STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155177	A. BUILDING 00 B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE - WEST LAFAYETTE	2741 N SALISBURY ST WEST LAFAYETTE, IN 47906

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00444575, IN00443524, IN00441342 and IN00440547. Complaint IN00444575 - No deficiencies related to the allegations are cited. Complaint IN00443524 - No deficiencies related to the allegations are cited. Complaint IN00441342 - Federal/state deficiencies related to the allegations are cited at F744. Complaint IN00440547- No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 24 and 25, 2025 Facility number: 000093 Provider number: 155177 AIM number: 201271750 Census Bed Type: SNF: 11 SNF/NF: 53 Residential: 62 Total: 126 Census Payor Type: Medicare: 11 Other: 53 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 6, 2025.	F 0000	Preparation, submission, and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report by Westminster Village West Lafayette. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. We respectfully request a desk review of this POC and a subsequent paper compliance revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristen Patz	Administrator	03/20/2025

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure staff followed the physician's ordered medication parameters were followed for 2 of 5 residents reviewed for quality of care. (Residents 45 and 33) Findings include: 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, congestive heart failure, pulmonary edema and atrial fibrillation. A care plan, dated 7/17/24, indicated Resident 45 had a diagnosis of congestive heart failure and chronic end stage renal failure. Interventions included, but were not limited to, give medications as ordered. A physician's order, dated 7/22/24, indicated to give metoprolol (a blood pressure medication) 12.5 milligrams (mg) twice daily with instructions to hold the medication for a systolic blood pressure of less than 100 or a heart rate of less than 60. The Medication Administration Record (MAR), dated 11/1/24 through 11/30/24, indicated metoprolol was administered: a. On 11/7/24, in the morning with a heart rate of 56. b. On 11/15/24, in the evening with a systolic blood pressure of 97. The MAR, dated 12/1/24 through 12/31/24, indicated metoprolol was administered: a. On 12/2/24, with a heart rate of 58.	F 0684	**F684 Quality of Care** **S=D** I Residents #45 and #33 had no negative consequences from the alleged deficient practice. The physician orders were reviewed by the physician, for both residents, and the determination was made to maintain the current order. II All residents who have doctor orders with medication parameters have the potential to be affected. III Nursing management staff have audited all current orders for parameters for accuracy and updated orders to include wording of “less than”, “equal to”, “greater than” for clarity. All nurses and QMA’s to be educated on policies and procedures for order parameters and holding of medications. Director of Nursing Services (DON) and/or designee will: Audit a random sample of a minimum of 20% of residents’ Physician Orders and medication administration records to ensure compliance with medication administration parameters; Audits	03/20/2025

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	b. On 12/5/24, with a heart rate of 54. c. On 12/16/24, with a heart rate of 50 and a systolic blood pressure of 90. The MAR, dated 1/1/25 through 1/31/25, indicated metoprolol was administered: a. On 1/18/25, in the morning with a systolic blood pressure of 91. A MAR, dated 2/1/25 through 2/28/25, indicated metoprolol was administered: a. On 2/14/25, in the evening with a systolic blood pressure of 90. During an interview, on 2/25/25 at 4:20 p.m., the Director of Nursing (DON) indicated Resident 45's metoprolol should not have been given outside of the parameters. She indicated a "H" in parenthesis meant the medication was held. 2. The clinical record for Resident 33 was reviewed on 2/20/25 at 11:15 a.m. The diagnoses included, but were not limited to, orthostatic hypotension (low blood pressure), Parkinson ' s disease, depression, dementia, and anxiety disorder. A physician's order, dated 2/20/24, indicated to give midodrine (used to treat low blood pressure) 5 mg tablet three times a day if the systolic blood pressure (SBP) was less than 130. The Medication Administration Record (MAR), for 2/1/25 to 2/28/25, indicated the 9:00 a.m. dose was given the following dates: a. On 2/1/25, midodrine 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 systolic blood pressure was 185. d. On 2/8/25, midodrine was given when the		will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and DON will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV The facility will be in and remain in compliance by: March 20, 2025	

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	systolic blood pressure was 146. e. On 2/9/25, midodrine was given when the systolic blood pressure was 149. f. On 2/12/25, midodrine was given when the systolic blood pressure was 194. g. On 2/13/25, midodrine was given when the systolic blood pressure was 146. h. On 2/16/25, midodrine was given when the systolic blood pressure was 159. i. On 2/18/25, midodrine was given when the systolic blood pressure was 142. j. On 2/21/25, midodrine was given when the systolic blood pressure was 142. k. On 2/23/25, midodrine was given when the systolic blood pressure was 143. l. On 2/25/25, midodrine was given when the systolic blood pressure was 144. The MAR, for 2/1/25 to 2/28/25, indicated the 1:00 p.m. dose was given the following dates: a. On 2/1/25, midodrine was given when the systolic blood pressure was 153. b. On 2/9/25, midodrine was given when the systolic blood pressure was 143. c. On 2/12/25, midodrine was given when the systolic blood pressure was 153. d. On 2/13/25, midodrine was given when the systolic blood pressure was 144. e. On 2/16/25, midodrine was given when the systolic blood pressure was 147. f. On 2/19/25, midodrine was given when the systolic blood pressure was 151. g. On 2/23/25, midodrine was given when the systolic blood pressure was 159. The MAR, for 2/1/25 to 2/28/25, indicated the 5:00 p.m. dose was given the following dates: a. On 2/8/25, midodrine was given when the systolic blood pressure was 155. b. On 2/12/25, midodrine was given when the			

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	systolic blood pressure was 140. c. On 2/18/25, midodrine was given when the systolic blood pressure was 167. d. On 2/23/25, midodrine was given when the systolic blood pressure was 141. During an interview, on 2/25/25 at 8:47 a.m., LPN 4 indicated if the resident ' s blood pressure was 130 or greater the medication should not have been given, and the physician should have been called. During an interview, on 2/25/25 at 4:36 p.m., the DON indicated there were several midodrine tablets given and she was not sure why they were given. A current facility policy, titled "Administering Medication," dated as revised on 4/2019 and received from the Clinical Executive Director on 2/25/25 at 11:45 p.m., indicated "...Medications are administered in a safe and timely manner, and as prescribed...Medications are administered in accordance with prescriber orders, including any required time frames...." A current facility policy, titled "Charting and Documentation," dated as revised on 6/2017 and received from the Clinical Executive Director on 2/24/25 at 2:06 p.m., indicated "...Documentation in the medical record may be electronic, manual or a combination...Medication administered...Treatments or services performed...." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview and record	F 0688	**F688 Increase/Prevent**	03/20/2025

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	review, the facility failed to ensure physician's orders were followed and therapy evaluations were completed in a timely manner for 2 of 4 residents review for position and mobility. (Resident 51 and 9) Findings include: During an observation, on 2/19/25 at 12:09 p.m., Resident 51 was in the dining room with her wheelchair pushed away from the table. The resident was leaning forward with her left arm dangling below the wheelchair seat. During an observation, on 2/19/25 at 3:08 p.m., the resident was sitting next to the nurse's station with her eyes closed. The resident was leaning forward and sitting crooked in her wheelchair. During an observation, on 2/20/25 at 10:27 a.m., the resident was sitting next to the nurse's office in her wheelchair. The resident was leaning forward trying to touch her left shoe. The nurse was sitting at the desk in the nurse's office with her back facing the resident and the Certified Nursing Assistant (CNA) was assisting residents out of the dining room. During an observation, on 2/21/25 at 10:49 a.m., the resident was sitting in her wheelchair, leaning to the left and touching her left ankle. During an observation, on 2/21/25 at 12:30 p.m., Resident 51 was observed with several staff members surrounding the resident in the common room. The resident fell out of her wheelchair and was lying on the floor. The resident was on her left side. During an observation, on 2/24/25 at 9:11 a.m., the		**Decrease in ROM/Mobility** **S=D** I Residents #51 and #9 had no negative consequences from the alleged deficient practice. Resident #51 has been evaluated by therapy for wheelchair positioning. A wheelchair cushion has been provided to assist with wheelchair positioning. The resident care plan has been reviewed and updated to ensure interventions to maintain range of motion and mobility at the highest possible level of functioning. Resident #9 has been evaluated for therapy related to a diagnosis of contractures. The treatment plan has been updated by the therapy team to provide treatment interventions. The resident care plan has been reviewed and updated to ensure interventions to maintain range of motion and mobility at the highest possible level of functioning. II All healthcare residents who require therapy evaluations and services have the potential to be affected. III An audit has been conducted of all residents with current therapy evaluation orders to ensure they have been evaluated in a timely manner. No concerns were noted during this audit.	

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	resident was sitting at a table with a visitor. The resident was leaning to the left side with her head down. The resident had her left wrist wrapped with a brown elastic wrap. During an observation, on 2/24/25 at 11:55 a.m., the resident was in the dining room eating her lunch. The resident had a white pillow propped under her left arm. The pillow was pushed down beside the resident and helping the resident sit up straight. The clinical record for Resident 51 was reviewed on 2/20/25 at 11:29 a.m. The diagnoses included, but were not limited to, left wrist fracture, hypertension, diabetes mellitus, dementia, and anxiety disorder. A care plan, dated 3/25/24, indicated the resident was at risk for injury related to falls. Interventions included, but were not limited to, therapy to screen and treat as needed. A care plan, dated 3/25/24, indicated the resident was at risk for decreased activities of daily living (ADL). Interventions included, but were not limited to, therapy to screen and treat as needed. A physician's order, dated 2/4/25, indicated physical therapy (PT) to evaluate and treat. A physician's order, dated 2/24/25, indicated occupational therapy (OT) to treat three times a week for eight weeks. Treatment may include self-care, therapy, and wheelchair management to increase independence in ADL's and facilitate optimal alignment in the wheelchair. The electronic health record did not have any documentation to indicate why it took the therapy		Education will be provided to nursing staff to alert the therapy department of all new therapy orders, via fax, during their scheduled shift. Director of Rehab Services or designee will: Perform an audits of 100% of therapy referral orders to ensure timely implementation of the order; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and DON will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV The facility will be in and remain in compliance by: March 20, 2025.	

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department 17 days to complete a therapy evaluation and treatment.

During an interview, on 2/24/25 at 12:15 p.m., CNA 6 indicated the resident leaned to the left and the staff propped the resident up on a pillow to keep her straight. She had noticed the resident leaning to the left multiple times and would assist her with positioning.

During an interview, on 2/24/25 at 12:24 p.m., the Therapy Director indicated the resident was receiving therapy. The resident was seen on 2/21/25 after the resident fell out of her wheelchair. She did not know if the resident had a history of leaning in her wheelchair. A wheelchair cushion was ordered to assist her with positioning. The Therapy Director did not know why the resident was not seen on 2/4/24 when a physician's order was written for the resident to be evaluated and treated by physical therapy. Normally, residents were seen within 48 hours after the physician's order, and it should not have taken days before the resident was evaluated.

2. During an interview, on 2/20/25 at 11:11 a.m., the Resident 9's family member indicated he had to ask the staff to reposition the resident while she was sitting in her wheelchair as they did not do it on their own. The resident had wounds on her buttocks in the past, but they are healed. Resident 9 would usually lay down after lunch and would get up at 3:00 p.m.

The clinical record for Resident 9 was reviewed on 2/20/25 at 11:29 a.m. The diagnoses included, but were not limited to, atrial fibrillation, age-related osteoporosis, Alzheimer's disease, dementia, hypertension, and anxiety disorder.

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A care plan, dated 8/12/16, indicated the resident had impaired ADL function. Interventions included, but were 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 included, but were not limited to, notify the nurse of any decline in contractures or if any new contractures noted.

A physician's telephone order, dated 2/4/25, indicated physical therapy (PT) and occupational therapy (OT) for evaluation and treatment with a diagnosis of contractures. The order was signed by the Director of Nursing (DON) and a LPN. The Nurse Practitioner signed the order on 2/9/25.

A Physical Therapy (PT) evaluation and plan of treatment form, dated 2/20/25, indicated the resident would have therapy from 2/20/25 to 4/18/25, 3 times a week for 8 weeks.

The electronic health record did not have any documentation to indicate why it took the therapy department 16 days to complete a PT evaluation and treatment.

During an interview, on 2/24/25 at 4:30 p.m., the DON indicated she did not know why the resident was not evaluated on 2/4/25.

During an interview, on 2/25/25 at 9:08 a.m., LPN 4 indicated when a physician gave a telephone order, staff would write it on a form, the white sheet went into the physician's folder and the yellow copy went in the Unit Manager folder. The Unit Manager took the order to the morning meeting. The order was reviewed in the meeting and two nurses signed off on the order. A

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separate order slip would be given to the therapy department. The therapy department was not supposed to take longer than 72 hours to do their evaluation on the resident. The resident was supposed to be seen for contractures.

A current facility policy, titled "Therapy Management Plan & Referral," dated as revised 2/2021 and received by the Unit Manager on 2/25/25 at 10:54 a.m., indicated "...For each resident...receiving management of ordered prescribed treatments or therapy services, the community will prepare and include in the care plan a physician referral for therapy based on decline with ADLs...Referral Criteria includes residents...should be referred for therapy when one or more of the following criteria are met...Declining Function: Observable decline in physical, cognitive...impacting daily functioning...Safety Concerns: Issues with balance, coordination, or risk of falls...Referral Process...Identification of Need: Any healthcare provider...or IDT Team who identifies a potential need for therapy should promptly assess the patient's situation to determine if therapy is appropriate...Observing changes in function...Consulting with family or caregiver about concerns...A formal referral is initiated once the need for therapy is recognized...The referral with physician orders is submitted to the therapy department...Upon receiving the referral, a licensed therapist...conducts a comprehensive assessment to evaluate their needs...."

A current facility policy, titled "Charting and Documentation," dated as revised 7/2019 and received by the Clinical Executive Director on 2/24/25 at 2:06 p.m., indicated "...The following information is to be documental in the resident medical record...Medication

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	administered...Treatments or services performed...Changes in the resident's condition...Events, incidents or accidents involving the resident...Documentation of procedures and treatments...whether the resident refused the procedure/treatment...notification of family, physicians or other staff...." 3.1-42(a)(2)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia			
	Based on observation, interview and record review, the facility failed to ensure staff initiated new person-centered dementia care interventions for residents with wandering behaviors and to check wanderguard placement for 2 of 5 residents reviewed for dementia care. (Resident B and C) Findings include: 1. During an observation, on 2/19/25 at 1:35 p.m., Resident B was walking in the common area near the exit doors. During an observation, on 2/20/25 at 12:15 p.m., the resident was ambulating down the hall towards the exit doors. During an observation, on 2/21/25 at 1:54 p.m., the resident was ambulating back from the exit door on her unit. During an observation, on 2/24/25 at 9:06 a.m., the resident was sitting on the couch in the common area in front of the main entrance doors. During an observation, on 2/25/25 at 12:15 p.m., the resident was walking near the front entrance	F 0744	**F744 Treatment/Services for Dementia** **S=D** I Residents B and C had no negative consequences from the alleged deficient practice. II All residents with wandering behaviors and wanderguards have the potential to be affected. III A 100% audit of all residents with behavior care plans for person-centered interventions was conducted. Care plans updated to reflect current level of care. A 100% audit of all residents with wanderguards has been completed to ensure documentation of wanderguard checks every shift and documentation regarding the monitoring of behaviors every shift. No new concerns were identified	03/20/2025

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	frequently looking at the doors. During an observation, on 2/25/25 at 2:05 p.m., the resident triggered the alarm on an exit door multiple times. The staff were redirecting her away from the door, but she returned to the door within minutes. The clinical record for Resident B was reviewed on 2/21/25 at 1:54 p.m. The diagnoses included, but were not limited to, dementia, history of falling, and insomnia. A care plan, dated 10/9/24, indicated the resident was at risk for leaving the facility by herself due to wandering. Interventions included, but were not limited to, a wanderguard was placed on her left ankle, and to remove her from potentially harmful situations. An Interdisciplinary note, dated 11/19/24 at 5:47 p.m., indicated the resident was wandering throughout the day and was at the exit door in the administration hallway. An Interdisciplinary note, dated 12/26/24 at 3:24 p.m., indicated the resident was restless, pacing, and had pushed on the door to the main building this morning and again around 3:20 p.m. A monthly summary report, dated 1/1/25 at 1:40 p.m., indicated the resident was confused with short and long-term memory problems, had moderately impaired decision making, and was able to walk steadily on her own. The report indicated there were no alarms present and no recorded behaviors. The monthly summary report did not indicate the resident had a wanderguard alarm ordered and		as a result of this audit. Education to all nursing staff members regarding the requirement to complete wanderguard checks every shift and to complete behavior monitoring documentation each shift. Facility will implement a monthly IDT behavioral monitoring meeting to: Review previous month's noted behaviors, current psychotropic medications, status and frequency of GDR's, current person-centered interventions of residents with noted behaviors in the previous month. DON or designee will audit: 20% of all Residents with wanderguards to ensure documentation of wanderguard checks every shift and documentation regarding the monitoring of behaviors every shift; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance.	

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	155177	A. BUILDING 00 B. WING	02/25/2025

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	had known wandering behaviors. An Interdisciplinary note, dated 1/3/25 at 1:19 a.m., indicated the resident wandered the unit continuously and was exit-seeking when awake. An Interdisciplinary note, dated 1/6/25 at 12:40 a.m., indicated the resident was confused, forgetful, wandered, and was exit-seeking. The resident also became combative with care during the night. An Interdisciplinary note, dated 1/6/25 at 12:31 p.m., indicated the resident had severely impaired decision making and cognitive abilities. The resident had a wanderguard in place due to "continuous wandering and exit-seeking". An elopement risk assessment, dated 1/6/25 at 3:53 p.m., indicated the resident was at risk for elopement based on her wandering and pushing on exit doors. An Interdisciplinary note, dated 1/7/25 at 9:29 a.m., indicated Resident B wandered daily and resumed wandering with 5 minutes after redirection. A monthly summary report, dated 2/3/25 at 6:20 p.m., indicated the resident was confused with short and long-term memory problems, had moderately impaired decision making, and was able to walk steadily on her own. The report indicated the resident had a bracelet alarm and no behaviors were recorded. The monthly summary report did not indicate the resident had known wandering behaviors. A signed facility statement, dated 2/24/25,		Social Services Director or designee will audit: Behavior care plans with every MDS or with changes of behavior. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and DON will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV The facility will be in and remain in compliance by: March 20, 2025.	

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indicated the Social Services Coordinator followed up with Resident 6 and 53 regarding Resident B wandering into their rooms. Resident B had tried to take Resident 6's teddy bear, but staff had intervened quickly. Resident B lived on a different unit.

A physician's order, dated 10/9/24, indicated to check the wanderguard placement every shift.
a. The Treatment Administration Record (TAR), dated 1/2025, indicated the wanderguard placement was not checked every shift on 1/23/25.
b. The TAR, dated 2/2025, indicated the wanderguard placement was not checked every shift on 2/1/25, 2/5/25, 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 monitor for behaviors daily on all shifts.
a. The Medication Administration Record (MAR), dated 1/2025, indicated behavior management monitoring for behaviors was blocked out and not charted for all shifts during the entire month.
b. The MAR, dated 2/2025, indicated behavior management monitoring for behaviors was blocked out and not charted for all shifts during the entire month. 2. The clinical record for Resident C was reviewed on 2/21/25 at 4:33 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with psychotic disturbance, delirium due to known physiological condition, history of falling, and anxiety disorder.

A care plan, dated 6/10/21, indicated the resident was at risk for leaving the facility unaccompanied due to wandering as evidenced by wandering through the hallways and attempting to exit seek and open doors. Interventions included, but were not limited to, wanderguard in place, assessing the area around wanderguard every shift for

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	circulation, motion, skin integrity, and feeling. A physician's order, dated 6/7/21, indicated to check the wanderguard placement every shift and to complete a wanderguard function test every week. A Treatment Administration Record (TAR), dated 1/1/25 to 1/31/25, indicated: a. Documentation was missing on 1/6, 1/7, 1/11 and 1/26/25, for the wanderguard placement check on the day shift. b. Documentation was missing on 1/5, 1/13, 1/20 and 1/22/25, for the wanderguard placement check on the evening shift. c. Documentation was missing on 1/4, 1/5, 1/8, 1/18, 1/19, 1/24 and 1/25/25, for the wanderguard placement check on the night shift. A TAR, dated 2/1/25 to 2/28/25, indicated: a. Documentation was missing on 2/2, 2/3, 2/20, 2/21 and 2/23/25, for the wanderguard placement check on the night shift. During an interview, on 2/24/25 at 10:48 a.m., Licensed Practical Nurse (LPN) 4 indicated the wanderguard was to be checked every shift and documented. If it was not documented, then it was not checked. During an interview, on 2/24/25 at 12:01 p.m., Certified Nursing Assistant (CNA) 5 indicated Resident C did have a wanderguard. During an interview, on 2/24/25 at 4:45 p.m., the Director of Nursing (DON) indicated if the MAR/TAR was not signed, there was no way to prove the monitoring was done. The MAR/TAR should be signed off and not left blank.			

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	During an interview, on 2/24/25 at 4:50 p.m., the Clinical Executive Director indicated the wanderguard was checked by the nurses and they used a handheld device. The maintenance department checked the doors quarterly and logged them in a binder. During an interview, on 2/25/25 at 11:47 a.m., the DON indicated the facility did not have wanderguard consents. The facility discussed the wanderguard during care plan meetings with the resident and the resident's family. A current facility policy, titled "Elopement Prevention Policy," dated as revised on 4/8/14 and received by the Clinical Executive Director on 2/25/25 at 1:38 p.m., indicated "...The Purpose of this policy is to establish procedures for ensuring elopement prevention devices are used in accordance with identified risk, physician orders and to ensure the security system is inspected to identify malfunctions should they occur...It is the policy of this facility to use elopement alert systems and devices when an assessment has identified the risk of elopement...Battery operated transmitter bracelets....The elopement alert exit door device will be inspected for proper working order monthly...recorded on the facility approved log...The anklet or bracelet device will be inspected by nursing personnel once each day...." A current facility policy, titled "Charting and Documentation," dated as revised 7/2019 and received by the Clinical Executive Director on 2/24/25 at 2:06 p.m., indicated "...The following information is to be documental in the resident medical record...Medication administered...Treatments or services performed...Changes in the resident's condition...Events, incidents or accidents			

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	involving the resident...Documentation of procedures and treatments...whether the resident refused the procedure/treatment...notification of family, physicians or other staff...." This citation relates to Complaint IN00441342. 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to ensure the pharmacy provided gradual dose reduction (GDR) requests to reduce or discontinue psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident 18, and 33) Findings include: 1. The clinical record for Resident 18 was reviewed on 2/24/25 at 10:17 a.m. The diagnoses included, but were not limited to, dementia with anxiety, mood disturbance, psychotic disturbance, generalized anxiety disorder, depression, and delusional disorder. a. A physician's order, with an original start date of 11/15/23, indicated to give buspirone (a medication used to treat anxiety) 10 milligrams (mg) three times per day. The clinical record did not include a GDR consideration for buspirone. The facility was unable to provide a GDR consideration for buspirone. b. A physician's order, with an original start date of 11/15/23, indicated to give duloxetine (a	F 0756	**F756 Drug Regimen Review, Report Irregular, Act on SS=D** I Residents #18 and #33 had no negative consequences from the alleged deficient practice. Resident #18 has had a medication review by the physician, to include a review of the Duloxetine and the Zyprexa for a Gradual Dose Reduction. All new orders have been implemented and the resident care plan has been updated. Resident #33 has had a medication review by the physician, to include a review of the Duloxetine and the 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 the potential to be affected.	03/20/2025

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	medication used to treat depression) 60 mg each day. A consultant pharmacist physician recommendation form, dated 5/16/24, indicated it was time to consider a GDR for duloxetine. The clinical record did not include the required second GDR consideration between 11/15/23 and 11/15/24. The facility was unable to provide a second GDR for duloxetine. c. A physician's order, with an original start date of 11/15/23, indicated to give Zyprexa (an antipsychotic medication) 5 mg nightly. A consultant pharmacist physician recommendation form, dated 12/18/24 and signed by the physician on 2/18/25, indicated it was time to consider a GDR for Zyprexa. The clinical record did not include the required two GDR considerations in separate quarters between 11/15/23 and 11/15/24. The facility was unable to provide additional GDR information. During an interview, on 2/25/25 at 4:00 p.m., the Director of Nursing (DON) indicated the facility had provided all the GDR documentation. 2. The clinical record for Resident 33 was reviewed on 2/20/25 at 11:15 a.m. The diagnoses included, but were not limited to, Parkinson's disease without dyskinesia, depression, dementia, and anxiety disorder. A physician's order, dated 1/9/24, indicated to give buspirone (a medication used to treat anxiety) 5 mg tablet two times a day. The clinical record did not include a GDR consideration for buspirone. On 2/25/25, a		II A whole house audit of residents on psychotropic medications was completed. The audit reviewed current psychotropic medications, last noted GDR, side effect monitoring. Facility will implement a monthly IDT behavioral monitoring meeting to: Review previous month's noted behaviors, current psychotropic medications, status and frequency of GDR's, current person-centered interventions of residents with noted behaviors in the previous month. Education provided to Social Services Director on policies and procedures for GDR's of psychotropic medications. Social Services or designee will audit: A random sample of 20% of residents on psychotropic medications to ensure compliance with GDR regulations; Audits will have a goal of 100% compliance; Audits will be completed monthly until 100% compliance is achieved for 6 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality	

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	consultant pharmacist physician recommendation form, undated and not signed by the physician, which indicated it was time to consider a GDR for buspirone was provided by the facility. During an interview, on 2/25/25 at 4:38 p.m., the Clinical Executive Director indicated the facility received a GDR for buspirone on 2/25/25. It had been over a year since the last GDR for buspirone was done. A current facility policy, titled "Tapering Medication and Gradual Drug Dose Reduction," dated as revised on 7/2022 and received from the 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)		Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and DON will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. III The facility will be in and remain in compliance by: March 20, 2025.	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			
	Based on interview and record review, the facility failed to ensure behavior and side effect monitoring for psychotropic medications, wound care treatments, and catheter care were documented for 4 of 4 residents reviewed for	F 0842	**F842 Resident Records – Identifiable Information** **S=E** I Resident # 18, #33, #20, and #12 had no negative	03/20/2025

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	documentation. (Resident 18, 33, 20 and 12) Findings include: 1. The clinical record for Resident 18 was reviewed on 2/24/25 at 10:17 a.m. The diagnoses included, but were not limited to, dementia with anxiety, mood disturbance, psychotic disturbance, anxiety disorder, depression, and delusional disorder. A physician's order, dated 2/15/24, indicated to monitor for side effects of antianxiety medication three times a day. a. The Medication Administration Record (MAR), dated 1/2025, indicated antianxiety medication side effect monitoring was not documented each shift on 1/1/25, 1/9/25, 1/12/25, 1/24/25 and 1/29/25. b. The MAR, dated 2/2025, indicated anti-anxiety medication side effect monitoring was not documented each shift on 2/16/25 and 2/18/24. A physician's order, dated 2/15/24, indicated to monitor side effects of antidepressant medication three times a day. a. The MAR, dated 1/2025, indicated anti-depressant medication side effect monitoring was not documented each shift on 1/1/25, 1/9/25, 1/12/25, 1/24/25, and 1/29/25. b. The MAR, dated 2/2025, indicated anti-depressant medication side effect monitoring was not documented each shift on 2/16/25 and 2/18/25. A physician's order, dated 2/15/24, indicated to monitor for side effects of antipsychotic medication three times a day. a. The MAR, dated 1/2025, indicated antipsychotic medication side effect monitoring was not documented each shift on 1/1/25, 1/9/25,		consequences from the alleged deficient practice. Resident #18's care plan has been reviewed and updated to reflect current level of care. Resident #33 has had no new or increased behavioral expressions noted or reported. The resident care plan has been reviewed to ensure proper interventions for behavioral expressions. Resident #20 has had a review of the resident wound care orders and skin management care plan to ensure no negative outcomes as a result of the missing wound care documentation. The resident care plan has been reviewed to ensure proper interventions for wound care. Resident #12 expired 2/23/2025. All nurses will be educated regarding the requirement to complete the required documentation for resident care interventions every shift, including documentation regarding monitoring for behaviors, wound care, and catheter care. II All residents have the potential to be affected. III Nursing management has reconstructed the delegations of units for nursing staff to ensure proper monitoring and documentation.	

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	1/12/25, 1/24/25, and 1/29/25. b. The MAR, dated 2/2025, indicated antipsychotic medication side effect monitoring was not documented each shift on 2/16/25 and 2/18/25. During an interview, on 2/24/25 at 2:46 p.m., Registered Nurse (RN) 1 indicated behavior monitoring and medication side effects should be monitored and documented in the medical record. 2. The clinical record for Resident 33 was reviewed on 2/20/25 at 11:15 a.m. The diagnoses included, but were not limited to, Parkinson's disease without dyskinesia, depression, dementia and anxiety disorder. A care plan, dated 12/22/21, indicated the resident was at risk for altered mood and behaviors. Interventions included, but were not limited to, observing signs and symptoms of behaviors, notifying social services of any changes in behaviors or an increase in signs and symptoms of hallucinations. A care plan, dated 2/15/24, indicated the resident was at risk for anxious moods. Interventions included, but were not limited to, notify social services of any changes in behavior and observe for signs and symptoms of anxiety. A physician's order, dated 5/17/22, indicated to monitor for side effects of antidepressant medication three times a day. a. The MAR, dated 1/2025, indicated anti-depressant medication side effect monitoring was not documented each shift on 1/5/25, 1/8/25, 1/10/25, 1/13/25, 1/18/25 and 1/19/25. b. The MAR, dated 2/2025, indicated anti-depressant medication side effect monitoring		A 100% audit of all residents with orders for behavior monitoring, wound care, and catheter care have been completed to ensure documentation as required. No new concerns were identified as a result of this audit. Education to be provided to all nursing staff on documentation policies and standards. DON or designee will audit: A random sample of 10% of residents, to include those with orders for behavior monitoring, wound care, and catheter care, will be completed by the Director of Nursing or Designee to ensure compliance with documentation requirements; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such time consistent substantial	

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	was not documented each shift on 2/13/25, 2/14/25 and 2/20/25. A physician's order, dated 9/12/23, indicated to monitor for side effects of antianxiety medication three times a day. a. The MAR, dated 1/2025, indicated antianxiety medication side effect monitoring was not documented each shift on 1/5/25, 1/8/25, 1/10/25, 1/13/25, 1/18/25 and 1/19/25. b. The MAR, dated 2/2025, indicated antianxiety medication side effect monitoring was not documented on the dayshift on 2/12/25. 3. The clinical record for Resident 20 was reviewed on 2/24/25 at 11:10 a.m. The diagnoses included, but were not limited to, Parkinson's disease, hypertension, fibromyalgia, rheumatoid arthritis, osteoarthritis, failure to thrive, anxiety, depression, and paroxysmal atrial fibrillation. A care plan, dated 7/30/23, indicated Resident 20 was at risk for pressure ulcers related to impaired mobility. Interventions included, but were not limited to, treatments if ordered. A physician's order, dated 2/4/24 to 2/18/25, indicated wound care was to be completed once a day to the right buttock. The Treatment Administration Record (TAR), dated 2/1/25 to 2/28/25, indicated wound care documentation was missing for 2/10, 2/12, 2/13, 2/14, and 2/17/25. During an interview, on 2/25/25 at 4:30 p.m., the Director of Nursing indicated the information should have been completed on the TAR. 4. The clinical record for Resident 12 was reviewed		compliance has been achieved as determined by the committee. The Administrator and DON will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV The facility will be in and remain in compliance by: March 20, 2025.	

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on 2/21/25 at 3:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus, chronic kidney disease, urine retention, and traumatic brain injury.

A care plan, dated 10/1/24, indicated Resident 12 had an indwelling catheter. Interventions included, but were not limited to, Foley catheter care every shift and as needed.

A physician's order, dated 10/1/24, indicated catheter care every shift.

The TAR, dated 1/1/25 to 1/31/25, indicated the following:
a. There was documentation missing for the catheter care on the day shift for 1/2, 1/7, 1/10, 1/16, 1/22, 1/24, 1/26, 1/29, and 1/30/25.
b. There was documentation missing for the catheter care on the evening shift for 1/3, 1,5, 1/6, 1/8, 1/10, 1/13, 1/16, 1/18, 1/19, 1/21, 1/23, and 1/28/25.
c. There was documentation missing for the catheter care on the night shift for 1/5, 1/6, 1/8, 1/18, 1/19, 1/25, and 1/30/25.

The TAR, dated 2/1/25 to 2/28/25, indicated the following:
a. There was documentation missing for the catheter care on the day shift for 2/1, 2/4, 2/6, 2/7, 2/8, 2/10, 2/12, 2/13, 2/14, 2/15, 2/17, 2/18, 2/20, and 2/22/25.
b. There was documentation missing for the catheter care on the evening shift for 2/6, 2/11, 2/13, 2/15, 2/16, and 2/22/25.
c. There was documentation missing for the catheter care on the night shift for 2/2, 2/7, 2/8, 2/9, 2/12, 2/15, 2/16, 2/17, 2/19, 2/20, 2/21, and 2/22/25.

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	155177	A. BUILDING 00 B. WING	02/25/2025

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	During an interview, on 2/25/25 at 4:30 p.m., the Director of Nursing indicated the information should have been completed on the TAR. During an interview, on 2/25/25 at 8:47 a.m., Licensed Practical Nurse (LPN) 4 indicated the documentation should be completed on the treatment administration record and if the record was left blank it meant it was not completed. A current facility policy, titled "Charting and Documentation," dated as revised on 6/2017 and received from the Clinical Executive Director on 2/24/25 at 2:06 p.m., indicated "...Documentation in the medical record may be electronic, manual or a combination...Medication administered...Treatments or services performed...." A current facility policy, titled "Psychotropic Medication Use," dated as revised on 7/2022 and received from the Director of Nursing (DON) on 2/26/25 at 1:38 p.m., indicated "...A psychotropic medication is any medication that affects brain activity associated with mental process and behavior...Drugs in the following categories...Anti-psychotics, Anti-depressants, Anti-anxiety medication and Hypnotics...Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes...Residents receiving psychotropic medications are monitored for adverse consequences...." A current facility policy, titled "Charting Errors and/or Omissions," dated as revised on 12/2006 and received from the Clinical Executive Director			

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	on 2/24/25 at 2:06 p.m., indicated "...Late entries in the medical record shall be dated at the time of entry and notes as a "late entry...." 3.1-50(a)(1) 3.1-50(a)(2)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on interview and record review, the facility failed to ensure influenza and pneumococcal vaccinations were provided for 1 of 5 residents reviewed for immunizations. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/21/25 at 1:54 p.m. The diagnoses included, but were not limited to, dementia, polyosteoarthritis, pure hyperglyceridemia, prediabetes, history of falling, and insomnia. An Informed Consent for Influenza Immunization, dated and signed on 10/9/24 at 4:43 p.m., indicated Resident B's representative gave permission for the influenza vaccination. An Informed Consent for Pneumococcal Immunization, dated and signed on 10/9/24 at 4:43 p.m., indicated Resident B's representative gave permission for the pneumococcal vaccination. An Immunization Report, dated 2/24/25, indicated the resident's last influenza vaccine was given on 9/27/23 and she had not received a pneumococcal vaccination. During an interview, on 2/25/25 at 4:20 p.m., Infection Preventionist (IP) 3 indicated the	F 0883	**F883 Influenza and Pneumococcal Immunizations S=D** I Resident B had no negative consequences from the alleged deficient practice. Resident B has since received the influenza immunization on 3/14/25 and Pneumococcal immunization on 3/18/2025. II All residents have the potential to be affected. A whole house audit, of admissions in the last 30 days, to ensure consent and administration of immunizations was completed with no concerns noted. III MDS and/or designee will audit: All new admits for accuracy and administration of all consented vaccines within the first 30 days of admission until 100% compliance is achieved for 6 consecutive evaluations. Additional audits will be completed as needed based upon the level of	03/20/2025

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	resident had received Tamiflu for an influenza exposure at the time of admission so she could not receive the vaccine right away. IP 3 indicated she did not know why the influenza vaccination was not given later or why the pneumococcal vaccination was not given. Resident B should have received both by now. A current facility policy, titled "Influenza Vaccine," dated as reviewed on 6/25/24 and provided on admission, indicated "...Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents...Only inactivated influenza vaccine will be offered to residents...." A current policy titled "Pneumococcal Vaccine," reviewed on 6/25/24 and provided on admission, indicated "... upon admission, residents will be ... offered the vaccine series within thirty (30) days of admission ... Pneumococcal vaccines will be administered to residents ...." "Tamiflu Interactions: Alcohol, Medications, and Others." https://www.healthline.com/health/drugs/tamiflu-interactions. Accessed 2/25/25, indicated "...Tamiflu and an inactivated flu vaccine will not interact. You should be able to receive an inactivated flu vaccine at any time before, during, or after Tamiflu treatment...." 3.1-18(b)(5)		compliance. Education to nurses to ensure they consult with MD prior to holding any vaccine. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and DON will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. IV The facility will be in and remain in compliance by: March 20, 2025.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included	R 0000	Preparation, submission, and implementation of this Plan of Correction does not constitute an	

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	the Investigation of Complaints IN00444575, IN00443524, IN00441342 and IN00440547. Complaint IN00444575 - No deficiencies related to the allegations are cited. Complaint IN00443524 - No deficiencies related to the allegations are cited. Complaint IN00441342 - Federal/state deficiencies related to the allegations are cited at F744. Complaint IN00440547- No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 24 and 25, 2025 Facility number: 000093 Residential Census: 62 Westminster Village - West Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on March 6, 2025.		admission or agreement with the facts and conclusions set forth on the survey report by Westminster Village West Lafayette. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. We respectfully request a desk review of this POC and a subsequent paper compliance revisit.	