

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2014
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 24, 25, 26, 27 and 28, 2014</p> <p>Facility number: 012993 Provider number: 155806 AIM number: 201208210</p> <p>Survey team: Angela Selleck, RN, TC Kim Davis, RN Karen Koeberlein, RN Jason Mench, RN</p> <p>Census bed type: SNF/NF: 21 Residential: 16 Total: 37</p> <p>Census payor type: Medicare: 13 Medicaid: 1 Other: 23 Total: 37</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>This plan of correction is to serve as Wellbrooke of Wabash's credible allegation of compliance.</p> <p>The creation and submission of the Plan of Correction does not constitute an admission by Wellbrooke of Wabash of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F000279 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview, and record review, the facility failed to ensure a plan of care was implemented regarding for 1 of 5 residents reviewed for unnecessary medications. (Resident #25).</p> <p>Findings include:</p> <p>The clinical record of Resident #25 was reviewed on 2/25/14 at 3:30 p.m. The</p>	F000279	<p>F279 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS It is the practice of Wellbrooke of Wabash to review and revise residents' comprehensive care plans. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plan for Resident #25 has been reviewed</p>	03/30/2014

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	<p>record indicated the resident's diagnoses included, but were not limited to, osteoarthritis, epilepsy, senility, and anxiety.</p> <p>The February 2014 Physician orders included medication orders, dated 8/19/13, for 0.5 mg (milligrams) of lorazepam (Ativan) to be given daily for anxiety, and 10 mg of Lexapro to be given daily for anxiety. The original start date of the Ativan was 7/17/13. The original start date for the Lexapro was 8/19/13.</p> <p>Review of the current care plan indicated a care plan for monitoring of medication side effects. There was no care plan related to anxiety or the needed use of the medications.</p> <p>The Social Service Director (SSD) was interviewed on 2/26/14 at 12:50 p.m. The SSD indicated he did not initiate a care plan for Resident #25. He did not chart or assess her anxiety, and she was not followed by Behavior Management.</p> <p>Further information and or a policy for monitoring of medications was requested of the Director of Nursing (DoN) on 2/28/14 at 9:00 a.m.</p> <p>No further information was presented.</p>		<p>and updated to reflect current diagnosis and medication use.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. 100% of all care plans have been reviewed to ensure that any behaviors and psychoactive drugs have been addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Center has a policy regarding care plans. The interdisciplinary team has been re-educated on this policy. This re-education included the need to include mood, behaviors, and medication use in the plan of care. Additional systemic changes are being implemented through our quality improvement processes as indicated below. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Social Service Director or designee is conducting quality improvement audits to further ensure compliance. A random sample of 10% of residents will be reviewed weekly for 4 weeks; then monthly for 6 months. Additional quality improvement</p>				

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F000282 SS=D	<p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure interventions identified in the resident's plan of care were completed to prevent further worsening of contractures for 1 of 1 residents reviewed for contractures. (Resident #33).</p> <p>Findings include:</p> <p>The clinical record for Resident #33 was reviewed on 2/26/14 at 9:24 a.m. Diagnoses for Resident #33 included, but were not limited to, dementia, hypertension, gout, and limb pain.</p> <p>Review of physician orders, dated 1/4/14, indicated Resident #33 was to have rolled towels placed in her hands to prevent</p>	F000282	<p>audits will be completed based upon the level of compliance. The pharmacy consultant is assisting with this review during monthly visits. The results of all audits will be reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary.</p> <p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN It is the practice of Wellbrooke of Wabash to provide services by qualified persons in accordance with each resident's written plan of care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plan for Resident #33 has been reviewed and found to be appropriate. The staff have been re-educated on the importance of PROM and how to properly document the care plan interventions. Resident #33 is receiving PROM and has been screened by Occupational Therapy for contractures. How other residents having the potential to be affected by the</p>	03/30/2014	

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	<p>further contracture and skin breakdown. Orders also indicated passive range of motion (PROM) was to be performed with the assist of staff twice daily.</p> <p>A health care plan, dated 1/17/14, indicated Resident #33 was to receive passive range of motion (PROM), due to risk of decline in functional range of motion related to contractures. Interventions for this problem included, but were not limited to, PROM; one set of 10 repetitions 2 times daily, staff to support joints while ranging, rolled towels placed in the hands, and therapy to screen as needed.</p> <p>During an interview on 2/25/14 at 11:10 a.m., CNA #6 indicated Resident #33 was assisted by 3rd shift staff with morning care, and was always up and dressed when CNA #6 arrived for the dayshift at 6:00 a.m. CNA #6 also indicated "it is getting harder and harder to get her hands open to put the towels in them, they've gotten worse". CNA #6 indicated 3rd shift staff had not reported any information in regard to Resident #33's ability or tolerance of morning PROM. CNA #6 indicated she would look at the morning documentation on the kiosk (a computer containing staff documentation) and retrieve the information.</p>		<p>same deficient practice will be identified and what corrective action will be taken? A restorative nursing range of motion assessment has been completed on all residents. Care plans have been reviewed and are reflective of residents' current needs. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A new functional range of motion tool has been developed and implemented. Licensed nurses have been educated on this new tool. This assessment is being completed on admission, quarterly and with significant changes in the resident's condition. Care plans are being reviewed quarterly with the MDS and updated to reflect the resident's current status. Nursing personnel have been re-educated regarding the importance of following the plan of care. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Health & Wellness Director or designee is completing quality improvement audits to ensure the residents' plan of care is followed. A random sample of 10% is being audited weekly for 4 weeks then monthly for 6 months to ensure that the plan of care is being followed. This audit includes</p>				

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F000323 SS=D	<p>On 2/25/14 at 1:10 p.m., the Administrator provided the informational log sheet used to document Resident #33's care and progress during PROM twice daily. The area of the sheet where documentation of Resident #33's morning PROM was to be entered, was blank. There was no documentation that Resident #33 had received PROM any time as ordered on either shift. CNA #6 had no explanation as to why there was no documentation.</p> <p>During an interview on 2/28/14, at 11:00 a.m., the DoN indicated being unable to provide a specific policy in regards to following physicians orders, or the care plan.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure 3 chemicals: 1 bottle of nail polish remover, 1 bottle of nail cleansing solution, and 1 bottle of liquid correction</p>	F000323	<p>monitoring CNA/restorative nursing performance and documentation. Additional audits will be completed based upon the level of compliance. The results of all audits will be reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary.</p> <p>F323 483.25(h) ACCIDENTS It is the practice of Wellbrooke of Wabash to ensure that the resident's environment remains as free from accident hazards as is possible; and each resident</p>	03/30/2014			

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	<p>fluid were secured in 1 of 1 facility beauty shop. The beauty shop was located in a main hallway, across from 1 of 2 facility dining rooms. This failure had the potential to affect 1 confused, ambulatory resident. (Resident #7)</p> <p>Findings Include:</p> <p>The lunch meal was observed on 2/24/14 between 11:30 a.m. and 1:00 p.m. The facility Beauty Shop was located in a main hall way directly across from from the Terrace dining room. The beauty shop door was a full, swinging door without a lock.</p> <p>During an observation of the beauty shop on 2/24/14 at 11:30 a.m., an unlocked nail station was observed in one corner.</p> <p>The nail station had two drawers and one cabinet. In the second drawer was a small bottle of liquid correction fluid. The correction fluid label indicated, "Keep out of reach of children."</p> <p>The unlocked nail station cabinet contained a nail cleansing solution and nail polish remover. The Material Safety Data (MSDS) sheets for the chemicals were requested from the administrator on 2/24/14 at 11:40 a.m.</p>		<p>receives adequate supervision and assistance devices to prevent accidents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #7 did not suffer any adverse outcome due to this situation; nor did the Resident go into the unlocked beauty shop. The chemicals were immediately secured when discovered during the survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A lock was installed on the nail station desk during the survey. A lock has been installed on the entrance to beauty salon. All Center personnel and the beautician have been re-educated regarding the Center policy to keep all hazardous items and chemicals secured when not in attendance. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Environmental Services Director or designee is</p>				

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	<p>The MSDS sheets were presented by the administrator on 2/24/14 at 12:00 p.m.</p> <p>The MSDS nail cleansing solution MSDS sheet indicated, "...If product is swallowed, may cause nausea, vomiting and/or diarrhea and central nervous system depression. Irritating to the eyes. Vapors of this product may be slightly irritating to the nose, throat and other tissues of the respiratory system...Keep out of reach of children..."</p> <p>The polish remover MSDS indicated, " If product swallowed, may cause nausea, vomiting, and/or diarrhea and central nervous system depression ...Keep out of reach of children".</p> <p>The hairdresser was interviewed on 2/25/14 at 3:15 p.m. During the interview, the hairdresser indicated she worked at the facility one day a week. She indicated she had not secured the chemicals in the nail polish station.</p> <p>The Maintenance Director was interviewed on 2/25/14 at 3:15 p.m. During the interview, the director indicated he needed to put a lock on the nail station in the facility beauty shop.</p> <p>3.1-19(f)</p>		<p>completing quality improvement audits of the beauty shop. The audits are being completed weekly for 4 weeks and monthly for 6 months. Additional quality improvement audits will be completed based upon the level of compliance. The General Manager will assist in auditing during routine rounds throughout the Center. The results of all audits will be reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary.</p>				

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure monitoring was completed and a plan of care implemented for 1 of 5 residents reviewed for unnecessary medications. (Resident #25).</p> <p>Findings include:</p> <p>The clinical record of Resident #25 was reviewed on 2/25/14 at 3:30 p.m. The</p>	F000329	<p>F329 483.25(I) UNNECESSARY DRUGS It is the practice of Wellbrooke of Wabash to ensure that each resident's drug regimen is free from unnecessary drugs. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The physician reviewed the medications for Resident # 25 and has made no changes to those orders. A plan of care was implemented for</p>	03/30/2014

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	<p>record indicated the resident's diagnoses included, but were not limited to, osteoarthritis, epilepsy, senility, and anxiety.</p> <p>The February 2014 Physician orders included medication orders for 0.5 mg (milligrams) of lorazepam (Ativan) to be given daily for anxiety, and 10 mg of Lexapro to be given daily for anxiety. The original start date the Ativan was 7/17/13. The original start date for the Lexapro was 8/19/13.</p> <p>Review of the current care plan, indicated a care plan for monitoring of medication side effects. There was no care plan for anxiety.</p> <p>Nursing notes and nursing assessments from 8/19/13 through 2/25/14 were reviewed. There were no assessments or notes related to the resident's anxiety.</p> <p>A nursing evaluation, dated 2/13/14, indicated psychoactive medications were administered to Resident #25 and no behaviors were present.</p> <p>Resident #25 was observed in her room, calmly watching television on 2/26/14 at 7:40 a.m., 2/27/14 at 9:00 a.m., and 2/28/14 at 3:00 p.m.</p>		<p>Resident #25 to reflect the use of the psychoactive medications. The interventions include monitoring for episodes of crying.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Any resident receiving a psychotropic medication has the potential to be affected by the alleged deficiency. A chart audit was completed by the Social Service Director; no other resident was found to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The center has a policy addressing unnecessary drugs. Licensed nurses have been re-educated on this policy. In addition, the Center has established a Behavior Management Interdisciplinary Team. Newly admitted residents, who are receiving psychoactive medications, will be reviewed during morning meeting. In addition, a monthly behavioral meeting will be held to address any changes in behavior or the introduction of a psychoactive medication. During this meeting the medication, as well as the care plan and behavior monitoring, will be reviewed.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur,</p>				

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F000356 SS=F	<p>Certified Nursing Assistant #7 was interviewed on 2/26/14 at 9:30 a.m. The CNA indicated Resident #25 was happy and friendly.</p> <p>The Social Service Director (SSD) was interviewed on 2/26/14 at 12:50 p.m. The SSD indicated he did not initiate a care plan for Resident #25, he did chart and assess her anxiety, and she was not followed by the Behavior Management Team. The SSD indicated he had not assessed Resident #25 for anxiety.</p> <p>Qualified Medicine Aide (QMA) #1 was interviewed on 2/27/14 at 9:00 a.m. During the interview, the QMA indicated Resident #25 was happy and pleasant.</p> <p>Further information and/or a policy for monitoring of medications was requested of the Director of Nursing (DoN) on 2/28/14 at 9:00 a.m.</p> <p>No further information was presented.</p> <p>3.1-48(a)(3)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.</p>		<p>i.e. what quality assurance program will be put into place? In addition the behavior management team review indicated above, the Social Service Director or designee is conducting quality improvement audits to further ensure compliance. A random sample of 10% of residents will be reviewed weekly for 4 weeks; then monthly for 6 months. Additional quality improvement audits will be completed based upon the level of compliance. The pharmacy consultant is assisting with this review during monthly visits. The results of all audits will be reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary.</p>		

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	<p>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure posted nursing staff information was accurate and up to date for 2 of 4 days of the survey (2/24/14 and 2/25/14). This practice had the potential to affect 21 of 21 residents residing in the facility.</p> <p>Findings include:</p> <p>During initial tour on 2/24/14, at 9:15</p>	F000356	<p>F356 483.30(e) POSTED NURSE STAFFING INFORMATION It is the practice Wellbrooke of Wabash to post the following information on a daily basis: a. facility name, b. the current date, c. the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care each shift: -Registered nurses -Licensed practical nurses</p>	03/30/2014

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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
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	<p>a.m., the posted nursing staff information form was found to be posted with an inaccurate summary of the nursing staff currently working in the facility, as well as the total number of hours the nursing staff was to be available in the facility for a 24 hour period.</p> <p>During a second tour of the facility on 2/25/14, at 8:15 a.m., the posted nursing staff information form was again found to be posted with an inaccurate summary of the nursing staff currently working in the facility, as well as the total number of hours the nursing staff was to be available in the facility for a 24 hour period.</p> <p>During an interview on 2/25/14, at 10:45 a.m., the Director of Nursing indicated one CNA (certified nursing assistant) had phoned in ill, and the nursing staff information form had not yet been updated. She also confirmed the posted nursing staff information form did not include the total number of hours licensed staff was to be available in the facility, and it was completed after staff had actually worked those hours.</p> <p>Review of a current facility policy provided by the DoN on 2/28/14 at 11:00 a.m., titled "Posting Direct Care Daily Staffing Numbers" indicated the</p>		<p>-Certified nurse aides d. resident census What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents residing at the Center have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Following discussion with the surveyor a new form was developed and implemented. The policy has been updated to include the new form called –“The Daily Staff Posting”. The nurse staffing will be posted at the beginning of each day. The Charge nurse on each shift will update The Daily Staff Posting throughout the day if changes occur. Licensed nurses have been educated on this policy and form. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Health and Wellness Director or designee is completing quality improvement</p>		

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F000371 SS=F	<p>following:</p> <p>"Policy Statement: Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents... g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non licensed nursing staff working for the posted shift."</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure hand washing was completed with soap and water, that food was not contaminated by gloves worn by dietary personnel during 2 of 2 meal observations in 2 of 2 dining rooms and that a beard restraint was worn by 1 of 1 cooks observed with a beard. (Cook #'s 2,3,4, and Dietary Manager)</p> <p>Findings Include:</p>	F000371	<p>audits to ensure the daily staff posting is accurate. The Daily Staff Posting is being checked 3 times weekly for 4 weeks, then weekly thereafter. The results of all audits will be reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary.</p> <p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY It is the practice of Wellbrooke of Wabash to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and to store, prepare, distribute, and serve food under sanitary conditions. What corrective action will be accomplished for those residents found to have been affected by the deficient</p>	03/30/2014			

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	<p>1. The lunch meal was observed on 2/24/14 at 11:30 a.m. in the Veranda Dining Room. The kitchen area was a large, open galley kitchen. The steam table was on one end, on the wall opposite the steam table was counter space with cupboards above. A refrigerator, juice machine, coffee machine and more cabinetry along another wall, with an open counter and an opening for staff to enter directly across from the refrigerator, coffee machine and juice machine. An island sat in the middle of the galley kitchen.</p> <p>Cook #2 was observed delivering a tray of food to residents at a table. Cook #2 had a beard. The beard was not covered with a hair restraint.</p> <p>Cook #2 returned to the galley kitchen. Without washing his hands, he returned to the galley kitchen, opened a cupboard, removed a juice glass, and filled the glass with juice from the juice machine. Cook #2 then left the kitchen area and delivered the juice to a resident in the dining area.</p> <p>Cook #2 returned to the galley kitchen and used an alcohol based hand cleaner to clean his hands and applied gloves. Cook #2 did not wash his hands with soap and water.</p>		<p>practice? No residents were affected by the alleged deficient practice. Cook# 2 is no longer employed at the Center. Cook #3, Cook #4, and the Dining and Catering Director (Dietary Manager) have been re-educated regarding hand washing, appropriate glove use, and hair restraints. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents residing at the Center have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Center has a policy addressing Employee Personal Cleanliness which includes hand washing and hair coverings. On 3/6/14 dietary personnel were re-educated on this policy. A hand washing return demonstration was successfully performed. The Registered Dietitian has also conducted re-education on safe food handling with dietary personnel and will re-educate quarterly. This re-education included/will include proper hand washing, glove use, handling of plates/utensils, preparation and serving food, and proper hair restraint. How the corrective action will be monitored to ensure the deficient practice</p>	

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	<p>Cook #2 walked to the steam table area. He picked up a plate from a stack of plates at the steam table, placing his thumb on top of the food surface of the plate. With the same gloves, Cook #2 prepared the meal and sat the plate on a tray across the steam table. With the same gloves, Cook #2 walked to the back of the galley kitchen, opened a cupboard and pulled out a small bowl. With the same gloves, Cook #2 dipped a ladle into a large plastic container on the counter that held fruit. Cook #2 put the fruit into the dish and sat the filled bowl on the counter, opened another cupboard, pulled out a coffee cup and filled the cup with coffee from the coffee machine. With the same original gloves, Cook #2 picked up the bowl of fruit and the coffee cup and placed them on the tray with the plate of food he had prepared.</p> <p>Wearing the same gloves, Cook #2 picked up another plate from the stack by the steam table and laid his thumb on top of the plate. Cook #2 removed the steel lid from a pan on the steam table and put a ladle into the pan. Cook #2 used one hand to scoop potatoes with the ladle, and the other hand he laid on the plate, holding onto the potatoes to guide the potatoes into place on the plate. Cook #2 added two more items to the plate with</p>		<p>will not recur, i.e. what quality assurance program will be put into place? The Dining and Catering Director or designee is conducting quality improvement audits of food sanitation. The Dining and Catering Director and/or designee will perform observations of personnel during meal preparation and serving 2 times weekly for 1 month then weekly for 1 month then monthly for 6 months. In addition, the Registered Dietitian is conducting monthly food sanitation audits including hand washing, glove use, and hair restraint. Additional quality improvement audits will be completed based upon the level of compliance. The results of all audits will be reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary.</p>		

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	<p>the potatoes, and prepared a glass of juice. Cook #2 sat the drink and plate on a serving tray across the steam table. Cook #2 changed his gloves. He did not wash his hands.</p> <p>Cook #2 returned to the steam table. He picked up another plate by laying his thumb across the plate. He walked to the back of the galley kitchen, pulled a hamburger bun from a bag of buns and made a sandwich. Using both hands, Cook #2 carried the sandwich to the steam table and put it onto the plate he had in place and sat the plate onto the serving tray.</p> <p>Cook #2 picked up another plate with the same gloved hand, holding the top of the plate with his thumb. He picked up a steel lid and ladle. Cook #2 used one hand to scoop potatoes on the plate. Cook #2 laid his other hand on the plate, touching the potatoes, and guided the potatoes in place on the plate. Cook #2 wiped both of his gloved hands on his uniform.</p> <p>Without washing his hands and changing his gloves, Cook #2 picked up a plate from the stack by the steam table, by laying his thumb across the plate. Cook #2 again, scooped out a ladle of potatoes. He used one hand for the scoop, and the</p>			

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	<p>other, he laid on the plate, and used his gloved fingers to guide the potatoes into place. Cook #2 walked to the back of the galley kitchen, prepared a bowl of fruit then walked to the open side of the galley kitchen, opened a large zip lock bag and pulled out a dinner roll. Cook #2 returned to the steam table, laid the dinner roll on the prepared plate, and sat the plate of food and bowl of fruit on a serving tray across the steam table to be served.</p> <p>Without washing his hands and changing gloves, Cook #2 picked up another plate from the stack, putting his thumb on top of the plate. Cook # 2 then walked to the back of the galley kitchen, pulled two pieces of bread from a bread bag, opened a large plastic container of chicken salad, and prepared a sandwich. Cook #2 carried the sandwich to the steam table and laid the sandwich on the plate then sat the plate on a serving tray across the steam table.</p> <p>Without washing his hands and changing gloves, Cook #2 picked up another plate laying his thumb on top of the plate, scooped out potatoes, using one hand for the scoop and the other to guide the potatoes into place by laying his hand on top of the plate, and touching the potatoes with his gloved fingers.</p>			

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	<p>Cook #2 left the steam table area, opened a cupboard and pulled out a small bowl. He opened the refrigerator, pulled out a large plastic container of applesauce and poured it into the bowl. Cook #2 carried the bowl to the steam table.</p> <p>With the same gloves, Cook #2 scooped out a ladle of potatoes. He used one hand for the ladle, and the other hand to lay across the plate, using his fingers to guide the potatoes into place.</p> <p>Cook #2 walked to the back of the galley kitchen. He opened a cupboard, and pulled out a bowl. Cook #2 opened the refrigerator, and pulled out a bag of lettuce salad and bag of cherry tomatoes. Cook #2 poured the lettuce into the bowl, then put his hand into the bag of cherry tomatoes. Pulling out a few tomatoes with the same gloved hand, Cook #2 added the cherry tomatoes to the bowl of lettuce salad, and carried it to the steam table. He walked to the open area of the galley kitchen, opened a zip lock bag of dinner rolls, removed a roll, and carried it to the steam table. The cook did not wash his hands and change gloves.</p> <p>With the same gloves, Cook #2 prepared another plate of food in the same manner. This practice continued through the remainder of the meal service. Cook #2</p>			

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	<p>did not wash his hands.</p> <p>Cook #4 was interviewed on 2/25/14 at 8:15 a.m. The cook indicated all dietary staff has been trained to work in all dietary areas.</p> <p>The Dietary Manager was interviewed on 2/25/14 at 1:15 p.m. The manager indicated Cook #2 works in the kitchen. He indicated all cooks come out of the kitchen to serve on a regular basis.</p> <p>2. The lunch meal was observed on 2/27/14 beginning at 11:30 a.m. in the Terrace Dining Room.</p> <p>Cook #4 washed her hands and put on gloves. She picked up a plate by laying two fingers on top. Cook #3 put a scoop of food on the plate, then put her hand into a bag of hamburger buns, pulling out one bun. Cook #3 prepared the sandwich and sat the plate on the serving tray and removed her gloves.</p> <p>Cook #3 entered the Terrace Dining Room serving kitchen at 11:45 a.m. Cook #3 had her hair pulled back, but was not wearing a hair net. Cook #3 did not wash her hands. She opened a cupboard and pulled out a glass and filled the glass with juice from the juice machine. Cook #3 walked out of the</p>			

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	<p>kitchen area to serve the juice. She then put her hands in her uniform pocket, returned to the kitchen area and washed her hands.</p> <p>The Dietary Manager (DM) entered the kitchen serving area. He put on gloves and picked up a divider plate by putting his thumb into the dish. The DM kept his thumb in the plate to hold it as he scooped food into the three compartments.</p> <p>With the same gloves, the DM, picked up a plate with his thumb on top of the plate. He added food to the plate with his thumb on top of the plate.</p> <p>With the same gloves, the manager then walked out the back galley kitchen's back door. He returned right away with a plate of food covered with saran wrap in hand and with gloves still on. The DM pulled the saran wrap off the plate of food, handed it to a staff member to be served, walked to the juice machine. He opened the juice machine, pulled out a large plastic jug of juice, then put the jug back into the machine. The DM washed his hands.</p> <p>Cook #4 walked into the galley kitchen serving area. She did not wash her hands. Cook #4 prepared a glass of juice</p>			

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	<p>and left the galley kitchen area to serve the glass of juice.</p> <p>At 11:40 a.m. the DM put on gloves. He reached into a bag of hamburger buns and pulled out one bun. The DM picked up a white paper menu, looked at the menu, and picked up a plate laying his thumb on top of the plate. The DM left the galley kitchen area wearing the same gloves.</p> <p>The Dietary Manager was interviewed on 2/27/14 at 1:35 p.m. The DM indicated he had presented hand hygiene training with his staff.</p> <p>The Hand Hygiene Inservice, dated 3/19/13, the Orientation training for Cook #2 a Dietician visit dated 2/22/14, an All Staff Inservice Training Record dated 1/10/14, the Orientation Training of Cook #2 and a Dietician Report dated 2/22/14 were presented by the administrator on 2/27/14 at 1:45 p.m.</p> <p>The Hygiene Inservice indicated Cook #3 and Cook #4 attended the inservice training presented by the DM.</p> <p>The Orientation training for Cook #2 indicated he completed his Job Specific Orientation, which included hand hygiene, on 2/19/14.</p>			

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F000502 SS=D	<p>The All Staff Training, included the facility "Hand Hygiene" policy dated 3/19/13. The policy indicated, Wash hands with soap and water before handling food and clean dishes and after removing gloves.</p> <p>The Dietician Report indicated the dietician had not observed meal service on his last visit.</p> <p>3.1-21(i)(3)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure labs were completed for 1 of 5 residents reviewed for lab results. (Resident #81)</p> <p>Findings include:</p> <p>The clinical record for Resident #81 was reviewed on 2/26/14 at 2:05 p.m. Diagnoses for the resident included, but were not limited to, hypothyroidism, hypertension, atrial fibrillation, peripheral vascular disease, hyperlipidemia, amputation above the knee, muscle weakness and macular degeneration.</p>	F000502	<p>F502 483.75(j)(1) ADMINISTRATION It is the practice of Wellbrooke of Wabash - to provide or obtain laboratory services to meet the needs of its residents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 81 no longer resides in the Center. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Any resident with lab orders has the</p>	03/30/2014

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	<p>Physician's orders, dated 2/7/14, indicated the resident had orders that included, " With next lab draw do Free T4 (Thyroxine hormone), TSH (Thyroid Stimulating Hormone)... "</p> <p>The review of the "February 2014 Treatments" indicated with an electronic signature, the labs Free T4 and TSH were completed on 2/10/14.</p> <p>A review of the labs completed on 2/10/14 for Resident #81 indicated no lab results for Free T4 or TSH.</p> <p>The review of the "Lab Tracking Form " indicated lab tests Free T4 and TSH for Resident #81 were not added to the form to be completed.</p> <p>During an interview with the Director of Nursing (DoN) on 2/27/14 at 1:58 p.m., she indicated the labs Free T4 and TSH for Resident #81 were not completed.</p> <p>3.1-49(a)</p>		<p>potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A Lab Completion Protocol was developed and implemented. The Daily Lab Tracking Form was revised during the survey. Licensed nurses were educated on this new practice on 2/27/14 and 3/1/14. The lab tracking book is being reviewed during daily clinical meetings Monday through Friday. The charge nurse reviews the book on week-ends.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Health and Wellness Director or Designee is completing quality improvement audits of laboratory services. The Health and Wellness Director or Designee is auditing the physician's orders for lab tests against the daily lab completion log. This will be done weekly for 1 month, then monthly for 6 months. Additional quality improvement audits will be completed based upon the level of compliance. The results of all audits will be reported to the Quality Assurance Improvement Committee monthly for additional recommendations as necessary.</p>		

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(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			
F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview, and record review, the facility failed to ensure a physician order was accurately transcribed for 1 of 10 records reviewed for physician orders. (Resident #25).</p> <p>Findings Include:</p> <p>The clinical record of Resident #25 was reviewed on 2/25/14 at 3:30 p.m. The record indicated the resident's diagnoses included, but were not limited to, osteoarthritis, epilepsy, senility, and anxiety.</p> <p>A telephone order, dated and signed by the physician on 1/20/14, indicated, "... D/C [discontinue] prn [as needed] Ativan (lorazepam)."</p>	F000514	<p>F514 483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ ACCESSIBLE It is the practice of Wellbrooke of Wabash to maintain each resident's clinical record in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #25's clinical record was corrected during the survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. What measures will be put into place</p>	03/30/2014			

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	<p>The February 2014 Physician orders, signed, but not dated by the doctor, included an order dated 8/18/13 for Ativan 0.5 milligrams (mgs). The order indicated "... also has prn/qd [daily] order..."</p> <p>The orders were not updated to reflect the physician order dated 1/20/14 to discontinue the as needed lorazepam.</p> <p>The current "Controlled Substance Record" indicated " Lorazepam 0.5 mg tablet. Give 1/2 tab PO [by mouth] daily in AM. Give 1/2 tab PO daily as needed for anxiety."</p> <p>The record was not updated to reflect the physician order to discontinue the Lorazepam on 1/20/14.</p> <p>Further information was requested of the Director of Nursing (DoN) on 2/28/14 at 8:30 a.m. No further information was presented.</p> <p>3.1-50(a)(2)</p>		<p>or what systemic changes will be made to ensure that the deficient practice does not recur? The Center has a policy addressing Clinical Records. Licensed nurses have been re-educated on this policy. All new orders are reviewed daily by the Night Shift Charge Nurse and then also reviewed during morning clinical meeting Monday through Friday to ensure that orders are transcribed correctly.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Health & Wellness Director or designee is completing quality improvement audits of clinical records. A random sample of 10% of clinical records is being audited weekly for 4 weeks then monthly for 6 months. Additional quality improvement audits will be completed based upon the level of compliance. The results of all audits will be reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary.</p>		