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	11/03/2022

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 27, 28, 31 and November 1, 2 and 3, 2022 Facility number: 000093 Provider number: 155177 AIM number: 20121750 Census Bed Type: SNF/NF: 6 SNF: 61 Residential: 38 Total: 105 Census Payor Type: Medicare: 17 Medicaid: 1 Other: 49 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 10, 2022.	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. We respectfully request a desk review of this POC and a subsequent paper compliance revisit.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gregory Steele	Administrator	11/23/2022

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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	effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on observation, interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when a new mental health diagnosis and antipsychotic medication was prescribed for 2 of 3 residents reviewed for PASARR. (Resident 44 and 12) Findings include: 1. The record for Resident 44 was reviewed on 10/31/22 at 2:48 p.m. Diagnoses included, but were not limited to, dementia without behaviors, a psychotic disorder with delusions due to a known physiological condition and disorientation. A physician's order, dated 3/29/22, indicated to give Seroquel (an antipsychotic) 25 mg (milligram) twice daily for dementia with behavior disturbance and psychotic disorder with delusions due to known physiological conditions. A physician's order, dated 10/3/22, indicated to give Seroquel three times daily for a psychotic disorder with delusions.	F 0644	**F 0644 Coordination of PASARR and Assessments** **SS=D CFR(s): 483.20(e)(1)(2)**– It is the practice of Westminster Village West Lafayette to ensure a PASARR is completed when a new mental health diagnosis and antipsychotic medication is prescribed. I. Residents #44 and #12 had no negative consequences from the alleged deficient practice. The Social Services Designee (SSD) submitted new PASARR screens for Resident #44 and #12. II. The community realizes all residents prescribed antipsychotic medications and residents with new mental health diagnosis, have the potential to be affected. An audit of all residents who receive psychotropic medication and with new mental health diagnosis within the past 30	12/14/2022

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	A PASARR Level I, dated 2/22/22, indicated the resident did not need a level II screen and had no evidence of a PASARR condition. The resident had anxiety and depression diagnoses and did not have a dementia diagnosis. There were no known mental health behaviors which affected interpersonal communications. The mental health medication was listed as buspirone (medication to treat anxiety disorders). If changes occurred or new information refuted these findings, a new Level I screen must be submitted. During an interview, on 10/31/22 at 4:15 p.m., the SSD (Social Services Designee) indicated there was not another PASARR after the resident was prescribed Seroquel and another PASARR level I should have been completed. 2. The record for Resident 12 was reviewed on 10/31/22 at 10:59 a.m. Diagnoses included, but were not limited to, Parkinson's disease (a disorder affecting movement), hypertension, dementia without behaviors, psychotic disorder with hallucinations, Alzheimer's disease and depressive disorder. A diagnosis of psychotic disorder with hallucinations was added 1/11/19. A diagnosis of psychotic disorder with delusions was added 1/11/19 and dementia was added 4/12/21. A physician's order, dated 10/1/22, indicated to give Seroquel (an antipsychotic medication) 25 mg (milligram) 1 tablet twice a day related to a psychotic disorder with hallucinations. A PASARR level I, dated 3/8/18, indicated the resident had a diagnoses of major depressive disorder. A level II was not recommended. If changes occurred or new information refuted these findings, a new Level I screen must be submitted.		days, has been completed, for PASARR compliance. Eight resident records reviewed withall found to be in compliance. Resident records updated as indicated. III. The Indiana PASRR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual has been reviewed and found meet clinical standards. Education provided to all Social Service Staff on the Indiana PASRR Level I & Level of Care Screening Procedures. Additionally, a tracking log specific to anti-psychotic medications and psychotic diagnoses has been created. This log will be discussed daily, Monday through Friday in morning clinical meeting. IV. The Social Service Designee will: Audit all new anti-psychotic medication and new psychiatric diagnoses utilizing log, daily, Monday through Friday, for 4 weeks, then twice a week for 3 months, then weekly 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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	During an interview, on 10/31/22 at 4:12 p.m., the Social Service Designee (SSD) indicated a new PASARR Level I should have been completed when the resident started an antipsychotic medication. During an interview, on 11/1/22 at 9:56 a.m., the SSD indicated Resident 12 did not have a Level I completed when Seroquel was started and should have had a new Level I completed. A current policy, titled "Indiana PASRR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual," dated as revised 4/29/20 and received from the Social Service Coordinator on 11/1/22 at 11:14 a.m., indicated "...Identifies people who have or might have a serious mental illness (SMI), Intellectual disability (ID), or a condition related to intellectual disability...determine services and supports any person with MI/ID/RC need. The PASRR Level II evaluation identifies the rehabilitative or specialized services that the person needs. Nursing facilities must plan for and deliver or arrange for the delivery of all rehabilitative services that the PASRR Level II identifies...The Level I screen gathers information about people with SMIs. This information includes the person's mental health diagnoses, their symptoms and intensity, and how much the condition and its symptoms have impacted the person's life and well being...If a NF resident's behavioral or mental status significantly changes, the NF must submit a new Level I to report the change through the PASRR process...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		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 facility will be in and remain in compliance by: December 14th, 2022.	

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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 observation, interview and record review, the facility failed to ensure a resident needing assistance with ADL's (activity of daily living) was provided the scheduled showers for 2 of 2 residents reviewed for activity of daily living. (Resident 4 and 45) Findings include: 1. During an observation, on 10/27/22 at 3:30 p.m., Resident 4's hair appeared greasy and uncombed. The resident indicated she did not always get a shower and it had been days since her hair was washed. During an interview, on 11/1/22 at 11:24 a.m., Resident 4 indicated she did not receive a shower on 10/27/22. The record for Resident 4 was reviewed on 10/28/22 at 4:33 p.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease (a movement disorder), cognitive communication deficit, psychotic disorder with hallucinations and depression. The MDS (Minimum Data Set) assessment, dated 7/21/22, indicated the resident needed one person extensive assist with showers and bathing. A Shower Schedule, received on 11/1/22 at 3:46 p.m., by the Director of Nursing, indicated Resident 4 had showers scheduled on	F 0677	**F 0677 ADL Care Provided for Dependent Residents** **SS=D CFR(s): 483.24(a)(2)** – It is the practice of Westminster Village West Lafayette to establish and maintain ADL care for all our residents. I. Residents #4 and #45 had no negative consequences from the alleged deficient practice. Residents #4 and #45 were provided a shower. II. The community realizes all residents needing assistance with ADLs, have the potential to be affected. An audit will be conducted of all residents requiring assistance with ADLs for shower schedule and completion and found to determine compliance per resident preference. III. The Activities of Daily Living (ADL's), Supporting Policy, was reviewed and found to meet clinical standards. Education was provided to all Health Center Nursing Staff on the policy, including providing services for residents who are unable to	12/14/2022

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	Wednesday and Saturday. A Shower Alert-Skin Alert indicated the resident missed the following showers: a. 7 showers in August. b. 6 showers in September. c. 9 showers in October. During an interview, on 11/2/22 at 1:56 p.m., CNA 5 indicated she was unaware if the resident refused showers. During an interview, on 11/2/22 at 2:28 p.m., CNA 5 indicated if the shower sheets were missing, the resident did not receive a shower. 2. During an observation, on 10/31/22 at 12:31 p.m., Resident 45 was sitting in her wheelchair, asleep. Her hair was greasy and uncombed. During an observation, on 11/01/22 at 10:30 a.m., the resident was sitting, in her wheelchair, with her eyes closed. Resident 45's hair was greasy. The record for Resident 45 was reviewed on 10/28/22 at 4:29 p.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease, cognitive communication deficit, hallucinations and depression. The MDS assessment, dated 9/22/22, indicated the resident was a two person total assist with showers and bathing. A Shower Schedule, received on 11/1/22 at 3:46 p.m., by the Director of Nursing, indicated Resident 45 had showers scheduled on Tuesday, Friday and Sunday. A Shower Alert-Skin Alert indicated Resident 45		carry out activities of daily living independently and receiving the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Additionally, the Unit Manager or designee will review shower sheets daily, Monday through Friday, for the previous day(s) to ensure residents received showers as scheduled and per resident preference. IV. The Director of Nursing or designee will: Audit a random sample of 20% of residents for point of care charting, shower alert-skin alert, to ensure residents are receiving showers per resident preference, weekly for 4 weeks, then bi-weekly 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 facility will be in and remain in compliance by: December 14th, 2022.	

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	missed the following showers: a. 7 showers in August. b. 8 showers in September. c. 10 showers in October. A current policy, titled "Activities of Daily Living (ADL's), Supporting," dated as revised 3/2018 and received from the Social Services Coordinator on 11/3/22 at 4:37 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 and oral hygiene...Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and the accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care)...If residents with cognitive impairment or dementia resist care, staff will attempt to identify underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate...The resident's response to interventions will be monitored, evaluated and revised as appropriate...." 3.1-38(a)(3)(B) 3.1-38-(b)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.			

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	The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to obtain complete physician's orders for the use of oxygen for 2 of 5 residents reviewed for oxygen. (Residents 33 and 214) Findings include: 1. The record for Resident 33 was reviewed on 11/01/22 12:23 p.m. Diagnoses included, but were not limited to, Alzheimer's terminal illness, anxiety, adult failure to thrive, depression, dementia, protein calorie malnutrition, restlessness and agitation. A physician's order, dated 6/7/21, indicated 2 to 4 liters of oxygen per nasal cannula as needed for comfort. The order did not indicate symptoms or parameters to titrate the oxygen from 2 to 4 liters. A care plan, dated 6/8/21, indicated the resident was receiving hospice care for end stage disease and terminal illness of Alzheimer's disease. She was to be supported to promote comfort and dignity through out her terminal illness. Interventions included, but were not limited to, if increased pain was noted notify hospice and comfort medications as ordered and needed. The interventions did not include oxygen for	F 0695	**F 0695** **Respiratory/Tracheostomy Care and Suctioning** **SS=D CFR(s): 483.25(i)** – It is the practice of Westminster Village West Lafayette to establish and maintain complete physician's orders including orders for the use of oxygen. I. Residents #33 and #214 had no negative consequences from the alleged deficient practice. Resident #214 no longer reside in community. Resident #33 has had the oxygen order updated and in is compliance. II. The community realizes all residents utilizing oxygen, have the potential to be affected. An audit has been completed of all #__ residents receiving oxygen. All residents' orders have been updated as indicated to and are in compliance. III. The Oxygen Administration Policy was reviewed and found to meet clinical standards.	12/14/2022

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	comfort. The electronic health record did not include a respiratory care plan. 2. The record for Resident 214 was reviewed on 11/01/22 at 9:43 a.m. Diagnoses included, but were not limited to, pneumonia, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia/hypercapnia, and takotsubo syndrome. A physician's order, dated 10/28/22, indicated oxygen to maintain saturations between 92-94% for chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia and hypercapnia. The physician's order did not contain a liter flow or route of administration. The medication record for October 2022 indicated the resident's oxygen saturations ranged from 90% to 97% and the oxygen liter flow ranged from 2-5 liters. During an interview, Resident 214 indicated he would adjust the oxygen flow rate as he desired. He indicated he was not sure of the staff's capabilities to adjust the oxygen During an interview, on 11/03/22 at 2:12 p.m., Licensed Practical Nurse 2 indicated an order to adjust oxygen to maintain a saturation, should have included an oxygen liter flow and should have been titrated to meet the desired saturation. She would start with a low oxygen liter flow and increase if the oxygen saturation was not in range. If the resident was on hospice and the order read 2 to 4 liters per nasal cannula, she would start with		Education provided to all Health Center Licensed Nurses on Oxygen Administration policy including physician's orders, symptoms for titration of oxygen and documentation of liter flow. Additionally, any new residents admitted to the community will have their physician orders reviewed during admission chart review for the appropriate and complete physician for oxygen. IV. The Director of Nursing or designee will: Audit all resident oxygen orders for accuracy, appropriateness, and completion weekly for 4 weeks, bi-weekly 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 facility will be in and remain in compliance by: December 14th, 2022.	

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	a low oxygen liter flow and increase with symptoms. A current policy, titled "Medication Orders," not dated and received from the Director of Nursing on 11/2/22 at 10:00 a.m., indicated "...oxygen orders...when recording orders for oxygen, specify the rate of flow or titration goal, route and rationale...." A current policy, titled "Oxygen Administration," dated 7/22/20 and received from the Director of Nursing on 11/2/22 at 10:00 a.m., indicated "...check physician's order for liter and flow and method of administration...monitor flow of oxygen and oxygen saturations every shift and as needed...." 3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse			

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	consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure residents who received prophylactic antibiotics on a long term basis were monitored for side effects for 2 of 2 residents reviewed for prophylactic antibiotic use. (Resident 61 and 45) Findings include: 1. The record for Resident 61 was reviewed on 11/1/22 at 1:05 p.m. Diagnoses included, but were not limited to, retention of urine, nodular prostate with lower urinary tract symptoms, urge incontinence and history of urinary tract infection. A physician order, dated 9/9/22 and no stop date, indicated trimethoprim (an antibiotic) 100 mg (milligram) once daily for a history of urinary tract infection (UTI). A care plan, dated 11/1/22, indicated the resident had an alteration in bladder elimination related to incontinence. The goal was to keep the resident without signs of a UTI. The approaches included, but were not limited to, observe the urine color, odor and frequency for signs of infection and to report symptoms of a UTI. The care plan did not include the use of a prophylactic antibiotic or to monitor for signs and symptoms of the antibiotic use. During an interview, on 11/3/22 at 12:05 p.m., the Infection Preventionist (IP) indicated the	F 0757	**F 0757 Drug Regimen is Free From Unnecessary Drugs** **SS=D CFR(s): 483.45(d)(1)-(6)** – It is the practice of Westminster Village West Lafayette to establish and maintain monitoring of signs and symptoms of adverse effects for residents receiving prophylactic antibiotics on a long-term basis in the plan of care. I. Residents #61 and #45 had no negative consequences from the alleged deficient practice. Resident #61 no longer resides in community. Resident's plan of care has been updated to include side effect monitoring. II. The community realizes all residents receiving prophylactic antibiotics on a long-term basis, have the potential to be affected. An audit has been conducted of residents receiving prophylactic antibiotics on a long-term basis and records updated as indicated. III. The Antibiotic Stewardship Policy was reviewed and found to meet clinical standards. Education has been provided to all Health Center Licensed Nursing	12/14/2022

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	prophylactic antibiotic for Resident 61 did not meet the McGeer Criteria (to monitor appropriate antibiotic use). There was no care plan or instructions on the Medication Administration Record to monitor for the potential side effects of long term antibiotic use. The facility should be monitoring for the potential side effects. The Nursing Drug Handbook indicated the potential side effects of the antibiotic included, pseudomembranous colitis (an inflammation of the colon which could cause severe damage to the colon and even be fatal), diarrhea, abdominal pain, renal failure, hemolytic anemia, hepatic necrosis, myalgia and shortness of breath. 2. The record for Resident 45 was reviewed on 10/28/22 at 4:29 p.m. Diagnoses included, but were not limited to, history of urinary tract infections (UTI), Alzheimer's disease, dementia and cystocele (a bulge of the bladder into the vagina). A physician's order, dated 4/2/22, indicated Nitrofurantoin (an antibiotic) 50 mg to give 1 capsule by mouth at bedtime for history of UTI's. A care plan, dated 1/5/21, indicated the resident was at risk for incontinence related to impaired mobility and a history of UTI's. Interventions included, but were not limited to, peri care every shift and as needed, observe for signs and symptoms of infection, assist with fluid intake, follow up with urologist if ordered and medication as ordered. The care plan did not include the prophylactic antibiotic and monitoring for potential side effects. During an interview, on 11/3/22 at 12:20 p.m., the Infection Preventionist indicated the resident did		Staff on the Antibiotic Stewardship Policy including the monitoring of side effects for long-term prophylactic antibiotic usage. Additionally, resident's records will be reviewed for new physician orders for prophylactic antibiotics with long-term usage daily, Monday through Friday in clinical meeting, verifying monitoring for side effects present in plan of care. IV. Director of Nursing or designee will: Audit all physician orders for long term prophylactic antibiotics and plan of care for side effect monitoring, weekly for 4 weeks, bi-weekly for 3 months, then monthly for 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 facility will be in and remain in compliance by: December 14th, 2022.	

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	not have a care plan for being on a prophylactic antibiotics for recurrent UTI's. The resident did not meet criteria for being on a monthly antibiotic. The Nursing Drug handbook indicated the potential side effects for Nitrofurantoin included, but were not limited to, nausea, vomiting, loss of appetite, headache, lung problems, cough, shortness of breath and chest pain. A current policy, titled "Antibiotic Stewardship," not dated and received from the Director of Nursing on 11/2/22 at 10:00 a.m., indicated "...Implementation an Antibiotic Stewardship Program (ASP) which will promote appropriate us of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs...The medical directors will communicate the facility's expectations for antibiotic use to prescribing clinicians...Infection Preventionist will be responsible for infection surveillance and MDRO tracking...Infection Preventionist will collect and review data such as: Type of antibiotic ordered, route of administration...Whether appropriate tests such as cultures were obtained before ordering antibiotic...Whether the antibiotic was changed during the course of treatment...Educational opportunities as identified by the ASP Team, repeated regularly, should be provided for clinical staff as well as residents and their families on appropriate use of antibiotics...Inservicing for staff done by the Education Coordinator and Infections Preventionist...."			

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	3.1-48(a)(3)			
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending			

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	physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to ensure psychotropic medications were prescribed for approved diagnoses and gradual dose reductions (GDRs) had an appropriate clinical rationale when declined for residents with dementia for 6 of 8 residents reviewed for unnecessary medications. (Resident 34, 44, 47, 4, 12 and 33) Findings include: 1. The record for Resident 34 was reviewed on 10/31/22 at 11:55 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, generalized anxiety disorder, major depressive disorder, dementia with behavioral disturbance and a psychotic disorder with delusions due to known physiological conditions. A physician's order, dated 4/2/22, indicated to give divalproex (a medication for seizures, mania and migraines) 125 mg (milligram) two capsules once daily and one capsule in the evening for dementia with behavioral disturbance. A pharmacy recommendation, dated 10/5/22, indicated it was time to consider a GDR on divalproex 250 mg every morning and 125 mg in	F 0758	**F 0758 Free from Unnec Psychotropic Meds/PRN Use SS=E CFR(s): 483.45(c)(3)(1)-(5)**– It is the practice of Westminster Village West Lafayette to ensure psychotropic medications are prescribed for approved diagnoses and gradual dose reductions (GDRs) have an appropriate clinical rational when declined for residents with dementia. I. Residents #34, #44, #47, #4, #12 and #33 had no negative consequences from the alleged deficient practice. These residents' records have been updated to reflect approved diagnosis and gradual dose reductions have been re-issued to provider. II. The community realizes all residents prescribed psychotropic medications have the potential to be affected. An audit of all residents receiving	12/14/2022

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	the evening for dementia with behaviors. The prescriber response indicated the resident was on hospice and the medication was providing comfort for the resident. The current dosage and frequency had the achieved desired effects. The pharmacy recommendation did not include the diagnosis of dementia with behaviors was not approved for the use of the divalproex. The prescriber response did not include what the desired effects included. A care plan, dated 6/19/2020, indicated the resident was at a risk for socially inappropriate behavior related to the diagnosis of dementia and Alzheimer's. The resident had been found attempting to get into bed with her roommates and entering other resident rooms. The approaches included, but were not limited to, medication as ordered. During an interview, on 11/3/22 at 3:30 p.m., the facility pharmacist indicated she had planned to address the diagnosis for the Depakote prescribed for dementia with behaviors if the prescriber had not approved the GDR. She indicated she did see a lot of facilities use divalproex for dementia with behaviors. 2. The record for Resident 44 was reviewed on 10/31/22 at 2:48 p.m. Diagnoses included, but were not limited to, dementia without behaviors, a psychotic disorder with delusions due to a known physiological condition, depression and anxiety disorder. A physician's order, dated 3/29/22, indicated Seroquel (an antipsychotic) 25 mg twice daily for dementia with behavioral disturbance and		psychotropic medications has been conducted for approved diagnosis and gradual dose reduction. Diagnosis have been updated as indicated and gradual dose reductions have been re-issued for those residents lacking an appropriate clinical rationale for the declination of a reduction. III. The Antipsychotic Medication Use Policy was reviewed and found to meet clinical standards. Education has been provided to all Health Center Licensed Nursing Staff and Social Services staff on the Antipsychotic Medication Policy including approved diagnosis for usage and gradual dose reductions. IV. The Social Service Designee or designee will: Audit all new psychotropic medication orders for approved diagnosis, all pharmacy recommended gradual dose reductions, and a random sample of 20% residents with psychotropic medications for approved diagnosis and gradual dose reduction weekly for 4 weeks, bi-weekly for 3 months, then monthly for total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will	

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	psychotic disorder with delusions due to known physiological condition. A physician's order, dated 10/3/22, indicated Seroquel 25 mg three times daily for psychotic disorder with delusions. The Treatment Administration Record (TAR), dated October 2022, indicated the resident's targeted behaviors were calling out, anxiety and restlessness. The TAR showed the only behaviors documented for October were on 10/6/22, on the evening shift. A care plan, dated 4/8/22, indicated the resident experienced hallucinations and delusions. She often said she was dying or called out for help because she was scared. The care plan did not include any resident specific hallucinations or delusions. 3. The record for Resident 47 was reviewed on 10/31/22 at 3:01 p.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, major depressive disorder, anxiety disorder and chronic pain. A physician's order, dated 9/22/22, indicated Depakote 250 mg at bedtime for dementia with behavioral disturbance. A care plan, dated 9/20/22, indicated the resident had impaired cognition related to the diagnosis of dementia with behaviors and was prescribed medication. A care plan, dated 9/20/22, indicated the resident had an anxious mood and was also at risk for		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 facility will be in and remain in compliance by: December 14th, 2022.	

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	behaviors related to advanced dementia. The resident's behavior was spitting on the floor. During an interview, on 11/2/22 at 3:20 p.m., the Social Services Designee (SSD) indicated the resident's behavior was spitting and it was more of a habit. He would spit on the table and the floor of his room and in the dining room. During an interview, on 11/3/22 at 3:45 p.m., the facility pharmacist indicated she had planned to ask for a clarification for the diagnosis for the divalproex prescribed for dementia with behaviors and had not yet. 4. The record for Resident 4 was reviewed on 10/28/22 at 4:33 p.m. Diagnoses included, but were not limited to, dementia, Parkinson's disease (a movement disorder), cognitive communication deficit, psychotic disorder with hallucinations and depression. A Preadmission Screening and Resident Review (PASSAR), dated 7/26/21, indicated the resident was on Seroquel (an antipsychotic) 50 mg for a diagnoses of insomnia. A physician's order, dated 7/29/21, indicated Seroquel 25 mg at bedtime for a diagnoses of hallucinations. A care plan, dated 7/30/21, indicated the resident was at risk for potential drug related complications related to the use of an antipsychotic medication for hallucinations. Interventions included, but were not limited to, complete psychotropic medication alternatives and observe for antipsychotic side effects. 5. The record for Resident 12 was reviewed on 10/31/22 at 10:59 a.m. Diagnoses included, but were not limited to, Parkinson's disease (a disorder			

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	affecting movement), hypertension, dementia without behaviors, psychotic disorder with hallucinations, Alzheimer's disease and depressive disorder. A PASSAR level I, dated 3/8/18, indicated the resident did not have a diagnoses of psychotic disorder with hallucinations. A Psychology Progress note, dated 2/21/22, indicated the resident started Nuplazide 34 mg (an atypical antipsychotic) 1 daily on 6/10/22 and stopped on 7/21/20. On 5/2020, the residents hallucinations were reported as non-distressing. The resident was being treated for anxiety and depression. A physician's order, dated 10/1/22, indicated Seroquel 25 mg one tablet twice a day related to a psychotic disorder with hallucinations. A care plan, dated 1/11/19, indicated the resident was at risk for potential altered mood and behaviors having hallucinations (audio, visual and tactile) and delusions with history of thinking she had glue on her hands. Interventions included, but were not limited to, utilize gloves for hands, assist resident with calling her daughter(s) and offer activities. 6. The record for Resident 33 was reviewed on 11/01/22 at 12:23 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety, adult failure to thrive, depression, dementia, and restlessness and agitation. A physician's order, dated 8/5/22, indicated Risperdal (an antipsychotic) 0.5 mg three times daily for restlessness and agitation. A physician's order, dated 5/26/22, indicated ABH			

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	(Ativan [antianxiety], Benadryl [antihistamine] and Haldol [antipsychotic]) 1 milligram/25 milligrams/1 milligram per 0.5 milliliter gel twice daily for restlessness and agitation. A physician's order, dated 8/5/22, indicated buspirone (an anxiety medication) 5 milligram twice daily for dementia with behavioral disturbance. A progress note, dated 12/20/21 at 12:22 p.m., indicated the resident was packing personal items to go to her mothers house, she was not distressed, and her mood was pleasant and cooperative. The staff provided interventions which included, 1:1, assisted with packing and frequent visual checks. The staff was unable to redirect her from packing. A progress note, dated 6/5/22 at 7:10 p.m., indicated the resident was intermittently agitated and requesting to check out of her room, the attempts to redirect were ineffective. She refused her pain medication at 2:00 p.m. and the resident indicated she did not need the medication. A progress note, dated 6/5/22 at 7:24 p.m., a late note for dayshift 6/3/22, indicated the resident was disoriented to situation and place. The routine Risperdal 1 mg bid and ABH gel 0.5 ml continue for dementia with behavioral disturbance. The resident was easily redirected during the shift. A progress note, dated 6/22/22 at 6:06 p.m., indicated the resident was worried about getting to the airport to pick up a friend. The interventions included, but were not limited to, allowed to vent, a snack and was pushed around the unit in her wheel chair, but the interventions			

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	were not successful. A consultant pharmacist physician recommendation, dated 5/12/22, indicated it was time for a gradual dose reduction for risperidone (Risperdal). The physician's rationale was to continue as is and defer to hospice in the future. A notation, per the interdisciplinary team, indicated the dose reduction was not indicated per hospice order. A consultant pharmacist physician recommendation, dated 9/7/22, indicated it was time to consider a gradual dose for buspirone for dementia with behaviors. A notation indicated to consider updating the diagnosis to anxiety if clinically indicated. The rationale for decline indicated the resident was comfortable and was on hospice. Her dosage and frequency had achieved the desired effects. A care plan, dated 10/3/19, indicated the resident was at risk for anxious mood related to room moves and adjusting to change. She believed people had stolen items when they were in her room. She received an antianxiety and antipsychotic for diagnoses of anxiety, restlessness and agitation. A care plan, dated 3/17/22, indicated the resident was at risk for anxious mood as evidenced by becoming fidgety, restless, irritable, anxious and agitated. At times, it was a result of hallucinations and delusions, such as packing items to leave and asking about her care or refusing care. Antipsychotic and antianxiety medications were used for diagnoses of dementia with behavioral disturbances, anxiety, restless and agitation. A care plan, dated 10/2/19, indicated the resident			

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	was at risk for adverse effects related to the use of routine antidepressants secondary to diagnoses of depression and adult failure to thrive. Interventions included, but were not limited to, assess, record and report to MD drug related cognitive or behavioral impairment, or change in ADL functioning, assess need for continued use. A care plan, dated 10/2/19, indicated the resident was at risk for adverse effects related to the use of antipsychotic medications secondary to agitation and restlessness related to Alzheimer's disease. During an interview, on 11/02/22 at 11:40 a.m., the nurse indicated the ABH gel was initiated due to the resident becoming upset and resistive to care. She would become angry and paranoid. She was looking for car keys and trying to leave and was difficult to redirect. During an interview, on 11/02/22 at 3:28 p.m., the Social Service Designee (SSD) indicated the resident became agitated and wanted to go home. She indicated she became distressed and would wheel towards doors and was not easily redirected. A recent publication of "PDR.net" indicated "...Seroquel (quetiapine) was indicated for the treatment of bipolar disorder, including mania, bipolar depression and major depressive disorder...the black box warning indicated antipsychotic's are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Seroquel in this population should be avoided if possible due to an increase in morbidity and mortality...." A recent publication of "PDR.net" indicated "...Depakote (Divalproex) was indicated for the			

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	treatment of bipolar disorder including mania...the black box warning indicated antipsychotic's are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Depakote in this population should be avoided if possible due to an increase in morbidity and mortality...." A recent publication of "PDR.net" indicated "...risperidone (Risperdal) was indicated for the treatment of schizophrenia...the black box warning indicated antipsychotic's are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of risperidone in this population should be avoided if possible due to an increase in morbidity and mortality...." A recent publication of "PDR.net" indicated "...Haldol (haloperidol) was indicated for the treatment of schizophrenia...the black box warning indicated antipsychotic's are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Haldol in this population should be avoided if possible due to an increase in morbidity and mortality...." A current policy, titled "Antipsychotic Medication Use," dated December 2016 and received from the Director of Nursing on 11/3/22 at 4:37 p.m., indicated "...antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective...diagnosis of a specific condition for which antipsychotic medications are necessary to treat will based on a comprehensive assessment of the resident...antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record...conditions included, but were not limited to, schizophrenia, schizoaffective disorder,			

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	schizophreniform disorder, delusional disorder, delusional disorder, mood disorder, psychosis in the absence of dementia...." A current policy, titled "Medication Therapy," dated April 2007 and received from the Director of Nursing on 11/2/22 at 10:00 a.m., indicated "...all decisions related to medications shall include appropriate elements of the care process such as....principles of prescribing for the elderly...periodically and when circumstances are present that represent a greater risk for medication-related complications, the staff and practitioner will review the medication regimen for continued indication, proper dosage and duration, and possible adverse consequences...." 3.1-48(b)(1) 3.1-48(b)(2)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure recipes were followed when staff prepared altered diets for 1 of 1 staff member observed preparing puree foods. (Chef 8)	F 0804	**F 0804 Nutritive Value/Appear, Palatable/Prefer Temp** **SS=D CFR(s): 483.60(d)(1)(2)** – It is the practice of Westminster Village West Lafayette to ensure recipes are followed when staff	12/14/2022

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	155177	A. BUILDING 00 B. WING	11/03/2022

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

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	Finding includes: During an observation, on 10/28/22 at 10:24 a.m., Chef 8 used a gloved left hand and placed 3 handfuls of mixed vegetables into the blender. He began to blend the vegetables and added an unmeasured amount of boiling water to the vegetables. Chef 8 cleaned the blender. He put on gloves and added 5 unmeasured pieces of salmon into the blender. He poured an unmeasured amount of hot water into the blender and started to blend the salmon. Chef 8 indicated he could have used broth instead of water. The chef used another blender and placed 7 unmeasured pieces of chicken into the blender. He added an unmeasured cup of chicken broth into the blender. The chicken was too thick and Chef 8 added an unmeasured amount of water into the blender to get the chicken a pudding consistency. The Chef 8 indicated the facility had a recipe book and he did not need to follow the recipe. During an interview, on 10/28/22 at 10:55 a.m., the Assistant Director of Culinary indicated the facility did not have a policy for preparing puree food. The staff would follow the Puree Procedures guide posted above the puree station. A current Puree Procedure guide, not dated, indicated the following: a. Measure 1 cup of vegetables or starch per serving for the number of servings needed. Puree to pudding consistency, add thickener or juice if needed. The serving size per resident was 1/2 cup. b. Measure 6 oz of meat per serving for the number of servings needed. Puree the meat to a pudding consistency by adding thickener or broth if needed. The serving size per resident was 1/2 cup.		prepare puree foods for altered diets. I. No residents had any negative consequences from the alleged deficient practice. Chef 8 has received individual education on recipes on preparing altered diets. II. All residents receiving altered diets have the potential to be affected. No residents experienced any negative consequences. III. The Puree Procedure Guide was reviewed and found to meet clinical standards. Education was provided to the Health Center Culinary Service Team on the Puree Procedure Guide including altered diet recipe instructions. IV. The Director of Culinary Services or designee will Audit the preparation of pureed foods and following an altered diet recipe three times weekly for 8 weeks, then weekly for 8 weeks, 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	

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	The guide did not include adding water to the pureed foods. The facility did not have a policy for preparing puree food. They followed the facility Puree Procedure guide. 3.1-21(a)(1)		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 facility will be in and remain in compliance by: December 14th, 2022.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 27, 28, 31 and November 1, 2 and 3, 2022 Facility number: 000093 Residential Census: 38 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 10, 2022.	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. We respectfully request a desk review of this POC and a subsequent paper compliance revisit.	

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R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a cognitively impaired resident was free from neglect, when the resident left the facility grounds without staff knowledge and failed to ensure the elopement was thoroughly investigated for 1 of 1 resident reviewed for elopement. (Resident 42) Finding includes: During an interview, on 10/28/22 at 3:47 p.m., Resident 42's spouse indicated the resident had been lost after he left the salon in the building and got farther away from the building than he had planned. A man had drove him back to the facility and dropped him off at the concierge desk. The record for Resident 42 was reviewed on 11/1/22 at 10:35 a.m. Diagnoses included, but were not limited to, cerebral infarct, TIA (transient ischemic attack which is caused by a temporary disruption in the blood supply to the brain) and hypertension. A service plan for residential care, dated 9/21/22, indicated the resident's mental status was checked as 'other". The resident would need cues and reminders for meals. For hearing and vision, the resident was hard of hearing and the staff would need to assist with setting up transports and appointments.	R 0052	**R 052 410 IAC 16.2-5-1.2(v)(1-6) Resident Rights – Offense** – It is the practice of Westminster Village West Lafayette to maintain resident rights and ensure all residents are free from neglect and to thoroughly investigate all elopements. I. Resident #42 had no negative consequences from the alleged deficient practice. Resident no longer resides in Assisted Living. II. The community realizes all residents with a Mini-Mental State Examination (MMSE) indicating cognitive impairment have the risk for elopement and have the potential to be affected. All current Assisted Living residents MMSE scores have been reviewed and service plans updated as needed to reflect the cognitive impairment and risk for elopement. III. The Abuse and Neglect Policy was reviewed and found to meet clinical standards.	12/14/2022

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	A Facility Incident Report, dated 10/10/22, indicated the resident was dropped off to the facility at 12:40 p.m., by a independent living home member. The member indicated the resident was located at [name] park which was to the north of the facility. The resident had approached the member who was at the park with his spouse and asked for directions back to the facility. The member transported the resident back to the facility. A Mini-Mental State Examination (used to determine cognitive function), dated 10/22/22, indicated the resident had a score of 21 out of 30. A score below 24 would indicate possible cognitive impairment. The Mini-Mental Examination was not completed until after the resident eloped from the building. A written statement by LPN 3, not dated, indicated the resident was supposed to have a salon appointment at 11:00 a.m., and was not in his room when LPN 3 went to escort the resident to the salon. LPN 3 called the salon and the resident had arrived at 11:10 a.m. LPN 3 instructed the salon staff the resident was confused and would need an escort to and from the salon. Then at 12:40 p.m., the concierge desk called to report the resident was picked up by an independent living home member who brought the resident to the concierge desk. The resident had been located at [name] park. During an interview, on 11/1/22 at 3:58 p.m., the Health Facility Administrator (HFA) indicated the resident had left the building after a salon appointment through a door which was at the back of the community. The resident walked to		Education provided to Assisted Living Staff on the Abuse and Neglect Policy including MMSE scores, cognitive impairment, and elopement risk. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Director of Assisted Living or designee will: Audit all new admission and recently updated MMSE scores, potential cognitive impairment, risk for elopement, and accuracy of service plans three times weekly for 8 weeks, then weekly for 8 weeks, 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 facility will be in and remain in compliance by: December 14th, 2022.	

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	[name] park. There was a couple of independent living residents at the gazebo at the park and the resident was able to give them his apartment number although he did not know how to get back to the facility. The couple brought the resident back to the front desk. The resident was probably out of the building for 15-20 minutes. The salon staff on duty was not interviewed about the incident. During an interview, on 11/2/22 at 4:55 p.m., Salon Staff 4 could remember giving the resident a haircut, did not remember getting instruction from the staff about the resident being confused and not able to use his call pendant on his own. She was not aware the resident had left the building, on 10/10/22, after the salon appointment. She was not asked questions about the incident until 11/2/22. A Google map indicated the walking distance to [name] park was 15 minutes from the facility. A current policy, titled "Abuse and Neglect," dated as revised on 1/2009 and received from the HFA upon entrance, indicated "...To ensure that a comprehensive program exists in all aspects of facility operations involving the prevention, identification, reporting, and investigating of abuse and neglect...The safety and welfare of the residents entrusted to our care shall be maintained at all times...NEGLECT is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...."			