STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155177	A. BUILDING 00 B. WING	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE - WEST LAFAYETTE	2741 N SALISBURY ST WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 22, 23, 24, 25 and 26, 2024. Facility number: 000093 Provider number: 155177 AIM number: 201271750 Census Bed Type: SNF/NF: 47 SNF: 14 Residential: 69 Total: 130 Census Payor Type: Medicare: 14 Medicaid: 1 Other: 46 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 2, 2024.	F 0000	R- 0000 This plan of correction is to serve as Westminster Village West Lafayette's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Westminster Village West Lafayette or the management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Our plan of correction is prepared and executed as a means to improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to ensure a resident received mouth care	F 0677	**F677 ADL Care Provided for Dependent Residents**	02/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hannah Montgomery	Administrator	02/14/2024

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

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	twice daily for 1 of 2 residents reviewed for activities of daily living (ADL) care. (Resident 37) Finding includes: During an interview, on 1/22/24 at 2:22 p.m., Resident 37's wife indicated the resident had full upper dentures and a partial bottom denture anchored to his remaining natural teeth. The staff would forget to brush his teeth, the toothbrush was dry when she checked it, and she had observed food and debris on natural teeth. The clinical record for Resident 37 was reviewed on 1/24/24 at 10:38 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis affecting one side of the body) following cerebral infarction, Alzheimer's disease, dysarthria (slurred speech) following cerebral infarction, and dysphagia (difficulty swallowing) following cerebral infarction. A care plan, dated 10/14/21, indicated the resident had a need for dental care related to having some permanent teeth, a lower partial, and full upper denture. The approaches included, but were not limited to, a need for dental care related to having some permanent teeth, a partial lower denture, and full upper denture, as the resident allowed. A physician's order, dated 4/6/23, indicated to assist the resident with brushing his teeth twice daily in the morning and in the evening. A Treatment Administration Record (TAR), dated November 1 through November 30, 2023, indicated mouth care was not documented as being completed on the following dates: a. On 11/22/23, for morning mouth care. b. On 11/3/23 and 11/17/23, for evening mouth		**SS=D CFR(s): 483.24(a)(2)** I Resident 37 had no negative consequences from the alleged deficient practice. Resident 37 was provided oral care. It is the practice of Westminster Village West Lafayette to establish and maintain ADL care for all our residents. II The community realizes all residents needing assistance with ADLs have the potential to be affected. An audit has been conducted of all residents requiring assistance with ADLs for oral care to determine compliance per resident preference. III The Activities of Daily Living (ADL's) policy was reviewed and found to meet clinical standards. Education will be provided to all Health Center Nursing Staff on the policy, including providing services for residents who are unable to carry out activities of daily living independently and receiving the services necessary to maintain oral hygiene. Additionally, the Unit Manager or designee will review ADL documentation daily, Monday through Friday, for the previous day(s) to ensure residents received oral care as scheduled and per resident preference. Additional systemic changes are being addressed through our quality assurance process	

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	care. A TAR, dated December 1, 2023, through December 31, 2023, indicated mouth care was not documented as being completed on the following dates: a. On 12/6/23, 12//7/23, 12/11/23 and 12/21/23, for morning mouth care. b. On 12/8/23, 12/9/23, 12/12/23, 12/15/23, 12/20/23, 12/21/23, 12/23/23, 12/25/23, 12/27/23, and 12/29/23, for evening mouth care. A TAR, dated January 1, 2024, through January 24, 2024, indicated mouth care was not documented as being completed on the following dates: a. On 1/14/24 and 1/22/24, for morning mouth care. b. On 1/4/24, 1/6/24, 1/7/24 and 1/9/24, for evening mouth care. During an interview, on 1/26/24 at 11:41 a.m., CNA 8 indicated the dentures were rinsed, adhesive was applied, and the resident was assisted with putting in his dentures. The resident did not have natural teeth, so they did not brush his teeth. Night shift removed the resident's dentures and put them in a cup with a denture tablet. A current policy, titled "Activities of Daily Living [ADL,s], Support," dated 7/13/20 and received from the Director of Nursing on 1/26/24 at 3:00 p.m, indicated "...Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living [ADLs]...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal hygiene...Appropriate care and services will be provided for residents who are unable to		described below. IV The Director of Nursing or designee will: Audit a random sample of 20% of residents for point of care charting and/or visual oral cavity checks, to ensure residents are receiving oral care per resident preference, weekly for 1 month, then every 2 weeks for 3 months, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V The community will be in and remain in compliance by: February 29th, 2024.	

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	carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with...Hygiene [bathing, dressing, grooming and oral care]...." 3.1-38 (a)(3)(C)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure residents with a diagnosis of congestive heart failure (CHF) were weighed as ordered by the physician, a resident had accu-checks completed as ordered by the physician and failed to assess and document a non-pressure skin impairment for 4 of 4 residents reviewed for quality of care. (Resident 2, 33, 30 and 25) Findings include: 1. The clinical record for Resident 2 was reviewed on 1/24/24 at 3:10 p.m. The diagnoses included, but were not limited to, heart failure, atrial fibrillation, cardiomegaly, Alzheimer's, dementia, depression, and anxiety disorder. A care plan, dated 1/3/24, indicated the resident had congestive heart failure. Interventions	F 0684	**F 684 Quality of Care** **SS=E CFR(s): 483.25** I Residents #2, 33, 30, and 25 had no negative consequences from the alleged deficient practice. It is the practice of Westminster Village West Lafayette to establish and follow physician's orders including orders for daily weights, accuchecks, and skin issues. II The community realizes all residents have the potential to be affected. An audit has been completed of all residents with heart failure and daily weight orders and accucheck monitoring for compliance and completion. An	02/29/2024

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	included, but were not limited to, obtain weights as ordered and to monitor and document edema. A physician's order, dated 7/19/22, indicated the resident had congestive heart failure, to monitor weights every other day, and notify the physician of a greater than 5-pound gain. A resident vital stats report, dated 9/1/23 through 1/25/24, indicated the following weights were missing: a. 9/7, 9/9, 9/21 and 9/23/23 b. 10/23, 10/27 and 10/30/23 c. 11/1, 11/3, 11/5, 11/9 and 11/11/23 d. 1/8, 1/10, 1/12, and 1/14/24 During an interview, on 1/26/24 at 12:20 p.m., Unit Manager (UM) 7 indicated she did not know why the resident was not weighed. During an interview, on 1/26/24 at 12:29 p.m., the Director of Nursing (DON) indicated weights should be followed by the physician's order. She did not know why the weights were missing. During an interview, on 1/26/24 at 12:40 p.m., the DON indicated there were no other weights for the resident. 2. The clinical record for Resident 33 was reviewed on 1/24/24 at 4:08 p.m. The diagnoses included, but were not limited to, aphasia (affects how you communicate), congestive heart failure, anxiety disorder, and depression. A care plan, dated 8/17/20, indicated the resident had a history of congestive heart failure. Interventions included, but were not limited to, evaluate extremities for edema (swelling), update the physician as needed, and administer		audit of all resident skin assessment and treatment orders has been conducted for accuracy and compliance. III Physician's Orders, Heart Failure-Clinical Protocol, and Non-pressure Skin Wounds Policies were reviewed and found to meet clinical standards. Education has been provided to all Health Center Licensed Nurses on Glucose Monitoring, Physician Orders, Heart Failure-Clinical Protocol, and Non-pressure Skin Wound policies. Additionally, any new residents admitted to the community will have their physician orders reviewed during admission chart review for accuracy. Additional systemic changes are being addressed through our quality assurance process described below. IV The Director of Nursing or designee will: Audit all residents with heart failure and daily weight orders and/or accucheck testing for order accuracy and completion weekly for 1 month, every 2 weeks for 3 months, then monthly for a total duration of 12 months. Audit a random sample of 20% of residents for completed skin assessments for proper assessment and documentation of non-pressure skin areas verifying appropriate treatments in place	

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	medications as ordered. A physician's order, dated 11/16/22, indicated to obtain a daily weight first thing in the morning, post-void, in pajamas, and before breakfast. Notify the physician of a weight gain greater than 2 pounds in 24 hours and/or 5 pounds in 1 week. A resident weight tracking system report, dated 1/24/24, indicated the following weights were missing: a. 11/2, 11/3, 11/5, 11/6, 11/8, 11/9, 11/16 and 11/17/23 b. 12/8, 12/9, 12/16, 12/17 and 12/21/23 c. 1/2, 1/13, 1/14 and 1/15/24 During an interview, on 1/24/24 at 3:29 p.m., Resident 33 indicated the staff did weigh her this morning, but they did not always weigh her. During an interview, on 1/25/24 at 10:20 a.m., the DON indicated if a resident had a daily weight order her expectations was for the order to be followed and the resident should be weighed. The weighing of the resident was to be completed in the morning and after they void. The staff was to use the same scale. During an interview, on 1/25/24 at 10:32 a.m., CNA 6 indicated the residents with daily weights were weighed first thing in the morning and used the same scale. During an interview, on 1/25/24 at 10:34 a.m., CNA 4 indicated the daily weights should be done first thing when the resident got up for the day. During an interview, on 1/25/24 at 11:21 a.m., UM 7 indicated a daily weight was to be done in the morning and after the resident voided. The staff		weekly for 1 month, then every 2 weeks for 3 months, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V The community will be in and remain in compliance by: February 29th, 2024.	

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	were required to use the same scale and approximately the same time every day. If the weight was not recorded, then it was not completed. During an interview, on 1/26/24 at 3:29 p.m., the DON indicated no additional weights could be found. 3. The clinical record for Resident 30 was reviewed on 1/25/24 at 6:32 a.m. The diagnoses included, but were not limited to, diabetes mellitus, Parkinson's disorder, and mild cognitive impairment. A physician's order, dated 9/22/23, indicated to check blood glucose levels twice a day. The Medication Administration Record, dated 12/1/23 through 1/26/24, indicated the following were missing: a. The 6:00 a.m., accu-check on 12/16/23 was missing. b. The 3:00 p.m., accu-checks on 12/9/23, 12/16/23, 12/27/23, 1/6/24, 1/7/24, 1/9/24, 1/15/24 and 1/19/24 were missing. During an interview, on 1/26/24 at 11:47 a.m., the DON indicated she was not aware of the missing accu-checks. The accu-checks should be documented. During an interview, on 1/26/24 at 3:37 p.m., UM 7 indicated the resident was missing accu checks. She did not notice the missing accu-checks and the physician was not notified. 4. During an observation, on 1/23/24 at 12:31 p.m., Resident 25 was observed, in her wheelchair, wearing open toe sandals with a small bandage on her left great toe.			

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	During an observation, on 1/26/24 at 11:17 a.m., the resident was sitting up, in her wheelchair, she had sandals on, and a small bandage was noted on her left great toe. The bandage was not dated and had some red drainage present. The clinical record for Resident 25 was reviewed on 1/26/24 at 10:50 a.m. The diagnosis included, but were not limited to, Alzheimer disease, type 1 diabetes mellitus with diabetic neuropathy, bell's palsy, osteoarthritis, and venous insufficiency. A physician's order, dated 1/18/24, indicated the resident may be seen by a wound doctor. A podiatrist note, dated 1/18/24, indicated the resident had non palpable pulses in her bilateral feet and edema was noted. The feet were dry, cool, rubor (red), and her nails were long, moderately thick, and discolored. There was no documentation of bleeding, or a small bandage being applied. A review of Resident 25's nursing progress notes, from 1/20/24 to 1/26/24 had no information about the small bandage on the residents left great toe or the visit with the podiatrist. During an interview, on 1/26/24 at 11:07 a.m., LPN 9 indicated the bandage on the left great toe was from a recent podiatry appointment. The podiatrist would have added the bandage if treatment caused bleeding. During an interview, on 1/26/24 at 1:59 p.m., LPN 10 indicated she would check the progress note from the podiatrist. If nothing was documented about the bandage, she would assess the toe, and then call the physician for a treatment order.			

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	A current policy, titled "Heart Failure - Clinical Protocol," received from the DON on 1/25/24 at 11:00 a.m., indicated "...The physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report findings to the physician, etc...." A current policy, titled "Glucose Monitoring," dated 3/20/14 and received from the DON on 1/26/24 at 12:42 p.m., indicated "...The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. The physician will order the frequency of glucose monitoring...." A current policy, titled "Physician's Orders," dated 3/26/23 and received from the DON on 1/26/24 at 10:30 a.m., indicated "...Physician Orders will be carried out as ordered...." A current policy, titled "Non-Pressure Skin Wounds," dated 5/3/18 and received from Unit Manager on 1/26/24 at 3:30 p.m., indicated "...Evaluate and document wound in resident medical records per facility protocol...Obtain a physicians order as needed...." 3.1-37(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.			

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	(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review, the facility failed to ensure posted nurse staffing was up to date and had the correct hours of staff nurses for 2 of 2 posted nurse staffing lists. (1/23/24 and 1/24/24) Finding includes:	F 0732	**F732 Posted Nurse Staffing Information** **SS=C CFR(s): 483.35(g)(1)-(4)** I No residents experienced negative consequences from the alleged deficient practice. The community	02/29/2024

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	During an observation, on 1/24/24 at 3:25 p.m., the front door had staffing posted for 1/23/24. During an observation, on 1/24/24 at 3:40 p.m., the posted nurse staffing, dated 1/24/24, on the Terrace Unit indicated 2.5 nurses were scheduled for the 2:30 p.m., through 10:30 p.m., shift. During an interview, on 1/24/24 at 3:45 p.m., the Health Facility Administrator (HFA) indicated the staffing at the front door was not the correct date and the posted nurse staffing on the Terrace Unit did not have 2 and a half nurses working. There were 2 nurses working the entire shift and one nurse working a split shift. A current policy, titled "Posting Direct Care Daily Staffing Numbers," dated as revised on August 2022 and received from the Director of Nursing on 1/26/24 at 3:20 p.m., indicated "...Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents...Within two [2] hours of the beginning of each shift, the number of licensed nurses...and the number of unlicensed nursing personnel...directly responsible for resident care is posted in a prominent location [accessible to residents and visitors] and in a clear and readable format...The information recorded on the form shall include the following...The current date...The actual time worked during that shift for each category and type of nursing staff...." 3.1-17(a)		added specific shift times to the posting during the survey immediately upon surveyor notification. It is the practice of Westminster Village West Lafayette to assure that the posted nursing staff information is updated daily with the facility name, current date and hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. II As stated above, daily staff posting was changed to reflect specific hours of staff during the survey. III The Posting Direct Care Staffing Numbers Policy was reviewed and found to meet clinical standards. Education provided to Westminster Village West Lafayette Staffing Coordinator and designee on including specific shift times on the daily nursing staff posting. Additional systemic changes are being addressed through our quality assurance process described below. IV Director of Nursing or designee will: Audit daily nursing staff posting to ensure specific hours are listed on staff posting completed every day, including weekends, for 1 month,	

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WESTMINSTER VILLAGE - WEST LAFAYETTE	2741 N SALISBURY ST WEST LAFAYETTE, IN 47906

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			then one time weekly for 2 months, then one time monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V The community will be in and remain in compliance by: February 29th, 2024.	
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview and record review, the facility failed to ensure all areas of the wireless call system were functioning properly for 2 of 2 residents reviewed for call devices. (Residents 19 and 13) Findings include:	F 0919	**F919 Resident Call System** **SS=D CFR(s): 483.90(g)(1)(2)** I Residents 19 and 13 had no negative consequences from the alleged deficient practice. Resident 19's pendant was	02/29/2024

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	1. During an interview, on 1/22/24 at 1:14 p.m., Resident 19 indicated sometimes call lights were not answered or could take a long time to be answered. He used his call pendant around his neck as his call light. During an observation and interview, on 1/22/24 at 1:45 p.m., Resident 19 pressed his call pendant around his neck. During an observation and interview, on 1/22/24 at 1:56 p.m., RN 2 indicated she did not know the resident's call light was pressed. She did not have a notification to her Vocera (wireless communication system staff members wore to receive call light notifications and talk to other staff). There was no indication the resident's call light was pressed per the call light monitor screen out in the hall. During an interview, on 1/22/24 at 1:58 p.m., RN 2 indicated the resident's call pendant was not working. During an interview, on 1/26/24 at 4:10 p.m., the DON (Director of Nursing) indicated their SARA daily system status report (system for showing missing and low batteries) showed low batteries and missing batteries for the residents. Somehow Resident 19's call pendant got missed and they were working on figuring out why. The clinical record for Resident 19 was reviewed on 1/22/24 at 2:50 p.m. The diagnoses included, but were not limited to, unspecified paraplegia, pain in the lower left and right knee, and unspecified osteoarthritis. 2. During an interview, on 1/23/24 at 12:31 p.m., Resident 13 indicated the staff did not always answer the call lights and it		immediately replaced with a new functioning pendant. It is the practice of Westminster Village West Lafayette to ensure all areas of the wireless call system are functioning properly. II The community realizes that all residents have the potential to be affected. An audit has been conducted of all wireless call pendants to ensure functionality. All pendants showed to be functional and in working order. III Nurse Call System policy was reviewed and found to meet clinical standards. Education was provided to all Health Center Nursing Staff on the policy, including answering call lights, replacement and monitoring of device function, and reporting call light function issues. IV Administrator or designee will: Audit five random resident pendants to ensure proper functioning, completed three times weekly for 1 month, weekly for 1 month, every 2 weeks for 2 months, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance	

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	took a long time after you press your call light for the staff to answer. During an observation, on 1/23/24 at 12:31 p.m., the resident pressed her pendant and the light on the pendant flashed red. The pendant did not make a sound when it was pressed. During an observation, on 1/23/24 at 12:42 p.m., the resident pressed the pendant again. During an observation, on 1/23/24 at 12:46 p.m., Unit Manager (UM) 7 walked by the room and did not look in the resident's room. The clinical record for Resident 13 was reviewed on 1/25/24 at 9:38 a.m. The diagnoses included, but were not limited to, atrial fibrillation, muscle weakness, pain right knee, cognitive impairment of uncertain or unknown etiology, pacemaker, epilepsy, congestive heart failure, cardiomegaly, depression, and history of (healed) traumatic fracture. A care plan, dated 2/6/23, indicated the resident was at risk for falls related to impaired mobility, history of falls, and history of a fractured left femur. Interventions included, but were not limited to, frequent visual checks, resident was not to be left unattended, and a 2-person maximum assist using a mechanical lift. A physician's order, dated 11/27/23, indicated the resident's activity level was weight bearing as tolerated. During an interview, on 1/23/24 at 12:58 p.m., QMA 3 indicated she knew the resident's call light was going off.		has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V The community will be in and remain in compliance by: February 29th, 2024.	

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	During an interview, on 1/23/24 at 12:59 p.m., QMA 5 indicated she had a pager, but the battery was dead, and she probably should get a new one. During an interview, on 1/23/24 at 1:05 p.m., UM 7 indicated a pager would need to be replaced right away if the pager was not working properly. The screens with the call lights are on both ends of the halls and at the nurse's station. The devices the staff carry would beep and flash the room number when a call light was pressed. The staff could look at the screens to see who had their call light on. UM 7 saw Resident 13's call light when she walked by the room. She was too busy to answer the call light. During an interview, on 1/26/24 at 2:17 p.m., the DON indicated when a resident pressed their pendant or room call light the resident's room number would appear on the staff's vocera. The location of the resident would also appear on a wall computer screen. There were computer screens on each hallway and nurse's station. The screen would light up red and would indicate the location of the resident. The staff would have to search for the resident if they moved locations. The call light pendant the staff wore would beep when the devices battery was low and would inform the staff the battery was low. When the batteries were not replaced, the device would turn off. The extra batteries were stored at the nurse's station. When the batteries were dead then you would have to check the screens. A Qualified Medication Aide (QMA) position description indicated the QMA was to answer resident's calls promptly. A Certified Nurse Aide (CNA) position			

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	description indicated the CNA was to monitor residents through frequent rounds to ensure their personal care needs were being met and to answer resident's calls promptly. A current policy, titled "Nurse Call System," dated as revised 4/29/19 and received from the Admissions Nurse on 1/26/24 at 3:40 p.m., indicated "...If the Nurse Call System is temporarily out of service for more than thirty (30) minutes, the Charge Nurse will notify the Administrator and/or Designee...." 3.1-19(u)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure items were not stored on the floor in resident rooms, carpet squares edges were not peeling, and the walls were free of gouges for 4 of 4 rooms reviewed for environment. (Room A10, A9, A3 and C11D.) Findings include: 1a. During an observation, on 1/22/24 at 10:30 a.m., Room A10 had a small pile of magazines, two decorative boxes, and opened mail on the floor. 1b. During an observation, on 1/25/24 at 12:20 p.m., Room A10 had a large cardboard box with papers inside and opened mail stored on the floor. 2. During an observation, on 1/22/24 at 10:36 a.m., Room A9 had a grocery sack with the resident's	F 0921	**F921** **Safe/Functional/Sanitary/Comfortable Environ** **SS=D CFR(s): 483.90(i)** I Residents in Rooms A10, A9, A3, and C11D were evaluated and have no negative consequences from the alleged deficient practice. During the survey, a work order was placed upon finding of wall gouge in Room C11D on 1/23/24 and was repaired and painted. A work order was placed upon finding carpet squares peeling up in Room A3. Carpet squares were repaired on 1/23/24. A10 and A9 were provided with a plastic box to store their items in as resident prefers. It is the practice of	02/29/2024

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	personal items on the floor next to the window. 3. During an observation, on 1/22/24 at 2:51 p.m., Room A3 had four squares of carpet peeling up in the center of the four squares. 4. During an observation, on 1/22/24 at 3:49 p.m., Room C11D had a large area of gouges in the drywall and missing paint. During an interview, on 1/22/24 at 12:20 p.m., Certified Nurse Aide (CNA) 6 indicated the sack on the floor of A9, the boxes, and the opened mail should not be left on the floor. The items on the floor could make the residents fall or it could cause bugs. During an interview, on 1/22/24 at 3:39 p.m., the resident in Room C11D indicated the facility had made no attempts to repair the wall since the resident moved in on 7/28/23. During an interview, on 1/25/24 at 11:21 a.m., Unit Manager 7 indicated the boxes, mail on the resident's floor, and the carpet tiles peeling up could be a tripping hazard. The cardboard box and papers could be an infection control problem as they could attract bugs. During an interview, on 1/25/24 at 12:20 p.m., the Director of Nursing (DON) indicated the items should not be on the floor. A current policy, titled "Homelike Environment," dated as revised 2/2021 and received from the Director of Nursing on 1/24/24 at 4:47 p.m., indicated "...Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personnel belongings to the extent possible. Staff provides		Westminster Village West Lafayette to provide and maintain a safe, clean, comfortable, and home-like environment for every resident. II The community realizes all residents have the potential to be affected. This is being addressed by the systems described below. III The Homelike Environment Policy was reviewed and found to meet clinical and environmental standards. Education provided to all Health Center Nursing Staff and Plant Operations Staff on Homelike Environment Policy and expectations. Additional systemic changes are being addressed through our quality assurance process described below. IV Administrator or designee will: Audit five random resident rooms to ensure homelike environment is maintained, completed three times weekly, for 1 month, then one time weekly for 2 months, then one time monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined	

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	person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences...clean, sanitary and orderly environment...." 3.1-19(f)(5)		by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V The community will be in and remain in compliance by: February 29th, 2024.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 22, 23, 24, 25 and 26, 2024. Facility number: 000093 Residential Census: 69 Westminster Village - West Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on February 2, 2024.	R 0000	R- 0000 This plan of correction is to serve as Westminster Village West Lafayette's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Westminster Village West Lafayette or the management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Our plan of correction is prepared and executed as a means to improve the quality of care and to comply with all applicable state and federal regulatory requirements.	