIP COD		
					SALISBURY ST		
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE		WESTL	_AFAYETTE, IN 47906		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Services Coordinator followed		TAG	DEI ICIENCI I		DATE
		and 53 regarding Resident B					
	-	r rooms. Resident B had tried					
	-	teddy bear, but staff had					
		Resident B lived on a different					
	unit.						
	A physician's order	, dated 10/9/24, indicated to					
	check the wandergu	ard placement every shift.					
		dministration Record (TAR),					
		ated the wanderguard					
	•	checked every shift on 1/23/25.					
	,	2/2025, indicated the					
		nent was not checked every					
		25, 2/6/25, 2/7/25, 2/8/25,					
	2/16/25, 2/18/25, 2/	22/25, and 2/24/25.					
	A physician's order	, dated 1/28/25, indicated to					
		ors daily on all shifts.					
		Administration Record (MAR),					
	dated 1/2025, indica	ated behavior management					
	monitoring for beha	viors was blocked out and not					
	charted for all shifts	s during the entire month.					
		2/2025, indicated behavior					
	•	oring for behaviors was					
		charted for all shifts during					
		The clinical record for					
		iewed on 2/21/25 at 4:33 p.m.					
	-	ided, but were not limited to,					
		e, dementia with psychotic					
		m due to known physiological falling, and anxiety disorder.					
	condition, mstory o	i iaining, and anxiety disorder.					
	A care plan, dated 6	5/10/21, indicated the resident					
	was at risk for leavi	ng the facility unaccompanied					
	due to wandering as	s evidenced by wandering					
	through the hallway	s and attempting to exit seek					
	-	terventions included, but were					
		lerguard in place, assessing					
	the area around war	nderguard every shift for					

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	IT OF DEFICIENCIES OF CORRECTION				(X3) DATE COMPL 02/25 /	ETED	
	ROVIDER OR SUPPLIEF	WEST LAFAYETTE		2741 N	DDRESS, CITY, STATE, ZIP COD SALISBURY ST AFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		skin integrity, and feeling.					DITI D
	check the wanderguto complete a wand week.	, dated 6/7/21, indicated to hard placement every shift and erguard function test every					
	1/1/25 to 1/31/25, is	nistration Record (TAR), dated ndicated: was missing on 1/6, 1/7, 1/11					
	on the day shift. b. Documentation v	wanderguard placement check was missing on 1/5, 1/13, 1/20					
	on the evening shift c. Documentation v	vas missing on 1/4, 1/5, 1/8, 1 1/25/25, for the wanderguard					
	a. Documentation v	25 to 2/28/25, indicated: was missing on 2/2, 2/3, 2/20, or the wanderguard placement shift.					
	Licensed Practical I wanderguard was to	ov, on 2/24/25 at 10:48 a.m., Nurse (LPN) 4 indicated the obe checked every shift and was not documented, then it was					
	_	y, on 2/24/25 at 12:01 p.m., assistant (CNA) 5 indicated e a wanderguard.					
	Director of Nursing MAR/TAR was not prove the monitoring	y, on 2/24/25 at 4:45 p.m., the g (DON) indicated if the t signed, there was no way to ag was done. The MAR/TAR if and not left blank.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155177	B. W	'ING		02/25/	2025
NAME OF F	PROVIDER OR SUPPLIER	· {	•		ADDRESS, CITY, STATE, ZIP COD	_	
MESTAL	NOTED VIII ACE	MEST LACAVETTE			SALISBURY ST		
NAE21MI	NOTEK VILLAGE -	WEST LAFAYETTE	,	MESIL	_AFAYETTE, IN 47906		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	_	w, on 2/24/25 at 4:50 p.m., the Director indicated the					
		hecked by the nurses and they					
		vice. The maintenance					
		the doors quarterly and					
	logged them in a bit						
	logged dieni in a on	iluci.					
	During an interview	v, on 2/25/25 at 11:47 a.m., the					
	_	facility did not have					
		nts. The facility discussed the					
	wanderguard during	g care plan meetings with the					
	resident and the res	ident's family.					
		olicy, titled "Elopement					
	-	dated as revised on 4/8/14 and					
	I -	nical Executive Director on					
	_	, indicated "The Purpose of					
		ablish procedures for ensuring					
		on devices are used in					
		entified risk, physician orders					
		ecurity system is inspected to					
		ns should they occurIt is the					
	l * *	ty to use elopement alert					
	1 -	s when an assessment has					
		of elopementBattery operated					
		sThe elopement alert exit					
		inspected for proper working					
		orded on the facility approved					
	_	bracelet device will be					
	inspected by nursing	g personnel once each day"					
	A current facility no	olicy, titled "Charting and					
		ated as revised 7/2019 and					
		nical Executive Director on					
	1	., indicated "The following					
	_	documental in the resident					
	medical recordMe						
	administeredTrea						
	performedChange						
		incidents or accidents					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155177	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2025	
	PROVIDER OR SUPPLIEI	WEST LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP COD 2741 N SALISBURY ST WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION	
F 0756 SS=D Bldg. 00	involving the reside procedures and treater refused the procedures as 1.3-37(a) 483.45(c)(1)(2)(4) Drug Regimen Reson Based on interview failed to ensure the dose reduction (GE discontinue psychotresidents reviewed (Resident 18, and 3) Findings include: 1. The clinical recon on 2/24/25 at 10:17 but were not limited mood disturbance, generalized anxiety delusional disorder a. A physician's ord of 11/15/23, indicated medication used to (mg) three times per the clinical record consideration for bundle to provide a buspirone. b. A physician's ord of 1.4 physician's ord of 1.5	s to Complaint IN00441342. (5) (5) Eview, Report Irregular, Act and record review, the facility pharmacy provided gradual (6) (7) (8) (8) (8) (9) (9) (1) (1) (1) (1) (2) (3) (4) (5) (6) (7) (8) (8) (9) (9) (9) (1) (1) (1) (1) (1	F 07:	56	F756 Drug Regimen Review Report Irregular, Act on SS=D I Residents #18 a #33 had no negative consequences from the alleg deficient practice. Resident # has had a medication review the physician, to include a revof the Duloxetine and the Zypfor a Gradual Dose Reduction new orders have been implemented and the resident plan has been updated. Resident and Zyprexa for a Gradual Dose Reduction. All new orders have been implemented and the resident care plan has been updated. I All residents on psychotropic medications have potential to be affected.	ed 18 by view brexa n. All t care dent view the	03/20/2025	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/25/2025 155177 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2741 N SALISBURY ST WESTMINSTER VILLAGE - WEST LAFAYETTE WEST LAFAYETTE, IN 47906 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medication used to treat depression) 60 mg each A whole house audit of residents on psychotropic A consultant pharmacist physician medications was completed. The recommendation form, dated 5/16/24, indicated it audit reviewed current was time to consider a GDR for duloxetine. The psychotropic medications, last clinical record did not include the required second noted GDR, side effect monitoring. GDR consideration between 11/15/23 and 11/15/24. The facility was unable to provide a Facility will implement a monthly second GDR for duloxetine. IDT behavioral monitoring meeting to: Review previous month's noted c. A physician's order, with an original start date behaviors, current psychotropic of 11/15/23, indicated to give Zyprexa (an medications, status and frequency antipsychotic medication) 5 mg nightly. of GDR's, current person-centered interventions of residents with A consultant pharmacist physician noted behaviors in the previous recommendation form, dated 12/18/24 and signed month. by the physician on 2/18/25, indicated it was time to consider a GDR for Zyprexa. The clinical record Education provided to Social did not include the required two GDR Services Director on policies and considerations in separate quarters between procedures for GDR's of 11/15/23 and 11/15/24. The facility was unable to psychotropic medications. provide additional GDR information. Social Services or designee will During an interview, on 2/25/25 at 4:00 p.m., the audit: A random sample of 20% of Director of Nursing (DON) indicated the facility residents on psychotropic had provided all the GDR documentation. medications to ensure compliance with GDR regulations; Audits will 2. The clinical record for Resident 33 was reviewed have a goal of 100% compliance; on 2/20/25 at 11:15 a.m. The diagnoses included, Audits will be completed monthly but were not limited to, Parkinson's disease until 100% compliance is achieved without dyskinesia, depression, dementia, and for 6 consecutive evaluations. anxiety disorder. Additional audits will be completed as needed based upon the level of A physician's order, dated 1/9/24, indicated to compliance. give buspirone (a medication used to treat anxiety) 5 mg tablet two times a day. Results of all audits will be brought to QAPI for review and The clinical record did not include a GDR revision as needed. The audits will consideration for buspirone. On 2/25/25, a be reviewed by the Quality

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/25/2025 155177 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2741 N SALISBURY ST WEST LAFAYETTE, IN 47906 WESTMINSTER VILLAGE - WEST LAFAYETTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE consultant pharmacist physician recommendation Assurance Committee until such form, undated and not signed by the physician, time consistent substantial which indicated it was time to consider a GDR for compliance has been achieved as buspirone was provided by the facility. determined by the committee. The Administrator and DON will be During an interview, on 2/25/25 at 4:38 p.m., the responsible for sustained Clinical Executive Director indicated the facility compliance. This will be received a GDR for buspirone on 2/25/25. It had submitted to QAPI monthly for been over a year since the last GDR for buspirone review. was done. A current facility policy, titled "Tapering The facility will be in Medication and Gradual Drug Dose Reduction," and remain in compliance by: dated as revised on 7/2022 and received from the March 20, 2025. DON on 2/26/25 at 1:38 p.m., indicated "...Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions...The staff and practitioner will consider tapering under certain circumstances...The physician will order appropriate tapering of medication...Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts) unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually...." 3.1-48(b)(2)F 0842 483.20(f)(5), 483.70(i)(1)-(5) SS=E Resident Records - Identifiable Information Bldg. 00 Based on interview and record review, the facility F 0842 F842 Resident Records -03/20/2025 failed to ensure behavior and side effect **Identifiable Information** monitoring for psychotropic medications, wound S=E care treatments, and catheter care were Resident # 18, #33, documented for 4 of 4 residents reviewed for #20, and #12 had no negative

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Event ID:

JRKX11

Facility ID: 000093

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155177	B. W	ING _		02/25/	/2025
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			SALISBURY ST		
WESTM	INSTER VILLAGE	WEST LAFAYETTE			LAFAYETTE, IN 47906		
VVESTIVII	. VILLAGE -	WESTERIATETTE		WEST			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	documentation. (Re	esident 18, 33, 20 and 12)			consequences from the allege	ed	
					deficient practice. Resident #	18's	
	Findings include:				care plan has been reviewed	and	
					updated to reflect current leve	el of	
		rd for Resident 18 was reviewed			care. Resident #33 has had n	0	
		a.m. The diagnoses included,			new or increased behavioral		
		d to, dementia with anxiety,			expressions noted or reported	d.	
	1	psychotic disturbance, anxiety			The resident care plan has be	een	
	disorder, depression	n, and delusional disorder.			reviewed to ensure proper		
					interventions for behavioral		
		, dated 2/15/24, indicated to			expressions. Resident #20 ha	ıs	
	monitor for side eff	fects of antianxiety medication			had a review of the resident v	vound	
	three times a day.				care orders and skin manage	ment	
	a. The Medication	Administration Record (MAR),			care plan to ensure no negati	ve	
	dated 1/2025, indic	ated antianxiety medication			outcomes as a result of the		
	side effect monitor	ing was not documented each			missing wound care		
	shift on 1/1/25, 1/9	/25, 1/12/25, 1/24/25 and			documentation. The resident	care	
	1/29/25.				plan has been reviewed to en	sure	
		2/2025, indicated anti-anxiety			proper interventions for woun	d	
	medication side eff	ect monitoring was not			care. Resident #12 expired		
	documented each s	hift on 2/16/25 and 2/18/24.			2/23/2025. All nurses will be		
					educated regarding the		
		, dated 2/15/24, indicated to			requirement to complete the		
		s of antidepressant medication			required documentation for		
	three times a day.				resident care interventions ev	-	
	a. The MAR, dated				shift, including documentation		
		dication side effect monitoring			regarding monitoring for beha	viors,	
		d each shift on 1/1/25, 1/9/25,			wound care, and catheter car	e.	
	1/12/25, 1/24/25, a						
	b. The MAR, dated				II All residents have	е	
	_	dication side effect monitoring			the potential to be affected.		
		d each shift on 2/16/25 and					
	2/18/25.						
		, dated 2/15/24, indicated to			III Nursing manager		
		fects of antipsychotic			has reconstructed the delega		
	medication three tin	-			of units for nursing staff to en	sure	
	a. The MAR, dated				proper monitoring and		
		cation side effect monitoring			documentation.		
	was not documente	d each shift on 1/1/25, 1/9/25,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155177	B. WI	ING		02/25/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	l .
NAME OF F	PROVIDER OR SUPPLIEF	3			SALISBURY ST	
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE			LAFAYETTE, IN 47906	
	Г		1		, T	(77.5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		
	1/12/25, 1/24/25, at				A 100% audit of all residents v	
	b. The MAR, dated				orders for behavior monitoring	
		cation side effect monitoring			wound care, and catheter care	
		d each shift on 2/16/25 and			have been completed to ensur	
	2/18/25.				documentation as required. N	
	D	2/24/25 -+ 2:46			new concerns were identified	as a
	_	v, on 2/24/25 at 2:46 p.m.,			result of this audit.	
		RN) 1 indicated behavior			Education to be received as	
		dication side effects should be			Education to be provided to al	
	monitored and doct	umented in the medical record.			nursing staff on documentation	n
	2 751 11 1	1 C D :1 +22 : 1			policies and standards.	
		rd for Resident 33 was reviewed				
		a.m. The diagnoses included,			DON or designee will audit: A	
		d to, Parkinson's disease			random sample of 10% of	
		depression, dementia and			residents, to include those wit	
	anxiety disorder.				orders for behavior monitoring	
		10/00/01 : 1:			wound care, and catheter care	
		12/22/21, indicated the resident			will be completed by the Direct	
		ed mood and behaviors.			of Nursing or Designee to ens	
		ded, but were not limited to,			compliance with documentation	
		l symptoms of behaviors,			requirements; Audits will have	
		vices of any changes in			goal of 100% compliance; Aud	
		rease in signs and symptoms			will be completed weekly until	
	of hallucinations.				100% compliance is achieved	
	, , , , , , , , , , , , , , , , , , ,	2/15/24 : 1:			consecutive evaluations, then	
		2/15/24, indicated the resident			every other week until 100%	
		ous moods. Interventions			compliance is achieved for 3	
		not limited to, notify social			consecutive evaluations, and	
	1	nges in behavior and observe			monthly until 100% complianc	e is
	for signs and sympt	toms of anxiety.			achieved for 3 consecutive	
	, , , , , ,	1 - 15/15/20			evaluations. Additional audits	
		, dated 5/17/22, indicated to			be completed as needed base	ed
		fects of antidepressant			upon the level of compliance.	
	medication three tir	-				
	a. The MAR, dated				Results of all audits will be	
	anti-depressant medication side effect monitoring				brought to QAPI for review an	
was not documented each shift on 1/5/25, 1/8/25,				revision as needed. The audit	s will	
	1/10/25, 1/13/25, 1/				be reviewed by the Quality	
	b. The MAR, dated				Assurance Committee until su	ch
	anti-depressant med	dication side effect monitoring	1		time consistent substantial	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLE			
		155177	B. W	ING	NG 02/25/2025				
NAME OF I	PROVIDER OR SUPPLIEI	?	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	_			
					SALISBURY ST				
WESTMI	INSTER VILLAGE -	WEST LAFAYETTE		WEST	LAFAYETTE, IN 47906				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		ed each shift on 2/13/25, 2/14/25			compliance has been achieve				
	and 2/20/25.				determined by the committee Administrator and DON will b				
	Δ nhysician's order	, dated 9/12/23, indicated to			responsible for sustained	e			
		fects of antianxiety medication			compliance. This will be				
	three times a day.	icets of unitaritiety integreditori			submitted to QAPI monthly for	or			
	1	1/2025, indicated antianxiety			review.				
		ect monitoring was not							
		hift on 1/5/25, 1/8/25, 1/10/25,							
	1/13/25, 1/18/25 ar				IV The facility will be				
		2/2025, indicated antianxiety			and remain in compliance by:	:			
		ect monitoring was not			March 20, 2025.				
	documented on the	dayshift on 2/12/25.							
	3 The clinical reco	rd for Resident 20 was reviewed							
		a.m. The diagnoses included,							
		d to, Parkinson's disease,							
		myalgia, rheumatoid arthritis,							
		re to thrive, anxiety,							
	depression, and par	oxysmal atrial fibrillation.							
	A gara plan datad	7/30/23, indicated Resident 20							
	_	sure ulcers related to impaired							
	_	ions included, but were not							
	limited to, treatmer								
		, dated 2/4/24 to 2/18/25,							
		are was to be completed once a							
	day to the right but	tock.							
	The Treatment Adr	ministration Record (TAR),							
		8/25, indicated wound care							
		s missing for 2/10, 2/12, 2/13,							
	2/14, and 2/17/25.								
	D	2/25/25 + 4.20							
		y, on 2/25/25 at 4:30 p.m., the g indicated the information							
	`	ompleted on the TAR.							
	Should have been c	ompleted on the TAK.							
	4. The clinical reco	rd for Resident 12 was reviewed							

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155177	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2025	
	ROVIDER OR SUPPLIEF	WEST LAFAYETTE		2741 N	DDRESS, CITY, STATE, ZIP COD SALISBURY ST .AFAYETTE, IN 47906		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R L SC IDENTIFYING INFORMATION	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	on 2/21/25 at 3:00 put were not limited kidney disease, urind brain injury. A care plan, dated that an indwelling of included, but were care every shift and the an indwelling of included, but were care every shift and the an indwelling of included, but were care every shift and the an indwelling of included, but were care every shift and the analysis order catheter care every the TAR, dated 1/15 following: a. There was document catheter care on the 1/16, 1/22, 1/24, 1/25. b. There was document catheter care on the 1/18, 1/19, 1/25, and the TAR, dated 2/15 following: a. There was document catheter care on the 1/18, 1/19, 1/25, and the TAR, dated 2/15 following: a. There was document catheter care on the 2/8, 2/10, 2/12, 2/12, 2/12, 2/12, 2/12, 2/12, 2/12, 2/15. b. There was document was document the analysis of th	execution in the diagnoses included, and to, diabetes mellitus, chronic the retention, and traumatic in 10/1/24, indicated Resident 12 that the term in the limited to, Foley catheter is as needed. Indicated 10/1/24, indicated shift. Indicated 10/1/24, indicated the intentation missing for the day shift for 1/2, 1/7, 1/10, 26, 1/29, and 1/30/25. Intentation missing for the evening shift for 1/3, 1,5, 1/6, 6, 1/18, 1/19, 1/21, 1/23, and intentation missing for the night shift for 1/5, 1/6, 1/8, d 1/30/25. Indicated the intentation missing for the night shift for 1/5, 1/6, 1/8, d 1/30/25. Indicated the intentation missing for the day shift for 2/1, 2/4, 2/6, 2/7, 3, 2/14, 2/15, 2/17, 2/18, 2/20, and intentation missing for the evening shift for 2/6, 2/11,		TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
	catheter care on the	nentation missing for the night shift for 2/2, 2/7, 2/8, 6, 2/17, 2/19, 2/20, 2/21, and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155177	B. W	'ING	<u> </u>	02/25	/2025
				CTDEET A	DDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
WESTMINSTER VILLAGE - WEST LAFAYETTE					SALISBURY ST		
WESTMI	NSTER VILLAGE -	WESTLAFAYETTE		WESIL	AFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	y, on 2/25/25 at 4:30 p.m., the					
	Director of Nursing	indicated the information					
	should have been co	ompleted on the TAR.					
	During an interview	v, on 2/25/25 at 8:47 a.m.,					
	Licensed Practical 1	Nurse (LPN) 4 indicated the					
	documentation shou	ald be completed on the					
	treatment administr	ation record and if the record					
	was left blank it me	ant it was not completed.	1				
	A current facility po	olicy, titled "Charting and					
	Documentation," da	ated as revised on 6/2017 and					
	received from the C	Clinical Executive Director on					
	2/24/25 at 2:06 p.m	., indicated "Documentation in					
	the medical record	may be electronic, manual or a					
	combinationMedi						
	administeredTrea	tments or services					
	performed"						
		olicy, titled "Psychotropic					
		ated as revised on 7/2022 and					
		Director of Nursing (DON) on					
	-	., indicated "A psychotropic					
	-	nedication that affects brain					
	-	with mental process and					
	behaviorDrugs in	_					
	-	ychotics, Anti-depressants,					
	Anti-anxiety medic		1				
	* *	eration of the use of any					
	psychotropic medic						
		ew of the resident. This					
		of the resident's signs and	1				
		to identify underlying					
		receiving psychotropic					
	medications are mo	nitored for adverse					
	consequences"						
		P. dd brot d P					
		olicy, titled "Charting Errors					
		dated as revised on 12/2006					
	and received from t	he Clinical Executive Director					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPL					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155177	A. BU B. W.		00	COMPL 02/25		
		100111	D. W.			02/23/	12023	
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD			
WESTMI	NSTER VILLAGE -	WEST LAFAYETTE		2741 N SALISBURY ST WEST LAFAYETTE, IN 47906				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	o.m., indicated "Late entries in						
	entry and notes as a	shall be dated at the time of						
	entry and notes as a	rate entry						
	3.1-50(a)(1)							
	3.1-50(a)(2)							
F 0883	483.80(d)(1)(2)							
SS=D	Influenza and Pne	eumococcal Immunizations						
Bldg. 00								
		and record review, the facility	F 0	383	F883 Influenza and		03/20/2025	
		uenza and pneumococcal			Pneumococcal Immunization	15		
	_	provided for 1 of 5 residents			S=D			
	reviewed for infilliu	nizations. (Resident B)			I Resident B had negative consequences from			
	Findings include:				alleged deficient practice.	uic		
	i manigo merade.				Resident B has since received	d the		
	The clinical record	for Resident B was reviewed			influenza immunization on 3/1			
	on 2/21/25 at 1:54	o.m. The diagnoses included,			and Pneumococcal immuniza	tion		
	but were not limited	d to, dementia,			on 3/18/2025.			
		oure hyperglyceridemia,						
	prediabetes, history	of falling, and insomnia.			II All residents have	€		
					the potential to be affected. A			
		ent for Influenza Immunization,			whole house audit, of admissi	ons		
	_	10/9/24 at 4:43 p.m., indicated			in the last 30 days, to ensure			
	the influenza vaccin	entative gave permission for			consent and administration of			
	the influenza vaccii	iation.			immunizations was completed	1		
	An Informed Conse	ent for Pneumococcal			with no concerns noted.			
		d and signed on 10/9/24 at 4:43						
		ident B's representative gave						
	•	oneumococcal vaccination.			III MDS and/or design	jnee		
					will audit: All new admits for			
		Report, dated 2/24/25, indicated			accuracy and administration of	of all		
		fluenza vaccine was given on			consented vaccines within the	first		
		d not received a pneumococcal			30 days of admission until 100)%		
	vaccination.				compliance is achieved for 6			
	.	0/05/05 + 4.00			consecutive evaluations.			
		v, on 2/25/25 at 4:20 p.m.,			Additional audits will be comp			
	i intection Prevention	nist (IP) 3 indicated the	1		I as needed based upon the lev	/PLOT	ì	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155177		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/25/2025				
	PROVIDER OR SUPPLIER	WEST LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP COD 2741 N SALISBURY ST WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	exposure at the time not receive the vaccishe did not know w was not given later vaccination was not have received both. A current facility por Vaccine," dated as a provided on admiss October 1st and Mainfluenza vaccine slientsOnly inable offered to resident A current policy title reviewed on 6/25/24 indicated " upon a offered the vaccine of admission Pne administered to residents" "Tamiflu Interaction Others." https://www.healthl.nteractions. Accesses "Tamiflu and an interact. You should	olicy, titled "Influenza reviewed on 6/25/24 and ion, indicated "Between rch 31st each year, the nall be offered to ctivated influenza vaccine will ints" ed "Pneumococcal Vaccine," 4 and provided on admission, admission, residents will be series within thirty (30) days umococcal vaccines will be dents" as: Alcohol, Medications, and ine.com/health/drugs/tamiflu-ied 2/25/25, indicated nactivated flu vaccine will not it be able to receive an ine at any time before, during,		compliance. Education to nurses to ensur they consult with MD prior to holding any vaccine. Results of all audits will be brought to QAPI for review a revision as needed. The aud be reviewed by the Quality Assurance Committee until stime consistent substantial compliance has been achiev determined by the committee Administrator and DON will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV The facility will be and remain in compliance by March 20, 2025.	nd its will such red as e. The oe			
R 0000								
Bldg. 00	Survey. This visit in	State Residential Licensure acluded a Recertification and vey. This visit also included	R 0000	Preparation, submission, and implementation of this Plan correction does not constitute.	of			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SUI		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED		
		155177	B. WING			02/25/2025		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 2741 N SALISBURY ST				
WESTMINSTER VILLAGE - WEST LAFAYETTE			\	WEST LAFAYETTE, IN 47906				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	EFIX			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE	
	the Investigation of Complaints IN00444575,			admission or agreement wit		the		
	IN00443524, IN004	441342 and IN00440547.			facts and conclusions set fort			
				the survey report by Westminster				
	Complaint IN00444575 - No deficiencies related to			Village West Lafayette. Our P		lan		
	the allegations are cited.				of Correction is prepared and			
	Complaint IN00443524 - No deficiencies related to				executed as a means to			
	the allegations are cited.				continuously improve the quality of			
	Complaint IN00441342 - Federal/state deficiencies related to the allegations are cited at F744.				care and to comply with all			
	Complaint IN00440547- No deficiencies related to			applicable state and federal				
	the allegations are cited.				regulatory requirements.			
	Survey dates: February 19, 20, 21, 24 and 25, 2025 Facility number: 000093 Residential Census: 62				We respectfully request a desk review of this POC and a			
				subsequent paper compliance revisit.		9		
	Westminster Villag	ge - West Lafayette was found						
	to be in compliance	with 410 IAC 16.2-5 in regard						
	to the State Resider	ntial Licensure Survey.						
	Quality review was	completed on March 6, 2025.						

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