STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD  3575 SENIOR PLACE WEST LAFAYETTE, IN 47906				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
R 0000 Bldg. 00	Survey. This visit in Complaints IN0040 IN00411305, and IN Complaint IN00407 to the allegations are complaint IN00410 the allegations are complaint IN00410 to the allegations are complaint IN00411 the allegations are compl	7016 - State deficiencies related e cited at R248.  2250 - No deficiencies related to cited.  2859 - State deficiencies related e cited at R214 and R248.  305 - No deficiencies related to cited.  20, 21, 22 and 26, 2023  4094  60  atial Findings are cited in 0 IAC 16.2-5.  completed on July 5, 2023.  5(h)	R 00	000			
Bldg. 00	Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.						

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

(X6) DATE

TITLE

Kristian Patterson Executive Director 07/24/2023

Any defiency statement 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 disclodays 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.

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 1 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  G 00	(X3) DATE SURVEY COMPLETED 06/26/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3575 SENIOR PLACE  WEST LAFAYETTE, IN 47906			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	ON (X5) BE COMPLETION DATE	
IAU	Based on record reversal failed to ensure a regular examination licensed veterinarian records reviewed. (In Finding includes:  The record reviewed of 6/26/2023 at 2:17 p. Resident Z had no concluded by the facility.  A current vaccional base of the pet away the facility.  A current facility per Certified Service At 11/01/2019 and record Director on 6/21/20 "Resident register provides evidence of the pet and the pet at the facility of the pet at the facility per Certified Service At 11/01/2019 and record per service at 11/01/2019 and record per service of 6/21/20 "Resident register provides evidence of the pet at the facility per service at 11/01/2019 and record p	iew and interview, the facility sident's pet was current with s and vaccinations by a 1 for 1 of 10 resident pet	R 0151	What corrective action(s) be accomplished for thos residents found to have be affected by the deficient practice; Pets who are housed within community should have perveterinary examinations and required immunizations. All residents have the potential affected by this alleged deficient practice at what corrective action will taken; All residents with pet will have immunizations. An audit was conducted by Executive Director of pet records. Pet vaccinate the 1 missing resident was attained on 07/14/2023.  What measures will be purplace or what systemic changes the facility will measure that the deficient practice does not recur; All current residents pet vaccinations will be checked monthly for updates needed new residents pet vaccinations will be checked new residents pet vaccinations. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality	will e een  n the riodic id l il to be riciency. fy e / the nd l be ave as rector tions for  it into nake nt  ed d. All ions will ion. A cords 8 for (s) re the	

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 2 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 06/26/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112		
R 0214	410 IAC 16.2-5-2(	(a)		assurance program will be pinto place; Activities director or designe audit pet records monthly. If a discrepancy is noted, it will be addressed at that time and reported to the ED.	e will any		
Bldg. 00	Evaluation - Defic (a) An evaluation each resident sha admission and sha semiannually and change in the resid A licensed nurse a needs of the resid Based on interview failed to follow the residents reviewed Finding includes:  During an interview Resident K indicate the dining area and rolling walker. He fi him. He did not hav call light, and two s	iency of the individual needs of II be initiated prior to all be updated at least upon a known substantial dent 's condition, or more ent 's or facility 's request. shall evaluate the nursing	R 0214	1. What corrective action will be accomplished for thos residents found to have been affected by the deficient practive all accidents appropriately. All residents appropriately. All residents had the potential to be affected by deficient practice.  How the facility will identify or residents having the potential be affected by the same deficient practice and what corrective	tice? ice ave y this other		
	6/26/2023 at 5:05 p were not limited to, stenosis, and history	not developed or signed by		actions will be taken? All residents have the potentibe affected · All service plans be audited and updated to incany behaviors and effective interventions that have been into place.  3. What measures will be put place or what systemic change.	s will clude put		

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 3 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WING 06/26/2023			2023	
				CERTER S	ADDRESS STEEL STEEL STEEL STEEL		
NAME OF P	ROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
14/10/2011					ENIOR PLACE		
WICKSHI	IRE WEST LAFAYE	- I I E		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	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					the facility will make to ensure		
	No nursing notes w	ere found to indicate and			that the deficient practice does		
	document the resident had a fall on 6/8/2023.  During an interview, on 6/20/2023 at 5:00 p.m., the				recur		
					Fall tool form has been create	d to	
					ensure service plans have bee		
	_	(ED) indicated Resident K had			updated to include any behavi		
		She had thought he had a fall			and effective interventions tha		
		l outage on 6/9/2023 but was			have been put into place. Nurs		
	_	I not find any nursing records			staff will be re-educated on wh	•	
		The resident did not have an			to updated the service plan to	ICH	
					include any behaviors and effe	active	
	updated service plan to reflect the change in condition with his current fall. The nurse should				interventions that have been p		
	have assessed and documented the resident's fall.				into place by August 15, 2023		
	The resident should have had an updated service						
		have had an updated service			4. How the corrective action(s	) WIII	
	plan.				be monitored to ensure the	_	
	A C . 1114	1' ('d 191 '1 (D)			deficient practice will not recui	,	
		olicy, titled "Incident Reports-			i.e., what quality assurance		
	-	anagement," dated as effective			program will be put into praction	ce	
		eived from the Executive			Tool form will be brought to		
		23 at 4:50 p.m., indicated			morning meeting for review wi		
	_	vith significant change in			team, Compliance will be mon	itor	
	-	nonths, annually and after			during monthly QA meeting.		
		he nurse will assess the			5. By what date the systemic		
		their risk for falls. a. Should			changes will be completed?		
	•	ommunity must show			August 31, 2023		
	documentation of a	-					
		e fall and interventions that					
		event or reduce risk of					
	subsequent falls"						
	This State tag relate	es to Complaint IN00410859.					
D 00 / 0							
R 0216	410 IAC 16.2-5-2(	,, ,,,					
	Evaluation - Nonc	•					
Bldg. 00		content of the evaluation					
		d in the facility policy					
	The state of the s	ninimum the needs					
	assessment shall	include an evaluation of the					
	following:						
	(1) The resident 's	s physical, cognitive, and					

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 4 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/26/2023		
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)		TE	(X5) COMPLETION DATE
	activities of daily (3) The resident ' admission and se (4) If applicable, t self-administer m (d) The evaluation writing and kept in Based on record re failed to take a resi for 1 of 7 residents (Resident G)  Finding includes:  The record for Res 6/26/2023 at 1:05 p were not limited to chronic kidney disc  There was no weig on 4/1/2023. There his admission.  During an interview Executive Director have any weights in have had a weight  A current facility p dated as effective 6 Executive Director indicated "The re-	s weight taken on miannually thereafter. he resident 's ability to edications. In shall be documented in the facility. Wiew and interview, the facility dent's weight upon admission reviewed for weights.	R 0.	216	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient pract All residents requiring semi-ar weights, had the potential to b affected by the alleged deficie practice. DON or designee wil provide an in-service to all CN QMAs and Nurses on proper obtaining and documenting or weights. How the facility will identify other residents having the potential to be affected by the same deficient practice an what corrective will be taken Employees found to be out of compliance with properly obta residents weights will receive additional education and poss corrective action. What measures will be put into place or what systemi changes the facility will make to ensure that the deficient practice does not recur: A weights binder will be prepa and all nursing staff educated the policy no later than Augus 2023. Any clinical staff member	ice inual e nt I As,  d ining ible c ared on t 15,	08/31/2023

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 5 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMPLETED 06/26/2023			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3575 SENIOR PLACE				
WICKSH	IRE WEST LAFAYE	TTE	WEST 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				out of compliance with facility's policies and protocols relating weights will receive progressive corrective action. The Director Nursing, or designee will educall newly hired clinical staff on policies and protocols relating obtaining weights during emplijob-specific orientation moving forward.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place:  The Director of Nursing or designee will audit weight bind two (2) times per month for tw months, then one (1) time a m for twelve (12) months, and th as needed to ensure that weig are being properly obtained ar recorded. Results to be review at monthly QI meetings and m further recommendations base audit results  By what date will the systematic changes be completed  Education and in-service will be provided to all clinical staff between now and concluding August 31, 2023	to //e r of cate  to oyee d  der o (2) conth en ghts nd //e //e //e //e //e //e //e //e //e //		
R 0217	410 IAC 16.2-5-2( Evaluation - Defici						
Bldg. 00	(e) Following complete facility, using approximately	oletion of an evaluation, the opriately trained staff entify and document the					

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 6 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/26/2023			
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3575 SENIOR PLACE  WEST 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
f ( ( r r ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	ollows:  1) The services of esident shall be at A) scope;  B) frequency; C) need; and D) preference; of the resident.  2) The services of evised as appropriesident and facilities thange. Either the equest a service plane are dependent upon request and dated of the services provided subsequent to the provision of resident to the provision to t	on service plan shall be by the resident, and a copy shall be given to the uest. In and documentation of is needed if evaluations initial evaluation indicate nge in services. In of medications or the Initial nursing services, or Icensed nurse shall be cation and documentation of provided. In and record review, the facility dents' service plans were Into the resident's Into the reside	R 0217	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All service plan for will be by 08/31/2023. How the facility widentify other residents having	vill		
	5/26/2023 at 1:05 p.	not signed by the resident or		potential to be affected by the same deficient practice and w corrective action will be taken, residents have the potential to affected by this deficiency. An	hat , all , be		

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 7 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  06/26/2023		
	PROVIDER OR SUPPLIER		3575 S	ADDRESS, CITY, STATE, ZIP COD SENIOR PLACE LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		
	A service plan was representative for 20 3. The record for Re 6/26/2023 at 1:25 p.  A service plan was representative for 20 4 service plan was representative for 20 4 p.  During an interview Executive Director have a service plan, resident signed the side discussed with him should have been si A current facility per Move-In," dated as received from the E at 4:50 p.m., indicat plan shall be signed	not signed by the resident or 222.  esident H was reviewed on a.m.  not signed by the resident or 222.  of on 6/26/2023 at 5:15 p.m., the indicated the residents did but it was not signed. The service plan when it was and his family. The form gned when it was discussed.  olicy, titled "Resident effective 6/1//2021 and executive Director on 6/26/2023 and "The agreed upon service and dated by the resident, rvice plan shall be given to		audit of resident service plans be completed by 08/31/2023. What measures will be put in place or what systemic changes the facility will mak to ensure that the deficient practice does not recur; Education for Health and Well Director on the Service Plan pwill be given 08/7/2023. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; The Director of Wellness or designee will conduct an audir resident service plans weekly weeks then monthly x 2 month Results of the audits will be brought to QA Committee meafor review/recommendations. By what date the systemic changes will be completed. Systemic change took effect 07/11/2023, Resident Care Coordinator begin audit change to care plan.	e Iness policy the ut of 5 x 4 ns. eting	
R 0248	410 IAC 16.2-5-4(	•				
Bldg. 00	premises or on ca nurse at all times. Based on interview failed to have availathe services of a lice resulted in 9 of 9 resulted.	I have available on the Il the services of a licensed and record review, the facility able on the premises or on call ensed nurse at all times which sidents not receiving insulin n or morning medications as	R 0248	What corrective action(s) wind be accomplished for those residents found to have been affected by the deficient practice;		

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 8 of 25

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		06/26/	2023
			<u> </u>	CTP PPT	ADDRESS CITY STATE ZIR COP		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
14/10/2011	IDE MEOT LAFAM				ENIOR PLACE		
WICKSH	IRE WEST LAFAYI	EIIE		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	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'E	DATE
	ordered by the phys	sician. (Residents V, N, K, B,			The facility will always maintai	n a	
Q, R, M, T and W)				licensed nurse on the premise			
				on call. The facility hired a He			
	Findings include:				and Wellness Nurse on Augus		
					07, 2023, who is within an hoเ		
	The Resident Medi	cation Administration Records			distance of the community.		
	(MARS) indicated	7 of 7 residents did not receive			How the facility will identify	,	
	the required insulin medication, on 6/10/2023, in				other residents having the		
	the a.m.				potential to be affected by th	e	
					same deficient practice and		
	The Resident MARS indicated 3 of 3 residents did				what corrective action will be	•	
	not receive physician ordered medications, on				taken;		
6/10/2023, in the a.m.				Facility will ensure that a nurse	e is		
					present or on call by continuo		
	1. The record for R	esident V was reviewed on			hiring nurses in the area to as		
	6/22/2023 at 2:46 p	o.m. Diagnoses included, but			with the needs of the commun		
	were not limited to	, Type 2 diabetes mellitus and	Currently the community has hired				
	epilepsy.				two nurses and will continue to		
					utilize the Corporate Specialis	t.	
	The MAR indicated	d Resident V was to receive			What measures will be put		
	Humalog Solution	100 unit/ml subcutaneous			into place or what systemic		
	every day before m	eals, inject 12 units. The			changes the facility will make	е	
	medication was not	given on 6/10/2023. The			to ensure that the deficient		
	reason the medicati	on was not given was the staff			practice does not recur;		
	did not have access	to the medication.			The facility has hired a Health	and	
					Wellness Director who will be	on	
		d Resident V was to receive			the premises during normal		
	_	100 unit/ml inject per sliding			working hours and on call duri	ng	
	scale after blood su	gar check before meals			non-working hours. During tim	es	
	subcutaneous every	day. The medication was not			with Corporate Specialist is		
	_	at 6:00 a.m. The reason the			supporting the community, wh	ile	
	medication was not	given was the staff did not			on the premises, the Corporat	е	
	have access to the r	nedication.			Specialist will assist with on ca	all	
					services. Both numbers are pl	aced	
		esident N was reviewed on			on the schedule and posted fo	or	
		o.m. Diagnoses included, but			staff to utilize.		
	were not limited to	, Type 2 diabetes mellitus.			How the corrective action(s)		
					will be monitored to ensure		
	The MAR indicated	d Resident N was to receive			the deficient practice will no	t	
	Humalog injection	solution per sliding scale			recur, i.e., what quality		

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 9 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00  B. WING		COMPLETED 06/26/2023			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3575 SENIOR PLACE				
WICKSH	IIRE WEST LAFAYE	ETTE		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	subcutaneously beformedication was not The reason the med staff did not have as The MAR indicated Humalog injection is subcutaneously beformedication was not The reason the med staff did not have as 3. The record for Refo/22/2023 at 1:50 p were not limited to, chronic pain syndro. The MAR indicated Humalog injection is sliding scale after b subcutaneous every given on 6/10/2023 medication was not not available.  4. The record for Refo/22/2023 at 2:55 p included, but were mellitus.  The MAR indicated Novolog injection is sliding scale after b subcutaneous every given on 6/10/2023 medication was not not available.  5. The record for Reformedication was not not available.	pre meals every day. The given on 6/10/2023 at 6:30 a.m. ication was not given was the excess to the medication.  Resident N was to receive solution 7 units pre meals every day. The given on 6/10/2023 at 6:30 a.m. ication was not given was the excess to the medication.  Resident K was reviewed on a.m. Diagnoses included, but Type 2 diabetes mellitus and		assurance program will be p into place; All clinical staff will be trained which personnel to contact du staffing concerns or clinical concerns. Training will take play on August 07, 2023, for staff to contact the Health and Wellne Director with clinical concerns By what date the systemic changes will be completed. All systemic changes will be implemented on August 31, 20	on ring ace o ss		

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 10 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPL			ETED
			B. WING 06/26/20			/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ENIOR PLACE		
WICKSH	IRE WEST LAFAYI	ETTE			_AFAYETTE, IN 47906		
							I
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORI			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BLI ICILINO I		DATE
	were not limited to, acute kidney failure, dysphagia, hypertension, and Type 2 diabetes						
	mellitus.						
	incircus.						
	The MAR indicated Resident Q was to receive						
		solution, inject 40 units					
	subcutaneous three times a day. The medication						
	was not given on 6/10/2023 at 6:00 a.m. The						
		ion was not given was the staff					
	did not have access	to the medication.					
	( T) 10 D						
	6. The record for Resident R was reviewed on 6/22/2023 at 2:10 p.m. Diagnoses included, but						
	were not limited to, Type 2 diabetes mellitus.						
	were not limited to, Type 2 diabetes mellitus.						
	The MAR indicated	d Resident R was to receive					
		cutaneous Solution 100 unit/ml					
		per sliding scale after blood					
	1	meals subcutaneous every					
	day. The medicatio	n was not given on 6/10/2023					
	at 7:30 a.m. The rea	ason the medication was not					
	given was the staff	did not have access to the					
	medication.						
	7 Th 10 B	anidant Managaria					
		esident M was reviewed on p.m. Diagnoses included, but					
		, anxiety, vitamin B deficiency					
	depression, and hyp						
	depression, and hyp	per tension.					
	The MAR indicated	d Resident M was to receive					
		ate tablet 5 mg by mouth every					
		n was not given on 6/10/2023					
	· ·	e reason the medication was not					
		did not have access to the					
	medication.						
		esident T was reviewed on					
	_	o.m. Diagnoses included, but					
		, tremor, retention of urine,					
	acute pharyngitis, a	and acute respiratory failure.					

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 11 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		06/26/	/2023
		_	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	· ·		3575 SE	ENIOR PLACE		
WICKSH	IRE WEST LAFAYE	ETTE		WESTL	_AFAYETTE, IN 47906		
(X4) ID	SUMMARY 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 APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
TAG	The MAR indicated Azithromycin oral to mouth once a day for 6/7/2023 for acute procession was not given on 6/10/2023 at 1:12 procession was not limited to, which is the following the am. The mot given was the stomatical did not have access 19. The record for Ref 6/22/2023 at 1:12 procession was understood to the MAR indicated Vitamin B 12 tablest Vitamin C tablet 50 ferrous sulfate tables day. The medication during the a.m. The not given was the stomatic motified was the stomatic form of the keys for the thir cart in the insulin cart in the	Resident T was to receive tablet 250 mg, one tablet by for four days starting on pharyngitis. The medication (10/2023 during the a.m. The on was not given was the staff to the medication.  Resident W was reviewed on the medication of the medication.  Resident W was to receive to 2000 mcg by mouth every day, and the table to medication of the medication of the medications were taff did not have access to the the medication and insuling the table to the medication and insuling the table to the medication carts. The to the facility to assist with the ond set of keys for the medication carts. The to the facility to assist with the ond set of keys for the medication carts. The to the facility to assist with the ond set of keys for the medication carts. The to the medication carts. The to the facility to assist with the ond set of keys for the medications. The pharmacy technician was sent to assist the medication carts. The total triangle of the medications and unlocked with insuling and morning the receive their medications. The DON arrived at the medications. The DON arrived at the medications.		TAG	DEFICIENCY)		DATE
	facility at 1:10 p.m.						
			1				Ī

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 12 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>00</u> CO		(X3) DATE SURVEY COMPLETED 06/26/2023
	PROVIDER OR SUPPLIE		3575 S	ADDRESS, CITY, STATE, ZIP COD SENIOR PLACE LAFAYETTE, IN 47906	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  DUES DEFINITION OF THE PROPERTY OF T	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER CONTROL OF THE APPROVIDER	BE COMPLETION
TAG	During an intervied DON indicated she facility the keys for inside one of the consecond set of keys were not with her. Office or the medicate her back because the She was aware resonant medicated home and went to residents received all was fine.  During an intervied QMA 3 indicated sin the insulin cart. Of keys and they we have been. The state facility and the DON said she did keys. The pharmace sent to open the consecution of the tech opened the CNA 4 indicated shocked by mistake looked for the second where they should not income the consecution of the consecution of the consecution of the second where they should have the second second in the consecution of the consec	w, on 6/21/2023 at 11:35 a.m., the was notified by the staff at the redication pass were locked arts and they could not find the She told the staff to look in her ration storage room. Staff called the keys could not be found. Idents had not received their the facility at 9:00 a.m. All their morning medications, and w, on 6/22/2023 at 2:15 p.m., whe locked the keys by mistake She looked for the second set there not where they should ff notified the ED who was in the DON was called. The mot have the second set of any was called, and a tech was rest. The tech opened the carts dents did not get their morning DON did not arrive until after the carts and she had the keys.  w, on 6/22/2023 at 2:18 p.m., the was aware the keys were in the insulin cart. Everyone and set of keys and they were fould have been. The staff to was in the facility and then the d. The DON said she did not to f keys. The pharmacy was was sent to open the carts. The rests. Residents did not get their mors. The DON did not arrive opened the carts and she had	TAG		DATE

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 13 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		06/26/	2023
	PROVIDER OR SUPPLIER			3575 SI	ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
R 0272 Bldg. 00	Substances," dated a received from the E at 4:50 p.m., indicat available on the pre a licensed nurse at a administered by lice qualified mediation  This State tag relate and IN00410859.  410 IAC 16.2-5-5. Food and Nutrition (e) All food shall b appropriate tempe Based on interview failed to ensure food prior to serving the days in June. This d potential to affect 6 food from the kitcher Finding includes:  During a record reverse the serving log temphad the following man a. There were missin 17 days in May (5/3 5/14, 5/15, and 5/17 b. There were missin 6/21 and 6/22/2023.  During an interview Executive Director is served.	In the second se	R 0.	272	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice It is the intention of Wickshire West Lafayette to follow established safe food handing guidelines including recording food temperatures prior to sen All residents have the potential be affected by this alleged deficiency. How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken Food temperatures at point of service will be recorded by die servers using the established tracking form. Any variances we be addressed to ensure safe	of vice. Il to  ner to ent ction	08/31/2023

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 14 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	•	SURVEY LETED 5/2023
	PROVIDER OR SUPPLIER		3575 S	ADDRESS, CITY, STATE, ZIP CO SENIOR PLACE LAFAYETTE, IN 47906	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE	(X5) COMPLETION DATE
	documentation coul	She did not know why the ld not be located for the dates was no policy and procedure numentation.		serving of food. All dieta be re-educated no later 08/20/2023 at mandator staff meeting on appropriatemps & procedures for such and how to addres variances to resolve temps wariances to resolve temponers.  What measures will be papered on the facility will make to estimate the deficient practic recur.  Compliance will be moniuse of an audit process tracking form. The Exect Director/designee will conduct as follows: 3 times for one month; weekly for months and monthly the Any deficiencies found in audits will be corrected a discovered and retraining to staff or additional more conducted, as necessary ensure safe food serving temperatures.  How the corrective action monitored to ensure the practice will not recur, i.e. quality assurance program put into place; and Findi reported to the QAPI Confor review and recomme By what date the system changes will be completed. All changes will be completed and the process of the process of the process of the policy of the process	than y dietary riate food recording s any riperature  out into changes ensure e does not  itored by and utive onduct this weekly or two reafter. In the at the time g provided nitoring y, to g  n(s) will be deficient e., what em will be mittee mdations. nic ed. pleted signee will ows: 3	

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 15 of 25

	OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/26/2023
	ROVIDER OR SUPPLIER		3575	FADDRESS, CITY, STATE, ZIP COD SENIOR PLACE LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				weekly for two months and monthly thereafter.	
R 0273	410 IAC 16.2-5-5.	• •			
Bldg. 00	(f) All food prepara (excluding areas in maintained in acco	nal Services - Deficiency ation and serving areas a residents ' units) are ordance with state and d safe food handling ang 410 IAC 7-24.			
	Based on observation review, the facility of labeled and dated in dry storage area of 1 practice had the potential practice had the potential practice had the potential practice had the potential practice.  During the tour of the p.m., the following of the following opened area. One (1) large bag b. one (1) large bag c. one (1) large bag c. one (1) large bag c. one (1) large bag dated.  2. The freezer area of following open and a. two (2) large ice of dated.  b. one (1) large shert dated.  3. The refrigerator a butter in a bowl covered the facility of	in, interview and record failed to ensure food was the refrigerator, freezer, and of 1 kitchen. This deficient ential to affect 60 of 60 we food from the kitchen.  The kitchen, on 6/26/2023 at 4:30 observations were made:  The area was observed to have the and not dated items:  The of sugar cane.  The of flour.  The of corn starch.  The area was observed to have the and not dated items:  The area was observed to have the and the observed to have the and the observed to have the and the observed to have the another open and not the container open and not the container open and not area was observed to have	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice It is the intention of Wickshire West Lafayette to follow established safe food handing guidelines including recording food temperatures prior to service All residents have the potential be affected by this alleged deficiency.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;  Food temperatures at point of service will be recorded by die servers using the established tracking form. Any variances we be addressed to ensure safe serving of food. All dietary staff be re-educated no later than 08/20/2023 at mandatory dieta staff meeting on appropriate for temps & procedures for records such and how to address any	of vice. I to  e tary vill f will

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 16 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  06/26/2023	
	PROVIDER OR SUPPLIE		3575 \$	SADDRESS, CITY, STATE, ZIP COD SENIOR PLACE LAFAYETTE, IN 47906	1
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O Manager, she indic labeled, and dated A current facility p Goods," dated as e received from the	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eated all items should be sealed, when opened.  policy, titled "Storage of ffective 11/01/2019 and Executive Director on 6/26/2023 atted "Cover all stored food.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)  Variances to resolve tempera concern.  What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;  Compliance will be monitored use of an audit process and tracking form. The Executive Director/designee will conduct audit as follows: 3 times week for one month; weekly for two months and monthly thereafted How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place; Any deficiencies found in the	DATE  ture  I by  It this kly  Per.  I the
R 0275 Bldg. 00	(h) Diet orders sh by the physician requires.	.1(h) onal Services - Deficiency all be reviewed and revised as the resident's condition view and interview, the facility	R 0275	audits will be corrected at the discovered and retraining pro to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. Findings will be reported to the QAPI Commit for review and recommendati By what date the systemic changes will be completed. Systemic changes will be completed by 08/31/2023	vided ng e tee ons.

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 17 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/26/2023
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE	
WICKSH	IRE WEST LAFAYE	ETTE		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAU		rders for 1 of 7 residents	TAU	accomplished for those resid found to have been affected	lents
	Finding includes:			deficient practice; All residents will have a diet of in their plan of care and physics.	
	The record for Reside 6/26/2023 at 1:05 p were not limited to,  A diet order was no medical orders for has 3/29/2023.  During an interview Executive Director have a diet order for in her doctor's order.  A current facility podated as effective 1 the Executive Director indicated "Diet or	blicy, titled "Special Diets," 1/01/2019 and received from tor on 6/26/2023 at 5:10 p.m., ders will be reviewed and cian as the resident's		in their plan of care and physorders. No negative outcome occurred. Residents without have the potential to be affect by the deficient practice. How the facility will identify or residents having the potential be affected by the same defipractice and what corrective will be taken; All residents have the potent be affected by deficient practice and clearly moted on in the old Updated orders will be given dietary immediately. What measures will be put in place or what systemic change the facility will make to ensur that the deficient practice docrecur; Wickshire's move in checklis	sician e order cted  ther al to cient action  ial to tice. ensure o diet hart. to  to ges re es not
				be implemented for all new noins by August 31, 2023 to en all resident upon admissions have diet orders. HWD will be trained on audits for dietary at have a complete audit complete by August 31, 2023. Residen without orders will be attain immediately by fax to physicial office.  How the corrective action(s) monitored to ensure the deficing practice will not recur, i.e., where the dietarchical control of the corrective action of the corrective will not recur, i.e., where the dietarchical control of the corrective action of the corrective will not recur, i.e., where the dietarchical control of the corrective action of the corrective will not recur, i.e., where the dietarchical control of the corrective action of the corrective will not recur, i.e., where the dietarchical control of the corrective action of the corrective will not recur, i.e., where the corrective action of the correction of the correction of the corrective action of the corrective action of the correction of the corr	sue will e and leted hts ian will be cient

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 18 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
			B. WI			06/26	
	PROVIDER OR SUPPLIE		•	3575 SI	ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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)  quality assurance program will put into place; and HWD and RCC will monitor progress over the next 4 week and will bring QA of updates to	I be	(X5) COMPLETION DATE
					weekly meeting with ED. ED v review all new resident checkl ensure each resident has diet orders. HWD and ED will revie annual physician assessments ensure no new diet orders have been written.  By what date the systemic changes will be completed Systemic changes will be completed by August 31, 2023	ew all s to e	
R 0306 Bldg. 00	(g) Medications a shall be disposed appropriate feder disposition of any destroyed medicathe resident 's clinclude the follow (1) The name of (2) The name and (3) The prescripti (4) The reason for (5) The amount do (7) The date of the (8) The signature the disposal of the dripposal of the dripp	Gervices - Noncompliance dministered by the facility I in compliance with al, state, and local laws, and released, returned, or ation shall be documented in inical record and shall ring information: the resident. d strength of the drug. on number. or disposal. isposed of. if disposition. e disposal. of the person conducting e drug. of a witness, if any, to the ug.					
	Based on observation review, the facility	failed to dispose of an edication pen for 1 of 8	R 03	306	What Corrective action(s) will be accomplished for those residents found to have been	•	08/31/2023

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 19 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY  COMPLETED  06/26/2023		
	PROVIDER OR SUPPLIE		357	EET ADDRESS, CITY, STATE, ZIP 5 SENIOR PLACE ST LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
mo	residents reviewed		i i i i i i i i i i i i i i i i i i i	affected by the deficie		DITTE
	insulin pens, on 6/Solostar (insulin) is an opened date of not have an expirar medication pen.  QMA 2 called the the expiration date should have been. was good for 28 days and the company of the compan	tion of medication storage for 21/2023 at 11:30 a.m., a Lantus njectable pen was found with 5/13/2023. The medication did tion date listed on the  local pharmacy and asked what for the insulin medication Lantus Solostar injectable pen nays after opening the pen.  the medication should have June 10, 2023 (after 6/9/2023  w, on 6/21/2023 at 11:45 a.m., the g (DON) indicated she was not ed medication in the medication insulin) Lantus Solostar pen was and the pen should have been		had the potential to be the alleged deficient proper and timely of expired or discontinued medications.  How the facility will identify other resident the potential to be affect the same deficient proper what corrective will be Employees found to be compliance with proper medications will received ucation and possible action.  What measures will be put into place or what changes the facility we to ensure that the defipractice does not record Director of Nursing or with provide education and Nurses on the time proper disposal of expressions.	e affected by practice. provide an and Nurses destruction of ed  as having ected by actice and e taken be out of er disposal of exe additional le corrective  e systemic ill make icient ur: a designee en to all QMAs nely and	
	Services," dated as from the Executive p.m., indicated " the facility shall be appropriate federal of prescription dru	solicy, titled "Pharmaceutical and the date 11/01/2019 and received to Director on 6/26/2023 at 4:50 Medications administered by the disposed in compliance with a large shall include the fissue and expiration date when		proper disposal of exp discontinued medicati than August 15, 2023 staff members out of of with facility's policies of protocols relating to a disposal of medication receive progressive of action. The Director of designee will educate hired clinical staff on p	ions no later . Any clinical compliance and ppropriate ns will orrective f Nursing, or all newly policies and	

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 20 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	B. WI		00	COMPL 06/26	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ENIOR PLACE		
WICKSH	IRE WEST LAFAY	ETTE		WEST	LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
R 0408	410 IAC 16.2-5-1				job-specific orientation moving forward. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be purinto place: The Director of Nursing or designee will audit the medicaroom and residents medicatio cabinets two (2) times per wer for eight (8) weeks, then one time a week for four (4) weeks and then as needed to ensure weights are being properly obtained and recorded. Result be reviewed at monthly QI meetings and make further recommendations based off a results By what date will the systematic changes be completed Education and in-service will provided to all clinical staff between now and concluding August 31, 2023	t n n ek (1) e, that ts to udit	
	Infection Control	- Noncompliance					
Bldg. 00	chest x-ray comp months prior to a Based on record re failed to have a dia for 1 of 7 residents x-rays. (Resident C	view and interview, the facility agnostic chest x-ray completed reviewed for admission chest	R 04	408	What corrective action(s) will accomplished for those reside found to have been affected be deficient practice; All residents will have a chest	ents by the	08/31/2023
	Finding includes:		1		x-ray upon admission. Reside	IIIO	

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 21 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER  WICKSHIRE WEST LAFAYETTE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  BEREIT ADDRESS, CITY, STATE, ZIP COD 3675 SENIOR PLACE  WEST LAFAYETTE, IN 47906  WEST LAFAYETTE, IN 47906  THE REGULATORY OR LSC IDENTIFYING INFORMATION  THE REGULATORY OR LSC IDENTIFYING INFORMATION  The record for Resident C was reviewed on 6/26/2023 at 1:05 p.m. Diagnoses included, but were not limited to, anxiety, and depression.  A diagnostic chest x-ray was not found for the admission date of 3/29/2023.  During an interview, on 6/26/2023 at 4:30 p.m., the Executive Director indicated the resident did not have a chest x-ray for her admission on 3/29/2023.  A current facility policy, titled "Resident Move-In," dated as effective 6/1/2021 and received from the Executive Director on 6/26/2023 at 4-59 p.m., indicated "Back resident shall have a diagnostic chest x-ray completed no more than six months prior to admission"  B WINSO  TAG  WICKSHIRE WEST LAFAYETTE  UP PREFIX  AGAIN ENGINEET ADDRESS, CITY, STATE, ZIP COD 3675 SENIOR PLACE  WEST LAFAYETTE, IN 47906  WEST LAFAYETTE, IN 47906  WISHOULX-ray have the potential to affected all residents by the deficient practice.  - How the facility will identify other resident shall be same deficient practice.  - How the facility will identify other resident will have a diagnostic chest x-ray completed no more than six months prior to admission"  Well will be affected by deficient practice.  - How the corrective action will be taken;  All residents have the potential to be affected by deficient practice.  - How the facility will identify other resident will have a chest x-ray completed by August 31, 2023. Residents without chest x-ray well be attain with Mobile X-ray services or by physician office.  - How the corrective action will be put into place; and the corrective action will be put into place; and the corrective action will be put into place; and the corrective action will be put into place; and the corrective action will be put into place; and the correctiv	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í		ONSTRUCTION 00	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER  WICKSHIRE WEST LAFAYETTE  SUMMARY STATEMENT OF DEFICIENCE  (PACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  The record for Resident C was reviewed on 6/26/2023 at 1:05 p.m. Diagnoss included, but were not limited to, amxiety, and depression.  A diagnostic chest x-ray was not found for the admission date of 3/29/2023.  During an interview, on 6/26/2023 at 4:30 p.m., the Executive Director indicated the resident did not have a chest x-ray for her admission on 3/29/2023.  A current facility policy, titled "Resident Move-In," dated as effective 6/11/2021 and received from the Executive Director on 6/26/2023 at 4:50 p.m., included by the same deficient practice. Each resident will have a diagnostic chest x-ray completed no more than six months prior to admission"  A current facility policy, titled "Resident Move-In," dated as effective 6/11/2021 and received from the Executive Director on 6/26/2023 at 4:50 p.m., included the resident shall have a diagnostic chest x-ray completed no more than six months prior to admission"  Whother the potential to be affected by the same deficient practice. Each resident will have a chest x-ray included the resident shall have a diagnostic chest x-ray completed no more than six months prior to admission"  Wickshire's move in checklist will be implemented for all new move in sby August 31, 2023. Residents without chest x-ray were on the completed by August 31, 2023. Residents without chest x-ray were one of the properties of the prope	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED 06/26/2023	
PREFIX TAG RECLETION MUST BE PRECEDED BY FULL REGLETORY OR ISE IDENTIFYING INFORMATION  The record for Resident C was reviewed on 6/26/2023 at 1:05 p.m. Diagnoses included, but were not limited to, anxiety, and depression.  A diagnostic chest x-ray was not found for the admission date of 3/29/2023.  During an interview, on 6/26//2023 at 4:30 p.m., the Executive Director indicated the resident did not have a chest x-ray for her admission on 3/29/2023.  A current facility policy, titled "Resident Move-In," dated as effective 6/1//2021 and received from the Executive Director on 6/26/2023 at 4:50 p.m., indicated "Fach resident shall have a diagnostic chest x-ray completed no more than six months prior to admission"  PREFIX TAG RESIGENT RECEIVED SMORTHS SEARCH SHALL BEASE SEARCH SHALL BEASE SHALL					3575 S	ENIOR PLACE		
TAG  REGULATORY OR ISC IDENTIFYING INFORMATION  The record for Resident C was reviewed on 6/26/2023 at 1:05 p.m. Diagnoses included, but were not limited to, anxiety, and depression.  A diagnostic chest x-ray was not found for the admission date of 3/29/2023.  During an interview, on 6/26/2023 at 4:30 p.m., the Executive Director indicated the resident did not have a chest x-ray for her admission on 3/29/2023.  A current facility policy, titled "Resident Move-In," dated as effective 6/1//2021 and received from the Executive Director on 6/26/2023 at 4:50 p.m., indicated "Each resident shall have a diagnostic chest x-ray completed no more than six months prior to admission"  What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice adoes not recur; Wickshire's move in checklist will be implemented for all new move in she y August 31, 2023 to ensue all resident upon admissions will x-ray completed. HVD will be trained on audits for dietary and have a complete audit completed by August 31, 2023. Residents without chest x-ray will be attain with Mobile X-ray services or by physician office.  - How the facility will make to enfected by the same deficient practice and what corrective action(s) will be monitored to ensure the deficient practice.  - How the facility will be attain with Mobile X-ray services or by physician office.  - How the facility will make to enfected by the same deficient practice.  - How the facility will make to enfected by fecient practice.  - How the facility will make to enfected by the same deficient practice.  - How the facility will make to ensure the deficient practice will not recur, i.e., when quality assurance program will be put into place; and HWD and RCC will monitor								
The record for Resident C was reviewed on 6/26/2023 at 1:05 p.m. Diagnoses included, but were not limited to, anxiety, and depression.  A diagnostic chest x-ray was not found for the admission date of 3/29/2023.  During an interview, on 6/26/2023 at 4:30 p.m., the Executive Director indicated the resident did not have a chest x-ray for her admission on 3/29/2023.  A current facility policy, titled "Resident Move-In," dated as effective 6/11//2021 and received from the Executive Director on 6/26/2023 at 4:50 p.m., indicated "Each resident shall have a diagnostic chest x-ray completed no more than six months prior to admission"  What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;  Wickshire's move in checklist will be implemented for all new move in s by August 31, 2023 to ensue all resident upon admissions will x-ray completed. HWD will be trained on audits for dietary and have a complete audit completed by August 31, 2023. Residents without chest x-ray will be attain with Mobile X-ray services or by physician office.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by deficient practice. Each resident will have a chest x-ray service will not recur; Wickshire's move in checklist will be implemented for all new move in s by August 31, 2023 to ensue all resident upon admissions will x-ray completed. HWD will be trained on audits for dietary and have a complete audit completed by August 31, 2023 to ensue all resident practice and have a corrective action(s) will be monitored to ensure the deficient practice and HWD and RCC will monitor		•				CROSS-REFERENCED TO THE APPROPRIA	NIE .	
and will bring QA of updates to weekly meeting with ED. ED will review all new resident checklist to		The record for Res 6/26/2023 at 1:05 were not limited to A diagnostic chest admission date of During an intervie Executive Director have a chest x-ray  A current facility p Move-In," dated a received from the at 4:50 p.m., indica a diagnostic chest	ident C was reviewed on p.m. Diagnoses included, but o, anxiety, and depression.  x-ray was not found for the 3/29/2023.  w, on 6/26//2023 at 4:30 p.m., the rindicated the resident did not for her admission on 3/29/2023.  policy, titled "Resident seffective 6/1//2021 and Executive Director on 6/26/2023 ated "Each resident shall have x-ray completed no more than			affected all residents by the deficient practice.  How the facility will identify other residents having potential to be affected by the same deficient practice and we corrective action will be taken All residents have the potential be affected by deficient practice. Each resident will have a che x-rays prior to admission that more than 90 days old.  What measures will be put into place or what system changes the facility will make ensure that the deficient practices and the put into place or what system changes the facility will make ensure that the deficient practice implemented for all new mins by August 31, 2023 to ensull resident upon admissions a x-ray completed. HWD will be trained on audits for dietary a have a complete audit complete by August 31, 2023. Resident without chest x-ray will be attained on the corrective action(s) will be monitored to ensure the deficient practice who trecur, i.e., what quality assurance program will be puplace; and HWD and RCC will monitor progress over the next 4 weel and will bring QA of updates to weekly meeting with ED. ED weekly meeting with	al to  g the  that ; al to ce. st no ee ic to cice will ove sue will nd eted s ain by  vill t into	

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 22 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING  B. WING	00	COMPLETED 06/26/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3575 SENIOR PLACE  WEST 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
				ensure each resident has ches x-rays. By what date the systemic changes will be completed Systemic changes will be completed by August 31, 2023			
R 0410	410 IAC 16.2-5-12 Infection Control -	. , . ,			'		
Bldg. 00	(e) In addition, a tu completed within the admission or upon forty-eight (48) to see result shall be reconstructed induration with the by whom administration with the by whom administration with the documented negaresult during the particular during the particular during the particular during the particular step is negative performed within construction after the first test. It testing will depend with tuberculosis.  (g) All residents who to the tuberculin shave a chest x-ray laboratory examina a diagnosis.	aberculin skin test shall be hree (3) months prior to admission and read at seventy-two (72) hours. The orded in millimeters of date given, date read, and ered and read. ho have not had a tive tuberculin skin test receding twelve (12) ne tuberculin skin testing two-step method. If the ve, a second test should be one (1) to three (3) weeks The frequency of repeat I on the risk of infection who have a positive reaction kin test shall be required to and other physical and attions in order to complete					
	failed to screen 3 res Tuberculosis (TB) a step process for TB	nd administer the admission 2 testing for 4 residents for 7 of 1 for Tuberculin skin tests.	R 0410	What corrective actions will be accomplished for those resider found to have been affected by finding: No negative outcome identified those residents affected. All resident have the potential to be affected.	nts / the		

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 23 of 25

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ í	JILDING	onstruction 00	(X3) DATE COMPL 06/26/	ETED
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE			3575 SE	ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	1. A Mantoux (Tub- for Resident B indic screening was not a  2. A Mantoux Test indicated the yearly not administered in  3. A Mantoux Test the yearly TB skin to administered in 202  4. A Mantoux Test the admission 2 step administered in 202  5. A Mantoux Test the admission 2 step administered in 202  6. A Mantoux Test indicated the admission to administered in  7. A Mantoux Test indicated the admission to administered in  202  During an interview Executive Director missing the yearly be and the admission 2 residents in 2023.  A current facility po Move-In," dated as received from the E	erculin skin test) Test record cated the yearly TB skin test or dministered in 2022.  record for Resident D  TB skin test or screening was 2022.  record for Resident F indicated cest or screening was not 2.  record for Resident C indicated o TB skin test was not 3.  record for Resident G indicated o TB skin test was not 3.  record for Resident H sion 2 step TB skin test was 2023.  record for Resident J indicated o TB skin test was not		TAG	How will you identify other residents having the potential be affected by the same finding and what corrective action will taken:  All residents had the potential be affected. No resident was adversely affected.  What measures will be put in place or what systemic change the facility will make to ensure that the deficient practice does recur:  Resident medical records will audited for annual tuberculings test or risk assessments. Any medical record found out of compliance will be corrected immediately.  How the corrective action(s) will monitored to ensure the finding not recur:  Wellness Director or designee monitor annual tuberculin sking tests or risk assessments 2 ximonth for 3 months and month thereafter  Systemic Change will occur by August 31, 2023	to g be to to s s not be kin fill be g will will	DATE
	_	mpleted within 3 months prior					

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 24 of 25

PRINTED: 08/03/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/26/2023	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP COD  3575 SENIOR PLACE  WEST LAFAYETTE, IN 47906			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	to admission or upo	n admission"					

State Form Event ID: KWOO11 Facility ID: 014094 If continuation sheet Page 25 of 25