STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN 46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00109832 and IN00109705. Complaint IN00109832 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00109705 - Substantiated. Federal/State deficiencies related to the allegation are cited at F241 and F312. Survey dates: July 5 & 6, 2012 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Sue Brooker RD TC Rick Blain RN Angie Strass RN Census bed type: SNF/NF: 61 Total: 61 Census payor type: Medicare: 15 Medicaid: 39 Other: 6 Total: 61	F0000	This plan of correction is prepared and executed because the provisions of the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the survey allegations. Wesley Healthcare Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare Center further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare Center requests paper compliance for F241 and F312. These were found to be low severity. There was no actual citation of harm to any of the residents.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	Sample: 11 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 7/10/12 Cathy Emswiller RN			

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F0241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation, interview and record review the facility failed to provide clean linens and personal care following incontinent care and gastric tube leakage in beds of 2 residents (Resident C and Resident D) and failed to answer call lights promptly for 5 residents (Resident B, Resident D, Resident E, Resident F and Resident G) in a sample of 11. Findings include: 1. The record for resident # C was reviewed on 7/5/12 at 8:00 A.M. Diagnoses included, but were not limited to, ventilator dependent respiratory failure, chronic obstructive pulmonary disease, and anxiety. An initial Minimum Data Set Assessment (MDS), dated 6/15/12, indicated Resident # C was alert and oriented. The MDS also indicated Resident # C required the limited assistance of one person to change positions in bed and to transfer to and from the bed to other surfaces such as a chair or wheelchair. The MDS further indicated Resident # C also required the	F0241	F241a. I. It is the policy of Wesley Healthcare that call lights are to be answered promptly, and that it is the responsibly of all staff. II. All staff was in serviced on 7/16/12 regarding the call light policy. All staff was educated to answer call lights, and if they are unable to assist the resident with their need to find appropriate staff that is able to assist. Staff was also informed that nursing administration would be monitoring call lights via the call light tracking system. Any employee assigned to a hall with call light response times grater than ten minutes will receive a progressive discipline write up. III. The ADON or designee will audit call light response times for day and night shift daily x 4 weeks, then monthly x 5 months, for response times to be less than 10 minutes. IV. Progressive discipline will be issued to staff not in compliance. V. The results of the audits will be reviewed monthly at the Q.A. meeting. This will be on going. VI. Date of Completion is7/16/12. b. I. It is the policy of Wesley Healthcare that bed linens are to be changed when visibly soiled. II. Following	07/16/2012

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	extensive assistance of one person to transfer to and from the toilet, commode, or bed pan. A "Resident-Data Collection" admission assessment form, dated 6/8/12, indicated Resident # C had a Foley catheter (indwelling urinary catheter) present on admission. The assessment also indicated Resident # C was alert, oriented, cooperative and had quick comprehension. A physician's order dated 7/3/12, indicated the resident's Foley catheter was discontinued. On 7/5/12 at 6:50 A.M., Resident # C was observed in her room, awake and lying in bed. There was a bed pad beneath the resident. The sheet under the bed pad was observed to have a dried, light brown stain, covering the sheet from side to side and running from beneath the resident to within twelve inches from the foot of the bed. There was an odor of urine in the room. During an interview with Resident # C at that time, she indicated that she had used her call light at approximately 4:00 A.M. that morning because she had to urinate. Resident # C indicated a CNA (Certified Nursing Assistant) had come into her		investigation of the incident on 7/5/12, the C.N.A. who placed a clean bed pad over a soiled sheet received a teachable moment write up. All C.N.A's were in serviced on7/16/12 regarding the bed making policy. Staff was educated that under no circumstance is it acceptable to place clean lines over soiled ones. III. The DON or designee will round to check beds and residents for soiled linens twice daily on day and night shift x 4 weeks, then monthly x 5 months. DON or designee will interview alert and oriented residents throughout bed check process to address any discrepancies or complaints. VII. Progressive discipline will be issued to staff not in compliance. VIII. The results of the audits will be reviewed monthly at the Q.A. meeting x 6 months. IX. Date of Completion is7/16/12.	

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	room in answer to the call light and had placed a bed pan beneath her and had then left the room. She indicated she did not know if the bed pan had overflowed or had simply spilled, but urine had gotten all over her bed. Resident # C indicated the CNA had returned to her room and had removed the bed pan. The resident indicated the CNA noticed the urine on the bed and wiped her off. She indicated the CNA did not clean the bed or change the soiled sheets, but had merely placed a clean bed pad beneath her. The resident indicated she had been lying in the soiled bed since then and she had found the experience to be extremely upsetting. The facility Director of Nursing (DON) was interviewed on 7/6/12 at 10:00 A.M. During the interview, the DON indicated that if a resident experienced incontinence while in bed, or if something else happened to cause the resident's sheets to become soiled, the staff was expected to clean the resident up and remove the soiled linens and place clean, fresh linens on the bed. The DON further indicated it was unacceptable for staff to simply place a clean bed pad over the soiled sheets. 2. During an observation of the 300 Hall on 7/5/12 at 8:04 a.m., Resident D was observed seated next to her bed. A			

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	quilted pad was observed on top of the sheet on her bed with a wet area visible under the quilted pad. The quilted pad was picked up from the sheet on her bed and a large wet area, measuring approximately 12 inches by 20 inches, was observed under the quilted pad. Resident D was interviewed on 7/5/12 at 8:05 a.m. During the interview she indicated her G-tube had leaked at approximately 2:30 a.m. She also indicated staff corrected the leak from her G-tube, but did not change her wet sheet with a dry one. She further indicated staff only placed a quilted pad over the wet area and she went back to bed. Resident D was interviewed on 7/5/12 at 8:45 a.m. During the interview she indicated she always had to wait for staff to answer her call light, at times waiting for 2 hours. She also indicated she was soaked when her G-tube leaked. Staff did not clean her or help into a clean, dry gown. She further indicated that wasn't right. The clinical record for Resident D on 7/5/12 at 8:55 a.m., indicated the following: diagnoses included, but were not limited to,VDRF (vent dependent respiratory failure). Physician's order, for the month of July, 2012, indicated G-tube			

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	feedings at 70 ml(milliliter)/hour from 7:00 p.m. to 7:00 a.m. An MDS assessment for Resident D, dated 5/11/12, indicated she required extensive assistance with the physical assistance of 2 staff for personal hygiene. The assessment also indicated her comprehension was good, although she did have some confusion with new situations. A facility care plan for Resident D, dated 5/11/12, indicated the problem area of resident required extensive to dependent assist for ADL's (activities of daily living) secondary to diagnosis of VDRF. Interventions to the problem included, but were not limited to, assist with ADL's as needed and keep call light within reach. The Bed Activity log for Resident D, provided by the Director of Nursing on 7/5/12 at 11:20 a.m., indicated the following: from 6/14/12 through 7/4/12, 60 entries showed times ranged from the lowest of 21 minutes and 5 seconds to the highest of 1 hour 42 minutes and 54 seconds. 3. Review of the clinical record for Resident E on 7/5/12 at 7:05 a.m., indicated the following: diagnoses			

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	included, but were not limited to, VDRF and anxiety. Resident E was interviewed on 7/5/12 at 8:40 a.m. During the interview he indicated he has had to wait up to 1 hour for his call light to be answered. He also indicated this had caused him problems. An MDS assessment for Resident E, dated 6/19/12, indicated he required extensive assistance for the physical assistance of 2 staff for toileting and required extensive assistance with the physical assistance of 1 staff for personal hygiene. The assessment also indicated a score of 15 out of 15 on the Brief Interview for Mental Status. A facility care plan for Resident E, dated 5/31/12, indicated the problem of resident required extensive assist to dependent for ADL's secondary to diagnosis of VDRF. Interventions to the problem included, but were not limited to, assist with ADL's as needed, and keep call light within reach. The Bed Activity log for Resident E, provided by the Director of Nursing on 7/5/12 at 11:20 a.m., indicated the following: from 6/1/12 through 7/4/12, 89 entries showed times ranged from the lowest of 21 minutes and 11 seconds to the highest of 1 hour 21 minutes and 11			

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	seconds. 4. Review of the clinical record for Resident B on 7/5/12 at 6:00 a.m., indicated the following: diagnoses included, but were not limited to, amyotrophic lateral sclerosis (ALS), VDRF, and anxiety. Resident B was interviewed on 7/5/12 at 9:10 a.m. During the interview he indicated call lights being answered was a problem. He also indicated on the previous night he had to wait for 1 1/2 hours for staff to answer his call light. Resident B was interviewed on 7/6/12 at 9:55 a.m. During the interview he indicated he could hold his urine until staff answered his call light, but it often caused him a great deal of pain due to the time it took for staff to respond. An MDS assessment for Resident B, dated 3/16/12, indicated was totally dependence with the physical assistance of 2 staff for toileting and personal hygiene. The assessment also indicated a score of 14 out of 15 on the Brief Interview for Mental Status. A facility care plan for Resident B, dated 3/7/12, indicated the problem area of resident dependent on staff for ADL's			

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	secondary to diagnosis of ALS. Interventions to the problem included, but were not limited to, assist with ADL's as needed, and keep call light within reach. The Bed Activity log for Resident B, provided by the Director of Nursing on 7/5/12 at 11:20 a.m., indicated the following: from 6/1/12 through 7/5/12, 27 entries showed times ranged from the lowest of 21 minutes to the highest of 57 minutes. The Director of Nursing was interviewed on 7/6/12 at 10:05 a.m. During the interview she indicated call lights should be answered within 10 minutes. 5. Interview with Resident F on 7/5/12 at 11:0-0 a.m. indicated she had concerns with getting her call light answered timely. The resident indicated sometimes it takes more than 30 minutes. Review of the clinical record for Resident F on 7/6/12 at 9:45 a.m. indicated she was admitted to the facility on 7/8/11 with diagnoses including but not limited to Ventilator Dependent Respiratory Failure, Myotonic Dystrophy , Dysphagia and Anxiety. Resident F was assessed by the nursing staff as being alert and oriented. Interview with the Director of Nursing on 7/6/12 at 10:00 a.m. indicated the facility			

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	was able to generate from the computer a log of call light times and responses. The Activity Log indicated the following: from 5/31/12 through 7/6/12, 27 entries showed times ranged from the lowest of 15 minutes and 37 seconds to the highest of 1 hour and 38 minutes. 6. Interview with Resident G on 7/5/12 at 11:15 a.m. indicated she had a concern with staff not answering her call light in a timely manner. The resident indicated it made her anxious due to the fact she was ventilator dependent. Review of the clinical record for Resident G on 7/5/12 at 11:30 a.m. indicated the resident was admitted to the facility on 6/22/12 with diagnoses including but not limited to Chronic Respiratory Failure, Seizure Disorder, Morbid Obesity and Chronic Anxiety. Review of the nursing admission assessment on 6/25/12 indicated the resident was alert and oriented, and required assistance with her activities of daily living. Interview with the Director of Nursing on 7/5/12 at 11:40 a.m. indicated the facility had computer generated call light logs. The Activity Log indicated the following: from 6/29/12 through 7/4/12, 7 entries			

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	showed times ranged from the lowest of 14 minutes and 36 seconds to the highest time of 33 minutes and 57 seconds. An undated current facility policy "Your Rights as a Nursing Home Resident", provided by the Director of Nursing on 7/6/12 at 9:00 a.m., indicated "...You have the right to be treated with respect and dignity...." An undated current facility job description for Certified Nursing Assistant, provided by the Director of Nursing on 7/6/12 at 9:00 a.m., indicated "...Keep residents dry (i.e. change gown, clothing linen, when it becomes soiled or wet)...Change linens whenever necessary...Answer resident call lights promptly...." This federal tag relates to complaint number IN00109705. 3.1-3(t)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 provide clean linens and personal care following incontinent care and gastric tube leakage in beds of 2 residents (Resident C and Resident D) in a sample of 11. Findings include: 1. The record for resident # C was reviewed on 7/5/12 at 8:00 A.M. Diagnoses included, but were not limited to, ventilator dependent respiratory failure, chronic obstructive pulmonary disease, and anxiety. An initial Minimum Data Set Assessment (MDS), dated 6/15/12, indicated Resident # C was alert and oriented. The MDS also indicated Resident # C required the limited assistance of one person to change positions in bed and to transfer to and from the bed to other surfaces such as a chair or wheelchair. The MDS further indicated Resident # C also required the extensive assistance of one person to transfer to and from the toilet, commode,	F0312	F312 I. See F241	07/16/2012

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	or bed pan. A "Resident-Data Collection" admission assessment form, dated 6/8/12, indicated Resident # C had a Foley catheter (indwelling urinary catheter) present on admission. The assessment also indicated Resident # C was alert, oriented, cooperative and had quick comprehension. A physician's order dated 7/3/12, indicated the resident's Foley catheter was discontinued. On 7/5/12 at 6:50 A.M., Resident # C was observed in her room, awake and lying in bed. There was a bed pad beneath the resident. The sheet under the bed pad was observed to have a dried, light brown stain, covering the sheet from side to side and running from beneath the resident to within twelve inches from the foot of the bed. There was an odor of urine in the room. During an interview with Resident # C at that time, she indicated that she had used her call light at approximately 4:00 A.M. that morning because she had to urinate. Resident # C indicated a CNA (Certified Nursing Assistant) had come into her room in answer to the call light and had placed a bed pan beneath her and had then			

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	left the room. She indicated she did not know if the bed pan had overflowed or had simply spilled, but urine had gotten all over her bed. Resident # C indicated the CNA had returned to her room and had removed the bed pan. The resident indicated the CNA noticed the urine on the bed and wiped her off. She indicated the CNA did not clean the bed or change the soiled sheets, but had merely placed a clean bed pad beneath her. The resident indicated she had been lying in the soiled bed since then and she had found the experience to be extremely upsetting. The facility Director of Nursing (DON) was interviewed on 7/6/12 at 10:00 A.M. During the interview, the DON indicated that if a resident experienced incontinence while in bed, or if something else happened to cause the resident's sheets to become soiled, the staff was expected to clean the resident up and remove the soiled linens and place clean, fresh linens on the bed. The DON further indicated it was unacceptable for staff to simply place a clean bed pad over the soiled sheets. 2. During an observation of the 300 Hall on 7/5/12 at 8:04 a.m., Resident D was			

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NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706	

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	observed seated next to her bed. A quilted pad was observed on top of the sheet on her bed with a wet area visible under the quilted pad. The quilted pad was picked up from the sheet on her bed and a large wet area, measuring approximately 12 inches by 20 inches, was observed under the quilted pad. Resident D was interviewed on 7/5/12 at 8:05 a.m. During the interview she indicated her G-tube had leaked at approximately 2:30 a.m. She also indicated staff corrected the leak from her G-tube, but did not change her wet sheet with a dry one. She further indicated staff only placed a quilted pad over the wet area and she went back to bed. Resident D was interviewed on 7/5/12 at 8:45 a.m. During the interview indicated she was soaked when her G-tube leaked. Staff did not clean her or help into a clean, dry gown. She further indicated that wasn't right. The clinical record for Resident D on 7/5/12 at 8:55 a.m., indicated the following: diagnoses included, but were not limited to,VDRF (vent dependent respiratory failure). Physician's order, for the month of July, 2012, indicated G-tube feedings at 70 ml(milliliter)/hour from 7:00 p.m. to 7:00 a.m.			

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	An MDS assessment for Resident D, dated 5/11/12, indicated she required extensive assistance with the physical assistance of 2 staff for personal hygiene. A facility care plan for Resident D, dated 5/11/12, indicated the problem area of resident required extensive to dependent assist for ADL's (activities of daily living) secondary to diagnosis of VDRF. Interventions to the problem included, but were not limited to, assist with ADL's as needed. An undated current facility policy "Your Rights as a Nursing Home Resident", provided by the Director of Nursing on 7/6/12 at 9:00 a.m., indicated "...You have the right to be treated with respect and dignity...." An undated current facility job description for Certified Nursing Assistant, provided by the Director of Nursing on 7/6/12 at 9:00 a.m., indicated "...Keep residents dry (i.e. change gown, clothing linen, when it becomes soiled or wet)...Change linens whenever necessary...." This federal tag relates to complaint number IN00109705.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN 46706

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	3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			