STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/26/2023

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00407016, IN00409250, IN00410859, IN00411305, and IN00411543. Complaint IN00407016 - State deficiencies related to the allegations are cited at R248. Complaint IN00409250 - No deficiencies related to the allegations are cited. Complaint IN00410859 - State deficiencies related to the allegations are cited at R214 and R248. Complaint IN00411305 - No deficiencies related to the allegations are cited. Complaint IN00411543 - No deficiencies related to the allegations are cited. Survey dates: June 20, 21, 22 and 26, 2023 Facility number: 014094 Residential Census: 60 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 5, 2023.	R 0000		
R 0151 Bldg. 00	410 IAC 16.2-5-1.5(h) 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	TITLE	(X6) DATE
Kristian Patterson	Executive Director	07/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on record review and interview, the facility failed to ensure a resident's pet was current with regular examinations and vaccinations by a licensed veterinarian for 1 of 10 resident pet records reviewed. (Resident Z) Finding includes: The record review of resident pet vaccinations, on 6/26/2023 at 2:17 p.m., indicated the pet for Resident Z had no current vaccination record. During an interview, on 6/26/2023 at 2:19 p.m., the Executive Director indicated Resident Z did not have a current vaccination record. The resident had been notified to get a vaccination for the pet or give the pet away. The pet was still on site at the facility. A current facility policy, titled "Pets/ADA Certified Service Animals," dated as effective 11/01/2019 and received from the Executive Director on 6/21/2023 at 5:10 p.m., indicated "...Resident registers pet with the community and provides evidence of all appropriate vaccinations upon move-in and on an annual basis...."	R 0151	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Pets who are housed within the community should have periodic veterinary examinations and required immunizations. All residents have the potential to be affected by this alleged deficiency. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with pet will have immunizations. An audit was conducted by Executive Director of pet records. Pet vaccinations for the 1missing resident was attained on 07/14/2023. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**; All current residents pet vaccinations will be checked monthly for updates needed. All new residents pet vaccinations will be attained prior to admission. A calendar for monthly pet records was created on 07/14/2023 for date due of vaccinations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	07/14/2023

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			assurance program will be put into place; Activities director or designee will audit pet records monthly. If any discrepancy is noted, it will be addressed at that time and reported to the ED.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to follow the service plan policy for 1 of 3 residents reviewed for accidents. (Resident K) Finding includes: During an interview, on 6/26/2023 at 5:10 p.m., Resident K indicated he had a fall when he was in the dining area and his feet got tangled in his rolling walker. He fell and the walker fell on top of him. He did not have any injuries. He pushed his call light, and two staff members came to assist him. He was able to get upright with assistance. The record for Resident K was reviewed on 6/26/2023 at 5:05 p.m. Diagnoses included, but were not limited to, diabetes mellitus, spinal stenosis, and history of falling. A service plan was not developed or signed by the resident to include the fall and new interventions.	R 0214	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility will follow all service plan and review all accidents appropriately. All residents have the potential to be affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? All residents have the potential to be affected · All service plans will be audited and updated to include any behaviors and effective interventions that have been put into place. 3. What measures will be put into place or what systemic changes	08/31/2023

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	No nursing notes were found to indicate and document the resident had a fall on 6/8/2023. During an interview, on 6/20/2023 at 5:00 p.m., the Executive Director (ED) indicated Resident K had a fall on 6/8/2023. She had thought he had a fall during the electrical outage on 6/9/2023 but was mistaken. She could not find any nursing records regarding his fall. The resident did not have an updated service plan to reflect the change in condition with his current fall. The nurse should have assessed and documented the resident's fall. The resident should have had an updated service plan. A current facility policy, titled "Incident Reports-Falls & Mobility Management," dated as effective 11/01/2019 and received from the Executive Director on 6/26/2023 at 4:50 p.m., indicated "...Upon move in, with significant change in condition, every 6 months, annually and after every fall episode, the nurse will assess the resident to determine their risk for falls. a. Should a resident fall, the community must show documentation of an analysis of the circumstances of the fall and interventions that were initiated to prevent or reduce risk of subsequent falls...." This State tag relates to Complaint IN00410859.		the facility will make to ensure that the deficient practice does not recur Fall tool form has been created to ensure service plans have been updated to include any behaviors and effective interventions that have been put into place. Nursing staff will be re-educated on when to updated the service plan to include any behaviors and effective interventions that have been put into place by August 15, 2023. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into practice Tool form will be brought to morning meeting for review with team, Compliance will be monitor during monthly QA meeting. 5. By what date the systemic changes will be completed? August 31, 2023	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and			

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	mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to take a resident's weight upon admission for 1 of 7 residents reviewed for weights. (Resident G) Finding includes: The record for Resident G was reviewed on 6/26/2023 at 1:05 p.m. Diagnoses included, but were not limited to, anxiety, diabetes mellitus, and chronic kidney disease. There was no weight recorded for his admission on 4/1/2023. There was no weight recorded since his admission. During an interview, on 6/26//2023 at 4:30 p.m., the Executive Director indicated the resident did not have any weights in his clinical record. He should have had a weight taken on admission. A current facility policy, "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 "...The resident's weight taken at on admission and semiannually thereafter...."	R 0216	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice All residents requiring semi-annual weights, had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all CNAs, 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 and what corrective will be taken Employees found to be out of compliance with properly obtaining residents weights will receive additional education and possible corrective action. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: A weights binder will be prepared and all nursing staff educated on the policy no later than August 15, 2023. Any clinical staff member	08/31/2023

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			out of compliance with facility's policies and protocols relating to weights will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to obtaining weights during employee 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 put into place: The Director of Nursing or designee will audit weight binder two (2) times per month for two (2) months, then one (1) time a month for twelve (12) months, and then as needed to ensure that weights are being properly obtained and recorded. Results to be reviewed at monthly QI meetings and make further recommendations based of 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 on August 31, 2023	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the			

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to ensure residents' service plans were signed by the resident or the resident's representative for 3 of 7 residents reviewed for service plans. (Residents F, H, and J) Findings include: 1. The record for Resident F was reviewed on 6/26/2023 at 1:05 p.m. A service plan was not signed by the resident or representative for 2022.	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 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 this deficiency. An	08/31/2023

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	2. The record for Resident J was reviewed on 6/26/2023 at 1:15 p.m. A service plan was not signed by the resident or representative for 2022. 3. The record for Resident H was reviewed on 6/26/2023 at 1:25 p.m. A service plan was not signed by the resident or representative for 2022. During an interview, on 6/26/2023 at 5:15 p.m., the Executive Director indicated the residents did have a service plan, but it was not signed. The resident signed the service plan when it was discussed with him and his family. The form should have been signed when it was discussed. 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 "...The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request...."		audit of resident service plans will be completed by 08/31/2023. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Education for Health and Wellness Director on the Service Plan policy will be given 08/7/2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Director of Wellness or designee will conduct an audit of 5 resident service plans weekly x 4 weeks then monthly x 2 months. Results of the audits will be brought to QA Committee meeting for review/recommendations. **By what date the systemic changes will be completed.** Systemic change took effect 07/11/2023, Resident Care Coordinator begin audit changes to care plan.	
R 0248 Bldg. 00	410 IAC 16.2-5-4(f) Health Services - Deficiency (f) The facility shall have available on the premises or on call the services of a licensed nurse at all times. Based on interview and record review, the facility failed to have available on the premises or on call the services of a licensed nurse at all times which resulted in 9 of 9 residents not receiving insulin injection medication or morning medications as	R 0248	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	08/31/2023

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	ordered by the physician. (Residents V, N, K, B, Q, R, M, T and W) Findings include: The Resident Medication Administration Records (MARS) indicated 7 of 7 residents did not receive the required insulin medication, on 6/10/2023, in the a.m. The Resident MARS indicated 3 of 3 residents did not receive physician ordered medications, on 6/10/2023, in the a.m. 1. The record for Resident V was reviewed on 6/22/2023 at 2:46 p.m. Diagnoses included, but were not limited to, Type 2 diabetes mellitus and epilepsy. The MAR indicated Resident V was to receive Humalog Solution 100 unit/ml subcutaneous every day before meals, inject 12 units. The medication was not given on 6/10/2023. The reason the medication was not given was the staff did not have access to the medication. The MAR indicated Resident V was to receive Humalog Solution 100 unit/ml inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 6/10/2023 at 6:00 a.m. The reason the medication was not given was the staff did not have access to the medication. 2. The record for Resident N was reviewed on 6/22/2023 at 2:50 p.m. Diagnoses included, but were not limited to, Type 2 diabetes mellitus. The MAR indicated Resident N was to receive Humalog injection solution per sliding scale		The facility will always maintain a licensed nurse on the premises or on call. The facility hired a Health and Wellness Nurse on August 07, 2023, who is within an hour distance of the community. **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;** Facility will ensure that a nurse is present or on call by continuously hiring nurses in the area to assist with the needs of the community. Currently the community has hired two nurses and will continue to utilize the Corporate Specialist. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The facility has hired a Health and Wellness Director who will be on the premises during normal working hours and on call during non-working hours. During times with Corporate Specialist is supporting the community, while on the premises, the Corporate Specialist will assist with on call services. Both numbers are placed on the schedule and posted for staff to utilize. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	subcutaneously before meals every day. The medication was not given on 6/10/2023 at 6:30 a.m. The reason the medication was not given was the staff did not have access to the medication. The MAR indicated Resident N was to receive Humalog injection solution 7 units subcutaneously before meals every day. The medication was not given on 6/10/2023 at 6:30 a.m. The reason the medication was not given was the staff did not have access to the medication. 3. The record for Resident K was reviewed on 6/22/2023 at 1:50 p.m. Diagnoses included, but were not limited to, Type 2 diabetes mellitus and chronic pain syndrome. The MAR indicated Resident K was to receive Humalog injection solution 100 unit/ml, inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 6/10/2023 at 6:00 a.m. The reason the medication was not given was the medication was not available. 4. The record for Resident B was reviewed on 6/22/2023 at 2:55 p.m. Diagnoses for Resident B included, but were not limited to, Type 2 diabetes mellitus. The MAR indicated Resident B was to receive Novolog injection solution 100 unit/ml, inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 6/10/2023 at 6:00 a.m. The reason the medication was not given was the medication was not available. 5. The record for Resident Q was reviewed on 6/22/2023 at 3:12 p.m. Diagnoses included, but		**assurance program will be put into place;** All clinical staff will be trained on which personnel to contact during staffing concerns or clinical concerns. Training will take place on August 07, 2023, for staff to contact the Health and Wellness Director with clinical concerns **By what date the systemic changes will be completed.** All systemic changes will be implemented on August 31, 2023.	

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	were not limited to, acute kidney failure, dysphagia, hypertension, and Type 2 diabetes mellitus. The MAR indicated Resident Q was to receive Humalog injection solution, inject 40 units subcutaneous three times a day. The medication was not given on 6/10/2023 at 6:00 a.m. The reason the medication was not given was the staff did not have access to the medication. 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. The MAR indicated Resident R was to receive Insulin Lispro Subcutaneous Solution 100 unit/ml pen injector, inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 6/10/2023 at 7:30 a.m. The reason the medication was not given was the staff did not have access to the medication. 7. The record for Resident M was reviewed on 6/22/2023 at 12:59 p.m. Diagnoses included, but were not limited to, anxiety, vitamin B deficiency depression, and hypertension. The MAR indicated Resident M was to receive Amlodipine Besylate tablet 5 mg by mouth every day. The medication was not given on 6/10/2023 during the a.m. The reason the medication was not given was the staff did not have access to the medication. 8. The record for Resident T was reviewed on 6/22/2023 at 1:10 p.m. Diagnoses included, but were not limited to, tremor, retention of urine, acute pharyngitis, and acute respiratory failure.			

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	The MAR indicated Resident T was to receive Azithromycin oral tablet 250 mg, one tablet by mouth once a day for four days starting on 6/7/2023 for acute pharyngitis. The medication was not given on 6/10/2023 during the a.m. The reason the medication was not given was the staff did not have access to the medication. 9. The record for Resident W was reviewed on 6/22/2023 at 1:12 p.m. Diagnoses included, but were not limited to, iron deficient anemia. The MAR indicated Resident W was to receive Vitamin B 12 tablet 2000 mcg by mouth every day, Vitamin C tablet 500 mg by mouth every day, and ferrous sulfate tablet 325 mg by mouth two times a day. The medications were not given on 6/10/2023 during the a.m. The reason the medications were not given was the staff did not have access to the medications. During an interview, on 6/20/2023 at 4:10 p.m., the Executive Director (ED) indicated QMA 3 locked the keys for the third-floor medication and insulin cart in the insulin cart by mistake at 6:00 a.m., on 6/10/2023. The Director of Nursing (DON) was notified, and she indicated she did not have the second set of keys for the medication carts. The DON did not come to the facility to assist with the hunt to find the second set of keys for the residents' morning medications. The pharmacy was called, and a technician was sent to assist with the opening of the medication carts. The pharmacy tech arrived at 11:45 a.m. and unlocked the carts. Residents with insulin and morning medications did not receive their medications. There were 11 residents. The DON arrived at the facility at 1:10 p.m.			

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		A. BUILDING 00 B. WING	06/26/2023

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	During an interview, on 6/21/2023 at 11:35 a.m., the DON indicated she was notified by the staff at the facility the keys for medication pass were locked inside one of the carts and they could not find the second set of keys. She told the staff the keys were not with her. She told the staff to look in her office or the medication storage room. Staff called her back because the keys could not be found. She was aware residents had not received their morning medications. She found the keys at her home and went to the facility at 9:00 a.m. All residents received their morning medications, and all was fine. During an interview, on 6/22/2023 at 2:15 p.m., QMA 3 indicated she locked the keys by mistake in the insulin cart. She looked for the second set of keys and they were not where they should have been. The staff notified the ED who was in the facility and then the DON was called. The DON said she did not have the second set of keys. The pharmacy was called, and a tech was sent to open the carts. The tech opened the carts around noon. Residents did not get their morning medications. The DON did not arrive until after the tech opened the carts and she had the keys. During an interview, on 6/22/2023 at 2:18 p.m., CNA 4 indicated she was aware the keys were locked by mistake in the insulin cart. Everyone looked for the second set of keys and they were not where they should have been. The staff notified the ED who was in the facility and then the DON was called. The DON said she did not have the second set of keys. The pharmacy was called, and a tech was sent to open the carts. The tech opened the carts. Residents did not get their morning medications. The DON did not arrive until after the tech opened the carts and she had the keys.			

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	A current facility policy, titled "Controlled Substances," dated as effective 11/01/2019 and received from the Executive Director on 6/26/2023 at 4:50 p.m., indicated "...The facility shall have available on the premises or on call the services of a licensed nurse at all times...Medication shall be administered by licensed nursing personnel qualified mediation aides...." This State tag relates to Complaints IN00407016 and IN00410859.			
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on interview and record review, the facility failed to ensure food temperatures were checked prior to serving the meal on 17 days in May and 2 days in June. This deficient practice had the potential to affect 60 of 60 residents who receive food from the kitchen. Finding includes: During a record review, on 6/26/2023 at 4:48 p.m., the serving log temperatures for the facility meals had the following missing dates: a. There were missing or no records for meals on 17 days in May (5/31 thru 20th, and 5/7, 5/10, 5/13, 5/14, 5/15, and 5/17/2023). b. There were missing or no records for meals on 6/21 and 6/22/2023. During an interview, on 6/26/2023 at 6:10 p.m., the Executive Director indicated the temperature records should have been completed prior to	R 0272	**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 of food temperatures prior to service. All residents have the potential to be affected by this alleged deficiency. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Food temperatures at point of service will be recorded by dietary servers using the established tracking form. Any variances will be addressed to ensure safe	08/31/2023

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	serving the meals. She did not know why the documentation could not be located for the dates listed above. There was no policy and procedure for temperature documentation.		serving of food. All dietary staff will be re-educated no later than 08/20/2023 at mandatory dietary staff meeting on appropriate food temps & procedures for recording such and how to address any variances to resolve temperature concern. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct this audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. 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; and Findings will be reported to the QAPI Committee for review and recommendations. By what date the systemic changes will be completed. All changes will be completed 08/31/2023, Director/designee will conduct this audit as follows: 3 times weekly for one month;	

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			weekly for two months and monthly thereafter.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food was labeled and dated in the refrigerator, freezer, and dry storage area of 1 of 1 kitchen. This deficient practice had the potential to affect 60 of 60 residents who receive food from the kitchen. Findings include: During the tour of the kitchen, on 6/26/2023 at 4:30 p.m., the following observations were made: 1. The dry storage area was observed to have the following opened and not dated items: a. one (1) large bag of sugar cane. b. one (1) large bag of flour. c. one (1) large bag of corn starch. 2. The freezer area was observed to have the following open and not dated items: a. two (2) large ice cream containers open and not dated. b. one (1) large sherbet container open and not dated. 3. The refrigerator area was observed to have butter in a bowl covered, but not dated. During an interview, on 6/26/2023 at 4:55 p.m., with the Executive Director and acting Dietary	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 of food temperatures prior to service. All residents have the potential to be affected by this alleged deficiency. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Food temperatures at point of service will be recorded by dietary servers using the established tracking form. Any variances will be addressed to ensure safe serving of food. All dietary staff will be re-educated no later than 08/20/2023 at mandatory dietary staff meeting on appropriate food temps & procedures for recording such and how to address any	08/31/2023

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	Manager, she indicated all items should be sealed, labeled, and dated when opened. A current facility policy, titled "Storage of Goods," dated as effective 11/01/2019 and received from the Executive Director on 6/26/2023 at 4:50 p.m., indicated "...Cover all stored food. Label and date any leftover foods...."		variances to resolve temperature concern. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Compliance will be monitored by use of an audit process and tracking form. The Executive Director/designee will conduct this audit as follows: 3 times weekly for one month; weekly for two months and monthly thereafter. **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;** Any deficiencies found in the audits will be corrected at the time discovered and retraining provided to staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. Findings will be reported to the QAPI Committee for review and recommendations. **By what date the systemic changes will be completed.** Systemic changes will be completed by 08/31/2023	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview, the facility	R 0275	What corrective action(s) will be	08/31/2023

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	failed to have diet orders for 1 of 7 residents reviewed for diets. (Resident C) Finding includes: 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 diet order was not found in the resident's medical orders for her admission to the facility on 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 diet order for her admission, on 3/29/2023, in her doctor's orders. A current facility policy, titled "Special Diets," dated as effective 11/01/2019 and received from the Executive Director on 6/26/2023 at 5:10 p.m., indicated "...Diet orders will be reviewed and revised by the physician as the resident's condition requires...."		accomplished for those residents found to have been affected by the deficient practice; All residents will have a diet order in their plan of care and physician orders. No negative outcome occurred. Residents without order have the potential to be affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by deficient practice. Each chart will be check to ensure resident diet orders are up to diet and clearly noted on in the chart. Updated orders will be given to dietary immediately. 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 ins by August 31, 2023 to ensue all resident upon admissions will have diet orders. HWD will be trained on audits for dietary and have a complete audit completed by August 31, 2023. Residents without orders will be attain immediately by fax to physician office. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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			quality assurance program will be put into place; and HWD and RCC will monitor progress over the next 4 weeks and will bring QA of updates to weekly meeting with ED. ED will review all new resident checklist to ensure each resident has diet orders. HWD and ED will review all annual physician assessments to 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.	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, interview and record review, the facility failed to dispose of an outdated insulin medication pen for 1 of 8	R 0306	What Corrective action(s) will be accomplished for those residents found to have been	08/31/2023

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	residents reviewed for insulin. Finding includes: During an observation of medication storage for insulin pens, on 6/21/2023 at 11:30 a.m., a Lantus Solostar (insulin) injectable pen was found with an opened date of 5/13/2023. The medication did not have an expiration date listed on the medication pen. QMA 2 called the local pharmacy and asked what the expiration date for the insulin medication should have been. Lantus Solostar injectable pen was good for 28 days after opening the pen. QMA 2 indicated the medication should have been discarded on June 10, 2023 (after 6/9/2023 usage). During an interview, on 6/21/2023 at 11:45 a.m., the Director of Nursing (DON) indicated she was not aware of an outdated medication in the medication insulin cart. The (insulin) Lantus Solostar pen was good for 28 days and the pen should have been discarded. A current facility policy, titled "Pharmaceutical Services," dated as date 11/01/2019 and received from the Executive Director on 6/26/2023 at 4:50 p.m., indicated "...Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws...Labeling of prescription drugs shall include the following...Date of issue and expiration date when applicable...."		affected by the deficient practice All residents receiving medication had the potential to be affected by the alleged deficient practice. DON or designee will provide an in-service to all QMAs and Nurses on proper and timely destruction of expired or discontinued medications. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken Employees found to be out of compliance with proper disposal of medications will receive additional education and possible corrective action. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Director of Nursing or designee with provide education to all QMAs and Nurses on the timely and proper disposal of expired and discontinued medications no later than August 15, 2023. Any clinical staff members out of compliance with facility's policies and protocols relating to appropriate disposal of medications will receive progressive corrective action. The Director of Nursing, or designee will educate all newly hired clinical staff on policies and protocols relating to medication disposal during employee	

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			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 put into place: The Director of Nursing or designee will audit the medication room and residents medication cabinets two (2) times per week for eight (8) weeks, then one (1) time a week for four (4) weeks, and then as needed to ensure that weights are being properly obtained and recorded. Results to be reviewed at monthly QI meetings and make further recommendations based off 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 on August 31, 2023	
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to have a diagnostic chest x-ray completed for 1 of 7 residents reviewed for admission chest x-rays. (Resident C) Finding includes:	R 0408	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All residents will have a chest x-ray upon admission. Residents	08/31/2023

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	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...."		without x-ray have the potential to affected all residents by the deficient practice. • 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-rays prior to admission that no more than 90 days old. • 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 ins 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 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; and HWD and RCC will monitor progress over the next 4 weeks and will bring QA of updates to weekly meeting with ED. ED will review all new resident checklist to	

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			ensure each resident has chest x-rays. By what date the systemic changes will be completed Systemic changes will be completed by August 31, 2023.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to screen 3 residents for yearly Tuberculosis (TB) and administer the admission 2 step process for TB testing for 4 residents for 7 of 7 residents reviewed for Tuberculin skin tests. (Residents B, D, F, C, G, H, and J) Findings include:	R 0410	What corrective actions will be accomplished for those residents found to have been affected by the finding: No negative outcome identified for those residents affected. All resident have the potential to be affected.	08/31/2023

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WICKSHIRE WEST LAFAYETTE	3575 SENIOR PLACE WEST LAFAYETTE, IN 47906

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	1. A Mantoux (Tuberculin skin test) Test record for Resident B indicated the yearly TB skin test or screening was not administered in 2022. 2. A Mantoux Test record for Resident D indicated the yearly TB skin test or screening was not administered in 2022. 3. A Mantoux Test record for Resident F indicated the yearly TB skin test or screening was not administered in 2022. 4. A Mantoux Test record for Resident C indicated the admission 2 step TB skin test was not administered in 2023. 5. A Mantoux Test record for Resident G indicated the admission 2 step TB skin test was not administered in 2023. 6. A Mantoux Test record for Resident H indicated the admission 2 step TB skin test was not administered in 2023. 7. A Mantoux Test record for Resident J indicated the admission 2 step TB skin test was not administered in 2023. During an interview, on 6/26//2023 at 4:30 p.m., the Executive Director indicated the residents were missing the yearly health screening for TB in 2022 and the admission 2 step TB test for new residents in 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 "...In addition, a tuberculin skin test shall be completed within 3 months prior		How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken: All residents had the potential to be affected. No resident was adversely affected. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Resident medical records will be audited for annual tuberculin skin test or risk assessments. Any medical record found out of compliance will be corrected immediately. How the corrective action(s) will be monitored to ensure the finding will not recur: Wellness Director or designee will monitor annual tuberculin skin tests or risk assessments 2 x month for 3 months and monthly thereafter Systemic Change will occur by August 31, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/26/2023

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

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	to admission or upon admission...."			