STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> COM			(X3) DATE S	ETED	
			B. WI	NG		04/20/2	2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	_{TE}	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
R 0000							
R 0000	IN00405295, IN004 IN00404948, IN004 Complaint IN00405 to the allegations ar R296. Complaint IN00405 the allegations are complaint IN00406 the alle	5686 - No deficiencies related to cited. 5586 - No deficiencies related to cited. 5948 - No deficiencies related to cited. 5646 - No deficiencies related to cited. 5646 - No deficiencies related to cited. 5749 - No deficiencies related to cited. 5749 - No deficiencies related to cited. 5759 - No deficiencies related to cited. 5759 - No deficiencies related to cited. 5759 - No deficiencies related to cited.	R 00	000	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Qualified, competent, and trainstaff will be present and availate to administer the insulin injectamedication or any injectable medication for the residents of facility. Facility will review schedule bi-weekly with the scheduler, Executive Director. Health and Wellness Director. ensure insulin cerified QMAs a 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 as what corrective action will be taken; Facility will audit injectable medications monthly for change 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 the put into place or what system	ning ble able able and To are ad ges h ure will	
					working with residents.		
					put into place or what systen	nic	

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

(X6) DATE

TITLE

Kristian Patterson Executive Director 05/16/2023

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 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.

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 1 of 11

PRINTED: 05/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
			B. W	ING		04/20/	2023
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
WICKSH	IRE WEST LAFAYE	ETTE			LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	+	TAG			DATE
					changes the facility will mak to ensure that the deficient	е	
					practice does not recur;		
					A Health and Wellness Director	or	
					has been hired and begun trai		
					on 5/16/2023. This change wil	-	
					ensure that nursing personnel		
					leader will be present to assis	t	
					with injectable if no coverage	is	
					available. Staff will be directed		
					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 quali	-	
					assurance program will be p into place; and	uı	
					Executive Director, Scheduler	and	
					Health and Wellness Director		
					review the schedule bi-weekly		
					ensure each day is properly		
					staffed with qualified staff. Eac	ch	
					month the Health and Wellnes		
					Director will audit each		
					medications to ensure no		
					additional injectable medication	ns	
					have been changed.		
					By what date the		
					systemic changes will be		
					completed.	ntod	
					These changes were impleme on May 15, 2023.	iilea	
					On May 10, 2023.		
R 0117	410 IAC 16.2-5-1.	4(b)					
	Personnel - Defici	• •					
Bldg. 00		sufficient in number,					
	qualifications, and	training in accordance with					
	applicable state la	ws and rules to meet the					
	twenty-four (24) h	our scheduled and					

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. WING 04/20/2023				/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		1	ENIOR PLACE		
WICKSH	IIRE WEST LAFAYE	ETTE		WEST LAFAYETTE, IN 47906			
	1		1		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	COMPLETION
IAG		R LSC IDENTIFYING INFORMATION ds of the residents and		TAG	DELICIENCE!		DATE
		. The number, qualifications,					
	1	aff shall depend on skills					
	_	e for the specific needs of					
		ninimum of one (1) awake					
		current CPR and first aid					
		be on site at all times. If					
		residents of the facility					
	regularly receive r	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						
	_	ial nursing services or medication, or both, shall					
		(1) additional nursing staff					
		d on duty at all times for					
	1 '	fty (50) residents. Personnel					
		only those duties for which					
	_	p perform. Employee duties					
	1	n written job descriptions.					
	Based on interview	and record review, the facility	R 0	117	What corrective action(s)		05/15/2023
	failed to have availa	able on the premises or on-call			will be accomplished for thos	se	
		ensed nurse at all times to			residents found to have beer	1	
		ceived insulin administration			affected by the deficient		
		who required insulin			practice;		
	· ·	sidents L, M, N, F, G, D, O, and			Qualified, competent, and train	•	
	P)				staff will be present and availa to administer the insulin injecta		
	Findings include:				medication or any injectable	able	
	i manigo morado.				medication for the residents of	the	
	The resident Medic	ation Administration Records			facility. Facility will review	uio	
		8 of 8 residents (Residents L,			schedule bi-weekly with the		
	` '	and P) did not receive the			scheduler, Executive Director	and	
		edication on 3/27/2023.			Health and Wellness Director.		
					ensure insulin cerified QMAs a	are	
	_	ndicated there was no			scheduled, if not the Health ar	ıd	
		aff available to administer the			Wellness Director to cover		
	T	No nursing personnel was			injectable medications.		
	available to admini	ster the insulin injectable			How the facility will		

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU				ETED
			B. W	NG		04/20/	2023
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
14/10/70/1	IDE MEOT LAFAM				ENIOR PLACE		
WICKSH	IRE WEST LAFAYE	EIIE		WEST	LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(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 APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	medication or any injectable medication for the				identify other residents having	ng	
	residents of the faci	lity.			the potential to be affected b	-	
					the same deficient practice a	-	
	During an interview	v, on 4/19/2023 at 11:00 a.m.,			what corrective action will be		
	QMA 2 indicated th	ne residents did not get insulin			taken;		
	injection medication	ns because she was not			Facility will audit injectable		
		ulin injections. She notified the			medications monthly for chang	ges	
		and no nurse was available to			that would require specialty	-	
	administer injection	ns for the residents on			personnel. During audit, Healt	h	
	3/27/2023 until afte	er 2:00 p.m.			and Wellness Director will ens		
					that appropriate personnel are	:	
	During an interview, on 4/19/2023 at 11:11 a.m., the				scheduled to work the shifts.		
	Health and Wellness Director indicated he had				Health and Wellness Director	will	
	been contacted rega	arding the staffing issue and			ensure proper training and		
	the insulin medicati	on not given to residents. He			certifications are attain prior to)	
	indicated staff had	not been scheduled who were			working with residents.		
	qualified to adminis	ster insulin injections. Staff was			What measures will be	e	
	not available for inj	ections until after 2:00 p.m., on			put into place or what system	nic	
	3/27/2023. There w	as no nurse on duty to come			changes the facility will make	е	
	into the facility and	administer injectable			to ensure that the deficient		
	medications for the	residents.			practice does not recur;		
					A Health and Wellness Directo	or	
	During an interview	y, on 4/19/2023 at 11:20 a.m., the			has been hired and begun trai	ning	
	Executive Director	indicated she was aware of the			on 5/16/2023. This change wil	I	
	medication adminis	tration issue and attempted to			ensure that nursing personnel		
	get a nurse to admir	nister the medication. No			leader will be present to assist	t	
	nursing staff was av	vailable to meet the needs of			with injectable if no coverage i	S	
	the residents.				available. Staff will be directed	l to	
					Health and Wellness Director	staff	
	A current facility po	olicy, titled "Pharmaceutical			coverage and training.		
	Services," with an e	effective date of 11/01/2019 and			How the corrective		
		Executive Director on 4/18/2023			action(s) will be monitored to)	
	*	ated "Injectable medications			ensure the deficient practice		
		by licensed personnelThe			will not recur, i.e., what quali	ty	
		ve available on the premises or			assurance program will be p	ut	
		s of a licensed nurse at all			into place; and		
	times"				Executive Director, Scheduler	and	
					Health and Wellness Director	will	
	This Residential tag	g related to Complaint			review the schedule bi-weekly	to	
	IN00405295.				ensure each day is properly		

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 4 of 11

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/20/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
WICKSH	IRE WEST LAFAYE	ETTE		LAFAYETTE, IN 47906	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION DATE
170	REGULATORY	LSC IDENTIFYING INFORMATION	TAU	staffed with qualified staff. Each month the Health and Wellnes Director will audit each medications to ensure no additional injectable medication have been changed. By what date the systemic changes will be completed. These changes were impleme on May 15, 2023.	ch s
R 0248	410 IAC 16.2-5-4(Health Services -	•			
Bldg. 00	(f) The facility shal premises or on canurse at all times. Based on interview failed to have availated the services of a lice deficient practice has 60 residents at the firmlings include: The resident Medica (MARS) indicated 8 the required insulin The nursing notes in qualified nursing stainsulin injections. Navailable to administ medication or any in residents of the facilibration of the facilibration medication	Il 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. This ad the potential to affect 60 of acility. Administration Records 8 of 8 residents did not receive medication on 3/27/2023. Indicated there was no aff available to administer the Io nursing personnel was ster the insulin injectable mjectable medication for 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 licensed nurse on the premise on call. The facility hired a Heat and Wellness Nurse on May 1 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 at what corrective action will be taken; Facility will ensure that a nurse present or on call by continuous hiring nurses in the area to assembly with the needs of the communication currently the community has hear one nurse and will continue to	n a s or alth 5, ng y nd e e is usly sist ity.

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
			B. W	ING		04/20/	2023
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
MICKOLL			3575 SENIOR PLACE				
WICKSH	IRE WEST LAFAYE	EIIE		WEST	LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DEOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	Executive Director,	, and no nurse was available to			utilize the Corporate Specialis	t.	
	administer injection	ns for the residents on			What measures will be		
	3/27/2023 until afte				put into place or what system		
		•			changes the facility will make		
	During an interview	v, on 4/19/2023 at 11:11 a.m., the			to ensure that the deficient		
	_	ss Director indicated he had			practice does not recur;		
		arding the staffing issue and			The facility has hired a Health	and	
	_	ion not given to residents. He			Wellness Director who will be		
		not been scheduled who were			the premises during normal		
		ster insulin injections. Staff was			working hours and on call duri	na	
	not available for injections until after 2:00 p.m., on				non-working hours. During tim	-	
	3/27/2023. There was no nurse on duty to come				with Corporate Specialist is		
	into the facility and administer injectable				supporting the community, wh	ile	
	medications for the residents.				on the premises, the Corporat		
	incureurous for the residents.				Specialist will assist with on ca		
	During an interview	v, on 4/19/2023 at 11:20 a.m., the			services. Both numbers are pl		
	-	indicated she was aware of the			on the schedule and posted for		
		stration issue and attempted to			staff to utilize.	•	
		nister the medication. No			How the corrective		
		vailable to meet the needs of			action(s) will be monitored to	,	
	the residents.				ensure the deficient practice		
					will not recur, i.e., what quali		
	A current facility po	olicy, titled "Pharmaceutical			assurance program will be p	-	
		effective date of 11/01/2019 and			into place; and		
	· ·	Executive Director on 4/18/2023			All clinical staff will be trained	on	
		eated "Injectable medications			which personnel to contact du		
	-	by licensed personnelThe			staffing concerns or clinical	9	
		ve available on the premises or			concerns. Training will take pla	ace	
	_	s of a licensed nurse at all			on May 19, 2023, for staff to		
	times"				contact the Health and Wellne	SS	
					Director with clinical concerns.		
	This Residential tag	g related to Complaint			By what date the	•	
	IN00405295.	5			systemic changes will be		
					completed.		
					All systemic changes will be		
					implemented on May 19, 2023	.	
					pioinontod on ividy 10, 2020	•	
R 0296	410 IAC 16.2-5-6((b)					
		ervices - Noncompliance					
Bldg. 00		all maintain clear written					
J	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		ı		I		

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 6 of 11

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/20/2023	
	PROVIDER OR SUPPLIEI			3575 S	ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	l '	edures on medication					
	assistance. The facility shall provide for						
		o ensure competence of					
	medication staff.	and manad marriage, the facility	D O	207	NAME OF STREET		05/10/2022
		and record review, the facility dications were given as	K U	296	What corrective		05/19/2023
		-			action(s) will be accomplished for those residents found to	ŧu	
	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)				have been affected by the		
					deficient practice;		
					The facility will ensure		
					medications are given as orde	red	
					by the resident's physician an		
	Findings include:				supervised by a licensed nurs		
					the premise or on call. A Heal		
	1. The record for Resident D was reviewed on				and Wellness Director begun		
	4/17/2023 at 2:46 p	o.m. Diagnoses included, but			employment on May 15, 2023	, to	
		, epilepsy, convulsions, type 2			ensure medications are being		
		uman immunodeficiency			supervised.		
	disorder, and chron	ic kidney disease.			How the facility will		
					identify other residents having	-	
		Iministration Record (MAR)			the potential to be affected b	-	
		D was to receive Humalog			the same deficient practice a		
		nl subcutaneous every day			what corrective action will be	9	
		o inject 12 units. The			taken;		
		t given on 3/27/2023 at 6:30 n. The reason the medication			Health and Wellness Director supervise all medication	WIII	
		the staff was not qualified to			administration. Health and		
	inject medications.	•			Wellness Director will be pres	ent	
	inject incurcations.				or on call for medication	Ont	
	The MAR indicated	d Resident D was to receive			administration. Health and		
		100 unit /ml inject per sliding			Wellness Director will ensure	all	
	_	gar check before meals			staff administrating medication		
		day. The medication was not			are competent and trained.		
	given on 3/27/2023	at 6:00 a.m., and 11:30 a.m. The			What measures will I	ре	
		ion was not given was the staff			put into place or what syster	nic	
	was not qualified to	inject medications.			changes the facility will mak	е	
					to ensure that the deficient		
		esident G was reviewed on			practice does not recur;		
		o.m. Diagnoses included, but			Health and Wellness Director		
were not limited to, anemia, depression, acute				hired for overseeing the nursir	ng		

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 7 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WING 04/20/20			/2023	
				_			
NAME OF P	ROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
					ENIOR PLACE		
WICKSH	IRE WEST LAFAYI	ETTE		WEST	LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	respiratory failure, hypertension, and type 2				department. The Health and		
	diabetes mellitus.				Wellness Director will educate	:	
					staff on appropriate times to c	all	
	The MAR indicated	d Resident G was to receive			and educate them about clinic	al	
	-	100 unit/ml pen injector, and to			concerns. The Health and		
	inject per sliding sc	cale after blood sugar check			Wellness will be on-site during	3	
	before meals and at	t bedtime subcutaneous every			normal working hours and on-	call	
	day. The medication	n was not given on 3/27/2023			during non-normal working ho	urs.	
	at 7:30 a.m., and 11:30 a.m. The reason the				How the corrective		
	medication was not given was the staff was not				action(s) will be monitored to)	
	qualified to inject medications.				ensure the deficient practice		
					will not recur, i.e., what quali	ity	
	3. The record for Resident P was reviewed on				assurance program will be p	ut	
	4/20/2023 at 1:50 p	o.m. Diagnoses included, but			into place; and		
	were not limited to,	, aphasia, dyspnea,			The facility will maintain a nurs	se	
	hypertension, and t	ype 2 diabetes mellitus.			always overseeing the commu	ınity.	
					Health and Wellness Director	will	
	The MAR indicated	d Resident P was to receive			be supported by the Corporate	9	
	Humalog injection	solution 100 unit/ml, and to			Clinical Director.		
	inject per sliding sc	cale after blood sugar check			By what date the		
	before meals subcu	taneous every day. The			systemic changes will be		
	medication was not	given on 3/27/2023 at 6:30			completed.		
	a.m., and 11:30 a.m	n. The reason the medication			These changes will occur on N	Лау	
	was not given was	the staff was not qualified to			19,2023		
	inject medications.						
	4 751 10 5	11 (37					
		esident N was reviewed on					
	_	o.m. Diagnoses included, but					
		, anxiety, depression,					
	bronchitis, and type	e 2 diabetes mellitus.					
	The MAR indicated	d Resident N was to receive					
		0 unit/ml, and to inject 5 units					
		per day. The medication was					
		2023 in the morning. The reason					
		not given was the staff was					
	not qualified to inje						
	not quantied to fift	et medications.					
	5. The record for R	esident L was reviewed on					
		a.m. Diagnoses included, but					
	20, 2025 at 11.57	Diagnoses moraded, out	1				I

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 8 of 11

PRINTED: 05/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED D/2023		
NAME OF PROVIDER OR SUPPLIES WICKSHIRE WEST LAFAYS		STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906					
PREFIX (EACH DEFICIEN TAG REGULATORY OF were not limited to, dysphagia, hyperter	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION acute kidney failure, nsion, and type 2 diabetes	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
Insulin Glargine Su unit/ml, and to injectimes a day. The mr 3/27/2023 during the medication was not qualified to inject in 6. The record for R 4/20/2023 at 2:10 p were not limited to, kidney disease, depinellitus. The MAR indicated Insulin Lispro Subcipen injector, and to blood sugar check be every day. The medication was not qualified to inject injector. The record for R 4/19/2023 at 12:59	esident O was reviewed on .m. Diagnoses included, but pulmonary fibrosis, chronic ression, and type 2 diabetes I Resident O was to receive entaneous Solution 100 unit/ml inject per sliding scale after perfore meals subcutaneous lication was not given on .m., and 11:30 a.m. The reason not given was the staff was per medications. esident M was reviewed on p.m. Diagnoses included, but						
chronic pain syndromellitus. The MAR indicated Insulin Glargine Suinjector 100unit/ml units twice daily. Ton 3/27/2023 during	anxiety, epilepsy, edema, gout, ome, and type 2 diabetes I Resident M was to receive beutaneous Solution Pen subcutaneous, and to inject 20 he medication was not given g the day. The reason the given was the staff was not pedications.						

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 9 of 11

PRINTED: 05/17/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, ,	ILDING	NSTRUCTION 00	(X3) DATE COMPL 04/20 /	ETED	
	PROVIDER OR SUPPLIEF		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)	TE	(X5) COMPLETION DATE
	Insulin Lispro Inject to inject per sliding before meals subcurmedication was not a.m., and 11:30 a.m. was not given was tinject medications. 8. The record for Red/18/2023 at 1:10 p were not limited to, depression, heart di 2 diabetes. The MAR indicated Lantus Solution 100 inject 18 units one to not given on 3/27/2 the medication was not qualified to inject 18 units one to not given on 3/27/2 the medication was not qualified to inject 18 units one to not given on 3/27/2 the medication was not qualified to inject 18 units one to not given on 3/27/2 the medication was not qualified to inject medication was not given was to inject medications. During an interview QMA 2 indicated the injection medication certified to give ins Executive Director, During an interview of the property of the	Resident M was to receive tion Solution 100 unit/ml, and scale after blood sugar check taneous every day. The given on 3/27/2023 at 6:30. The reason the medication he staff was not qualified to esident F was reviewed on .m. Diagnoses included, but edema, pain in joint, sease, hypertension, and type I Resident F was to receive 0 unit/ml subcutaneous, and to ime daily. The medication was 023 in the morning. The reason not given was the staff was ct medications. I Resident F was to receive 00 unit/ml, and to inject per lood sugar check before meals entaneous every day. The given on 3/27/2023 at 6:30. The reason the medication he staff was not qualified to The reason the medication he staff was not qualified to The residents did not get insuling the secure she was not the modified the and the MDs of the residents. I Resident F was to receive 1000 unit/ml, and to inject per 11000 unit/ml, and to inject pe					
	Health and Wellnes	s Director indicated he had					

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 10 of 11

PRINTED: 05/17/2023 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	(X3) DATE SURVEY COMPLETED 04/20/2023	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE		3575 \$	ADDRESS, CITY, STATE, ZIP COD SENIOR PLACE LAFAYETTE, IN 47906	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
1/40	been contacted regathe insulin medicated staff had a qualified to administ not obtained for injudeen served to the non duty to come into medications for the During an interview Executive Director medication administ get a nurse to administ get a nurse to administ get an urse to administ get an urse to administ get and the residents. A current facility properties," with an executive from the Eat 12:15 p.m., indict will be given only be community will have on-call the services times"	arding the staffing issue and ion not given to residents. He not been scheduled who were ster insulin injections. Staff was ections until after lunch had residents. There was no nurse to the facility and administer	IAU			DATE

State Form Event ID: QBB811 Facility ID: 014094 If continuation sheet Page 11 of 11