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	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST LAFAYETTE ALF OPERATIONS	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 IN00422275, IN00429097, IN00429939, and IN00430509. Complaint IN00422275 - No deficiencies related to the allegations are cited. Complaint IN00429097 - No deficiencies related to the allegations are cited. Complaint IN00429939 - No deficiencies related to the allegations are cited. Complaint IN00430509 - No deficiencies related to the allegations are cited. Survey dates: March 25, 26, 27, and 28, 2024. Facility number: 014094 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 5, 2024.	R 0000	Allegation of Substantial Compliance West Lafayette Assited Living has or will have substantially corrected the alleged deficiencies and achieved substantial compliance on or before the date specified herein. The Plan of Correction constitutes West Lafayette Assisted Living's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before 08/01/2024. The statements made on this plan of correction are to correct the deficiencies continue to remain in substantial compliance with Indiana state requirements for health facilities found at 410 IAC 16.2, West Lafayette Assisted Living (herein after referred to as "community") has taken or will take the actions set forth in this plan of correction.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristie Cottrell	Executive Director	04/24/2024

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	simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on record review and interview, the facility failed to hold fire drills for 7 of 12 months reviewed for fire drills. (March 2023, April 2023, August 2023, September 2023, October 2023, November 2023 and December 2023). Finding includes: During a record review of the facility fire drills, on 3/27/2024 at 4:10 p.m., the facility failed to hold fire drills for 7 months. During an interview, on 3/27/2024 at 4:18 p.m., the Executive Director indicated there were no records of fire drills in the facility for the 7 months of March 2023, April 2023, August 2023, September 2023, October 2023, November 2023 and December 2023. A current facility policy, titled "Fire Drills," dated as effective 11/01/2019 and received from the Executive Director on 3/27/2024 at 4:40 p.m.,	R 0092	West Lafayette Assited Living was deficient with 7 out of 12 fire drills for the year. ED and Maintenance Director have started this correction. Fire Drills will be scheduled a certain week for the next four months alternating shifts. Maintenance Director and ED will go over the audit binder every month after and sign off that Fire Drills are completed until we are in compliance in December 2024. The month of: April- 2nd Shift: April 21-April 24 Drill will be conducted May- 1st Shift May5-May 11 Drill will be	12/30/2024

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	indicated "...1. Fire drills will be conducted at each community on a monthly basis...."		conducted June- 2nd Shift June 16-June 22 Drill will be conducted July- 1st Shift July 1st-July 6 Drill will be conducted	
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 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 record review and interview, the facility	R 0117	West Lafayette Assisted Living	05/17/2024

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	failed to ensure the staff on duty met the requirements of first aid training certification for 3 of 21 shifts reviewed. Finding include: A record review of the employee worked schedule, on 3/28/2024 at 11:45 a.m., indicated during the week of 3/4/2024 through 3/10/2024, the facility had 3 out of 21 shifts without a first aid certified staff member in the facility. During an interview, on 3/28/2024 at 12:08 p.m., the Director of Nursing indicated first aid training certified staff members were not on duty at the facility for the 3 shifts indicated on the staffing schedule reviewed for 3/4/2024 through 3/10/2024. During an interview, on 3/28/2024 at 12:30 p.m., the Executive Director indicated after final review of the records, first aid certified staff members were not on duty at the facility for the 3 shifts indicated on the staffing schedule reviewed for 3/4/2024 through 3/10/2024. A current facility policy, titled " Policy CPR," not dated, received from the Executive Director on 3/28/2024 at 12:24 p.m., indicated "...A minimum of one (1) awake staff person, with current CPR and first aid certification, shall be on site at all times...."		was deficient with CPR/First Aid Certification 3 out of 21 shifts. ED and BOM will have all staff members completed with CPR/First Aid Certification by May 17, 2024. Nobody will be allowed to be on a shift if they are not certified in CPR/First Aid. ED and BOM will audit every week for a month, then bi-weekly for a month, then monthly for 2 months to ensure compliance.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention,			

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	safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure dementia education was completed for 4 of 10 staff members reviewed for dementia training. (Staff Members 2, 3, 4, and 5) Findings include: 1. The employee record for Staff Member 2 was reviewed on 3/27/2024 at 3:33 p.m. The employee	R 0120	West Lafayette Assisted Living was deficient with 4 out of 10 employees for Dementia training. ED and BOM will ensure everyone has completed their hours of training by May 30, 2024. ED and BOM will audit the Dementia training weekly for a month, Bi-weekly for a month, then	05/30/2024

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	dementia training was not completed. 2. The employee record for Staff Member 3 was reviewed on 3/27/2024 at 3:36 p.m. The employee dementia training was not completed. 3. The employee record for Staff Member 4 was reviewed on 3/27/2024 at 3:38 p.m. The employee dementia training was not completed. 4. The employee record for Staff Member 5 was reviewed on 3/27/2024 at 3:42 p.m. The employee dementia training was not completed. During an interview, on 3/27 /2024 at 4:02 p.m., the Executive Director indicated Staff Members 2, 3, 4, and 5 did not have dementia training records in their files. She indicted the facility did not have a policy and procedure for this activity.		monthly for two months until in compliance.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin			

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	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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to perform a health screening for 2 of 10 employees and to ensure new personnel were screened for Tuberculosis (TB) using the two-step procedure skin test for 5 of 10 employees reviewed for employee records. (Staff Members 6, 7, 8, 9 and 10). Findings include: 1. During a review of Staff Member 6's health record on 3/28/2024 at 11:15 a.m., the record indicated a hire date of 10/5/2024. No first step TB skin test was completed. No second step skin test was completed. There was no health screening completed. 2. During a review of Staff Member 7's health	R 0121	West Lafayette Assisted Living was deficient with TB testings for 2 out of 10 employees. Ed and BOM will be in compliance with TB testing requirements by May 17, 2024. BOM and ED will audit all TB testing weekly for a month, Bi-weekly for a month, and then monthly for two months until in compliance.	05/17/2024

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	record on 3/28/2024 at 11:30 a.m., the record indicated a hire date of 12/4/2024 . No first step TB skin test was completed. No second step skin test was completed. 3. During a review of Staff Member 8's health record on 3/28/2024 at 11:38 a.m., the record indicated a hire date of 1/17/2024. No first step TB skin test was completed. No second step skin test was completed. 4. During a review of Staff Member 9's health record on 3/28/2024 at 12:04 p.m., the record indicated a hire date of 10/24/2024. There was no health screening completed. No first step TB skin test was completed. No second step skin test was completed. 5. During a review of Staff member 10's health record on 3/28/2024 at 12:10 p.m., the record indicated a hire date of 2/6/2024. No first step TB skin test was completed. No second step skin test was completed. During an interview, on 3/28/2024 at 1:10 p.m. the Executive Director indicated the employees were missing the health screening and the new staff hired did not have the two-step process for TB testing in orientation. A current facility policy, titled " New Hire Policy," not dated, received from the Executive Director on 3/28/2024 at 12:24 p.m., indicated "...DON/RCC to complete drug screening and TB at time of hire...."			
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			

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	immunizations. 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 E) Finding includes: The record review of resident pet vaccinations, on 3/26/2024 at 2:17 p.m., indicated the pet for Resident E had no current vaccination record. During an interview, on 3/26/204 at 2:19 p.m., the Executive Director indicated Resident E did not have a current vaccination record. A current facility policy titled, "Pets/ADA Certified Service Animals," dated as effective 11/01/2019 and received from the Executive Director on 3/26/2024 at 5:10 p.m., indicated "...a. Resident registers pet with the community and provides evidence of all appropriate vaccinations upon move-in and on an annual basis...."	R 0151	West Lafayette Assisted Living was deficient with 1 out of 9 pet vaccinations not completed. For Pet Vaccinations West Lafayette Assisted Living will be in compliance with all updated pet vaccinations requirements by May 17, 2024. ED and BOM will audit weekly for a month, then every two week for a month, then monthly for two months until we are in compliance.	05/17/2024
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 18 days in January 2024, 20 days in February, 6 days in March 2024 , there were no temperature records for April 2023 thru December 2023. This deficient practice had the potential to affect 51 of 51 residents who receive food from the kitchen. Finding includes:	R 0272	West Lafayette Assisted Living was not in compliance with food temperatures. Director of Food Services and ED will audit Temperatures weekly for a month, Bi-weekly for a month, and monthly for two months.	05/30/2024

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	During a record review, on 3/27/2024 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 18 days in January 2024. b. There were missing or no records for meals on 20 days in February 2024. c. There were missing or no records for meals on 6 days in March 2024. d. There were no records for meals in April 2023 thru 12/2023. During an interview, on 3/27/2024 at 6:10 p.m., the Executive Director indicated the temperature records should have been completed prior to serving the meals. She did not know why the documentation was incomplete and the months April thru December could not be located. There was no policy and procedure for temperature documentation. During an interview on 3/28/2024 at 2:50 p.m. with the Dietary Manager he indicated the missing temperature were because he did not do them and another staff member did not document the temperatures. He indicated he did not review the temperature logs for accuracy and compliance. He did not know where the logs were that were missing prior to his hire date.			
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			

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	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 observation; the facility failed to follow sanitation policies and procedures and have garbage can lids for 3 of 3 cans in the kitchen and in 2 of 2 garbage receptacles in the outdoor storage area These deficient practices had the potential to affect 60 of 60 residents who receive food from the kitchen. Findings include: During the tour of the kitchen, on 3/27/2024 at 2:15 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 bin of brown sugar . b. one bin of rice. c. one bin of salt. d. 2 bags of rice. e. 1 bag of pasta. f. 3 loaves of white bread g. 2 packages of buns 2. The freezer area was observed to have the following open and not dated items: a. one (1) large bag of French toast not sealed. 3. The stove/ oven combination was dirty , rusty and had debris 4. The toaster was dirty , rusty and full of debris 5. Eight serving storage trays near the oven were rusty, dirty and had debris 6. Six serving trays in the refrigerator were rusty and had debris 7. Dishwasher logs for the wash and rinse temperatures were incomplete for January,	R 0273	West Lafayette Assisted Living was not in compliance with Labeling and dating as well as sanitations policies. Director of Dietary and ED will audit these policies and be compliant by May 17, 2024. ED and Food Director will audit weekly for a month, bi-weekly for a month, and monthly for two months until in compliance.	05/17/2024

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	February and March 2024 / there were not logs for April thru December 2023 8. Kitchen refrigerator logs were incomplete for September 2023, January 2024, and February 2024. There were no logs for March 2023 thru August 2023. 9. Freezer logs were incomplete for September 2023 and January 2024. There were no logs for April 2023 thru August 2023. 10. Refrigerator in serving area had incomplete logs for September 2023, October 2023 and January 2024. There were no logs for temperatures April 2023 thru August 2023. During an interview, on 3/27/2024 at 6:10 p.m., the Executive Director indicated the temperature records should have been completed. She did not know why the documentation was incomplete for the months noted in 2023 and 2024. She did not know why the the other records were missing. All kitchen items should be dated and sealed. There was no policy and procedure for temperature documentation or sealing and dating opened food. She indicated the garbage cans should have been closed with a lid. During an interview on 3/28/2024 at 2:50 p.m. with the Dietary Manager he indicated the missing temperatures were because he did not do them and another staff member did not document the temperatures. He indicated he did not review the temperature logs for accuracy and compliance. He did not know where the logs were that were missing prior to his hire date. He indicated the open items should have been sealed and dated when opened. He indicated the garbage cans should have been closed with a lid.			
R 0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance			

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Bldg. 00	(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 6 residents reviewed for insulin. Finding includes: During an observation of medication storage for insulin pens, on 3/26/2024 at 1:25 p.m., a Lispro (insulin) injectable pen was found with no opened or expiration date. The medication had been open and used. Staff Member 2 indicated the medication should have been dated since the medication had been opened. During an interview, on 3/26/2024 at 1:40 p.m., the Acting Director of Nursing indicated she was not aware the mediation had not been dated when it was opened for resident utilization. .	R 0306	West Lafayette Assisted Living was not in compliance with disposing of outdated insulin medication pens for 1 out of 6 residents. ED and DON will audit and watch closely for outdated insulin. ED and DON will conduct an audit on outdated insulin pens as well as medication in carts 1 time weekly for a month, bi-weekly for a month, then monthly for two months until in compliance.	05/30/2024

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	03/28/2024

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

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	A current facility policy titled, "Medication and Administration or Stored Medication," not dated and received from the Director of Nursing on 3/28/2024 at 3:39 p.m., indicated "...5) Labeling of the prescription drugs shall include the following:... F) Date of issue and expiration date (when applicable)...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to track and trace infections in the facility from March 2023 through July 2023. This deficiency had the potential to affect 51 of 51 residents. Finding includes: During a record review of the facility infection control records, on 3/28/2024 at 11:30 a.m., the facility failed to have a documented program to tack and trace infections throughout the facility for the months of 3/2023 through 7/2023. During an interview, on 3/28/2024 at 11:38 a.m., the Executive Director indicated there were no records found for the infection control monitoring of	R 0407	West Lafayette Assisted Living was deficient with tracking and tracing infection control. This affects all residents. DON and ED will audit all tracing of infection control reviews weekly for a month, bi-weekly for a month, then monthly for two months until in compliance.	05/30/2024

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	03/28/2024

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	residents from 3/2023 through 7/2023. The facility should have had a system to track and track infections as they occurred throughout the facility. She indicted the facility did not have a policy and procedure for this activity.			
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 G) Finding includes: The record for Resident G was reviewed on 3/27/2024. Diagnoses included, but were not limited to, diabetes type II. A diagnostic chest x-ray was not found for the admission date of 3/24/2023. During an interview, on 3/27/2024 at 4:30 p.m., the Director of Nursing, she indicated the resident did not have a chest x-ray for her admission on 3/24/2023. A current facility policy, titled "Resident Move-In," dated as effective 6/1//2021 and received from the Executive Director on 3/27/2024 at 4:50 p.m., indicated "...Each resident shall have a diagnostic chest x-ray completed no more than six months prior to admission...."	R 0408	West Lafayette Assisted Living was deficient with 1 out of 7 admission without a chest x-ray. DON and ED will audit weekly for month, bi-weekly for a month and 1 time a month for two months to ensure x-rays are submitted to community before the resident is admitted.	05/30/2024