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 12/11/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00140479 and Complaint IN00140729. Complaint IN00140479-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00140729-Substantiated. Federal/ state deficiencies related to the allegations are cited at F 309. Survey dates: December 9, 10, and 11, 2013 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Christine Fodrea, RN TC Census bed type: SNF/NF: 48 Total: 48	F000000	This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the state allegations. Wesley Healthcare LLC 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 LLC 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 LLC requests a paper compliance for 12/20/13. This was 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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	Census payor type: Medicare: 4 Medicaid: 39 Other: 5 Total: 48 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on December 12, 2013 by Randy Fry RN.			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to follow their policy for evaluating pain medication effectiveness for 1 of 3 residents reviewed receiving pain medication in a sample of 7. (Resident #U) Findings include: Resident #U's record was reviewed 12-9-2013 at 1:26 PM. Resident #U's diagnoses included but were not limited to high blood pressure, depression, and brain injury. A review of Resident #U's Medication Administration Record (MAR) dated 11-2013 indicated Resident #U received pain medication as follows: Tylenol 650 mg on 11-23 (no time was indicated on the record); Hydrocodone-Acetaminophen 5-325 mg on 11-24 at 1 AM, and 8 AM; on 11-25 at 8 AM; and 11-27 at 8 AM, and 8 PM; and Flexeril (also a muscle relaxer) on 11-28 at 6 PM, on 11-29 at 12 noon, and 11:30 PM; and	F000309	It is the intent of this facility that all residents be free from pain or at a pain level that is tolerable. The facility will take corrective action for those residents having the potential to be affected by the same deficit practice. All residents have the potential to be affected by this alleged deficient practice by not having their pain effectiveness monitored and documented. All MARS including PRN's were reprinted with the appropriate information that is required on them and placed in the current MARS. To allow for proper documentation of the effectiveness of the medication given. All nurses were in serviced on the importance of following up on the effectiveness of PRN medication administered to a resident and documenting the results. The director of nursing or designee will conduct weekly audits times 4 weeks of 4 -6 random sample residents identified with physician orders for pain medication to ensure resident assessment, pain medication was administered timely and the effectiveness of	12/20/2013

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	11-30-13 at 8 AM. The MAR also indicated on 11-28, and 11-29 at 12 noon the Flexeril was effective. There was no other notes on the MAR to indicate any of the other dosages of medication had been effective. A review of Nurse's notes dated 11-24-13 through 11-28-13 did not indicate whether the pain medication had been effective. A note dated 11-28-2013 at 1:43 PM indicated Resident #U was continuing to complain of pain, and the pain pill offered some relief, but did not indicate if the pain was alleviated. A further review of nurse's note did not indicate if any of the other doses of pain medication had been effective. A care plan titled new admission care plan dated 11-29-2013 indicated as an intervention to monitor for pain tolerance. In an interview on 12-9-2013 at 2:10 PM, LPN #1 indicated pain should be assessed, and the effectiveness of pain medications taken documented on the MAR or in the Nurse's notes. A current policy titled Pain Management dated 4-2013 provided on 12-10-2013 at 11:24 AM by the Director of Nursing indicated		the medication was monitored and documented. The results of these audits will be reviewed during the interdisciplinary team meeting weekly times 4 weeks. Negative findings will be addressed when identified. The director of nursing will report the results of the pain management audits to the quality assurance committee monthly times 3 months. The committee will evaluate the effectiveness of the plan based on trends identified additional interventions will be developed and implemented as needed. All corrective action will be in place by 12/20/13.	

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	documentation of the effectiveness of the pain management program can be found on the MAR or in the Nursing progress notes. This Federal tag relates to Complaint IN00140729. 3.1-37(a)			