STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155811		06/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBROOKE OF AVON	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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00174440. Complaint IN00174440 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309, F315, and F514. Survey dates: June 1, 2, 2015 Facility number: 013085 Provider number: 155811 AIM number: 201279600 Census bed type: SNF: 38 SNF/NF: 1 Residential: 9 Total: 48 Census payor type: Medicare: 28 Medicaid: 1 Other: 10 Total: 39 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.1.	F 0000		

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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F 0282 SS=D Bldg. 00	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 record review and interview, the facility failed to clarify and/or implement medication orders according to the plan of care and failed to provide in and out urinary catheterization as ordered by the physician for 1 of 3 residents reviewed for plan of care (Resident B). Findings include: The record for Resident B was reviewed on 6/1/15 at 11:25 a.m. Resident B's diagnoses included, but were not limited to, chronic pain, urinary retention, sacral, pelvic, and femur fracture, and esophageal cancer. Admission orders from the hospital on 5/23/15 indicated albuterol (bronchodilator, antiasthmatic) 90 mcg (micrograms) inhalation aerosol 2 puffs was to be administered unscheduled as needed for wheezing. Handwritten next to this order was a question mark. The Recapitulation of Physician's Orders on Admission, dated May 2015 and	F 0282	F 282 It is the practice of Wellbrooke of Avon to provide services by qualified persons in accordance with each resident's care plan. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Resident # B has been discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Current residents' physician's orders were verified against their current medication administration record and treatment administration record. All new orders will be reviewed 5 days a week in clinical meeting for accurate transcription. **What measures will be put into place or what systemic changes will be made to ensure that the**	06/23/2015

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 06/02/2015
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	Recapitulation of Physician's Orders, dated June 2015 did not indicate an order for the albuterol inhaler During a confidential interview on 6/2/15 at 12:45 p.m., Resident B's friend indicated she provided the nurses with the resident's inhaler because she was informed it had not yet been received from the pharmacy. During an interview with the DON on 6/2/15 at 1:30 p.m., she indicated if a nurse did not understand an order, it should have been investigated for clarification instead of placing a question mark next to it A physician's order, dated 5/26/15, indicated Resident B was to have an in and out catheterization with a 14 french red rubber straight catheter (size and kind of straight catheter used for intermittent emptying of urinary bladder) every 4 - 6 hours and as needed. A social services note, dated 5/28/15, indicated Resident B was cognitively intact according to her BIMS (Brief Interview of Mental Status) score. Nursing notes indicated on 5/26/15 at 12:23 p.m., Resident B returned from her urologist's appointment with an order for		**deficient practice does not reoccur?** Licensed nursing staff has been in-serviced on transcribing new physician orders and process of clarifying if unclear. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** QAA monitoring tool will be completed by ADNS/Designee on implementation of new physician orders. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. **Date to be completed** 6/23/2015	

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	in and out catheterization. The nurses's notes indicated at shift changes on 7 a.m. - 3 p.m. shift and on 3 p.m - 11 p.m. shift the resident was asked if she was ready to be catheterized and indicated the resident responded she did not feel full, her abdomen was soft, and she did not think it was necessary at that time. During an interview with Resident B on 6/1/15 at 10:15 a.m., she indicated the first time she was in and out catheterized was at 9:30 p.m. on 5/26/15. She indicated she asked the nurse to catheterize her "around 9:00 p.m." Resident B indicated 13 hours passed from removal of her indwelling catheter before she requested the in and out catheterization. She indicated she should have been catheterized "much earlier." During an interview with the DON (Director of Nursing) on 6/1/15 at 12:55 p.m., she indicated a nurse incorrectly transcribed the catheter order "as needed." The DON indicated the error was discovered the next morning and corrected. This federal tag relates to Complaint IN00174440 3.1-35(g)(2)			

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F 0309 SS=D Bldg. 00	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 record review and interview, the facility failed to ensure timely administration of pain medication to relieve pain for 1 of 3 residents reviewed for pain (Resident B). Findings include: The record for Resident B was reviewed on 6/1/15 at 11:25 a.m. Resident B's diagnoses included, but were not limited to, chronic pain, urinary retention, sacral, pelvic, and femur fracture, and esophageal cancer. A social service note, dated 5/28/15, indicated Resident B was cognitively intact according to her BIMS (Brief Interview of Mental Status) score. A physician's order, dated 5/23/15, indicated Resident B was prescribed Norco (a controlled substance pain medication) 10-325 mg (milligrams) tablet every 6 hours as needed.	F 0309	F 309 It is the practice of Wellbrooke of Avon to provide all residents with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Resident # B has been discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Current residents' medication orders were verified against their current medication administration record and verified that all medication were currently available. All new orders will be reviewed 5 days a week in	06/23/2015

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	Another physician's order, dated 5/23/15, indicated Resident B was prescribed oxycodone-acetaminophen (a narcotic pain medication) 7.5-325 mg 2 tablets every 4 hours as needed. During an interview with Resident B on 6/1/15 at 10:15 a.m., she requested pain medications be brought from her home on the day of admission because the pharmacy had not yet delivered her pain medication to the facility. During an interview with Resident B on 6/2/15 at 12:45 p.m., she indicated she asked for pain medication "all evening the day she was admitted", and indicated the nurse informed her the medication had not been delivered to the facility yet and indicated she requested the medication be brought from her home. An EDK (Emergency Drug Kit) medication list was provided by the MDS (Minimum Data Set) Coordinator on 6/1/15 at 10:08 a.m. The list of medications available to the staff in the EDK included, but was not limited to, Norco 10-325 mg 24 tablets available, and oxycodone/APAP (acetaminophen) 7.5-325 mg 10 tablets available. A charge ticket indicated an antibiotic had been removed from the EDK for the resident, but did not indicate pain medication had		clinical meeting for timely delivery of medication or utilization of emergency drug kit (EDK). **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff has been in-serviced on ordering of medication and emergency drug kit (EDK) procedures. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** QAA monitoring tool will be completed by ADNS/Designee on medication ordering and emergency drug kit (EDK) utilization. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. **Date to be completed** 6/23/2015	

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	been removed from EDK for Resident B. A Nurses Note, dated 5/24/15 at 7:30 a.m., indicated the pharmacy authorization code to remove a narcotic from the EDK was received. The narcotic sign out sheets indicated the oxycodone/APAP was first given 5/24/15 at 7:00 p.m. .The Norco had been discontinued by the physician on 5/24/15, and there was no record any had been administered to the resident. The MAR (Medication Administration Record) for 5/23/15 through 6/1/15 (record is computerized) did not indicate Norco was administered on any days and indicated the first dose of oxycodone/APAP was administered on 5/25/15 at 12:49 a.m. Pharmacy delivery sheets indicated Norco 10-325 mg, 12 tablets, and oxycodone/APAP 7.5-325 mg 18 tablets, had been filled at the pharmacy on 5/24/15 at 10:52 a.m., and delivered to the facility at 11:45 a.m. During an interview with LPN #1 on 6/1/15 at 9:55 a.m., she indicated there is an extensive list of medications available in the EDK, even narcotic medications, for the nurses to administer to residents			

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	who need them prior to delivery of medications from the pharmacy. During an interview with the DON on 6/2/15 at 1:30 p.m., she indicated she would have expected pain medication to have been removed from the EDK for a resident complaining of pain prior to delivery of their medications to keep them comfortable. The DON also indicated she was waiting to hear from the pharmacy if narcotics had been removed from the EDK for Resident B. A current facility policy titled "Medication Ordering And Receiving From Pharmacy", dated/1/13 was provided by the Administrator on 6/1/15 at 2:10 p.m. The policy indicated, "...Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy...New medications, EXCEPT for emergency or 'stat' medications, are ordered as follows...b. Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to delivery...." This federal tag relates to Complaint			

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	IN00174440. 3.1-37(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to provide in and out catheterization for a resident as ordered by the physician to prevent potential urinary retention and/or urinary tract infection for 1 of 3 residents reviewed for urinary catheters (Resident B). Findings include: The record for Resident B was reviewed on 6/1/15 at 11:25 a.m. Resident B's diagnoses included, but were not limited to, chronic pain, urinary retention, sacral, pelvic, and femur fracture, and	F 0315	F 315 It is the practice of Wellbrooke of Avon to ensure that a resident who is incontinent of bladder receives appropriate treatment and services. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Resident # B has been discharged from the facility. **How other residents having the potential to be affected by the**	06/23/2015

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	esophageal cancer. A social services note, dated 5/28/15, indicated Resident B's BIMS (Brief Interview of Mental Status) evaluation showed Resident B was cognitively intact. A physician's order, dated 5/26/15, indicated Resident B was to have an in and out catheterization with a 14 french red rubber straight catheter (size and kind of straight catheter used for intermittent emptying of urinary bladder) every 4 - 6 hours and as needed. A social services note, dated 5/28/15, indicated Resident B was cognitively intact according to her BIMS (Brief Interview of Mental Status) score. Nursing notes indicated on 5/26/15 at 12:23 p.m., Resident B returned from her urologist's appointment with an order for in and out catheterization. The nurses's notes indicated at shift changes on 7 a.m. - 3 p.m. shift and on 3 p.m - 11 p.m. shift the resident was asked if she was ready to be catheterized and indicated the resident responded she did not feel full, her abdomen was soft, and she did not think it was necessary at that time. During an interview with Resident B on		**same deficient practice will be identified and what corrective action will be taken?** Residents who require catheters were reviewed to ensure their physician orders matched the treatment administration record. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff has been in-serviced on transcribing and clarifying catheter orders. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** QAA monitoring tool will be completed by ADNS/Designee on catheter use and current physician orders for their use. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. **Date to be completed** 6/23/2015	

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	6/1/15 at 10:15 a.m., she indicated the first time she was in and out catheterized was at 9:30 p.m. on 5/26/15. She indicated she asked the nurse to catheterize her "around 9:00 p.m." Resident B indicated 13 hours passed from removal of her indwelling catheter before she requested the in and out catheterization. She indicated she should have been catheterized "much earlier." During an interview with the DON (Director of Nursing) on 6/1/15 at 12:55 p.m., she indicated a nurse incorrectly transcribed the catheter order "as needed." The DON indicated the error was discovered the next morning and corrected. This federal tag relates to Complaint IN00174440. 3.1-41(a)(2)			
F 0514 SS=D Bldg. 00	483.75(l)(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. The clinical record must contain sufficient			

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	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. Based on record review and interview, the facility failed to ensure admission orders were accurately transcribed for 1 of 3 residents reviewed for documentation of admission orders (Resident B). Findings include: The record for Resident B was reviewed on 6/1/15 at 11:25 a.m. Resident B's diagnoses included, but were not limited to, chronic pain, urinary retention, sacral, pelvic, and femur fracture, and esophageal cancer. Admission orders from the hospital on 5/23/15 indicated albuterol (bronchodilator, antiasthmatic) 90 mcg (micrograms) inhalation aerosol 2 puffs was to be administered unscheduled as needed for wheezing. Handwritten next to this order was a question mark. The Recapitulation of Physician's Orders on Admission, dated May 2015 and Recapitulation of Physician's Orders, dated June 2015 did not indicate an order for the albuterol inhaler	F 0514	**F 514** It is the policy of Wellbrooke of Avon to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurate, accessible, and systematically organized. **What corrective action will take place for those residents affected by the deficient practice?** Resident #B has been discharged from facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Current residents' physician's orders were verified against their current medication administration record and treatment administration record. All new orders will be reviewed 5 days a week in clinical meeting for accurate transcription. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Licensed nursing staff has been in-serviced on transcribing new physician orders and process of clarifying if unclear. **How the corrective action will be monitored to ensure the**	06/23/2015

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	During a confidential interview on 6/2/15 at 12:45 p.m., Resident B's friend indicated she provided the nurses with the resident's inhaler because she was informed it had not yet been received from the pharmacy. During an interview with the DON on 6/2/15 at 1:30 p.m., she indicated if a nurse did not understand an order, it should have been investigated for clarification instead of placing a question mark next to it This federal tag relates to Complaint IN00174440. 3.1-50(f)(3)		**deficient practice does not reoccur?** QAA monitoring tool will be completed by ADNS/Designee on implementation of new physician orders. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly **Date to be completed.** 6/23/2015	