

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
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F000000	<p>This visit was for the Investigation of Compliant IN00159385.</p> <p>This visit was done in conjunction with a Recertification and State Licensure Survey that included the Investigation of Complaint IN00158666 and a State Residential Licensure Survey.</p> <p>Complaint IN00159385 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323, F157, and F309.</p> <p>Survey dates: November 6, 7, 10, 11, 12, & 13, 2014.</p> <p>Facility number: 013085 Provider number: 155811 AIM number: N/A</p> <p>Survey Team: Megan Burgess, RN, TC Lora Brettnacher, RN Tracina Moody, RN Kewanna Gordon, RN</p> <p>Census bed type: SNF: 38 SNF/NF: 16 Residential: 9</p>	F000000	<p>This plan of correction is to serve as Wellbrooke of Avon's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Wellbrooke of Avon or the management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this Center. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>This was a one -time past event which was identified and corrected by Wellbrooke of Avon prior to the complaint survey. We are in full compliance by 12/4/2014 and we respectfully request paper review.</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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F000157 SS=D	<p>Total: 63</p> <p>Census Payor type: Medicare: 38 Other: 16 Total: 54</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 11/14/14 by Brenda Marshall, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse</p>			

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	<p>consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to immediately notify a physician of a resident's injuries related to a fall. This deficient practice affected 1 of 3 residents reviewed for physician notification (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 11/13/2014 at 10:00 a.m. A nurse's noted, dated 10/22/2014 at 6:51 a.m., indicated Resident B fell and sustained a "large" hematoma (bruise) to the top right corner of her forehead. The hematoma had a "small" abrasion in the center with a "moderate amount of bleeding" noted. This note indicated Resident B complained of pain and required narcotic</p>	F000157	<p>F157 483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>-</p> <p>It is the practice of Wellbrooke of Avon to:</p> <p>(i) immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or interested family member when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or</p>	12/04/2014

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	<p>pain medication. The record lacked evidence the facility immediately notified a physician regarding Resident B's head injury.</p> <p>An untimed physician's telephone order, dated 10/22/2014, indicated the physician was notified and gave orders to send Resident B to the emergency room to be evaluated and treated.</p> <p>During an interview on 11/13/2014 at 12:55 p.m., Registered Nurse (RN) #1 indicated she arrived at the facility at 7:49 a.m. on 10/22/2014. Upon arrival to the facility, she assessed Resident B's head injury and was notified by Licensed Practical Nurse (LPN) #1 that a physician had not been notified. RN #1 notified Resident B's physician and informed him of her head injury. RN #1 indicated the physician gave an order for Resident B to be sent to the Emergency Room to be evaluated and treated.</p> <p>During an interview on 11/13/2014 at 2:51 p.m., the Director of Nursing (DON) indicated a head injury or bleeding was a medical emergency and Resident B's nurse failed to immediately notify the physician of her head injury with bleeding.</p> <p>A policy titled "Change in a Resident's</p>		<p>psychosocial status;</p> <p>(C) A need to alter treatment significantly; or</p> <p>(D) A decision to transfer or discharge the resident from the facility.</p> <p>(ii) The facility also notifies the resident or responsible party of-</p> <p>(A) A change in the room or roommate assignment</p> <p>(B) A change in resident's rights</p> <p>(iii) The facility records and periodically updates the address and phone number of the resident's legal representative or interested family member.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B no longer resides at the Center.</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?</p>	

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	<p>Condition or Status" identified by the DON as a current policy on 11/13/2014 at 2:43 p.m., indicated, "Our facility shall promptly notify... his or her Attending Physician... of changes in the resident's medical/mental condition and/or status... The Nurse...will notify the resident's Attending Physician or On-Call Physician when there has been: An accident or incident involving the resident..."</p> <p>This Federal tag relates to complaint IN00159385.</p> <p>3.1- 5(a)(1)</p>		<p>All residents have the potential to be affected. This has been addressed by the systems listed below.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>The center has a policy in place regarding physician notification. The policy has been reviewed and found to be complete. On the day of the event, licensed nurses were re-educated on the policy. Further education was completed by 11/26/2014. In addition, the Health and Wellness Director (DON) or the nurse on call are being notified of any resident incident that involves injury. Licensed nurses have been educated on this protocol.</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?</p> <p>The Health and Wellness Director (DON) or designee is conducting quality improvement audits of physician notification. Random samples of 5% of residents are being reviewed weekly for one</p>	

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F000309 SS=D	<p>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.</p> <p>Based on record review and interview, the facility delayed physician notification of a resident's head injury and abnormal vital signs resulting from a fall, and failed to arrange immediate medical transportation to the hospital emergency department after it was ordered by the physician for 1 of 3 residents reviewed for quality of care related to accidents (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 11/13/2014 at 10 a.m. A nurse's noted,</p>	F000309	<p>month for timely notification; then every two weeks for one month; then monthly for 4 months. Additional audits will be completed based upon the level of compliance. The results of all audits are reported to the Quality Assurance Improvement Committee monthly for additional recommendations as necessary.</p> <p>F309 483.25 PROVIDE CARE SERVICES FOR HIGHEST WELL BEING</p> <p>It is the practice of Wellbrooke of Avon to 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.</p>	12/04/2014

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	<p>dated 10/22/2014 at 6:51 a.m., indicated Resident B fell and sustained a "large" hematoma (bruise) to the top right corner of her forehead. The hematoma had a "small" abrasion in the center with a "moderate amount of bleeding" noted. This note indicated Resident B was "shaken up" by the incident. This note indicated Resident B complained of pain and required narcotic pain medication.</p> <p>A "Neurological Assessment", dated 10/22/2014, indicated Resident B's blood pressures after the fall as the following: 6:00 a.m.: 174/88 6:15 a.m.: 189/66 6:30 a.m.: 162/87 6:45 a.m.: 164/85 7:15 a.m.: 211/91 7:45 a.m.: 200/124 8:15 a.m.: 210/97 8:45 a.m.: 190/100</p> <p>Review of Resident B's Vital Sign Report, dated 10/21/2014 at 9:11 a.m., indicated Resident B's blood pressure as 166/56 the day before her fall occurred.</p> <p>An untimed physician's telephone order, dated 10/22/2014, indicated the physician was notified and gave orders to send Resident B to the emergency room to be evaluated and treated.</p>		<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B no longer resides in the Center. LPN #1 is no longer employed at the Center. RN #1 has been re-educated.</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?</p> <p>All residents have the potential to be affected. This has been addressed by the systems listed below.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>The nurse practice act requires a licensed nurse to apply the nursing process including assessing the health status of the patient/resident and making safe judgments. It is the Center's opinion that this does not require written policy as it is the responsibility of any prudent</p>	

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	<p>Review of an Emergency Department Physician Progress Note, dated 10/22/14, indicated Resident B was assessed at the Emergency Room on 10/22/14 at 10:09 a.m., with complaints of head and neck pain.</p> <p>A radiology report, dated 10/22/2014 at 10:38 a.m., indicated Resident B had an "acute" left "C1 (cervical) lamina fracture."</p> <p>An Admission History and Physical Note, dated 10/22/14 at 3:04 p.m., indicated Resident B was "found to have a C1 fracture and transferred to [hospital named] for further evaluation...."</p> <p>A nurse's note, dated 10/22/2014 at 4:28 p.m., indicated Resident B's daughter arrived at the facility and expressed concern regarding her mother's condition and that she had not yet been transported to the Emergency Room. This note indicated Resident B was transferred to the Emergency Room by her daughter at 9:50 a.m.</p> <p>During an interview on 11/13/2014 at 12:55 p.m., Registered Nurse (RN) #1 indicated she arrived at the facility at 7:49 a.m. on 10/22/2014. Upon arrival to the facility, she assessed Resident B's head injury. RN #1 indicated she would</p>		<p>licensed nurse. On the day of the event licensed nurses were re-educated on the requirements of the nurse practice act. A complete investigation of the event was completed. The policy regarding Fall Management and Event Management were reviewed and updated to include emergent care for any resident who falls with head injury. In addition, a policy regarding Emergency Care and Treatment was implemented to further ensure licensed nurses are aware of Center expectations. Licensed nurses were re-educated on this policy following the event. An additional re-education occurred on 11/26/2014.</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?</p> <p>The Health & Wellness Director (DON) or designee is conducting quality improvement audits of resident falls. All resident falls are being audited to ensure that physician notification, resident assessment, and emergent care (if warranted) is provided. This audit will continue ongoing. The results of all audits are reported to the Quality Assurance Improvement Committee monthly for additional recommendations</p>	

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	<p>have expected Resident B's nurse to contact the physician based on Resident B's increasing blood pressure ranges which followed after the fall. RN #1 notified Resident B's physician and informed him of her head injury and indicated the physician gave orders for Resident B to be sent to the Emergency Room to be evaluated. RN #1 indicated she instructed LPN #1 to send Resident B to the Emergency Room. RN #1 indicated she "assumed" LPN #1 called 911 emergency medical transport service, but later realized LPN #1 had called the facility's non-emergency transportation provider, which had an estimated arrival time of an hour and a half.</p> <p>During an interview on 11/13/2014 at 2:55 p.m., the Director of Nursing (DON) indicated at the time of Resident B's head injury, the facility did not have a policy which directed nurses on whether to call emergency or non-emergency transportation services. She indicated the facility nurses were allowed to use their nursing judgment to make that decision. She indicated a "prudent" nurse would have known a head injury was an emergency situation and the emergency transportation services should have been called. She stated..."I would have expected the nurse to call 911...."</p>		as necessary.	

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F000323 SS=G	<p>This Federal tag relates to complaint IN00159385.</p> <p>3.1-37(b)</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 record review and interview, the facility failed to utilize a gait belt during the transfer of resident, which resulted in a resident falling and sustaining a head injury that required emergency room evaluation/treatment and hospitalization. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 11/13/2014 at 10 a.m. Resident B had diagnoses which included, but were not limited to, muscle weakness, difficulty in walking, and a history of a stroke. A Minimum Data Set assessment tool (MDS), dated 8/19/2014, indicated she had cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 9 out of 15 and required the physical assistance of staff for transfers.</p>	F000323	<p>F323 483.25(h) ACCIDENTS It is the practice of Wellbrooke of Avon to ensure that the resident's environment remains as free from accident hazards as is possible; and each resident 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 B no longer resides in the Center. CNA #1 is no longer employed at 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? Even though this was an isolated event, the Center realizes 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? As</p>	12/04/2014

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	<p>A nurse's noted, dated 10/22/2014 at 6:51 a.m., indicated Resident B fell while being transferred by a Certified Nursing Assistant (CNA). This note indicated the CNA stated "she was unable to keep her from falling." This note indicated Resident B was "shaken up" by the incident. This note indicated Resident B sustained a "large" hematoma (bruise) to the top right corner of her forehead. The hematoma had a "small" abrasion in the center with a "moderate amount of bleeding" noted. This note indicated Resident B complained of pain and required narcotic pain medication.</p> <p>An untimed physician's telephone order, dated 10/22/2014, indicated the physician was notified and gave orders to send Resident B to the emergency room to be evaluated and treated.</p> <p>Review of an Emergency Department Physician Progress Note, dated 10/22/14, indicated Resident B was assessed at the Emergency Room on 10/22/14 at 10:09 a.m., with complaints of head and neck pain.</p> <p>A radiology report, dated 10/22/2014 at 10:38 a.m., indicated Resident B had an "acute" left "C1 (cervical) lamina fracture."</p>		<p>indicated in the survey report, the Center has a policy regarding safe transfers and the use of gait belts. This policy has been reviewed and found to be complete. Nursing personnel were re-educated on the policy following the event. An additional re-education will be completed by 12/4/2014. In addition, nursing personnel have completed competency skills testing regarding transferring a resident from a wheelchair including the importance of locking the wheels and using a gait belt. 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 (DON) or designee is conducting quality improvement audits of resident transfers including the use of gait belts. A random sample of 10 resident transfers is being audited weekly for 30 days; then every two weeks for 30 days; then monthly for four months. Additional audits will be completed based upon the level of compliance. The results of all audits are reported to the Quality Assurance Improvement Committee monthly for additional recommendations as necessary.</p>	

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	<p>An Admission History and Physical Note, dated 10/22/14 at 3:04 p.m., indicated Resident B was "found to have a C1 fracture and transferred to [hospital named] for further evaluation...."</p> <p>During an interview on 11/13/2014 at 12:00 p.m., CNA #1 indicated that she had transferred Resident B from a wheelchair to her recliner and Resident B lost her balance and fell. She indicated she failed to use a gait belt while transferring Resident B. She indicated she was aware that a gait belt should have been utilized as an intervention to prevent falls.</p> <p>During an interview on 11/13/2014 at 2:55 p.m., the Director of Nursing (DON) indicated all residents should be transferred with the use of a gait belt. She indicated CNA #1 failed to utilize a gait belt at the time Resident B fell and sustained a head injury. The DON indicated Resident B was transferred to the Emergency Room and admitted to the hospital after evaluation of her head injury.</p> <p>A policy titled "Gait Belt Transfers" identified as current by the DON on 11/13/2014 at 1:30 p.m., indicated "Gait belts are provided to assist staff to safely</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/13/2014
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON			STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234		
(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	
	<p>transfer or ambulate residents...Unless otherwise noted in the resident's care plan, a gait belt should be utilized for all residents during manual transfers...."</p> <p>This Federal tag relates to complaint IN00159385.</p> <p>3.1-45(a)(2)</p>				