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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village - West Lafayette	2741 N Salisbury St West Lafayette, IN 47906

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49708 Based on interview and record review, the facility failed to ensure a resident received mouth care twice daily for 1 of 2 residents reviewed for activities of daily living (ADL) care. (Resident 37) Finding includes: During an interview, on 1/22/24 at 2:22 p.m., Resident 37's wife indicated the resident had full upper dentures and a partial bottom denture anchored to his remaining natural teeth. The staff would forget to brush his teeth, the toothbrush was dry when she checked it, and she had observed food and debris on natural teeth. The clinical record for Resident 37 was reviewed on 1/24/24 at 10:38 a.m. The diagnoses included, but were not limited to, hemiplegia (paralysis affecting one side of the body) following cerebral infarction, Alzheimer's disease, dysarthria (slurred speech) following cerebral infarction, and dysphagia (difficulty swallowing) following cerebral infarction. A care plan, dated 10/14/21, indicated the resident had a need for dental care related to having some permanent teeth, a lower partial, and full upper denture. The approaches included, but were not limited to, a need for dental care related to having some permanent teeth, a partial lower denture, and full upper denture, as the resident allowed. A physician's order, dated 4/6/23, indicated to assist the resident with brushing his teeth twice daily in the morning and in the evening. A Treatment Administration Record (TAR), dated November 1 through November 30, 2023, indicated mouth care was not documented as being completed on the following dates: a. On 11/22/23, for morning mouth care. b. On 11/3/23 and 11/17/23, for evening mouth care. A TAR, dated December 1, 2023, through December 31, 2023, indicated mouth care was not documented as being completed on the following dates: a. On 12/6/23, 12//7/23, 12/11/23 and 12/21/23, for morning mouth care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 12/8/23, 12/9/23, 12/12/23, 12/15/23, 12/20/23, 12/21/23, 12/23/23, 12/25/23, 12/27/23, and 12/29/23, for evening mouth care. A TAR, dated January 1, 2024, through January 24, 2024, indicated mouth care was not documented as being completed on the following dates: a. On 1/14/24 and 1/22/24, for morning mouth care. b. On 1/4/24, 1/6/24, 1/7/24 and 1/9/24, for evening mouth care. During an interview, on 1/26/24 at 11:41 a.m., CNA 8 indicated the dentures were rinsed, adhesive was applied, and the resident was assisted with putting in his dentures. The resident did not have natural teeth, so they did not brush his teeth. Night shift removed the resident's dentures and put them in a cup with a denture tablet. A current policy, titled Activities of Daily Living [ADL,s], Support, dated 7/13/20 and received from the Director of Nursing on 1/26/24 at 3:00 p.m, indicated .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living [ADLs] . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with .Hygiene [bathing, dressing, grooming and oral care] 3.1-38 (a)(3)(C)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 44598 Based on observation, interview and record review, the facility failed to ensure residents with a diagnosis of congestive heart failure (CHF) were weighed as ordered by the physician, a resident had accu-checks completed as ordered by the physician and failed to assess and document a non-pressure skin impairment for 4 of 4 residents reviewed for quality of care. (Resident 2, 33, 30 and 25) Findings include: 1. The clinical record for Resident 2 was reviewed on 1/24/24 at 3:10 p.m. The diagnoses included, but were not limited to, heart failure, atrial fibrillation, cardiomegaly, Alzheimer's, dementia, depression, and anxiety disorder. A care plan, dated 1/3/24, indicated the resident had congestive heart failure. Interventions included, but were not limited to, obtain weights as ordered and to monitor and document edema. A physician's order, dated 7/19/22, indicated the resident had congestive heart failure, to monitor weights every other day, and notify the physician of a greater than 5-pound gain. A resident vital stats report, dated 9/1/23 through 1/25/24, indicated the following weights were missing: a. 9/7, 9/9, 9/21 and 9/23/23 b. 10/23, 10/27 and 10/30/23 c. 11/1, 11/3, 11/5, 11/9 and 11/11/23 d. 1/8, 1/10, 1/12, and 1/14/24 During an interview, on 1/26/24 at 12:20 p.m., Unit Manager (UM) 7 indicated she did not know why the resident was not weighed. During an interview, on 1/26/24 at 12:29 p.m., the Director of Nursing (DON) indicated weights should be followed by the physician's order. She did not know why the weights were missing. During an interview, on 1/26/24 at 12:40 p.m., the DON indicated there were no other weights for the resident. 2. The clinical record for Resident 33 was reviewed on 1/24/24 at 4:08 p.m. The diagnoses included, but were not limited to, aphasia (affects how you communicate), congestive heart failure, anxiety disorder, and depression. A care plan, dated 8/17/20, indicated the resident had a history of congestive heart failure. Interventions included, but were not limited to, evaluate extremities for edema (swelling), update the physician as needed, and administer medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 11/16/22, indicated to obtain a daily weight first thing in the morning, post-void, in pajamas, and before breakfast. Notify the physician of a weight gain greater than 2 pounds in 24 hours and/or 5 pounds in 1 week. A resident weight tracking system report, dated 1/24/24, indicated the following weights were missing: a. 11/2, 11/3, 11/5, 11/6, 11/8, 11/9, 11/16 and 11/17/23 b. 12/8, 12/9, 12/16, 12/17 and 12/21/23 c. 1/2, 1/13, 1/14 and 1/15/24 During an interview, on 1/24/24 at 3:29 p.m., Resident 33 indicated the staff did weigh her this morning, but they did not always weigh her. During an interview, on 1/25/24 at 10:20 a.m., the DON indicated if a resident had a daily weight order her expectations was for the order to be followed and the resident should be weighed. The weighing of the resident was to be completed in the morning and after they void. The staff was to use the same scale. During an interview, on 1/25/24 at 10:32 a.m., CNA 6 indicated the residents with daily weights were weighed first thing in the morning and used the same scale. During an interview, on 1/25/24 at 10:34 a.m., CNA 4 indicated the daily weights should be done first thing when the resident got up for the day. During an interview, on 1/25/24 at 11:21 a.m., UM 7 indicated a daily weight was to be done in the morning and after the resident voided. The staff were required to use the same scale and approximately the same time every day. If the weight was not recorded, then it was not completed. During an interview, on 1/26/24 at 3:29 p.m., the DON indicated no additional weights could be found. 3. The clinical record for Resident 30 was reviewed on 1/25/24 at 6:32 a.m. The diagnoses included, but were not limited to, diabetes mellitus, Parkinson's disorder, and mild cognitive impairment. A physician's order, dated 9/22/23, indicated to check blood glucose levels twice a day. The Medication Administration Record, dated 12/1/23 through 1/26/24, indicated the following were missing: a. The 6:00 a.m., accu-check on 12/16/23 was missing. b. The 3:00 p.m., accu-checks on 12/9/23, 12/16/23, 12/27/23, 1/6/24, 1/7/24, 1/9/24, 1/15/24 and 1/19/24 were missing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 1/26/24 at 11:47 a.m., the DON indicated she was not aware of the missing accu-checks. The accu-checks should be documented. During an interview, on 1/26/24 at 3:37 p.m., UM 7 indicated the resident was missing accu checks. She did not notice the missing accu-checks and the physician was not notified. 49708 4. During an observation, on 1/23/24 at 12:31 p.m., Resident 25 was observed, in her wheelchair, wearing open toe sandals with a small bandage on her left great toe. During an observation, on 1/26/24 at 11:17 a.m., the resident was sitting up, in her wheelchair, she had sandals on, and a small bandage was noted on her left great toe. The bandage was not dated and had some red drainage present. The clinical record for Resident 25 was reviewed on 1/26/24 at 10:50 a.m. The diagnosis included, but were not limited to, Alzheimer disease, type 1 diabetes mellitus with diabetic neuropathy, bell's palsy, osteoarthritis, and venous insufficiency. A physician's order, dated 1/18/24, indicated the resident may be seen by a wound doctor. A podiatrist note, dated 1/18/24, indicated the resident had non palpable pulses in her bilateral feet and edema was noted. The feet were dry, cool, rubor (red), and her nails were long, moderately thick, and discolored. There was no documentation of bleeding, or a small bandage being applied. A review of Resident 25's nursing progress notes, from 1/20/24 to 1/26/24 had no information about the small bandage on the residents left great toe or the visit with the podiatrist. During an interview, on 1/26/24 at 11:07 a.m., LPN 9 indicated the bandage on the left great toe was from a recent podiatry appointment. The podiatrist would have added the bandage if treatment caused bleeding. During an interview, on 1/26/24 at 1:59 p.m., LPN 10 indicated she would check the progress note from the podiatrist. If nothing was documented about the bandage, she would assess the toe, and then call the physician for a treatment order. A current policy, titled Heart Failure - Clinical Protocol, received from the DON on 1/25/24 at 11:00 a.m., indicated .The physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report findings to the physician, etc A current policy, titled Glucose Monitoring, dated 3/20/14 and received from the DON on 1/26/24 at 12:42 p.m., indicated .The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. The physician will order the frequency of glucose monitoring A current policy, titled Physician's Orders, dated 3/26/23 and received from the DON on 1/26/24 at 10:30 a.m., indicated .Physician Orders will be carried out as ordered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current policy, titled Non-Pressure Skin Wounds, dated 5/3/18 and received from Unit Manager on 1/26/24 at 3:30 p.m., indicated .Evaluate and document wound in resident medical records per facility protocol . Obtain a physicians order as needed 3.1-37(a)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 36454 Based on observation, interview and record review, the facility failed to ensure posted nurse staffing was up to date and had the correct hours of staff nurses for 2 of 2 posted nurse staffing lists. (1/23/24 and 1/24/24) Finding includes: During an observation, on 1/24/24 at 3:25 p.m., the front door had staffing posted for 1/23/24. During an observation, on 1/24/24 at 3:40 p.m., the posted nurse staffing, dated 1/24/24, on the Terrace Unit indicated 2.5 nurses were scheduled for the 2:30 p.m., through 10:30 p.m., shift. During an interview, on 1/24/24 at 3:45 p.m., the Health Facility Administrator (HFA) indicated the staffing at the front door was not the correct date and the posted nurse staffing on the Terrace Unit did not have 2 and a half nurses working. There were 2 nurses working the entire shift and one nurse working a split shift. A current policy, titled Posting Direct Care Daily Staffing Numbers, dated as revised on August 2022 and received from the Director of Nursing on 1/26/24 at 3:20 p.m., indicated .Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents .Within two [2] hours of the beginning of each shift, the number of licensed nurses .and the number of unlicensed nursing personnel .directly responsible for resident care is posted in a prominent location [accessible to residents and visitors] and in a clear and readable format .The information recorded on the form shall include the following .The current date .The actual time worked during that shift for each category and type of nursing staff 3.1-17(a)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48525 Based on observation, interview and record review, the facility failed to ensure all areas of the wireless call system were functioning properly for 2 of 2 residents reviewed for call devices. (Residents 19 and 13) Findings include: 1. During an interview, on 1/22/24 at 1:14 p.m., Resident 19 indicated sometimes call lights were not answered or could take a long time to be answered. He used his call pendant around his neck as his call light. During an observation and interview, on 1/22/24 at 1:45 p.m., Resident 19 pressed his call pendant around his neck. During an observation and interview, on 1/22/24 at 1:56 p.m., RN 2 indicated she did not know the resident's call light was pressed. She did not have a notification to her Vocera (wireless communication system staff members wore to receive call light notifications and talk to other staff). There was no indication the resident's call light was pressed per the call light monitor screen out in the hall. During an interview, on 1/22/24 at 1:58 p.m., RN 2 indicated the resident's call pendant was not working. During an interview, on 1/26/24 at 4:10 p.m., the DON (Director of Nursing) indicated their [NAME] daily system status report (system for showing missing and low batteries) showed low batteries and missing batteries for the residents. Somehow Resident 19's call pendant got missed and they were working on figuring out why. The clinical record for Resident 19 was reviewed on 1/22/24 at 2:50 p.m. The diagnoses included, but were not limited to, unspecified paraplegia, pain in the lower left and right knee, and unspecified osteoarthritis. 44598 2. During an interview, on 1/23/24 at 12:31 p.m., Resident 13 indicated the staff did not always answer the call lights and it took a long time after you press your call light for the staff to answer. During an observation, on 1/23/24 at 12:31 p.m., the resident pressed her pendant and the light on the pendant flashed red. The pendant did not make a sound when it was pressed. During an observation, on 1/23/24 at 12:42 p.m., the resident pressed the pendant again. During an observation, on 1/23/24 at 12:46 p.m., Unit Manager (UM) 7 walked by the room and did not look in the resident's room. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record for Resident 13 was reviewed on 1/25/24 at 9:38 a.m. The diagnoses included, but were not limited to, atrial fibrillation, muscle weakness, pain right knee, cognitive impairment of uncertain or unknown etiology, pacemaker, epilepsy, congestive heart failure, cardiomegaly, depression, and history of (healed) traumatic fracture. A care plan, dated 2/6/23, indicated the resident was at risk for falls related to impaired mobility, history of falls, and history of a fractured left femur. Interventions included, but were not limited to, frequent visual checks, resident was not to be left unattended, and a 2-person maximum assist using a mechanical lift. A physician's order, dated 11/27/23, indicated the resident's activity level was weight bearing as tolerated. During an interview, on 1/23/24 at 12:58 p.m., QMA 3 indicated she knew the resident's call light was going off. During an interview, on 1/23/24 at 12:59 p.m., QMA 5 indicated she had a pager, but the battery was dead, and she probably should get a new one. During an interview, on 1/23/24 at 1:05 p.m., UM 7 indicated a pager would need to be replaced right away if the pager was not working properly. The screens with the call lights are on both ends of the halls and at the nurse's station. The devices the staff carry would beep and flash the room number when a call light was pressed. The staff could look at the screens to see who had their call light on. UM 7 saw Resident 13's call light when she walked by the room. She was too busy to answer the call light. During an interview, on 1/26/24 at 2:17 p.m., the DON indicated when a resident pressed their pendant or room call light the resident's room number would appear on the staff's vocera. The location of the resident would also appear on a wall computer screen. There were computer screens on each hallway and nurse's station. The screen would light up red and would indicate the location of the resident. The staff would have to search for the resident if they moved locations. The call light pendant the staff wore would beep when the devices battery was low and would inform the staff the battery was low. When the batteries were not replaced, the device would turn off. The extra batteries were stored at the nurse's station. When the batteries were dead then you would have to check the screens. A Qualified Medication Aide (QMA) position description indicated the QMA was to answer resident's calls promptly. A Certified Nurse Aide (CNA) position description indicated the CNA was to monitor residents through frequent rounds to ensure their personal care needs were being met and to answer resident's calls promptly. A current policy, titled Nurse Call System, dated as revised 4/29/19 and received from the Admissions Nurse on 1/26/24 at 3:40 p.m., indicated .If the Nurse Call System is temporarily out of service for more than thirty (30) minutes, the Charge Nurse will notify the Administrator and/or Designee 3.1-19(u)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44598 Based on observation, interview and record review, the facility failed to ensure items were not stored on the floor in resident rooms, carpet squares edges were not peeling, and the walls were free of gouges for 4 of 4 rooms reviewed for environment. (Room A10, A9, A3 and C11D.) Findings include: 1a. During an observation, on 1/22/24 at 10:30 a.m., Room A10 had a small pile of magazines, two decorative boxes, and opened mail on the floor. 1b. During an observation, on 1/25/24 at 12:20 p.m., Room A10 had a large cardboard box with papers inside and opened mail stored on the floor. 2. During an observation, on 1/22/24 at 10:36 a.m., Room A9 had a grocery sack with the resident's personal items on the floor next to the window. 3. During an observation, on 1/22/24 at 2:51 p.m., Room A3 had four squares of carpet peeling up in the center of the four squares. 4. During an observation, on 1/22/24 at 3:49 p.m., Room C11D had a large area of gouges in the drywall and missing paint. During an interview, on 1/22/24 at 12:20 p.m., Certified Nurse Aide (CNA) 6 indicated the sack on the floor of A9, the boxes, and the opened mail should not be left on the floor. The items on the floor could make the residents fall or it could cause bugs. During an interview, on 1/22/24 at 3:39 p.m., the resident in Room C11D indicated the facility had made no attempts to repair the wall since the resident moved in on 7/28/23. During an interview, on 1/25/24 at 11:21 a.m., Unit Manager 7 indicated the boxes, mail on the resident's floor, and the carpet tiles peeling up could be a tripping hazard. The cardboard box and papers could be an infection control problem as they could attract bugs. During an interview, on 1/25/24 at 12:20 p.m., the Director of Nursing (DON) indicated the items should not be on the floor. A current policy, titled Homelike Environment, dated as revised 2/2021 and received from the Director of Nursing on 1/24/24 at 4:47 p.m., indicated .Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personnel belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences .clean, sanitary and orderly environment 3.1-19(f)(5)