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	04/20/2023

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00405295, IN00402894, IN00405686, IN00406586, IN00404948, IN00406646, and IN00406363. Complaint IN00405295 - State deficiencies related to the allegations are cited at R117, R248 and R296. Complaint IN00402894 - No deficiencies related to the allegations are cited. Complaint IN00405686 - No deficiencies related to the allegations are cited. Complaint IN00406586 - No deficiencies related to the allegations are cited. Complaint IN00404948 - No deficiencies related to the allegations are cited. Complaint IN00406646 - No deficiencies related to the allegations are cited. Complaint IN00406363 - No deficiencies related to the allegations are cited. Survey dates: April 17, 18, 19 and 20, 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 April 28, 2023.	R 0000	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Qualified, competent, and training staff will be present and available to administer the insulin injectable medication or any injectable medication for the residents of the facility. Facility will review schedule bi-weekly with the scheduler, Executive Director and Health and Wellness Director. To ensure insulin cerified QMAs are scheduled, if not the Health and Wellness Director to cover injectable medications. • **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 audit injectable medications monthly for changes that would require specialty personnel. During audit, Health and Wellness Director will ensure that appropriate personnel are scheduled to work the shifts. Health and Wellness Director will ensure proper training and certifications are attain prior to working with residents. • **What measures will be put into place or what systemic**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristian Patterson	Executive Director	05/16/2023

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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			changes the facility will make to ensure that the deficient practice does not recur; A Health and Wellness Director has been hired and begun training on 5/16/2023. This change will ensure that nursing personnel leader will be present to assist with injectable if no coverage is available. Staff will be directed to Health and Wellness Director staff coverage and training. • **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** Executive Director, Scheduler and Health and Wellness Director will review the schedule bi-weekly to ensure each day is properly staffed with qualified staff. Each month the Health and Wellness Director will audit each medications to ensure no additional injectable medications have been changed. • **By what date the systemic changes will be completed.** These changes were implemented on May 15, 2023.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and			

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	unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. 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 to ensure residents received insulin administration for 8 of 8 residents who required insulin administration. (Residents L, M, N, F, G, D, O, and P) Findings include: The resident Medication Administration Records (MARS) indicated 8 of 8 residents (Residents L, M, N, F, G, D, O, and P) did not receive the required insulin medication on 3/27/2023. The nursing notes indicated there was no qualified nursing staff available to administer the insulin injections. No nursing personnel was available to administer the insulin injectable	R 0117	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Qualified, competent, and training staff will be present and available to administer the insulin injectable medication or any injectable medication for the residents of the facility. Facility will review schedule bi-weekly with the scheduler, Executive Director and Health and Wellness Director. To ensure insulin cerified QMAs are scheduled, if not the Health and Wellness Director to cover injectable medications. • **How the facility will**	05/15/2023

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	medication or any injectable medication for the residents of the facility. During an interview, on 4/19/2023 at 11:00 a.m., QMA 2 indicated the residents did not get insulin injection medications because she was not certified to give insulin injections. She notified the Executive Director, and no nurse was available to administer injections for the residents on 3/27/2023 until after 2:00 p.m. During an interview, on 4/19/2023 at 11:11 a.m., the Health and Wellness Director indicated he had been contacted regarding the staffing issue and the insulin medication not given to residents. He indicated staff had not been scheduled who were qualified to administer insulin injections. Staff was not available for injections until after 2:00 p.m., on 3/27/2023. There was no nurse on duty to come into the facility and administer injectable medications for the residents. During an interview, on 4/19/2023 at 11:20 a.m., the Executive Director indicated she was aware of the medication administration issue and attempted to get a nurse to administer the medication. No nursing staff was available to meet the needs of the residents. A current facility policy, titled "Pharmaceutical Services," with an effective date of 11/01/2019 and received from the Executive Director on 4/18/2023 at 12:15 p.m., indicated "...Injectable medications will be given only by licensed personnel...The community will have available on the premises or on- call the services of a licensed nurse at all times...." This Residential tag related to Complaint IN00405295.		**identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Facility will audit injectable medications monthly for changes that would require specialty personnel. During audit, Health and Wellness Director will ensure that appropriate personnel are scheduled to work the shifts. Health and Wellness Director will ensure proper training and certifications are attain prior to working with residents. • **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 Health and Wellness Director has been hired and begun training on 5/16/2023. This change will ensure that nursing personnel leader will be present to assist with injectable if no coverage is available. Staff will be directed to Health and Wellness Director staff coverage and training. • **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** Executive Director, Scheduler and Health and Wellness Director will review the schedule bi-weekly to ensure each day is properly	

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			staffed with qualified staff. Each month the Health and Wellness Director will audit each medications to ensure no additional injectable medications have been changed. • **By what date the systemic changes will be completed.** These changes were implemented on May 15, 2023.	
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. This deficient practice had the potential to affect 60 of 60 residents at the facility. Findings include: The resident Medication Administration Records (MARS) indicated 8 of 8 residents did not receive the required insulin medication on 3/27/2023. The nursing notes indicated there was no qualified nursing staff available to administer the insulin injections. No nursing personnel was available to administer the insulin injectable medication or any injectable medication for the residents of the facility. During an interview, on 4/19/2023 at 11:00 a.m., QMA 2 indicated the residents did not get insulin injection medications because she was not certified to give insulin injections. She notified the	R 0248	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The facility will always maintain a licensed nurse on the premises or on call. The facility hired a Health and Wellness Nurse on May 15, 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 one nurse and will continue to	05/19/2023

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	Executive Director, and no nurse was available to administer injections for the residents on 3/27/2023 until after 2:00 p.m. During an interview, on 4/19/2023 at 11:11 a.m., the Health and Wellness Director indicated he had been contacted regarding the staffing issue and the insulin medication not given to residents. He indicated staff had not been scheduled who were qualified to administer insulin injections. Staff was not available for injections until after 2:00 p.m., on 3/27/2023. There was no nurse on duty to come into the facility and administer injectable medications for the residents. During an interview, on 4/19/2023 at 11:20 a.m., the Executive Director indicated she was aware of the medication administration issue and attempted to get a nurse to administer the medication. No nursing staff was available to meet the needs of the residents. A current facility policy, titled "Pharmaceutical Services," with an effective date of 11/01/2019 and received from the Executive Director on 4/18/2023 at 12:15 p.m., indicated "...Injectable medications will be given only by licensed personnel...The community will have available on the premises or on- call the services of a licensed nurse at all times...." This Residential tag related to Complaint IN00405295.		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 assurance program will be put into place; and** All clinical staff will be trained on which personnel to contact during staffing concerns or clinical concerns. Training will take place on May 19, 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 May 19, 2023.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written			

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	policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview and record review, the facility failed to ensure medications were given as ordered by the resident's physician and supervised by a licensed nurse on the premises or on-call for 8 of 8 residents reviewed for administration of medications. (Residents D, G, P, N, L, O, M and F) Findings include: 1. The record for Resident D was reviewed on 4/17/2023 at 2:46 p.m. Diagnoses included, but were not limited to, epilepsy, convulsions, type 2 diabetes mellitus, human immunodeficiency disorder, and chronic kidney disease. The Medication Administration Record (MAR) indicated Resident D was to receive Humalog Solution 100 unit/ml subcutaneous every day before meals, and to inject 12 units. The medication was not given on 3/27/2023 at 6:30 a.m., and 11:30 a.m. The reason the medication was not given was the staff was not qualified to inject medications. The MAR indicated Resident D 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 3/27/2023 at 6:00 a.m., and 11:30 a.m. The reason the medication was not given was the staff was not qualified to inject medications. 2. The record for Resident G was reviewed on 4/18/2023 at 2:50 p.m. Diagnoses included, but were not limited to, anemia, depression, acute	R 0296	• **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The facility will ensure medications are given as ordered by the resident's physician and supervised by a licensed nurse on the premise or on call. A Health and Wellness Director begun employment on May 15, 2023, to ensure medications are being supervised. • **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;** Health and Wellness Director will supervise all medication administration. Health and Wellness Director will be present or on call for medication administration. Health and Wellness Director will ensure all staff administrating medications are competent and trained. • **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Health and Wellness Director was hired for overseeing the nursing	05/19/2023

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	respiratory failure, hypertension, and type 2 diabetes mellitus. The MAR indicated Resident G was to receive Admelog Solostar 100 unit/ml pen injector, and to inject per sliding scale after blood sugar check before meals and at bedtime subcutaneous every day. The medication was not given on 3/27/2023 at 7:30 a.m., and 11:30 a.m. The reason the medication was not given was the staff was not qualified to inject medications. 3. The record for Resident P was reviewed on 4/20/2023 at 1:50 p.m. Diagnoses included, but were not limited to, aphasia, dyspnea, hypertension, and type 2 diabetes mellitus. The MAR indicated Resident P was to receive Humalog injection solution 100 unit/ml, and to inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 3/27/2023 at 6:30 a.m., and 11:30 a.m. The reason the medication was not given was the staff was not qualified to inject medications. 4. The record for Resident N was reviewed on 4/19/2023 at 2:55 p.m. Diagnoses included, but were not limited to, anxiety, depression, bronchitis, and type 2 diabetes mellitus. The MAR indicated Resident N was to receive Lantus Solution 100 unit/ml, and to inject 5 units subcutaneous once per day. The medication was not given on 3/27/2023 in the morning. The reason the medication was not given was the staff was not qualified to inject medications. 5. The record for Resident L was reviewed on 4/20/2023 at 11:39 a.m. Diagnoses included, but		department. The Health and Wellness Director will educate staff on appropriate times to call and educate them about clinical concerns. The Health and Wellness will be on-site during normal working hours and on-call during non-normal working hours. • **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** The facility will maintain a nurse always overseeing the community. Health and Wellness Director will be supported by the Corporate Clinical Director. • **By what date the systemic changes will be completed.** These changes will occur on May 19,2023	

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	were not limited to, acute kidney failure, dysphagia, hypertension, and type 2 diabetes mellitus. The MAR indicated Resident L was to receive Insulin Glargine Subcutaneous Solution 100 unit/ml, and to inject 115 unit subcutaneous two times a day. The medication was not given on 3/27/2023 during the day. The reason the medication was not given was the staff was not qualified to inject medications. 6. The record for Resident O was reviewed on 4/20/2023 at 2:10 p.m. Diagnoses included, but were not limited to, pulmonary fibrosis, chronic kidney disease, depression, and type 2 diabetes mellitus. The MAR indicated Resident O was to receive Insulin Lispro Subcutaneous Solution 100 unit/ml pen injector, and to inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 3/27/2023 at 7:30 a.m., and 11:30 a.m. The reason the medication was not given was the staff was not qualified to inject medications. 7. The record for Resident M was reviewed on 4/19/2023 at 12:59 p.m. Diagnoses included, but were not limited to, anxiety, epilepsy, edema, gout, chronic pain syndrome, and type 2 diabetes mellitus. The MAR indicated Resident M was to receive Insulin Glargine Subcutaneous Solution Pen injector 100unit/ml subcutaneous, and to inject 20 units twice daily. The medication was not given on 3/27/2023 during the day. The reason the medication was not given was the staff was not qualified to inject medications.			

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	The MAR indicated Resident M was to receive Insulin Lispro Injection Solution 100 unit/ml, and to inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 3/27/2023 at 6:30 a.m., and 11:30 a.m. The reason the medication was not given was the staff was not qualified to inject medications. 8. The record for Resident F was reviewed on 4/18/2023 at 1:10 p.m. Diagnoses included, but were not limited to, edema, pain in joint, depression, heart disease, hypertension, and type 2 diabetes. The MAR indicated Resident F was to receive Lantus Solution 100 unit/ml subcutaneous, and to inject 18 units one time daily. The medication was not given on 3/27/2023 in the morning. The reason the medication was not given was the staff was not qualified to inject medications. The MAR indicated Resident F was to receive Novolog Solution 100 unit/ml, and to inject per sliding scale after blood sugar check before meals and at bedtime subcutaneous every day. The medication was not given on 3/27/2023 at 6:30 a.m., and 11:30 a.m. The reason the medication was not given was the staff was not qualified to inject medications. During an interview, on 4/19/2023 at 11:00 a.m., QMA 2 indicated the residents did not get insulin injection medications because she was not certified to give insulin injections. She notified the Executive Director, and the MDs of the residents. During an interview, on 4/19/2023 at 11:11 a.m., the Health and Wellness Director indicated he had			

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	been contacted regarding the staffing issue and the insulin medication not given to residents. He indicated staff had not been scheduled who were qualified to administer insulin injections. Staff was not obtained for injections until after lunch had been served to the residents. There was no nurse on duty to come into the facility and administer medications for the residents. During an interview, on 4/19/2023 at 11:20 a.m., the Executive Director indicated she was aware of the medication administration issue and attempted to get a nurse to administer the medication. No nursing staff was available to meet the needs of the residents. A current facility policy, titled "Pharmaceutical Services," with an effective date of 11/01/2019 and received from the Executive Director on 4/18/2023 at 12:15 p.m., indicated "...Injectable medications will be given only by licensed personnel...The community will have available on the premises or on-call the services of a licensed nurse at all times...." This Residential tag related to Complaint IN00405295.			