PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | JILDING | onstruction 00 | (X3) DATE COMPL 08/11 / | ETED | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE | | | 3575 SE | ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906 | | | |
| (X4) ID PREFIX TAG R 0000 | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| Bldg. 00 | IN00413270, IN004 Complaint IN00413 to the allegations are complaint IN00413 the allegations are complaint IN00414 the allegations are complaint I | 1814 - No deficiencies related to ited. 1325 - No deficiencies related to ited. 1315 - No deficiencies related to ited. 1316 - No deficiencies related to ited. 1317 - No deficiencies related to ited. 1318 - No deficiencies related to ited. | R 0 | 000 | | | |
| R 0241 Bldg. 00 | provision of reside as ordered by the shall be supervise the premises or or (1) Medication sha licensed nursing p medication aides. During interview ar failed to keep the re medication error. The | Offense Ition of medications and the Intial nursing care shall be It resident 's physician and It by a licensed nurse on | R 0 | 241 | Immediately assured that an insulin certified associate was the schedule to administer insulins and blood sugar checi | on | 10/04/2023 |

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 disclodays 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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PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|------------------------------------------------------|---------------------|----------------------------------------------------------|-------------------|-----------|---------------------------------------------------------------------------------------------------------|-------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | a. building <u>00</u> | | COMPLETED | | | |
| | | | B. WING 08/11/202 | | | /2023 | |
| | | <u> </u> | | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | ENIOR PLACE | | |
| MICKSH | IRE WEST LAFAYI | ETTE | | | LAFAYETTE, IN 47906 | | |
| WICKSII | | | | WEST | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | - | TAG | DEFICIENCY) | | DATE |
| | physician (Reside | nts B, D, G, H, J and K) | | | Audit was completed of cert | ified | |
| | | | | | staff to be able to administer | | |
| | Findings included: | | | | insulin by Health and Wellness | 3 | |
| | | | | | Director and Business Office | | |
| | | ident H was reviewed on | | | Manager. | | |
| | 8/10/2023 at 2:46 p | o.m. | | | 3. Schedule to be reviewed by | | |
| | Diagnage for D | dont II included but a -t | | | Health and Wellness Director | | |
| | | dent H included, but not Diabetes Mellitus and Epilepsy. | | | Executive Director weekly time | es | |
| | minicu io, Type 2 I | Diadetes Menitus and Ephiepsy. | | | four weeks. 4. Staff members who are ins | ulin | |
| | The Resident Medi | cation Administration History | | | certified will be administrating | uilli | |
| | | licated Resident H was to | | | insulin 100% of the time. Ever | vone | |
| | receive Humlog So | | | | administrating insulin will be | yonc | |
| | 1 | day before meals- inject 12 | | | insulin certified. All insulin | | |
| | | on was not given on 7/9/2023 | | | certifications will be verified up | on | |
| | | 1:30 a.m. The reason the | | | hire and new certifications. He | | |
| | | given was the staff did not | | | and Wellness Director will aud | | |
| | | administer the medication. | | | schedules on going. | | |
| | | | | | 3 5 | | |
| | The MARS record | indicated Resident H was to | | | | | |
| | receive Humalog S | olution 100 unit /ml inject per | | | | | |
| | _ | blood sugar check before meals | | | | | |
| | | day. The medication was not | | | | | |
| | _ | at 6:00 a.m. and 11:30 a.m.The | | | | | |
| | | ion was not given was the staff | | | | | |
| | | cation to administer the | | | | | |
| | medication. | | | | | | |
| | TEI 10 F | | | | | | |
| | | ident C was reviewed on | | | | | |
| | 8/10/2023 at 5:30 p | o.m. | | | | | |
| | Diagnoses for Desi | dent C included but not limited | | | | | |
| | to, Type 2 Diabetes | dent C included, but not limited | | | | | |
| | io, Type 2 Diabetes | o ivicinitus. | | | | | |
| | The MARS record | indicated Resident C was to | | | | | |
| | | njection solution per sliding | | | | | |
| | | ly before meals every day. | | | | | |
| | | s not given on 7/9/2023 at 8:00 | | | | | |
| | | The reason the medication was | | | | | |
| | _ | taff did not have certification | | | | | |
| | l ~ | | 1 | | | | I |

State Form Event ID: Y0NO11 Facility ID: 014094 If continuation sheet Page 2 of 10

PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | LDING | 00 | COMPL 08/11/ | ETED | |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|---------------------|-------------------------------------------------------------------------------------------------------------------------|------|----------------------------|
| | ROVIDER OR SUPPLIER | | | 3575 SE | DDRESS, CITY, STATE, ZIP COD ENIOR PLACE AFAYETTE, IN 47906 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | P | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | to administer the more receive the medicate | edication. The resident did not ion on an additional n. No reason was given for no | | | | | |
| | The record for Reside 8/102023 at 4:00 p.s. | dent J was reviewed on m. | | | | | |
| | _ | lent J included, but not limited Mellitus. and COPD | | | | | |
| | receive Novolog inj inject per sliding so before meals subcut medication was not and 11:30 a.m. The given was the staff of administer the medicate 7/4/2023 at 9:00 p.r. | ndicated Resident J was to ection solution 100 unit/ml ale after blood sugar check aneous every day. The given on 7/9/2023 at 6:30 a.m. reason the medication was not did not have certification to cation. The resident did not ion on additional dates n., 7/20/203 at 9:00 p.m., m. and 7/29 at 4:30p.m. and 9:00 n for no medication | | | | | |
| | receive Lantus Solo units subcutaneousl medication was not | ndicated Resident J was to star 100Unit/ML inject 18 y one time a day. The given on 7/9/2023 in the a.m. ication was not given was the ed to administer the | | | | | |
| | The record for Resident 8/10/2023 at 3:30 p. | dent G was reviewed on m. | | | | | |
| | Diagnoses for Resid to, type 2 Diabetes I | lent G included, but not limited Mellitus. | | | | | |

State Form Event ID: Y0NO11 Facility ID: 014094 If continuation sheet Page 3 of 10

PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|------------------------------------------------------|----------------------|----------------------------------|-------|-----------------------|------------------------------------------------------------------------|--------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | a. building <u>00</u> | | | COMPLETED | |
| | | | B. WI | NG | | 08/11/ | /2023 | |
| | | . | | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | ENIOR PLACE | | | |
| WICKSH | IRE WEST LAFAYI | ETTE | | | _AFAYETTE, IN 47906 | | | |
| WICKOII | | | | WLOTE | -AI AI EI I E, III 47 300 | | | |
| (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 APPROPRIA | TE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | | indicated Resident G was to | | | | | | |
| | | tion 100 unit/ml - inject 40 | | | | | | |
| | | one time a day. The | | | | | | |
| | | given on 7/20/2023 and 7/29 | | | | | | |
| | | was no reason the medication | | | | | | |
| | was not given. | | | | | | | |
| | The MARS record | indicated Resident G was to | | | | | | |
| | | jection solution 100 unit/ml | | | | | | |
| | | eale after blood sugar check | | | | | | |
| | | taneous every day. The | | | | | | |
| | | given on 7/9/2023 at 7:00 a.m. | | | | | | |
| | | reason the medication was not | | | | | | |
| | given was the staff | did not have certification to | | | | | | |
| | administer the med | ication. The resident did not | | | | | | |
| | receive the medicat | ion on an additional date | | | | | | |
| | 9/29/2023 at 4:00 p | .m No reason was given for no | | | | | | |
| | medication adminis | stration. | | | | | | |
| | | | | | | | | |
| | | dent K was reviewed on | | | | | | |
| | 8/10/2023 at 4:46 p | o.m. | | | | | | |
| | D: | dans V in abadad bass and | | | | | | |
| | | dent K included, but not | | | | | | |
| | limited to, Type 2 I | Diabetes Menitus. | | | | | | |
| | The MARS record | indicated Resident K was to | | | | | | |
| | | ostar solution injection | | | | | | |
| | solution 100 unit/m | • | | | | | | |
| | | imes a day. The medication | | | | | | |
| | | /9/2023 at 7:00 a.m.,.The reason | | | | | | |
| | | not given was the staff did not | | | | | | |
| | | administer the medication. | | | | | | |
| | The resident did no | t receive the medication on an | | | | | | |
| | additional date 7/29 | 9/2023 at 3:00 p.m No reason | | | | | | |
| | | edication administration. | | | | | | |
| | | | | | | | | |
| | | indicated Resident K was to | | | | | | |
| | | olution injection solution 100 | | | | | | |
| | | nits subcutaneous three times | | | | | | |
| | a day. The medicati | ion was not given on 7/9/2023 | | | | | | |

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PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| 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 08/11/2023 | |
|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------|
| NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE | | 3575 SI | ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906 | | |
| (X4) II PREFI TAC | X (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | at 8:00 a.m. and 12 medication was not have certification to The resident did not additional date 7/25 was given for no medication and the record for Resident did not additional date 7/25 was given for no medicate for the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record for Resident did not a factor of the record did not a f | 200 p.mThe reason the given was the staff did not to administer the medication. It receive the medication on an 20/2023 at 5:00 p.m No reason edication administration Ident D was reviewed on p.m. dent D included, but not expressive disorder and type 2 indicated Resident D was to estar solution injection all inject 5 units subcutaneous expressive medication was not given on on the medication was not did not have certification to | | | |

State Form Event ID: Y0NO11 Facility ID: 014094 If continuation sheet Page 5 of 10

PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BU | A. BUILDING 00 B. WING | | COMPLETED 08/11/2023 | | |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE | | | 3575 SE | ADDRESS, CITY, STATE, ZIP COD ENIOR PLACE LAFAYETTE, IN 47906 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC 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) | .TE | (X5) COMPLETION DATE |
| R 0248 | The current facility ", effective date 11/0 Executive Director of indicated " h.1. M administered by lice qualified mediation 410 IAC 16.2-5-4(f | ensed nursing personnel aides" | | | | | |
| Bldg. 00 | premises or on cal nurse at all times. Based on interview failed to ensure a lic on-call or on the preinjection medication for 6 of 6 residents administration. (Res Findings include: 1. The record for Res 8/10/2023 at 2:46 p. were not limited to, epilepsy. The Medication Admindicated Resident F. Solution 100 unit/m | I have available on the Il the services of a licensed and record review, the facility tensed staff member was emises to administer insulin as as ordered by the physician | R 02 | 248 | 1. Immediately assured that an insulin certified associate was on the schedule to administer insulins and blood sugar checks. 2. Audit was completed of certified staff to be able to administer insulin by Health and Wellness Director and Business Office Manager. 3. Schedule to be reviewed by Health and Wellness Director and Executive Director weekly times four weeks. 4. Health and Wellness Director will audit schedules on going. | | 10/04/2023 |
| | not given on 7/9/202 The reason the medistaff did not have comedication. The MAR indicated Humalog Solution 1 | 23 at 6:30 a.m., and 11:30 a.m. ication was not given was the ertification to administer the Resident H was to receive 00 unit/ml, inject per sliding gar check before meals | | | | | |

State Form Event ID: Y0NO11 Facility ID: 014094 If continuation sheet Page 6 of 10

PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULT A. BUILE B. WING | DING | NSTRUCTION 00 | (X3) DATE S COMPL 08/11/ | ETED | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------|-------------------------------------------------------------------------------------------------------------------------|------|----------------------------|
| NAME OF F | ROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP COD NIOR PLACE | | |
| WICKSH | IRE WEST LAFAYE | ETTE | V | VEST L | AFAYETTE, IN 47906 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | PRI | D EFIX 'AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | subcutaneous every given on 7/9/2023 a reason the medication did not have certific medication. 2. The record for Res 8/10/2023 at 5:30 p were not limited to, The MAR indicated Humalog injection is subcutaneously beformedication was not and 12:00 p.m. The given was the staff administer the medicational date of 7/ was given for not accompany to the staff of the staff | day. The medication was not to 6:00 a.m., and 11:30 a.m. The on was not given was the staff ration to administer the desident C was reviewed on a.m. Diagnoses included, but type 2 diabetes mellitus. Resident C was to receive solution per sliding scale ore meals every day. The given on 7/9/2023 at 8:00 a.m., reason the medication was not did not have certification to cation. The receive the medication on an area of the medication on an area of the medication. The receive the medication on an area of the medication. The receive the medication on an area of the medication. The receive the medication on an area of the medication. The receive the medication on an area of the medication. The receive the medication on an area of the medication. The receive the medication on an area of the medication. The receive the medication on an area of the medication. The receive the medication on an area of the medication on an area of the medication. | | | CROSS-REFERENCED TO THE APPROPRIAT | TE | |
| | | on was not given was the staff ration to administer the | | | | | |
| | additional dates of 7 at 9:00 p.m., 7/28/2 | receive the medication on the 7/4/2023 at 9:00 p.m., 7/20/2023 023 at 9:00 p.m., and 7/29/2023 00 p.m. No reason was given for the medication. | | | | | |

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PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE STREET ADDRESS, CITY, STATE, ZIP COD 3575 SENIOR PLACE WEST LAFAYETTE, IN 47906 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG | (X5) COMPLETION DATE |
| The MAR indicated Resident J was to receive Lantus Solostar 100 unit/ml, inject 18 units subcutaneously one time a day. The medication was not given on 7/9/2023 in the a.m. The reason the medication was not given was the staff was not certified to administer the medication. 4. The record for Resident G was reviewed on 81/0/2023 at 3:30 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The MAR indicated Resident G was to receive Lantus solution 100 unit/ml, inject 40 units subcutaneous one time a day. The medication was not given on 7/20/2023 and 7/29/2023 at bedtime. There was no documentation for why the medication was not given. The MAR indicated Resident G was to receive Novolog injection solution 100 unit/ml, inject per sliding scale after blood sugar check before meals subcutaneous every day. The medication was not given on 7/9/2023 at 7:00 a.m., and 11:00 a.m. The reason the medication was not given was the staff did not have certification to administer the medication. The resident did not receive the medication on an additional date of 7/29/2023 at 4:00 p.m. No reason was given for not administering the medication. 5. The record for Resident K was reviewed on 8/10/2023 at 4:46 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The MAR indicated Resident K was to receive Lantus Solostar injection solution 100 unit/ml, inject 115 units subcutaneous two times a day. The medication was not given on 7/9/2023 at 7:00 | |

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PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | COM | e survey pleted 1/2023 | |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------|------------------------------|----------------------|
| | PROVIDER OR SUPPLIEF | | 3575 SI | ADDRESS, CITY, STATE, ZIP COI ENIOR PLACE LAFAYETTE, IN 47906 | D | _ |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| | | e medication was not given was we certification to administer | | | | |
| | additional date of 7 | t receive the medication on an /29/2023 at 3:00 p.m. No reason dministering the medication. | | | | |
| | Humalog injection units subcutaneous medication was not | d Resident K was to receive solution 100 unit/ml, inject 40 three times a day. The given on 7/9/2023 at 8:00 a.m., reason the medication was not | | | | |
| | administer the med | | | | | |
| | additional date of 7 | t receive the medication on an /29/2023 at 5:00 p.m. No reason dministering the medication. | | | | |
| | 8/10/2023 at 4:10 p | esident D was reviewed on .m. Diagnoses included, but major depressive disorder and litus. | | | | |
| | Lantus Solostar injoinject 5 units subcumedication was not the medication was | d Resident D was to receive ection solution 100 unit/ml, taneous one time a day. The given on 7/9/2023. The reason not given was the staff did not a administer the medication. | | | | |
| | QMA 2 indicated sl insulin injections or available to give the | v, on 8/11/2023 at 11:24 a.m., the was not certified to give the n 7/9/2023. There was no staff the residents' insulin injections. ecutive Director (ED). | | | | |
| | _ | v, on 8/11/2023 at 2:30 p.m., the support Staff indicated she was | | | | |

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PRINTED: 09/21/2023 FORM APPROVED OMB NO. 0938-039

| <u>`</u> | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 08/11/2023 | |
|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WICKSHIRE WEST LAFAYETTE | | | 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 R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | insulin medications should have been g made sure staffing medication administ During an interview Director of Nursing should have been so their insulin medicat A current facility possibly Substances," with a and received from to 8/11/2023 at 5:30 p shall be administered personnel qualified | 7, on 8/10/2023 at 5:05 p.m., the (DON) indicated the staff | | | | |

State Form Event ID: Y0NO11 Facility ID: 014094 If continuation sheet Page 10 of 10