PRINTED: 09/06/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00			COMPLETED	
			B. W	B. WING			08/12/2022	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
WICKSH	IRE WEST LAFAYE	ETTE			ENIOR PLACE LAFAYETTE, IN 47906			
					I		(X5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			
PREFIX TAG	-	ICY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
R 0000	REGULATORT OR	R LSC IDENTIFYING INFORMATION		IAG			DATE	
Bldg. 00								
Ü	This visit was for a	State Residential Licensure	R 0	000				
	Survey. This visit in	ncluded the Investigation of						
	-	30382, IN00384689, IN00385699						
	and IN00379980.							
	_	382 - Substantiated. State						
	Residential Finding	s are cited at R2/3.						
	Complaint IN00384	1689 - Substantiated - No						
	•	to the allegations are cited.						
	deficiencies related to the difegations are cited.							
	Complaint IN00385699 - Unsubstantiated due to							
	lack of evidence.							
	_	9980 - Substantiated - No						
	deficiencies related	to the allegations are cited.						
	Survey dates: Augu	sst 9, 10, 11 and 12, 2022						
	Survey dates, 11agu	12, 2022						
	Facility number: 01	4094						
	Residential Census:	: 57						
	These State Resider	ntial Findings are cited in						
	accordance with 41	_						
	accordance with 41	0 110 10.2-5.						
	Quality review was	completed on August 17, 2022.						
R 0092	440 140 400 5 4	2(;)/4 2)						
IV 0097	410 IAC 16.2-5-1.							
Dida oo	Administration and	u ivianagement -						
Bldg. 00	Noncompliance	d maintain a contitue f						
	. , ,	st maintain a written fire and						
	• •	ness plan to assure						
		of residents in cases of						
	emergency as foll							
		n facilities shall include the						
	transmission of a	fire alarm signal and						

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

TITLE (X6) DATE

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: XG8I11 Facility ID: 014094 If continuation sheet Page 1 of 21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2022		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	simulation of eme except that the market residents to safe the building is not conducted quarter familiarize all fact and emergency a conditions. At least every year, between 9 p.m. a announcement maudible alarms. (2) At least every shall attempt to min conjunction with A record of all tradocumented with of the personnel Based on record refailed to attempt to with the local fire months and the fact 11 of 12 months rethrough June 2022 Finding includes: During a record refered for 11 months for 11 mo	ergency fire conditions, novement of nonambulatory areas or to the exterior of trequired. Drills shall be erly on each shift to flity personnel with signals action required under varied est twelve (12) drills shall be when drills are conducted and 6 a.m., a coded may be used instead of exix (6) months, a facility hold the fire and disaster drill the hocal fire department. Sining and drills shall be the names and signatures present. Eview and interview, the facility hold a fire drill in conjunction department at least every 6 critisty failed to hold fire drills for eviewed for fire drills. (July 2021)	R 00		What corrective action(s) will accomplished for those reside found to have been affected by the same deficient practice. It is Wickshire West Lafayette intention to conduct schedule and disaster drills per ISDH guidelines. All residents and shave the potential to be affect by this alleged deficient pract. How the facility will identify of residents having the potential be affected by the same deficient practice and what corrective a will be taken; The community will conduct monthly fire drill on each shift ensure understanding and compliance by all. What measures will be put into place or what systemic change the facility will make to ensure	ents by the d fire staff ted ice. ther I to sient action	08/31/2022

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 2 of 21

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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. W	ING		08/12/	2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			ENIOR PLACE		
WICKSH	IRE WEST LAFAYE	ETTE	WEST LAFAYETTE, IN 47906				
WIOROIT				WEGI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview, on 9/11/2022 at 11:25 a.m., the Executive Director indicated she could not locate any fire drill records form July 2021 through June 2022.				that the deficient practice does recur; Drills will then be conducted according to the established quarterly schedule. The Maintenance Director will be responsible for completion of t safety drills, maintaining record of drills and completing a drill report to the Executive Director. The Executive Director will be responsible for confirming that these drills take place per schedule and any concerns an addressed and resolved. How the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place; and	the ds or. tre ent ent be	
R 0116 Bldg. 00	410 IAC 16.2-5-1. Personnel - Nonco (a) Each facility sh procedures writter	ompliance			The Executive Director/design will review the fire and disaste logs monthly for two months. Findings will be reviewed at regularly scheduled QAPI meetings. The Executive Director may also request increased dror monitoring as needed at an time. Systemic change will be completed 08/30/2022	r drill ctor rills	
	screening of prosp	pective employees. ies shall be made for					

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 3 of 21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIER		3575 S	ADDRESS, CITY, STATE, ZIP COD SENIOR PLACE LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
IAU	prospective employ a personnel policy and any conviction 16-28-13-3. Based on record reversiled to make appresent of the employees in 5 of 5 references. (CNA 2. Dining Manager 5) Findings include: 1. The employee record on 8/12/2022 at 10: checks for CNA 2 where the employee records are the employee file. During an interview executive Director	yees. The facility shall have that considers references as in accordance with IC riew and interview, the facility opriate inquires for prospective employee files reviewed for QMA 1, CNA 3, Cook 4 and cord for CNA 2 was reviewed 200 a.m., the employee reference were not in the employee file. Ford for QMA 1 was reviewed 205 a.m., the employee reference were not in the employee file. Ford for CNA 3 was reviewed 110 a.m., the employee reference were not in the employee file. Ford for Cook 4 was reviewed 200 a.m., the employee file. Ford for Cook 4 was reviewed 200 a.m., the employee file. Ford for Dining Manager 5 was 202 at 10:30 a.m., the employee file. Ford for Dining Manager 5 was 202 at 10:30 a.m., the employee reference were not in the employee file.	R 0116	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice All residents are at risk of bei affected by this citing. The fact shall maintain current and accurate employee files. Reference checks should be completed on all new hires arremain in employee's file. 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; Audit conducted by the Busin Office Manager for all current employee files. The BOM will notify all current staff of any missing documents and sche time for completion What measures will be put in place or what systemic change the facility will make to ensure that the deficient practice docrecur BOM will complete monthly a off all new employee files to ensure compliance with ISDI-How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality	ng cility nd ne ee eess dule to ges es not eudit d.

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 4 of 21

PRINTED: 09/06/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMPLETED 08/12/2022	
	ROVIDER OR SUPPLIER		3575 S	ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE	
WICKSH	IRE WEST LAFAYE	TTE	WEST	LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0117 Bldg. 00	qualifications, and applicable state lat twenty-four (24) ho unscheduled need services provided. and training of staff required to provide the residents. A m staff person, with ocertificates, shall b fifty (50) or more regularly receive re or administration of least one (1) nursificate at all times. Recover one hundred receiving residentical administration of m	ency ufficient in number, training in accordance with ws and rules to meet the		assurance program will be p into place; and Audits of employee files will b conducted by the Business Of Manager and reported at the C meeting that will be held every third Thursday of the month to ensure compliance with ISDH. will cont. monthly x2 months a then quarterly with no end datany discrepancy is noted, it wi addressed at that time and reported to the ED. Systemic changes will be completed by 09/12/2022	re ffice QA / . QA and e. If

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 5 of 21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2022			
WICKSH	PROVIDER OR SUPPLIER	ETTE	STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	every additional fit shall be assigned they are trained to shall conform with Based on record reversalled to ensure the requirements of care (CPR) and first aid shifts) Finding includes: A record review of schedule, on 8/12/2 during the week of facility had 4 out of certified staff members where the certified staff members were not certified staff members were not certified staff.	the employee worked 022 at 9:45 a.m., indicated 8/2/2022 through 8/8/2022, the of 21shifts without a CPR per in the facility. 7, on 8/12/2022 at 4:08 p.m., the indicated CPR and first aid off members were not on duty the 19 shifts indicated on the viewed for 8/2/2022 through 7, on 8/12/2022 at 10:30 a.m., the indicated after final review of the different differe	R 0117	What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice All residents are at risk of being affected by this citing. A minity of 1 awake staff person, with and first aid certificates, shall on site at all times. First Aid/O training will be completed by current nursing staff no later to 9/30/2022 to ensure compliant. 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; The Director of Nursing will be responsible for verifying that compliance is met daily on easient. The facility will provide aid and CPR certification onsumed be required by all current non-certified nursing staff. What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All newly hired nursing staff womplete First Aid/CPR training within 90 days of being hired. Director of Nursing will track	num CPR be CPR han nce. ne e e ch Tirst ite nto ie vill ng		

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PRINTED: 09/06/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMPLETED 08/12/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE	
WICKSH	IRE WEST LAFAYE	TTE	WEST	LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIENC	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)	DATE
				certification process to ensure compliance and verification of scheduled have certification. All nursing staff will be in-servion first aid and CPR regulation a mandatory all-staff in-service later than 9/30/2022.	staff iced ns in
R 0121 Bldg. 00	employee of a faci contact. The scree skin test, using the PPD), unless a precan be documenter recorded in millimedate given, date readministered. The following: (1) At the time of experience of facility tuberculosis. The following tuberculosis. The following that the read prior work. For health can a documented test result during the months, the baselist should employ the first step is negative performed one (1) first step. The frequence depend on the risk tuberculosis. (2) All employees a reaction to the skirter skin tubers a precision to the skirter skin tubers and the skirter skin tubers are skirter skirt	shall be required for each lity prior to resident in shall include a tuberculing Mantoux method (5 TU, eviously positive reaction and. The result shall be eaters of induration with the ead, and by whom facility must assure the employment, or within one employment, and at least and the expectation of the employees and nonpaid lies shall be screened for first tuberculin skin test to the employee starting are workers who have not a negative tuberculin skin test in the preceding twelve (12) the tuberculin skin testing two-step method. If the eye, a second test should be to three (3) weeks after the usency of repeat testing will			

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AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE WICKSHIRE WEST LAFAYETTE MICKSHIRE WEST LAFAYETTE WEST LAFAYETTE, IN 47906 SIMMARY STATIMENT OF DEPICIENCIE WEST LAFAYETTE, IN 47906 Baboratory 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 tuberculosis, including, but not limited to, cough, fever, nights wealts, 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 5 of 5 employees and to ensure new personnel were screened for Tuberculosis (TB) using the mostspep procedure skin test for 1 of 5 employees reviewed for employee records. (QMA 1, CNA 2, CNA 3, Cook 4 and Dining Manager 5) Findings include: 1. During a review of QMA 1's health record on 8172/2022 at 2:25 p.m., the record indicated a hire date of 59/2022. A first step TB skin test was completed. 2. During a review of CNA 2's health record on 8172/2022 at 2:238 p.m., the record indicated a hire date of 69/202. There was no health screening completed. 3. During a review of CNA 3's health record on 8172/2022 at 2:238 p.m., the record indicated a hire date of 69/202. There was no health screening completed. 4. During a review of CNA 4's health record on 8172/2022 at 2:238 p.m., the record indicated a hire date of 69/202. There was no health screening completed. 4. During a review of CNA 4's health record on 8172/2022 at 2:38 p.m., the record indicated a hire date of 69/202. There was no health screening completed. 4. During a review of CNA 4's health record on 8172/2022 at 2:38 p.m., the record indicated a hire date of 69/202. There was no health screening completed. 4. During a review of CNA 4's health record on 8172/2022 at 2:38 p.m., the record indicated a hire date of 69/2022. There was no health screening comp	STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
STREET ADDRESS, CITY, STATE, ZIP COD 3675 SENIOR PLACE WEST LAFAYETTE O(A) ID SUMMARY STATEMENT OF DEFICIENCIE BRIFIX TAG IBDOTRICINAY MUST BE PRECEDED BY PELL TAG IBDOTRICINAY MUST BE PRECEDED BY PELL TAG IBDOTRICINAY SECULATORY CORE COMPANY IBDOTRICINAY IBDOTRICINAY SECULATORY CORE COMPANY IBDOTRICINAY IDDOTRICINAY IBDOTRICINAY IBDOTRICIN	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPI	COMPLETED	
MICKSHIRE WEST LAFAYETTE IXA ID SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Interest of each employee that includes reports of all employment-related health screening of active disease, (symptoms suggestive of active ubserculosis, 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 filled to perform a health screening for 5 of 5 employees and to ensure new personnel were screened for Tuberculosis (TB) using the two-step procedure skin test for 1 of 5 employees reviewed for employee records. (OMA 1, CNA 2, CNA 3, Cook 4 and Dining Manager 5) Findings include: 1. During a review of QMA 1's health record on 8/12/2002 at 2:25 p.m., the record indicated a hire date of 39/2022. A first step IB skin test was completed. There was no health screening completed. 2. During a review of CNA 2's health record on 8/12/2022 at 2:39 p.m., the record indicated a hire date of 5/2/2022. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 630/202. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 630/202. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 630/202. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 630/202. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 630/202. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 630/				B. W	ING		08/12	/2022	
MICKSHIRE WEST LAFAYETTE IXA JED SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGILATORY OR LSC IDENTIFYING INFORMATION Interest of each employee that includes reports of all employment-related health screening of active disease, (symptoms suggestive of active disease, (symptoms sugges			l .		CTDEET /	ADDRESS CITY STATE 7ID COD	<u> </u>		
WEST LAFAYETTE, IN 47906 WEST LAFAYETTE, IN	NAME OF P	ROVIDER OR SUPPLIEF	₹						
NA ID RREFIX REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LES CIDENTENTICS IN FORMATION TAG REGULATORY OR LES CIDENTENTICS TAG	MICKSH	IDE WEST I VEVA	=TTE						
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Iaboratory 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 uberculosis, 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 5 of 5 cmployees and to ensure new personnel were screened for Tuberculosis (TB) using the two-step procedures kin test for 1 of 5 cmployees reviewed for employee records. (QMA 1, CNA 2, CNA 3, Cook 4 and Dining Manager 5) Findings include: 1. During a review of QMA 1's health record on 8/12/2022 at 2:25 p.m., the record indicated a hire date of 39/9/2022. Affar sts TB his kin test was completed. No second step skin test was completed. There was no health screening completed. 2. During a review of CNA 2's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 5/20/222. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 5/30/202. There was no health screening completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 5/30/202. There was no health screening completed. 4. Total maintenance of the Aprenopherate of all provided to a provide a deficient practice and what corrective action(s) will be taken; and the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents have the potential to be affected by the a	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		VIDER'S PLAN OF CORRECTION		
TAG REGILATORY OR ISC IDENTIFYING INFORMATION Application State Complete a diagnosis.	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
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completed. No second step skin test was completed. There was no health screening completed. 14 days of hire. 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; 3. During a review of CNA 3's health record on completed. 3. During a review of CNA 3's health record on 8/12/2022 at 2:38 p.m., the record indicated a hire date of 6/30/202. There was no health screening completed. 3. During a review of CNA 3's health record on government of the potential to be affected by the same deficient practice and what corrective action will be taken; All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 09/20/2022. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and		-							
completed. There was no health screening completed. 14 days of hire. 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 staff will be in-serviced on revised procedure in mandatory all-staff meeting on 09/20/2022. There was no health screening completed. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and			-			-			
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date of 5/2/2022. There was no health screening completed. what corrective action will be taken; All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 09/20/2022. date of 6/30/202. There was no health screening completed. taken; All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 09/20/2022. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and		_				1 -			
All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 09/20/2022. There was no health screening completed. All staff will be in-serviced on revised procedure in mandatory all-staff meeting on 09/20/2022. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and		-				<u>-</u>	е		
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8/12/2022 at 2:38 p.m., the record indicated a hire date of 6/30/202. There was no health screening completed. all-staff meeting on 09/20/2022. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and						All staff will be in-serviced on			
date of 6/30/202. There was no health screening completed. The Regional Nurse also in-serviced the Executive Director, Business Office Manager and		3. During a review	of CNA 3's health record on			revised procedure in mandato	ry		
completed. in-serviced the Executive Director, Business Office Manager and		-				_	2.		
Business Office Manager and		1							
4. During a review of Cook 4's health record on Nursing Managers on the TB						_			
8/12/2022 at 2:44 p.m., the record indicated a hire requirements. The Director of		8/12/2022 at 2:44 p	.m., the record indicated a hire			requirements. The Director of			

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 8 of 21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLI	ETED
			B. WI	NG		08/12/	2022
			_	CTREET	ADDRESS SITU STATE ZID SOD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
MICKELI					ENIOR PLACE		
MICKSH	IIRE WEST LAFAY	EIIE	WEST LAFAYETTE, IN 47906				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	date of 1/25/2022.	There was no health screening			Nursing audited all current		
	completed.				employee health records to er	nsure	
					compliance. Any concerns we		
	5. During a review	of Dining Manager 5's health			promptly addressed.		
	record on 8/12/2022 at 2:50 p.m., the record				What measures will be put in	ıto	
	indicated a hire date of 5/16/2022. There was no				place or what systemic		
	health screening completed.				changes the facility will mak	e l	
	heath screening completed.				to ensure that the deficient		
	During an interview, on 8/12/202 at 3:03 p.m., the				practice does not recur;		
	Executive Director indicated the employees were				The Business Office Manager	. as	
	missing a health screening and one staff member				coordinator of employee hiring		
	did not have the second step two of the two-step				training processes, will ensure		
	process for TB testing in orientation.				new hires and current employ		
	process for 1B testing in orientation.				remain compliant with this		
					regulation.		
					How the corrective action(s) w	/ill be	
					monitored to ensure the defici		
					practice will not recur, i.e., wh		
					quality assurance program wil		
					put into place; and		
					The Business Office		
					Manager/designee will audit/re	eview	
					all new hire personnel files an		
					current employees, monthly,	_	
					times 2 months. Any items of		
					concern will be promptly resol	ved.	
					BOM/designee will report		
					compliance at regularly sched	uled	
					Quality Assurance meetings.		
					Monitoring will be ongoing		
					By what date the systemic		
					changes will be completed.		
					Systemic changes will be		
					completed by 09/12/2022		
					15piotod by 00/12/2022		
R 0148	410 IAC 16.2-5-1	.5(e)(1-4)					
		ifety Standards - Deficiency					
Bldg. 00		all maintain buildings,					
g. 00	1 ' '	ipment in a clean condition,					
	و ا تا ت	.p	1		1		

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 9 of 21

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00 00	COMPLETED 08/12/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	adversely affect the residents or the put (1) Each facility shimplement a writte to ensure the cont (2) The electrical sappliances, cords, sources, fire alarm shall be maintaine functioning and concelectrical codes. (3) All plumbing shomply with state (4) At least yearly, systems shall be in Based on record revitable to inspect the system at least yearly This deficiency had residents. Finding includes: During a record revitable to have a year heating and ventilat During an interview Director of Mainten records found for the system maintenance. During an interview Executive Director of	all establish and in program for maintenance inued upkeep of the facility. System, including switches, alternate power and detection systems, do to guarantee safe impliance with state in all function properly and polumbing codes. The heating and ventilating inspected. The iew and interview, the facility heating and ventilating inspected. The potential to affect 57 of 57 is iew of the facility maintenance in all function properly and polumbing codes. The facility heating and ventilating in an interview, the facility heating and ventilating in a system. The facility maintenance in a system. The facility is in a system in	R 0148	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice All residents are at risk of bein affected by citing. Facility shall the heating and ventilating systems shall be inspected. A documented log will be maintated for inspection. How the facility will identify of residents having the potential be affected by the same deficing practice and what corrective a will be taken; The maintenance director will review the TELs log daily and verify compliance of annual and federal regulations are met. What measures will be put in place or what systemic changes the facility will mak to ensure that the deficient	ng II ained ther to ient action nd		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIE		3575 S	ADDRESS, CITY, STATE, ZIP COD SENIOR PLACE LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				practice does not recur; Maintenance Director will revie TELs service and inspection lo daily and complete outstandin items by Friday of each week. How the corrective action(s) will be monitored to ensure t deficient practice will not recur, i.e., what quality assurance program will be p into place; and Audits conducted by the maintenance director and will reported at the QA meeting the will be held every third Thursd the month to ensure compliane with ISDH. QA will cont. month x2 months and then quarterly no end date. If any discrepance noted, it will be addressed at t time and reported to the ED.	pgs g he ut be at ay of ce nly with ey is
R 0151 Bldg. 00	periodic veterinar immunizations. Based on record re failed to ensure a r regular examinatio	. ,	R 0151	What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient	
	records reviewed. (Finding includes: The record review on 8/12/2022 at 3:	Residents 2, 5, 6 and 7) of resident pets vaccinations, 19 p.m., indicated the pets for and 7 had no current vaccination		practice; Pets who are housed within the community should have period veterinary examinations and required immunizations. All residents have the potential to affected by this alleged deficients.	be be

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 11 of 21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLET	
			B. WING 08/12/2022			022	
WICKSH	PROVIDER OR SUPPLIEF	ETTE	STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906			(V5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
	ì ·				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	
TAG	records. During an interview Executive Director			TAG	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 vaccination the 4 missing residents was attained on 08/25/2022. What measures will be put in 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. An new residents pet vaccinations be attained prior to admission calendar for monthly pet record was created on 08/25/2022 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 assurance program will be pinto place; and Activities director or designee audit pet records monthly. If a discrepancy is noted, it will be addressed at that time and reported to the ED.	tor ns for nto e All s will . A rds r the ut will ny	DATE
11 02 11	Evaluation - Defic						

State Form Event ID: XG8I11 Facility ID: 014094 If continuation sheet Page 12 of 21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	DING	00	COMPLETED			
		B. WING 08/12/2022						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AVIOT CONDUCTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE	
Bldg. 00	(e) Following com facility, using appr members, shall ideservices to be profollows: (1) The services of resident shall be as (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of revised as appropresident and facilities change. Either the request a service (3) The agreed upsigned and dated of the service plar resident upon requested and the services provided subsequent to the no need for a chall (5) If administration provision of resides both, is needed, as involved in identifithe services to be Based on interview failed to ensure a services as a service of the services to be Based on interview failed to ensure a services as a service of the services and the services to be Based on interview failed to ensure a services.	pletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as offered to the individual appropriate to the: offered shall be reviewed and riate and discussed by the try as needs or desires a facility or the resident may plan review. The plan shall be by the resident, and a copy of shall be given to the uest. The nand documentation of its needed if evaluations initial evaluation indicate ange in services. The offered shall be cation and documentation of provided. and record review, the facility ervice plan was signed and	R 021		What corrective action(s) will be accomplished for those		08/22/2022	
	dated by the resident or resident's representative for 1 of 7 residents reviewed for service plans. (Resident D)				residents found to have beer affected by the deficient practice; All service plan for will be by	I		
	Finding includes:				09/01/2022 . How the facility will identify oth			
		dent D was reviewed on			residents having the potential			
8/12/2022 at 1:05 p.m. Diagnoses included, but				be affected by the same defici	ent			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/12/2022	
	ROVIDER OR SUPPLIER		3575 S	ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PECULATORY OF LSC INFINITEVING DIFFORMATION		ID PREFIX TAG		
TAG	were not limited to, the liver (alcoholic) A service plan was 2022. During an interview Director of Nursing have a service plan resident should sign discussed with him	atrial fibrillation, cirrhosis of and aphasia. not signed by the resident for atrial fibrillation, cirrhosis of and aphasia. not signed by the resident for atrial fibrillation, cirrhosis of and aphasia. not signed by the resident for atrial fibrillation, cirrhosis of and aphasia. atrial fibrillation, cirrhosis of and aphasia.	TAG	practice and what corrective a will be taken All residents have the potential be affected by this deficiency, audit of resident service plans be completed by 08/31/2022. What measures will be put in place or what systemic changes the facility will mak to ensure that the deficient practice does not recur; Education for Health and Well Director on the Service Plan p was given 08/17/2022. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p into place; and The Director of Wellness or designee will conduct an audit resident service plans weekly weeks then monthly x 2 month Results of the audits will be brought to QA Committee meet for review/recommendations. By what date the systemic changes will be completed. Systemic change took effect 08/22/2022.	ction al to An will ato e ness olicy the ut t of 5 x 4 ns.
R 0272	410 IAC 16.2-5-5.	• •			
Bldg. 00	(e) All food shall be appropriate temper Based on interview	nal Services - Deficiency e served at a safe and erature. and record review, the facility d temperatures were checked	R 0272	What corrective action(s) will be accomplished for those	I 09/20/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/12/2022				
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION			
TAG		LISC IDENTIFYING INFORMATION meal on many occasions	TAG	residents found to have bee	DATE			
		. This deficient practice had		affected by the deficient				
		ct 57 of 57 residents residing		practice				
	in the facility.			It is the intention of Wickshire				
				West Lafayette to follow				
	Finding includes:			established safe food handing]			
				guidelines including recording				
	•	iew, on 8/12/2022 at 4:48 p.m.,		food temperatures prior to ser				
		erature logs for the facility		All residents have the potentia	al to			
	meals the following	dates were missing:		be affected by this alleged				
	Tl			deficiency.				
	There were no records for September, October, November and December of 2021.			How the facility will identify				
	November and December of 2021.			other residents having the potential to be affected by the				
	There were no records for January, February,			same deficient practice and	ie			
		and 9 through 31, April 1		what corrective action will b	<u>_</u>			
	through 17, May an			taken				
				Food temperatures at point of	:			
	During an interview	y, on 8/12/2022 at 5:15 p.m., the		service will be recorded by die				
	_	ll Specialist indicated the		,				
	temperature records	should have been completed		servers using the established tracking form. Any variances will				
	prior to serving the	meals. He indicated he could		be addressed to ensure safe				
	not locate the record	ds for the dates listed above.		serving of food. All dietary sta	ff will			
				be re-educated no later than				
				09/20/2022 at mandatory diet	- ·			
				staff meeting on appropriate f				
				temps & procedures for recor	-			
				such and how to address any				
				variances to resolve temperate concern.	uie			
				What measures will be put in	nto			
				place or what systemic				
				changes the facility will make	e l			
				to ensure that the deficient				
				practice does not recur				
				Compliance will be monitored	d by			
				use of an audit process and				
				tracking form. The Executive				
				Director/designee will conduc				
				audit as follows: 3 times week	dy			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 08/12/2022	
	PROVIDER OR SUPPLIER		3575 S	ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				for one month; weekly for two months and monthly thereafte Any deficiencies found in the audits will be corrected at the discovered and retraining prove 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 printo 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. All changes will be completed on on this audit as follows: Stimes weekly for one month; weekly for two months and monthly thereafter.	time vided g he ut e nd
R 0273 Bldg. 00	(f) All food prepara (excluding areas in maintained in acco local sanitation an	nal Services - Deficiency ation and serving areas n residents ' units) are ordance with state and d safe food handling			
	review, the facility labeled and dated in kitchen area and the	ong 410 IAC 7-24. on, interview and record failed to ensure food was the refrigerator, freezer, open dry storage area in 1 of 1 erving kitchenette and failed to	R 0273	What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. W	B. WING 08/12/2022			/2022	
				_	_			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					ENIOR PLACE			
WICKSH	IIRE WEST LAFAY	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	ΙΤΕ	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	nperatures in the walk-in			It is the intention of Wickshire			
		lk-in serving area refrigerator			West Lafayette to follow			
		rigerator and freezer. This			established safe food handing	J		
	deficient practice h	ad the potential to affect 57 of			guidelines including recording	of		
	57 residents.				food temperatures prior to ser			
					All residents have the potentia	al to		
	Findings include:				be affected by this alleged			
					deficiency.			
	During the tour of	the kitchen, on 8/11/2022 at 2:13			How the facility will identify			
	p.m., the following	observations were made:			other residents having the			
					potential to be affected by th	ie		
	1. The refrigerator	in the kitchen was observed to			same deficient practice and			
	have the following	not dated items:			what corrective action will be	е		
	a. One bag of lettuc	ce not dated.			taken;			
	b. Two bags of bro	ccoli not dated.		Food temperatures at point of				
	c. Four bags of spre	outs not dated.			service will be recorded by die			
		french dressing opened and			servers using the established			
		as running down the sides of			tracking form. Any variances v			
	the container.	<u> </u>			be addressed to ensure safe			
	e. One turkey not d	ated or labeled.		serving of food. All dietary staff will				
	f. Two taco meat p			be re-educated no later than				
					09/20/2022 at mandatory dietary			
	2. The reach-in refi	rigerator, near the cooking area,			staff meeting on appropriate for			
		ve the following not dated			temps & procedures for record			
	items:	8			such and how to address any	-		
	a. One large contai	ner of BBQ sauce opened and			variances to resolve temperat			
	not dated.				concern.			
		g) of chopped onions opened,			What measures will be put in	nto		
	not sealed and not				place or what systemic			
		Sour cream opened and not			changes the facility will mak	Δ		
	dated.	sedicional opened and nev			to ensure that the deficient	·		
		cheese opened, not sealed and			practice does not recur;			
	not dated.	interest opened, not beared and			Compliance will be monitored	hy		
	e. One ham opened	and not dated.			use of an audit process and	~ y		
	^	corn syrup opened, not sealed			tracking form. The Executive			
	and not dated.	com syrup opened, not scared			Director/designee will conduct	t thic		
		of teriyaki sauce opened and			_			
	not dated.	or terryaki sauce opened and			audit as follows: 3 times week	-		
		a ananad and not dated			for one month; weekly for two			
		e opened and not dated.			months and monthly thereafte			
	1. One bag of cut ca	abbage opened and not dated.	- 1		How the corrective action(s)		I	

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL A. BUIL B. WINC	DING	nstruction <u>00</u>	(X3) DATE : COMPL 08/12/	ETED	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		TE	(X5) COMPLETION DATE
IAU	j. One bag of sliced dated. k. One jar of lemon 1. One jar of pineap m. One jar of cole so opened and not date a. One pkg of mixed dated and in a clear Vegetables were not the floor of the free from the shelf and so the floor. No clean during the tour. b. Two pkgs of means of the floor of the free from the shelf and so the floor. No clean during the tour. b. Two pkgs of ground. Six chicken pattice. Three pkgs of conf. Six cakes not date g. Twelve pkgs of ph. One container of dated. i. Three pkgs of has dated. 4. The dry storage of water puddle not confollowing opened and a. One flour tub has opened and not date b. One sugar tub has was opened and not date b. One pkg of grits sealed. d. One pkg of oreo e. Three pkgs of hot of was noted to have residued.	cucumbers opened and not juice opened and not dated. ple juice opened and not deted. ple juice opened and not opened and not opened and had spilled onto opened and had spilled onto opened and not dated. put of vegetables occurred at not dated. ple juice opened and not dated and it dated or sealed. ple juice opened and not dated. ple juice opened an		IAU	will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place; and Any deficiencies found in the audits will be corrected at the discovered and retraining provito staff or additional monitoring conducted, as necessary, to ensure safe food serving temperatures. Findings will be reported to the QAPI Committe for review and recommendations. By what date the systemic changes will be completed. Systemic changes will be completed by 09/20/2022	ut time rided	DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUI	A. BUILDING 00 B. WING			COMPLETED 08/12/2022	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	or sealed. h. One pkg of hamb i. Four pkgs of ange j. One pkg of muffin not sealed. k. One pkg of choco dated. 5. The serving area floors. The clean are well defined. There a soap bucket under rolling cart with dir the clean area near to was not cleaned and coffee maker had le countertop. A large walk-in refrigerator following opened ar a. One liquid contai labeled or dated and b. One liquid contai labeled or dated and c. One liquid contai labeled or dated and d. One box of sour not sealed (30 pkgs) e. One box of jams, sealed (14 pkgs). f. One box of ranch and not sealed (20 p g. One jelly jar out h. Two cottage chee 6/27/2022. i. One box of strawl j. One large box of not dated.	burger buns not dated. In mix opened, not dated and oblate powder opened and not was observed to have dirty ea and dirty areas were not was a bucket of dirty rags and othe clean serving tray area. A try glasses and utensils were in the serving trays. A toaster was in the clean area. The aked on the serving area puddle was noted. The was observed to have the not not labeled or dated items: ner of something red, not he opened. In opened. In opened. In opened. In opened, not dated and how opened, not dated and how opened, not dated and not dressing, opened, not dated and how opened, not dated and not dressing, opened, not dated and how opened, not dated and not dressing, opened, not dated sokgs). In the food of the dated and not dressing, opened, not dated and how opened, not dated and not dressing, opened, not dated as of 4/27/2022. The see tubs outdated as of						
	have the following:	washing area was observed to						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED					
			B. WI	NG		08/12/	2022
NAME OF F	PROVIDER OR SUPPLIER	3			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	``	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a. Dirty items were area.	on the clean side of the wash					
		e dirty with debris and sauces.					
		nderneath clean cups and					
	glasses.	•					
	d. Food was found	on the floor, on the clean					
	sidec, of the washir						
		ere hanging on rack, near the					
		ashed with sauces and debris.					
	debris and sauces.	room were splashed with dirt,					
	deon's and sauces.						
	7. The log books fo	or the refrigerators and freezers					
	were reviewed and	indicated the following:					
		x-in refrigerator temperatures					
		ovember 2021, March 24					
	_	April 1 through 16, June 1					
	through 4 and 17 th	rough 20 and July 19 through					
		igerator, near the cooking area,					
		vere missing for September 29					
	_	ber 2021, December 2021,					
		uary 2022, March 28 through					
	31, April 1 through	16, and July 21 through 31,					
	2022.						
		s were missing temperature					
		2021, March 22 through 31, 2022, June 1 through 4, and 17					
	through 20 and July	2					
		igerator in the serving area					
		missing for September,					
		r and December 2021, and					
	1	March 23 through 31 2022,					
	April, May, June ar	nd July 19 through 31.					
	During on intermier	v, on 8/11/2022 at 4:20 p.m., the					
	_	dicated all items should be					
	1	dated when opened and when					
		er and refrigerators. She					
	_	orage area should not have					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
			B. WING			08/12/	2022
NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE				3575 SE	DDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PR	EFIX			COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	Т	ΆG			DATE
	and dated. The Dir	ers and items should be sealed ing Manager indicated the I had been leaking since I had been addressed by					
	Regional Operation temperature record He indicated he co the dates listed abo	w, 8/12/2022 at 4:55 p.m., the nal Specialist indicated the s should have been completed. ald not locate the records for ve. tes to complaint IN00380382.					

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