

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: December 10, 11, 14, 15, 16, 17, 2015.</p> <p>Facility number: 013085 Provider number: 155811 AIM number: 201279600</p> <p>Census bed type: SNF: 51 Residential: 17 Total: 68</p> <p>Census payor type: Medicare: 33 Other: 18 Total: 51</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed December 22, 2015 by 29479</p>	F 0000	<p>R092</p> <p>It is the practice of Wellbrooke of Avon to maintain a written fire and disaster plan.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>No residents were identified in the deficiency.</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>Current residents will participate in monthly fire drills that include fire department participation at least twice per year.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Director of Plant Operations has been in-serviced on the need for fire drills that include local fire department participation at least twice per year. The campus has invited the city fire department to</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0156 SS=D Bldg. 00	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is		participate in our next monthly fire drill. How the corrective action will be monitored to ensure the deficient practice does not reoccur? QAA monitoring tool will be completed by the Executive Director/Designee to review fire drills including local fire department participation. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved. Date to be completed 1/14/16	

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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents who disagreed with Medicare Non-Coverage (NOMNC) were afforded their rights to dispute/appeal the decision of non-coverage for 1 of 3 residents reviewed for Medicare non-coverage (Resident #12).</p> <p>Findings include:</p> <p>Resident #12's record was reviewed on 12/15/15 at 12:28 p.m. The record</p>	F 0156	<p>F 156</p> <p>It is the practice of Wellbrooke of Avon to provide notice to the residents of their rights and all rules and regulations governing resident conduct and responsibilities.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 12 has been discharged</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>indicated Resident #12 was responsible for herself, was receiving therapy services covered by Medicare, and was discharged from the facility on 9/16/15. A Minimum Data Set (MDS) assessment indicated Resident #12 was cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 out of 15. The record lacked documentation the facility informed the resident of her right to appeal the decision.</p> <p>A NOMNC document dated 9/14/15, indicated "...The Effective Date Coverage of Your Current Skilled Therapy Services Will End: 9/14/15..." The document indicated Resident #12 had not agreed with the decision and indicated to the facility she felt she was being "kicked out," wasn't "ready to go home," and indicated "you can't do this to me." The document was not signed by Resident #12. The record lacked indication Resident #12 was provided information regarding her right to dispute the decision of non-coverage.</p> <p>During a telephone interview on 12/15/2015 at 12:28 a.m., Resident #12 indicated she refused to sign the NOMNC because she felt she hadn't met her rehabilitation potential and wanted more therapy. She indicated she felt like they were "kicking her out." She further</p>		<p>from the facility.</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>Current residents being removed from a skilled Medicare stay will receive a NOMNC letter that includes date and time of delivery. They will also be instructed of their right to appeal the decision of the Interdisciplinary Team.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Social Service staff has been in-serviced on the NOMNC letter, including appeal process and required documentation. All potential discharges from coverage will be reviewed in IDT meeting five days a week.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the Executive Director/Designee on all residents being removed from a skilled Medicare or Medicare Advantage plan. This will be completed weekly times eight weeks and then monthly</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>indicated she was not informed of her right to dispute the decision.</p> <p>During an interview on 12/15/15 at 12:37 p.m. the Executive Director indicated Resident #12 should not have received a NOMNC because she had not exhausted her Medicare days. He further indicated the facility did not have a policy regarding informing residents of Medicare non-coverage and appeal rights. He indicated he had cheat sheet they followed.</p> <p>During an interview on 12/16/2015 at 2:40 p.m., the Social Service Director (SSD) indicated she attempted to provide Resident #12 with the NOMNC on 9/14/15. She indicated Resident #12 was upset and had not agreed with the decision. The SSD indicated she informed therapy and asked them to educate Resident #12 regarding the reasons she no longer qualified for skilled therapy service however, she had not followed up to ensure Resident #12 was informed of her rights to dispute/appeal the decision.</p> <p>A document titled "Skilled Nursing Facility Notices of Non-Coverage Cheat Sheet" identified as a current procedure by the Executive Director on 12/15/15 at 12:37 p.m., indicated when a beneficiary</p>		<p>times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>dropped to a non-skilled level of care and their benefits had not been exhausted and the beneficiary remained in the facility a notice "Denial Letter and Notice of Medicare Non-Coverage" (NOMNC) was required no later than two days before covered services ended. The procedure further indicated if a beneficiary requested an expedited review a detailed explanation of non-coverage would be required as soon as notified the beneficiary requested the review.</p> <p>The "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS -10123" was reviewed on 12/15/15 at 2:37 p.m. The NOMNC instructions indicated, "A Medicare provider or health plan (Medicare Advantage plans and cost plans , collectively referred to as 'plans') must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services." The NOMNC instructions stated, "A NOMNC must be delivered even if the beneficiary agrees with the termination of services." The NOMNC instructions stated, "The provider must ensure that the beneficiary or representative signs and dates the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0176 SS=D Bldg. 00	<p>NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed."</p> <p>3.1-4(a)</p> <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview, and record review, the facility failed to provide an assessment for medication self administration for 1 of 1 residents reviewed for residents who self medicate (Resident #206).</p> <p>Findings include:</p> <p>On 12/11/15 at 9:08 a.m., an albuteral inhaler was observed on Resident #206's bedside table.</p> <p>On 12/14/15 at 9:47 a.m., an albuteral inhaler was observed on the bedside table. Resident #206 indicated she self administered the albuteral inhaler as</p>	F 0176	<p>F 176</p> <p>It is the practice of Wellbrooke of Avon to allow residents to self-administer medications if they desire and if the interdisciplinary team has determined that the practice is safe.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 206 has been discharged from the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2015
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>needed up to 4 times a day.</p> <p>On 12/16/15 at 10:08 a.m., an albuteral inhaler was observed on the bedside table.</p> <p>Resident #206's record was reviewed on 12/14/15 at 11:57 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation. A Minimum Data Set assessment (MDS), dated 12/01/15, indicated Resident #206 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>A physician's order dated 11/24/15, indicated albuteral sulfate 90 mcg, 2 puffs; inhalation four times a day. The order indicated Resident #206 may keep the inhaler at bedside. The Medication Administration Record indicated albuteral sulfate 90 mcg, ...may keep at bedside.</p> <p>During an interview on 12/16/15 at 9:00 a.m., the Director of Nursing (DON) indicated no medication self administration assessment was done on Resident #206 prior to her having the albuteral inhaler at bedside for self administration.</p>		<p>action will be taken?</p> <p>Current residents who self administer medications will have a self administration assessment completed by a licensed nurse. These results will be given to the physician for evaluation and an order for self medication.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Licensed nursing staff have been in-serviced on the self-administer medication assessment and policy. DHS or designees will review new residents requesting to self administer medications will have their orders and self administer assessments reviewed during IDT meeting five days a week as indicated.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the DHS/Designee on all residents currently self-administering medications. New residents requesting to self-administer medications will be added to the monitoring tool. This will be completed weekly times eight weeks and then monthly times 4months. The results will be</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 12/17/2015
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>During an interview on 12/16/15 at 2:58 p.m., Certified Nurses Aid (CNA) #11 indicated she had observed Resident #206 use her inhaler without staff assistance.</p> <p>During an interview on 12/16/15 at 3:06 p.m., Registered Nurse (RN) # 3 indicated Resident #206 used her inhaler at least twice a day, morning and afternoon, and as needed.</p> <p>The "Guidelines for Self Administration of Medications" policy was provided by the DON on 12/16/15 at 2:09 p.m. This current policy indicated the following:</p> <p>"PURPOSE: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care.</p> <p>PROCEDURE: 1. Residents requesting self-medicate or has self-medication as a part of their care plan shall be assessed for safety by a licensed nurse. 2. Results of the assessment will be presented to the physician for evaluation and an order for self-medication."</p> <p>3.1-11(a)</p>		<p>reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed 1/14/16</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to conduct a thorough investigation for an allegation of abuse for 1 of 3 abuse allegations reviewed (Resident #110).</p> <p>Finding includes:</p> <p>On 12/14/15 at 9:52 a.m., the Executive Director (ED) provided two investigated abuse allegations to review for abuse prohibition. The Indiana State Department of Health (ISDH) reported incident, dated 9/6/15, indicated Resident #110 had alleged Qualified Medication Aide (QMA) #12 had jerked her shirt out of her hands and reported a, "sore muscle to (right) mid back." The investigation indicated the incident occurred on 9/5/15 at approximately 7 p.m. to 8 p.m. The investigation indicated QMA #12 was suspended pending investigation, and Resident #110 and her family were interviewed. The report indicated Resident #110 had diagnoses including, but not limited to: diabetes, depressive disorder, incontinence, and history of cerebrovascular accident (CVA). The follow-up section on the ISDH reportable was not completed.</p> <p>The form titled, "Employee Statement,"</p>	F 0225	<p>F 225</p> <p>It is the practice of Wellbrooke of Avon to conduct thorough investigations on allegations of abuse and neglect.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 110 has been discharged from the facility.</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>Current residents were interviewed for any concerns about abuse with no new allegations reported. Residents were also educated at that time on reporting allegations including abuse definition and reporting. Families for the cognitively impaired residents were called and given education on reporting allegations.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2015
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>completed by the Director of Nursing (DON) on 9/6/15 at 2:35 p.m., indicated she had received a call from Licensed Practical Nurse (LPN) #14 stating Resident #110's daughter had reported rough care from QMA #12. The statement indicated the DON had called Resident #110's daughter and she stated, "I'm concerned. She reported that the aide was mean to her and jerked her and now she has a pulled muscle in her back, so yes this is very concerning."</p> <p>The form titled, "Employee Statement," completed by the Director of Nursing (DON) on 9/6/15 at 6:08 p.m., indicated the DON had a phone conversation with Resident #110's daughter. Resident #110's daughter stated, "mother was very upset and stated, 'she was mean to me and jerked me' and kept asking her not to leave her and it was alarming."</p> <p>The form titled, "Employee Statement," completed by the Director of Nursing (DON) on 9/6/15 at 6:45 p.m., indicated the DON interviewed Resident #110 with her daughter in law present regarding the allegation of abuse from QMA#12. The form stated, "she was holding her shirt in both hands in front of her chest and the staff member 'jerked it out of my hands', 'jerked it bad'...'I told her no, no, no,' then, 'she jerked the shirt out of my</p>		<p>Staff has been in-serviced on the abuse and neglect procedural guidelines. The ED/designee will develop a questionnaire specific to the concern to interview other residents during an abuse or neglect investigation.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the Executive Director/Designee on all abuse and neglect investigations. This will be completed weekly times eight weeks and then monthly times 4months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>hands." Resident then stated, "now my back hurts."</p> <p>The form titled, "Employee Statement," completed by the Director of Nursing (DON) on 9/6/15 at 7:39 p.m., indicated the DON had interviewed QMA #12. QMA #12 indicated she had cared for Resident #110 on the day of the allegation and denied the allegation.</p> <p>On 12/16/15 at 11:29 a.m., the ED provided the, "Family Call Log History Report," from 9/4/15 to 9/8/15 and indicated Resident #12 and Resident #49 would have had the same QMA as Resident #110. The ED indicated the family call log were the results of his interviews with residents and/or resident's families 24 hours after admission, 30 days after admission, 60 days after admission, and 90 days after admission. The report provided the resident's rating from zero to ten for the following areas: "Quality of Care, Staff Attitude & Responsiveness, Appearance and Cleanliness of the Campus, Food Quality and Selection, and Activities Today." The report did not include an assessment of abuse to the resident or other residents. The report indicated Resident #49 was interviewed the day prior to the allegation on 9/4/15. The report indicated a total of eight interviews</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>with residents or families had been conducted from 9/4/15 to 9/8/15, and four of the eight interviews occurred prior to the allegation of the abuse. During an interview on 12/14/15 at 3:37 p.m., the Executive Director (ED) indicated no other residents were interviewed during the abuse allegation investigation. The ED indicated a follow-up report was not completed because the allegation had been unsubstantiated.</p> <p>On 12/16/15 at 2:05 p.m., Resident #110's record was reviewed. The admission minimum data set (MDS) assessment, dated 9/4/15, indicated the resident had a brief interview for mental status (BIMS) score of 15 and was cognitively intact. The MDS indicated the resident was an extensive assist of one for bed mobility, dressing, toileting, and personal hygiene.</p> <p>During an interview on 12/16/15 at 10:58 a.m., the Director of Nursing (DON) indicated if she received an allegation of rough treatment to a resident by a staff member, then she would interview other residents, especially those on the same QMA's assignment, to determine if other residents had concerns with the staff member. She indicated she was familiar with Resident #110's allegation and did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>not believe other residents were interviewed, and was unsure why other residents on the QMA's assignment were not interviewed. She indicated other residents should have been interviewed to verify QMA #12 had not been rough with any other residents.</p> <p>During an interview on 12/16/15 at 11:11 a.m., the Executive Director (ED) indicated he did not interview other residents on QMA #12's assignment list because he did a family call program to check on the treatment of residents daily. He indicated Resident #110's family had retracted the abuse claim and apologized to QMA #12 prior to the completion of the follow-up of abuse allegation. He indicated he did not have documentation of the retraction of the compliant.</p> <p>On 12/15/15 at 8:00 a.m., the ED provided the current abuse policy titled, "Abuse and Neglect Procedural Guidelines." The policy stated, "PHYSICAL ABUSE- includes hitting, slapping, pinching, spitting, holding or handling roughly." The policy stated, "Assure that prevention techniques are implemented in the campus. Identify, correct, and intervene in situations where abuse and/or neglect are more likely to occur." The policy stated, "The Executive Director is accountable for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0226 SS=D Bldg. 00	<p>investigating and reporting. Refer to the Incident and Accident Program for investigation procedures."</p> <p>On 12/15/15 at 12:28 p.m., the ED provided the current policy titled, "Accidents and Incidents--Investigating and Recording." The policy stated, "All accidents or incidents occurring on our premises must be investigated and reported to the administrator." The policy stated, "the following data, as it may apply, must be included on the Accident Investigation Report Form...follow-up information...Other pertinent data as necessary or required."</p> <p>3.1-28(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement its written policies for investigating and reporting abuse allegations for 1 of 3 abuse allegations reviewed (Resident #110).</p> <p>Finding includes: On 12/14/15 at 9:52 a.m., the Executive</p>	F 0226	<p>F 226</p> <p>It is the practice of Wellbrooke of Avon to implement policies and procedures that prohibit abuse and neglect.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>Director (ED) provided two investigated abuse allegations to review for abuse prohibition. The Indiana State Department of Health (ISDH) reported incident, dated 9/6/15, indicated Resident #110 had alleged Qualified Medication Aide (QMA) #12 had jerked her shirt out of her hands and reported a, "sore muscle to (right) mid back." The investigation indicated the incident occurred on 9/5/15 at approximately 7 p.m. to 8 p.m. The investigation indicated QMA #12 was suspended pending investigation, and Resident #110 and her family were interviewed. The report indicated Resident #110 had diagnoses including, but not limited to: diabetes, depressive disorder, incontinence, and history of cerebrovascular accident (CVA). The follow-up section on the ISDH reportable was not completed.</p> <p>The form titled, "Employee Statement," completed by the Director of Nursing (DON) on 9/6/15 at 2:35 p.m., indicated she had received a call from Licensed Practical Nurse (LPN) #14 stating Resident #110's daughter had reported rough care from QMA #12. The statement indicated the DON had called Resident #110's daughter and she stated, "I'm concerned. She reported that the aide was mean to her and jerked her and now she has a pulled muscle in her back, so</p>		<p>by the deficient practice?</p> <p>Resident # 110 has been discharged from the facility.</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>Current residents were interviewed for any concerns about abuse with no new allegations reported. Residents were also educated at that time on reporting allegations including abuse definition and reporting. Families for the cognitively impaired residents were called and given education on reporting allegations.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Staff has been in-serviced on the abuse and neglect procedural guidelines. The ED/designee will develop a questionnaire specific to the concern to interview other residents during an abuse or neglect investigation.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>yes this is very concerning."</p> <p>The form titled, "Employee Statement," completed by the Director of Nursing (DON) on 9/6/15 at 6:08 p.m., indicated the DON had a phone conversation with Resident #110's daughter. Resident #110's daughter stated, "mother was very upset and stated, 'she was mean to me and jerked me' and kept asking her not to leave her and it was alarming."</p> <p>The form titled, "Employee Statement," completed by the Director of Nursing (DON) on 9/6/15 at 6:45 p.m., indicated the DON interviewed Resident #110 with her daughter in law present regarding the allegation of abuse from QMA#12. The form stated, "she was holding her shirt in both hands in front of her chest and the staff member 'jerked it out of my hands', 'jerked it bad'...'I told her no, no, no,' then, 'she jerked the shirt out of my hands.'" Resident then stated, "now my back hurts."</p> <p>The form titled, "Employee Statement," completed by the Director of Nursing (DON) on 9/6/15 at 7:39 p.m., indicated the DON had interviewed QMA #12. QMA #12 indicated she had cared for Resident #110 on the day of the allegation and denied the allegation.</p>		<p>completed by the Executive Director/Designee on all abuse and neglect investigations. This will be completed weekly times eight weeks and then monthly times 4months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>On 12/16/15 at 11:29 a.m., the ED provided the, "Family Call Log History Report," from 9/4/15 to 9/8/15 and indicated Resident #12 and Resident #49 would have had the same QMA as Resident #110. The ED indicated the family call log were the results of his interviews with residents and/or resident's families 24 hours after admission, 30 days after admission, 60 days after admission, and 90 days after admission. The report provided the resident's rating from zero to ten for the following areas: "Quality of Care, Staff Attitude & Responsiveness, Appearance and Cleanliness of the Campus, Food Quality and Selection, and Activities Today." The report did not include an assessment of abuse to the resident or other residents. The report indicated Resident #49 was interviewed the day prior to the allegation on 9/4/15. The report indicated a total of eight interviews with residents or families had been conducted from 9/4/15 to 9/8/15, and four of the eight interviews occurred prior to the allegation of the abuse.</p> <p>On 12/16/15 at 2:05 p.m., Resident #110's record was reviewed. The admission minimum data set (MDS) assessment, dated 9/4/15, indicated the resident had a brief interview for mental status (BIMS) score of 15 and was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>cognitively intact. The MDS indicated the resident was an extensive assist of one for bed mobility, dressing, toileting, and personal hygiene.</p> <p>During an interview on 12/14/15 at 3:37 p.m., the Executive Director (ED) indicated no other residents were interviewed during the abuse allegation investigation. The ED indicated a follow-up report was not completed because the allegation had been unsubstantiated.</p> <p>During an interview on 12/16/15 at 10:58 a.m., the Director of Nursing (DON) indicated if she received an allegation of rough treatment to a resident by a staff member, then she would interview other residents, especially those on the same QMA's assignment, to determine if other residents had concerns with the staff member. She indicated she was familiar with Resident #110's allegation and did not believe other residents were interviewed, and was unsure why other residents on the QMA's assignment were not interviewed. She indicated other residents should have been interviewed to verify QMA #12 had not been rough with any other residents.</p> <p>During an interview on 12/16/15 at 11:11 a.m., the Executive Director (ED)</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 12/17/2015	
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>indicated he did not interview other residents on QMA #12's assignment list because he did a family call program to check on the treatment of residents daily. He indicated Resident #110's family had retracted the abuse claim and apologized to QMA #12 prior to the completion of the follow-up of abuse allegation. He indicated he did not have documentation of the retraction of the compliant.</p> <p>On 12/15/15 at 8:00 a.m., the ED provided the current abuse policy titled, "Abuse and Neglect Procedural Guidelines." The policy stated, "PHYSICAL ABUSE- includes hitting, slapping, pinching, spitting, holding or handling roughly." The policy stated, "Assure that prevention techniques are implemented in the campus. Identify, correct, and intervene in situations where abuse and/or neglect are more likely to occur." The policy stated, "The Executive Director is accountable for investigating and reporting. Refer to the Incident and Accident Program for investigation procedures."</p> <p>On 12/15/15 at 12:28 p.m., the ED provided the current policy titled, "Accidents and Incidents--Investigating and Recording." The policy stated, "All accidents or incidents occurring on our premises must be investigated and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2015
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	
F 0242 SS=D Bldg. 00	<p>reported to the administrator." The policy stated, "the following data, as it may apply, must be included on the Accident Investigation Report Form...follow-up information...Other pertinent data as necessary or required."</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review, and interview, the facility failed to assess a resident's preferences for showers for 1 of 1 resident reviewed for choices (Resident #206).</p> <p>Finding includes:</p> <p>During an interview on 12/11/15 at 9:08 a.m., Resident #206 indicated she was to have a shower twice a week, but would like at least 3 showers a week. She indicated at home she took a shower everyday.</p>	F 0242	<p>F 242</p> <p>It is the practice of Wellbrooke of Avon to have residents make choices about aspects of their life in the facility that are significant to the resident.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 206 has been discharged from the facility.</p> <p>How other residents having the</p>	01/14/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>During an interview on 12/16/15 at 10:08 a.m., Resident #206 indicated she had not received a shower prior to Saturday 12/12/15. She indicated she had one "good" bed bath, but preferred showers.</p> <p>Resident #206 clinical record was reviewed on 12/14/15 at 11:57 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, and muscle weakness. A Minimum Data Set (MDS) assessment, dated 12/01/15, indicated Resident #206 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The resident required extensive assistance of 2 persons for transfers, and was very important to resident to choose between a tub bath, shower, or bed bath.</p> <p>Shower records were reviewed on 12/16/15 at 2:02 p.m., and showers were documented on:</p> <p>a. 12/13/15 shower was documented in progress notes.</p> <p>b. 12/15/15 shower was documented in point of care history.</p> <p>During an interview on 12/16/15 at 9:40 a.m., Registered Nurse (RN) #10 indicated residents received showers two days a week. She indicated Resident #206</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All new admissions will have preferences addressed on admission. Current residents will be interviewed to ensure that resident preferences are being honored and care plans will be updated as indicated.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Staff have been in-serviced on the resident right to make choices and the admission resident preference form. DHS/designee will review all new admission preferences during IDT meeting five days a week. Care plans including resident preferences will be reviewed quarterly and updated as warranted.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the DNS/Designee on honoring preferences. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>assigned shower days were Tuesday and Friday.</p> <p>During an interview on 12/16/15 at 9:53 a.m., Certified Nurses Aid (CNA) #1 indicated if a complete bed bath was given then the shower skin sheet was to be filled out.</p> <p>During an interview on 12/16/15 at 10:43 a.m., RN #10 indicated residents were informed on admission that they get 2 assigned shower days a week.</p> <p>On 12/16/15 at 10:15 a.m., the Director of Nursing (DON) provided a "Care Coordinator Admission Checklist " for Resident #206 with options for Shower, Spa, or Bed bath, and showers were checked as her preference.</p> <p>On 12/16/15 at 2:09 p.m., the DON provided a shower policy that lacked information about resident preferences as to how many showers they received.</p> <p>The "Residents Rights" policy was provided by the DON on 12/16/16 at 2:09 p.m. This current policy indicated, "...Residents Rights...Quality of Life...35....You have the right to...c. Make choices about aspects of your life in the nursing facility that are significant to you...."</p>		<p>Date to be completed</p> <p>1/14/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0246 SS=D Bldg. 00	<p>3.1-3(u)(3)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on interview and record review, the facility failed to provide a Hoyer sling required to provide a resident with showers for 1 of 1 resident reviewed for accommodation of needs (Resident #206).</p> <p>Finding includew:</p> <p>During an interview on 12/16/15 at 10:08 a.m., Resident #206 indicated she had only received bed baths until her shower on 12/13/15. She indicated she preferred showers.</p> <p>Resident #206's clinical record was reviewed on 12/14/15 at 11:57 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, muscle weakness</p>	F 0246	<p>F 246</p> <p>It is the practice of Wellbrooke of Avon to have residents receive services with reasonable accommodations of individual needs and preferences.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 206 has been discharged from the facility.</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 who require mechanical lifts were audited to ensure the</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2015
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>(generalized), anemia, Diabetes Mellitus, anxiety and depression. The admission Minimum Data Set assessment(MDS), dated 12/01/15, indicated Resident #206 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The resident required extensive assistance of 2 persons for transfers, and indicated it was very important for her to choose between a tub, shower, or bed bath.</p> <p>Shower records were reviewed on 12/16/15 at 2:02 p.m., and showers were documented on:</p> <p>a. 12/13/15 shower was documented in progress notes.</p> <p>b. 12/15/15 shower was documented in point of care history.</p> <p>During an interview on 12/16/15 at 10:43 a.m., Registered Nurse (RN) #10 indicated Resident #206 required bariatric equipment for a safe transfer. She indicated it took about a week for the equipment to arrive.</p> <p>During an interview on 12/16/2015 at 10:54 a.m., The Physical Therapist (PT) #15 indicated they try to have equipment in place prior to admission and nursing would set it up. She indicated resident #206 was identified to require specialized equipment. She indicated Resident #206</p>		<p>appropriate size and inventory supply of slings are available. Equipment was verified to be in place. All new admits will have equipment needs verified and in place during assessment for admission.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>All staff has been in-serviced on the process to notify and procure equipment if unable to locate. DHS/designee will review new admissions and new orders in IDT meeting five days per week to ensure all equipment needs are accommodated appropriately.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the DNS/Designee on equipment availability. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0250 SS=D Bldg. 00	<p>had one Hoyer sling with no backup hoyer sling available if it became soiled. She indicated the facility had ordered more Hoyer slings for the resident's use.</p> <p>During an interview on 12/16/15 at 11:02 a.m., the Director of Nursing (DON) indicated a back up Hoyer sling had to be ordered for Resident #206. The sling was ordered right before Thanksgiving and came in the Monday after Thanksgiving.</p> <p>3.1-3(v)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure social services were provided to meet the emotional needs of residents who were grieving, having difficulty adjusting, and had a decline in their PHQ-9 (Patient Health Questionnaire) score for 1 of 1 resident reviewed for social services (Resident #60).</p> <p>Finding includes:</p>	F 0250	<p>F 250</p> <p>It is the practice of Wellbrooke of Avon to provide medically-related social service to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>During an interview on 12/11/2015 at 9:18 a.m., Resident #60 was observed sobbing. She stated, "I want to go home. I lost my husband while I was in the hospital. A chain of things has happened. I have trouble remembering stuff. I am afraid they are going to put me in the home. I can still cook and do things. I don't know if anyone will trust me to go home. I don't know what to do. I am going to run away but that is an injustice to my girls. I want to go home. I haven't been home since before I went in the hospital. No one has talked to me about discharge planning. I don't know anything." Resident #60 was observed continually sobbing with tears flowing down her face holding her head in her hand. She stated, "I don't know anything. It worries me to death. They won't let me go home I've got a house to go to. I just feel beat up. My husband got sick and I got sick and now I don't have anything I can look forward to. I desperately need to go home. I need to go home. I don't remember what I agreed to or disagreed. We have had meetings but I can't make up my mind and when I do I don't remember which is a bad mark for me. There is a lot of people that go home. I can't go home. I don't understand why I am being punished." Resident #60 continued to sob with tears running down her face. She stated, "I'm sorry. I can't</p>		<p>Resident # 60 was offered outside counseling services. The resident also was started on an antidepressant on 12/22/15. An order for target behavior monitoring was added on 12/29/15.</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>Residents were reviewed for the need for counseling services. All those in need received a referral.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Staff has been in-serviced on the behavior monitoring tool. Those tools are reviewed in interdisciplinary meeting five days per week. The social service director will review all PHQs completed by social service designee.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the Social Service Director/Designee on residents that require additional social services and implementation of the services. This will be completed weekly times</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 12/17/2015	
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>convince anyone. I want to go home. I need to go home so bad. I need to be home and touch our stuff. Eventually, I will have to sell our house. I'm not going to like it. I can't have my girls telling me every move I make. I need to get smart enough to do what I want. I need to go home. I haven't been there since Spring. They have taken me there but I don't get to be there alone. Maybe they do know best but d---can't. I am not allowed to drive anymore. I am not allowed to do anything. I don't know how much more I can handle. I am just sitting around waiting for something else bad to happen."</p> <p>Resident #60's record was reviewed on 12/15/15 at 8:30 a.m. Resident #60 had recently admitted to the facility. A Minimum Data Set (MDS) assessment, dated 11/14/15, indicated she had diagnosis which included, but was not limited to, depression, had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 12 out of 15. This MDS indicated she had a PHQ-9 score of 3 (minimal depression), felt down, depressed, and/or hapless, felt bad about herself, and/or had let herself or her family down 2-6 days out of the week. and exhibited minimal depression with a PHQ-9 score of 3 (minimal depression). The record lacked</p>		<p>eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>indication of episode of tearfulness, hopelessness, and/or depression.</p> <p>A MDS, dated 8/17/15, indicated a PHQ-9 score of 18. A MDS, dated 9/1/15, indicated a PHQ-9 score of 4. A MDS, dated 9/22/15, indicated a PHQ-9 score of 1. A MDS, dated 10/20/15, indicated a PHQ-9 score of 3.</p> <p>A care plan, dated 8/14/15, indicated Resident had symptoms of mood distress as evidenced by verbalization of feeling down, depressed, or hopelessness due to her recent loss of her husband and her care condition. Goals included she would not exhibit symptoms of isolation, yelling out, or noncompliance interfering with her care or therapy. Interventions included encouragement to attend activities and social interactions and obtain psych consult/psychosocial therapy if needed.</p> <p>A care plan, dated 9/5/15, indicated Resident #60 was at risk for depression related to her husband had recently passed away. Interventions included staff were to provide coping techniques, allow her to voice her feelings, and monitor her mood and response to her antidepressant. The record lacked indication Resident #60 was administered medication to treat depression.</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>During an interview on 12/14/15 at 3:00 p.m., with Registered Nurse (RN) #4 and Certified Nursing Assistant (CNA) #13 present, RN #4 indicated Resident #60 was emotional. She indicated she had dementia and every day "was a new day to her." She indicated "she thinks her husband just died and it was several years ago." CNA #13 stated, "No it wasn't. It just happened a few months ago." CNA #13 indicated Resident #60 became "so teary eyed" thinking about her husband that just died and her lost wedding rings. She indicated it had been worse recently because of the "time of the year."</p> <p>During a telephone interview on 12/15/2015 at 9:15 a.m., Resident #60's daughter indicated she wasn't aware of specific interventions the facility had attempted to help her mother deal with the recent loss of her husband and/or adjust to living in the facility. She indicated she visited frequently and during those visits her mother would become tearful. She indicated her mother would then become apologetic for becoming tearful because she worried about hurting her feelings. She further indicated she felt her mother would benefit from having someone besides her family to talk to about her grief and sadness over the recent loss of her</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>husband and adjustment to living in the facility. She indicated she takes her mom out to church but they have a new pastor and he does not counsel her. She indicated when her mother was first admitted several months ago professional counseling was offered and at the time they declined because they felt the grieving process was normal and professional counseling was not necessary. She further indicated counseling was not mentioned during the last two care conferences and indicated her mother needed to talk to "someone." She indicated her mother was not taking anything for depression however, she would not be opposed to the idea.</p> <p>During an interview on 12/15/2015 at 8:38 a.m., the Social Service Director (SSD) indicated Resident #60 was not taking medication for depression. She indicated she was put on an antipsychotic for psychosis when she was first admitted but it was gradually being reduced. She indicated the care plan incorrectly indicated it was being used to treat depression. She indicated she wasn't aware she had exhibited symptoms of tearfulness, sadness, or difficulty adjusting. She indicated during her first care conference Resident #60 became tearful recalling her husband's death however, her family refused</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 12/17/2015	
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>psychological services at the time. She indicated the facility had chaplain services but those services were not offered to her because her family took her out to church. She indicated she had not realized they were not utilizing their pastor for counseling. She indicated she was available and "tries to get down there and check on her" and Resident #60 would seek her out if she was having a difficult time however, she didn't have a plan in place with interventions to ensure her psychosocial needs were met in regards to grieving and adjustment issues. She indicated nurses should have documented symptoms under events for behaviors and mood. She indicated "...we missed it obviously... I should have taken it one step further." She indicated her assistant administered the last PHQ-9 questionnaire and she had not been aware the score had increased.</p> <p>During an interview on 12/15/2015 at 9:55 a.m., the Program Director for therapy indicated Resident #60 "had moments...she did just lose her husband." She indicated it was notably more on her dialysis days due to her physical exhaustion. She indicated she was easily redirected, had not interfered with her therapy, and it had been reported to nursing.</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>During an interview on 12/15/2015 at 12:13 p.m., the Director of Nursing (DON) indicated during the daily intra disciplinary team meeting all progress notes including behavior notes were reviewed. She indicated the notes had not indicated Resident #60 had exhibited symptoms of depression</p> <p>A Behavior Observation policy, identified as current by the Director of Nursing on 12/16/15 at 1:36 p.m., indicated, "To provide guidelines for the observation, monitoring and tracking of behavior episodes. Each resident currently on a Mental Health Wellness/Behavior Management Program shall have a Behavior Monitoring Record either in paper form or via the Electronic Health Record (EHR). It is the practice of Trilogy Health Services to chart by exception. If no behaviors occur during the staff member's shift it is not necessary to document. Documenting behaviors in EHR, an order set may be chosen regarding targeted behaviors. A description of the behavior shall be described for shiftily documentation. If the behavior is new, a Mood and Behavior event can be started to indicated follow-up charting every shift for 72 hours."</p> <p>A Social Service Policy identified as</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>current by the Executive Director on 12/15/15 at 12:28 p.m., indicated, "Our facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being... The director of social services is a qualified social worker and is responsible for:</p> <ul style="list-style-type: none"> Consultation with other departments regarding program planning, policy development, and priority setting of social services; Consultation to allied professional health personnel regarding provisions for the social and emotional needs of the resident and family; Consultation and supervision to social services personnel; An adequate record system for obtaining, recording, and filing of social service data; In service training classes; Assistance in meeting the social and emotional needs of residents. <p>Medically related social services is provided to maintain or improve each resident's ability to control everyday physical needs...and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose). Factors that have a potentially negative effect on psychosocial functioning include:...</p> <p>Problems in coping with grief; disability or loss of function... Inc Behavioral problems (i.e., confusion, anxiety,</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
	loneliness, depressed mood, anger, fear, wandering, psychotic episodes)...The social services department is responsible for: Obtaining pertinent social data about personal and family problems medically related to the resident's illness and care; Identifying individual social and emotional needs: Assisting in providing corrective action for the resident's needs by developing and maintaining individualized social care plans; Maintaining regular progress and follow-up notes indicating the resident's response to the plan and adjustment to the institutional setting; Compiling and maintain up to date information about community health and her facility by assessing the impact of these changes and making arrangements for social and emotional support; and ... Inquiries concerning social services should be referred to the director of social services. needs of the resident as part of the total plan of care; Participating in the planning of the resident's admission, return to home and community, or transfer to another facility and ... of the in interdisciplinary staff conferences, providing social service information to ensure appropriate service agencies available for residents/referrals; Making referrals to social service agencies as necessary or appropriate;, marinating appropriate documentation of referrals			

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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F 0309 SS=G Bldg. 00	<p>and providing social service data summaries to such agencies; Maintaining contact with their residents family members, involving them in the residents total plan of care; Making supportive visits to residents and performing needed services (i.e., communication with the family or friends, coordinating resources and services to meet the resident's needs);...Working with individuals and groups in developing supportive services for residents according to their individual needs and interests...."</p> <p>3.1-34(a)</p> <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. Based on interview and record review the facility failed to ensure communication of health care, accurate assessments, and validation of a resident's ability to self-catheterize resulting in hospitalization for urosepsis for 1 of 1 resident reviewed for hospitalization</p>	F 0309	<p>F 309</p> <p>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</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>(Resident #113) and 1 of 1 resident reviewed for communication of health care related to dialysis (Residents #60). Findings include:</p> <p>1. Resident #113's closed record was reviewed on 12/11/2015 at 2:04 p.m. The record indicated Resident #113 had been hospitalized, for other than a planned elective surgery, within 30 days of his admission to the facility. Resident #113 had diagnoses which included, but were not limited to, end stage renal (kidney) disease, urinary retention, and benign prostatic hyperplasia (BPH).</p> <p>An Admission Assessment for Functional Status for Elimination, dated 6/23/2015, indicated Resident #113 utilized an indwelling catheter as a bladder appliance and the facility should provide catheter care per protocol.</p> <p>A care plan, dated 6/24/2015, indicated Resident #113 utilized a Foley catheter for BPH and urinary retention with a goal to have no difficulty with urination.</p> <p>A care plan, dated 6/24/2015, indicated Resident #113 had BPH with urinary retention and required an indwelling urinary catheter. The care plan indicated Resident #113 had been willing to have his Foley catheter removed and his output</p>		<p>psychosocial well-being.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 113 has been discharged from the facility. Resident #60 has communication packet that goes to and from dialysis with the resident.</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>Residents with catheters had their care plans and physician orders verified for appropriateness. Residents that receive dialysis have a communication packet that go to and from dialysis with them. Residents that receive dialysis had their care plans and physicians orders verified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Licensed nursing staff has been in-serviced on urinary catheter care policy, foley catheter removal policy, dialysis provider coordination communication procedure, and trilogy dialysis procedure. Licensed nursing also in-serviced to assess</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>should have been monitored when the attempt was made. Current interventions included staff stimulating the resident to void when the catheter was removed.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 6/30/2015, indicated Resident #113 was admitted with an indwelling urinary catheter and required extensive assistance with one staff member for toileting and extensive assistance with two staff members for transfers.</p> <p>A physician's order, dated 6/26/15, indicated Resident #113 should receive Foley catheter care every shift. This order was discontinued on 7/13/2015.</p> <p>A physician's assessment, dated 7/6/2015, indicated Resident #113 had been concerned about his existing catheter and wanted to see his urologist. The assessment and plan indicated the facility would make an appointment for Resident #113 with the urologist. The record did not include a progress report or physician's orders from the urology appointment on 7/10/2015.</p> <p>A nursing note, dated 7/10/2015 at 8:29 p.m., indicated, "Resident is alert and oriented and able to voice needs and wants...continent of bowel and</p>		<p>resident upon return from outside appointment and ensure that we have physician notes and document as indicated. DHS/designee will review new orders in IDT meeting five days a week. IDT has developed a self treatment assessment tool to assess a resident's ability to perform medical procedure including but not limited to self catheterization and will review self treatment assessment tool as implemented.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by DHS/Designee on catheter care, orders, dialysis communication, and self treatment assessment tool. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>bladder...." The record did not indicate a physical assessment to determine if bladder was distended and did not indicate monitoring of urinary output after the catheter was removed.</p> <p>A nursing note, dated 7/10/2015 at 4:21 a.m., indicated, "Resident is alert and oriented to person, place, and time...Had Foley catheter removed on 7/10/15, continent of bowel and bladder, minimal assist with ADL's and transfers...." The record did not indicate a bladder assessment and did not indicate monitoring of urinary output after the catheter was removed.</p> <p>A nursing note, dated 7/11/2015 at 8:30 p.m., indicated, "Resident alert and oriented to person, place and time, able to voice needs and wants...continent of bowel and bladder...." The record did not indicate a bladder assessment and did not indicate monitoring of urinary output after the catheter was removed.</p> <p>A nursing note, dated 7/12/2015 at 11:00 p.m., indicated, "Resident reported on 7/12/2015 at 10 p.m. that during self cathing urine showed presence of blood. Resident reported to writer that his Foley catheter was removed on 7/10/15 by urologist. Urologist also instructed resident to self cath every evening to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/17/2015
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>ensure bladder is empty to prevent infection. Facility did not receive any documentation from MD (physician) office appointment and facility was unaware of MD instruction to self cath daily...Spoke with wife who accompanied resident to appointment and she confirmed the information that was provided by the resident. Wife could not confirm if any documentation was received from that appointment."</p> <p>An "Elimination Circumstance and Reassessment" form, dated 7/12/2015 at 10:00 p.m., indicated Resident #113 had his indwelling Foley catheter discontinued by the urologist on 7/10/2015 and the staff were to monitor his urinary output related to urinary retention. The assessment indicated Resident #113 had a change in his continence status and urine color, clarity, consistency of urine should be assessed with output. The assessment indicated Resident was sent to the Emergency Room the morning of 7/13/2015.</p> <p>A Change in Condition Report, dated 7/13/2015 at 3:57 a.m., indicated, "Resident rang call light because he was "freezing," upon entering the room, nurse observed resident shaking uncontrollably. A base line temp (temperature) of 98.6 degrees Fahrenheit (oral) at 2:50 a.m. 2</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>hydrocodone/apap 5/325 milligram (mg) given per order. 3:00 a.m. oral temp of 99.3 degrees Fahrenheit. 3:05 a.m. oral temp of 100.5 degrees Fahrenheit. Resident's "shakiness" at this time had eased enough to attempt vitals: B/P (blood pressure) 142/64, Pulse 80 and bounding. Respirations 20 and rapid. Was unable to attain O2 (oxygenation) sats due to resident's unsteady hands. On call (physician) notified, and resident sent to hospital per MD (physician)."</p> <p>A hospital "Admission History and Physical," dated 7/13/2015, indicated Resident #113 had presented to the hospital with complaints of fever and shakiness. The impression and plan indicated Resident #113 had an admitting diagnosis of sepsis due to bacteremia and urinary tract infection (UTI), as evidenced by fever, leukopenia (reduced white blood cell count), altered mental status, and hypotension (low blood pressure).</p> <p>A hospital note, dated 7/14/2015, indicated Resident #113 was admitted on 7/13/2015 with a complaint of fever, chills, nausea, and confusion. He had an admission white blood cell count of 900 (normal range 4,500 to 10,000). Resident #113 had positive blood and urine cultures for Escherichia coli (bacteria).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>The assessment indicated Resident #113 had a diagnosis of urosepsis.</p> <p>During an interview on 12/15/2015 at 2:48 p.m., the Director of Nursing (DON) indicated Resident #113 had his Foley catheter removed during his urologist appointment on 7/10/2015 at 11:30 a.m. She indicated the facility had not followed up with the urologist's office for new orders after he returned to the facility with his Foley catheter removed. She indicated she expected her nursing staff to follow up with the doctor's office for new orders if the resident returned to the facility without them. She indicated the facility had been unaware that Resident #113 had been instructed by the urologist to perform self catheterization in the evenings. She indicated she could not provide documentation from the urologist appointment or the facility, that Resident #113 had been provided the education to perform self catheterization. She indicated she would expect her nursing staff to perform urinary assessments and monitor the resident's voiding each shift after the discontinuation of his Foley catheter.</p> <p>During an interview on 12/16/2015 at 10:53 a.m., the DON indicated she could not provide documentation that Resident #113's urine had been monitored during</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>the day or evening shift on 7/11/2015. She indicated the facility did not have parameters of output amount after a Foley catheter is discontinued. She indicated she expected her staff to document each shift that Resident #113 was able to void after the removal of his Foley catheter on 7/10/2015.2. Resident #60's record was reviewed on 12/15/15 at 8:30 a.m. Resident #60 had a diagnosis which included, but was not limited to, end stage renal disease.</p> <p>A physician order, dated 9/25/15, indicated dialysis three times a week. The record lacked indication the facility had communicated, either verbal or written, with the dialysis provider after Resident #60 returned from dialysis visits.</p> <p>During an interview on 12/16/2015 at 9:45 a.m., Licensed Practical Nurse (LPN) #15 indicated the facility did not have a form of communication, either verbal or written, with the dialysis provider when Resident #60 returned from her dialysis visits.</p> <p>During an interview on 12/16/15 at 10:53 a.m., the Director of Nursing indicated the facility did not have a system which ensured routine communication between the dialysis provider and the facility after dialysis visits.</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>During an interview on 12/16/15 at 1:28 p.m., Dialysis Provider Care Coordinator #17 indicated if the facility would send a communication form they would fill it out and send it back with Resident #60. She indicated otherwise they would call if they had significant issues or the resident was sent to the emergency room.</p> <p>A Dialysis policy, identified as current by the Director of Nursing on 12/16/15 at 1:10 p.m., indicated, "...To provide guidelines for communication and partnership of Dialysis Providers and the campus... A report (may be written or verbal) shall be requested from the Dialysis Provider so that will alert the campus regarding: tolerance to procedure, vital signs, medications administered, other information deemed necessary for the ongoing provision of care. Upon return from the Dialysis Provider the campus shall: Provide ongoing monitoring of the shunt site for signs of complication. Review the Dialysis Provider paperwork for any necessary follow up requirements...."</p> <p>A Urinary Catheter Care policy identified as current by the DON on 12/15/15 at 4:09 p.m., indicated, "... To prevent infection of the resident's urinary tract...Maintain an accurate record of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0312	<p>resident's daily output, per campus guidelines...determine if changes in daily urinary catheter procedures have been made (e.g., review of care plan, receipt of oral instructions from nurse supervisor, physician orders)...."</p> <p>A Guidelines for Removal of a Foley Catheter policy identified as current by the DON on 12/16/15 at 1:16 p.m., indicated, "...To provide guidelines for the approved method of removing a Foley catheter...Determine if the resident is on intake or output before discarding urine...Verify that there is a physician's order for this procedure. Review the residents care plan to assess for any special needs of the resident...Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter, and a resident with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible...."</p> <p>3.1-37(a)</p> <p>483.25(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
SS=D Bldg. 00	<p>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure staff provided assistance with scheduled activities of daily living, which included shaving and bathing, for 2 of 3 residents reviewed for activities of daily living (Resident #62 and #213).</p> <p>Findings include: 1. During an observation on 12/10/2015 at 1:10 p.m., Resident #62 was lying in bed with food crumbs on his face and shirt. A strong body odor could be smelled upon entrance into Resident #62's room and became more pungent within closer proximity to the resident.</p> <p>Resident #62's record was reviewed on 12/14/2015 at 11:00 a.m. The record indicated Resident #62 had diagnoses that included, but were not limited to, paraplegia and spinal disorder. A Minimum Data Set (MDS) assessment, dated 9/15/2015, indicated Resident #62 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and was cognitively intact. Resident #62 required extensive assistance of one person with</p>	F 0312	<p>F 312</p> <p>It is the practice of Wellbrooke of Avon to provide activities of daily living to residents unable to carry out themselves.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 62 will have preferences honored. Resident #213 has been discharged from the facility.</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>Current residents who require care have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Nursing staff has been in-serviced on the need and documentation of activity of daily living, including</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>bed mobility, dressing, and personal hygiene, with lower extremity impairment on both sides. The record lacked indication Resident #62 had refused bed baths for the month of December 2015.</p> <p>An MDS, dated 3/25/2015, indicated Resident #62 was the primary respondent for his preferences for customary routine assesment. The assesment indicated it was very important for Resident #62 to choose which clothes to wear and to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>An Activities of Daily Living (ADL) care plan, dated 3/28/2015, indicated Resident #62 had problems providing his own ADL care related to his decreased mobility and pain from spinal surgery. The goal indicated Resident #62 was to improve or maintain his current level of self care.</p> <p>An MDS, dated 6/18/2015, indicated Resident #62 required physical help of one person with bathing.</p> <p>The CNA shower assignment sheet, dated 12/2015, indicated Resident #62 was scheduled to receive bed baths on Tuesdays and Fridays during the day shift.</p>		<p>interventions for refusals of care.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the DHS/Designee on activities of daily living and documentation of care. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>A point of care history report, dated 12/2015, indicated Resident #62 had not received a bed bath between 12/4/2015 to 12/14/2015. Resident #62 had received a partial bed bath on 12/1/2015, 12/3/2015, and 12/16/2015. The resident had received a complete bed bath on 12/15/2015. The record lacked documentation Resident #62 had received additional bathing for December 2015.</p> <p>A "Care Coordinator Admission Checklist," un-dated, indicated Resident #62 preferred bed baths during any time of the day. The record lacked indication Resident #62 had been assessed for his preferences regarding the amount of bathing to receive weekly.</p> <p>During an interview on 12/16/2015 at 2:06 p.m., Resident #62 indicated he had received less than two baths a week during the month of December 2015. The resident indicated he required assistance from staff to bathe and get dressed. Resident #62 indicated he had not refused a bed bath during the month of December 2015.</p> <p>During an interview on 12/16/2015 at 2:27 p.m., the Director of Nursing (DON) indicated she could not provide documentation Resident #62 had received</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
F 0314 SS=G Bldg. 00	<p>more than three partial bed baths and one complete bed bath for the month of December 2015. She indicated she expected her nursing staff to ensure each resident received their assigned showers and baths at the end of each shift. She indicated she expected her nursing staff to document in a nursing note if a resident was unable to receive or refused their bed bath or shower.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure pressure ulcer prevention interventions were evaluated and revised to prevent a resident who was admitted without a pressure ulcer from developing a stage 3 (full thickness skin loss) and two stage 2 (partial thickness/loss of skin layers) for 1 of 1 resident reviewed for pressure ulcers (Resident #69).</p> <p>Finding includes:</p>	F 0314	<p>F 314</p> <p>It is the practice of Wellbrooke of Avon to ensure residents who enter the facility without pressure sores do not develop pressure sores.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident #69 has been discharged</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>During an interview on 12/10/15 at 12:16 p.m., Registered Nurse (RN) #10 indicated Resident #69 had a stage 3 (full thickness skin loss) pressure ulcer on his right buttock, and stage 2 (partial thickness/loss of skin layers) pressure ulcers on bilateral heels.</p> <p>On 12/14/15 from 11:07 a.m. to 11:35 a.m., a pressure dressing change to the stage 3 pressure on the resident's buttock was observed with the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN) #16. Resident #69 was observed to have an incontinence diaper on while lying on his back on the low air loss mattress. The open area had pink edges and a brown hard center. No drainage was observed from the wound. The ADON indicated the open area measured 3 centimeters (cm) long by 3 cm wide and had more eschar than previously measured.</p> <p>On 12/14/15 from 11:51 a.m. to 12:16 p.m., a pressure dressing change to the stage 2 pressure on Resident #69's right heel was observed with the ADON and LPN #16. Resident #69 was observed lying on his back with his right hip propped up on a pillow on the low air loss mattress. The open area on the right heel had a bright red center, and a</p>		<p>from the facility.</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>Review of all residents skin condition to ensure the following: 1). Assessment of skin 2). Observation of pressure prevention interventions to ensure they are appropriate and implemented and the care plan reflects the resident's current status 3). If new skin impairment is observed, ensure the nurse completes the assessment, MD and family notification, treatment order received and interventions implemented</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>1). DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: A). Pressure prevention B). Weekly Assessment C). Wound Rounds D). Wound Risk E). Skin Impairment Circumstance Form (Investigation, Assessment, Intervention) 2) DHS/Designee will in-service the CNAs on : Pressure prevention interventions, completing skin sheet, and notifying nurse of new skin areas.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>moderate amount of serosanguinous (containing or relating to both blood and the liquid part of blood) drainage. The bottom of the foot had a white sticky substance surrounding the wound. The ADON indicated the open area measured 3 cm in length by 5.8 cm in width x 0.1 cm in depth.</p> <p>On 12/14/15 from 12:17 p.m. to 12:26 p.m. a pressure dressing change to the stage 2 pressure on Resident #69's left heel was observed with the ADON and LPN #16. The open area had red tissue with three small areas of black tissue, and a small amount of serosanguinous drainage. The ADON indicated the open area measured 3 cm in length by 2.5 cm in width. The ADON requested LPN #16 to go get gauze and inform the physician she was changing the treatment for the pressure ulcer on Resident #69's left heel due to an increased amount of eschar.</p> <p>On 12/15/15 at 1:30 p.m., Resident #69's record was reviewed. The admission skin assessment, dated 10/8/15, stated the resident had the following skin impairment risk factors: decreased activity level, and immobility.</p> <p>The physician orders prior to the development of Resident #69's pressure ulcers, dated 10/8/15 to 11/1/15, included</p>		<p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the DNS/Designee on pressure sores and interventions. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>but were not limited to: barrier cream to back right flank, regular diet with pureed consistency and thin liquids, "high compression hose to assist in BLE (bilateral lower extremity) edema management daily," and, "resident to lay down daily after lunch to rest."</p> <p>The admission Minimum Data Set (MDS) assessment, dated 10/15/15, indicated Resident #69 was at risk for pressure ulcers, had no unhealed pressure ulcer, and was an extensive assist of two for bed mobility, transfer, and toileting. The MDS indicated the resident was an extensive assist of one for dressing, eating, bathing, and personal hygiene. The MDS indicated the resident was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>The care plan, dated 10/17/15, for risk of skin break down stated, "Assist/remind me with turning and repositioning when I am in bed."</p> <p>The form titled, "Pressure Wound Circumstance," dated 11/2/15 at 6:53 p.m., indicated stage 2 pressure ulcers were found on Resident #69's bilateral heels. The form indicated the measurements of the each pressure ulcer were 6 cm in length by 6 cm in width. The form stated the contributing factors</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>to the development of the pressure ulcer included the following: "dementia, incontinence, immobility." The form stated the following interventions were in place: "pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer care, application of nonsurgical dressing, applications of ointments/medications other than to feet, application of dressing to feet." The form indicated the resident had diagnoses including, but not limited to the following: traumatic subdural hemorrhage, aphasia, dysphagia, and muscle weakness.</p> <p>The physician orders after the development of Resident #69's stage 2 pressure ulcers on his bilateral heels, dated 11/2/15 to 11/22/15, included but were not limited to: barrier cream to back right flank, heel cushion boots at all times, bilateral edema wraps, bilateral Lymphedema wraps to lower extremities therapy to mange and change three times a week.</p> <p>The 30 day MDS, dated 11/5/15, indicated Resident #69 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 and was cognitively intact. The MDS indicated the resident was at risk of pressure, had had two</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>unhealed stage 2 pressure ulcers. The MDS indicated the resident was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>The nursing progress note, dated 11/11/15, stated, "...stage 2 pressure ulcers to bilateral heels. Right heel pressure ulcer intact, measure 6 cm x 9 cm. Blister is larger than previous assessment. Left heel pressure ulcer no change measuring 6 cm x 6 cm. "</p> <p>The nursing progress note, dated 11/23/15 at 11:53 p.m., stated, "Resident noted with open area to his R (right) lateral buttock at the distal end, presents as a stage 3 pressure ulcer. Site measures approximately 4 cm x 0.8 cm x 0.2 cm....New orders for Medihoney (ointment) to wound bed, cover with fluffed gauze, cover with dry dressing." The note stated, "Resident is to be without briefs when in bed."</p> <p>The physician orders after the development of Resident #69's stage 3 pressure ulcer on his right buttock, dated 11/23/15 to 12/15/15, included but were not limited to: cleanse right buttock wound with normal saline and apply skin prep to periwound and cover with Medihoney, and apply Hydrogel to right heel pressure ulcer.</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>The form titled, "Pressure Wound Circumstance," dated 11/24/15, indicated Resident #69 had a stage 3 pressure ulcer on his right buttock, and it measured 4 cm in length by 0.8 cm in width by 0.2 cm in depth. The form indicated the pressure area was discovered on 11/23/15. The form stated the contributing factors to the development of the pressure ulcer included the following: "incontinence, immobility, and contractures." The form stated the following interventions were in place: "pressure reducing device chair, pressure reducing device for bed, turning/repositioning program, pressure ulcer care, dressings, and applications of ointments/medications."</p> <p>The Interdisciplinary team (IDT) note, dated 11/24/15 at 10:30 a.m., stated, "IDT review of stage 3 pressure ulcer to right buttock. Wound assessed 11/23/15 with charge nurse. Patient sleeps on Flow T pressure reduction mattress." The note indicated therapy was to evaluate the resident's current, "enhanced foam wedge cushion," in his wheelchair and replace it with a Roho cushion. The note indicated the resident was an extensive assist for repositioning and transfers, and was incontinent of bladder. The notes indicated Resident #69 was to be turned</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>and repositioned every two hours while in bed and not wear incontinence briefs while in bed.</p> <p>The nursing progress note, dated 12/1/15 at 5:35 p.m., stated, "weekly wound evaluation of Stage 3 pressure ulcer to right buttock. Wound has deteriorated. Wound measures 4 cm x 3 cm x 0.2 cm. Wound bed is 75% soft brown eschar (dead tissue) ...New order noted to change treatment to twice weekly Santyl (enzymatic debriding ointment) to aid in debridement of eschar/slough. Broda chair ordered this evening for OT (occupational therapy) to trial positioning in new chair with ROHO cushion in the AM. "</p> <p>The 60 day MDS, dated 12/3/15, indicated the resident had a BIMS score of 13 out of 15 and was cognitively intact. The MDS indicated the resident was at risk for pressure ulcers, had two unhealed stage 2 pressure ulcers, and one stage 3 pressure ulcer. The MDS indicated the resident was occasionally incontinent of bladder and always continent of bowel.</p> <p>The nursing progress note, dated 12/8/15 at 12:00 p.m., stated, "Stage 3 pressure ulcer to right buttock measures 3.5 cm x 2.8 cm x 0.2 cm. Wound bed is 75 % soft</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>brown eschar ... He is unable to turn or reposition himself in bed and is assisted by staff for transfer needs with a mechanical lift only as he cannot bear any weight due to contractures, pain, muscle spasms and cognitive impairment."</p> <p>During an interview on 12/14/15 at 9:30 a.m., LPN #16 indicated she was Resident #69's nurse, but was unaware if she was the one that did Resident #69's dressing change.</p> <p>During an interview on 12/14/15 at 10:46 a.m., LPN #16 indicated she would perform all dressing changes.</p> <p>During an interview on 12/14/15 at 12:36 p.m., the Assistant Director of Nursing (ADON) indicated all of Resident #69's pressure ulcers were acquired at the facility. She indicated the resident obtained heel pressure areas by rubbing his heels on the mattress as his legs continued to contracture. She indicated his pressure ulcer on his buttock was due to pressure with contracture and sliding and it was a stage 3 when it was found. She indicated prior to his pressure ulcers the resident was on a composure mattress and it was changed to a low air loss mattress after the pressure areas developed.</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>During an interview on 12/14/15 at 2:01 p.m., the ADON indicated the following interventions were in place prior to the development of pressure ulcers on Resident #69's feet: encourage fluids, physical and occupational therapy, turning and reposition, keep resident clean and dry, keep linens wrinkle free, passive range of motion (PROM) exercises for his contractures, and a foot board on wheelchair. She indicated the foot board on the wheelchair was to stop the resident from pulling his feet back as his legs contracted, but it was discontinued because the resident was rubbing his heels against it.</p> <p>During an interview on 12/15/15 at 2:53 p.m., Certified Nursing Assistant (CNA) #1 indicated Resident #69 was to be repositioned every 2 to 3 hours and was to only wear incontinence briefs while up in the wheelchair. She indicated the resident required extensive assist with movement and repositioning and was unable to reposition himself.</p> <p>During an interview on 12/16/15 at 10:06 a.m., the ADON indicated Resident #69's ankle boots were ordered after the stage 2 pressure areas developed on his heels. She indicated prior to the development of the stage 2 pressure ulcers Resident #69's</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 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>care plan stated to turn and reposition and did not specify how often. She indicated prior to the development of pressure ulcers there was no order to turn and reposition or a timed CNA task to turn and reposition the resident. She indicated Resident #69 now was to be turned every two hours and repositioned. She indicated she determined the efficacy of wound interventions with weekly assessments including: measurements, pain levels, and signs of infection. She indicated if signs of deterioration such as increased eschar, signs or symptoms of infection, or an increased size she would change treatment plans and revise the care plan interventions.</p> <p>On 12/15/15 at 12:28 p.m., the Executive Director provided the current policy titled, "General Wound and Skin Care Guidelines." The policy stated, "Turn/reposition residents who are immobile according to their care plan requirements...use a lift sheet to prevent shearing of skin...use pillows or wedges for positioning to avoid skin on skin contact...evaluate the need for a pressure reduction surface for bed/chair and the need for the elbow protectors and/or heel floats."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0323 SS=E Bldg. 00	<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, interview, and record review, the facility failed to ensure the doors to supply rooms were locked for 5 of 5 observations of environmental hazards.</p> <p>Findings include:</p> <p>During an observation on 12/10/15 at 9:42 a.m., on Renaissance Hall 1 the door to the oxygen supply room containing 4 large oxygen canisters, 4 portable oxygen tanks and 3 oxygen concentrators was unlocked. The door to C140, supply storage, was unlocked. The contents of the room included, but was not limited to, 11 bottles of mouthwash, and 12 bottles of hand sanitizer, 3 boxes of 50 razors, and 1 opened box of 22 razors, hand lotion, and 4 boxes dental cleaner with the words "keep out of reach of children" on the box. The door to the equipment supply was unlocked. All doors had a key</p>	F 0323	<p>F 323</p> <p>It is the practice of Wellbrooke of Avon to provide an environment that is of as free of accidents and hazards as possible.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>No resident was identified in this deficiency.</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 had the potential to be affected.</p> <p>What measures will be put into place or what systemic changes will</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>pad locking system on them.</p> <p>During an observation on 12/10/15 at 9:50 a.m., an observation was made on Renaissance 2 hall during initial tour: the oxygen storage door was not locked and door was not shut all the way, and the soiled utility door was unlocked. The staff restroom door was observed to be propped open in hallway.</p> <p>During an observation on 12/11/15 at 9:05 a.m., the doors to the oxygen supply room, equipment storage, and supply room was unlocked.</p> <p>During an observation on 12/14/15 at 9:22 a.m., the doors to the oxygen supply room, equipment storage, and supply room was unlocked.</p> <p>During an observation on 12/15/15 at 9:37 a.m., the doors to the oxygen supply room, equipment storage, and supply room was unlocked.</p> <p>During an interview on 12/15 /15 at 9:37 a.m., Registered Nurse (RN) #15 indicated she thought the doors were locked, and required a code to unlock the supply rooms. She was able to open the doors without a code, and was not able to lock them.</p>		<p>be made to ensure that the deficient practice does not reoccur?</p> <p>All staff has been in-serviced on identifying and removal of potential accidents and hazards. The ability to bypass the keypad lock was removed from the lock. All storage rooms are now locked.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the Executive Director/Designee on all hazardous room doors being secured. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0356 SS=C Bldg. 00	<p>During an interview on 12/15/15 at 2:32 p.m., the Executive Director indicated the doors to the supply and storage rooms should be locked, but they were disabled and unlocked. He indicated he did not have a policy for locking the oxygen supply room doors.</p> <p>3.1-45(a)(1)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. 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: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>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 the staff posting of actual hours worked for 5 of 6 days observed (12/10/15, 12/11/15, 12/14/15, 12/15/15, and 12/16/15).</p> <p>Findings include:</p> <p>On 12/10/15 at 9:42 a.m., during the initial tour staff posting was observed as follows: Days RNs 7a-3:30p - 4; LPNs 7a-3:30p - 5; CNAs 7a-3p - 5 Evenings RNs 3p-11:30p - 2; LPNs 3p-11:30p - 2; CNAs 3p-11p - 5 Nights RNs 11p-7:30a - 1; LPNs 11p-7:30a - 2; CNAs 11p-7a - 3</p> <p>On 12/10/15 at 1:47 p.m., staff posting was observed changed as follows: Days LPNs 7a-3:30p - 4; CNAs 7a-3p - 6 Evenings LPNs 3p-11:30p - 1; CNAs 3p-11p - 6 Nights CNAs 11p-7a - 4 The posting lacked indication of total</p>	F 0356	<p>F 356</p> <p>It is the practice of Wellbrooke of Avon to post the nurse staffing data on a daily basis for the public to review.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>No resident was identified in this deficiency.</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 were identified and the format of the sign has been changed to include total hours. Postings will be maintained for 18 months.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The staff development coordinator</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>hours worked.</p> <p>On 12/11/15 at 9:05 a.m., staff posting was observed as follows: Days RNs 7a-3:30p - 4; LPNs 7a-3:30p - 5; CNAs 7a-3p - 6 Evenings RNs 3p-11:30p - 2; LPNs 3p-11:30p - 3; CNAs 3p-11p - 5 Nights RNs 11p-7:30a - 1; LPNs 11p-7:30a - 2; CNAs 11p-7a - 4 The posting lacked indication of total hours worked.</p> <p>On 12/14/15 at 9:00 a.m., staff posting was observed as follows: Days RNs 7a-3:30p - 4; LPNs 7a-3:30p - 4; CNAs 7a-3p - 5 Evenings RNs 3p-11:30p - 2; LPNs 3p-11:30p - 2; CNAs 3p-11p - 4 Nights RNs 11p-7:30a - 2; LPNs 11p-7:30a - 1; CNAs 11p-7a - 3 The posting lacked indication of total hours worked.</p> <p>On 12/15/15 at 9:06 a.m., staff posting was observed as follows: Days RNs 7a-3:30p - 4; LPNs 7a-3:30p - 4; CNAs 7a-3p - 5 Evenings RNs 3p-11:30p - 2; LPNs 3p-11:30p - 2; CNAs 3p-11p - 4 Nights RNs 11p-7:30a - 2; LPNs 11p-7:30a - 1; CNAs 11p-7a - 3 The posting lacked indication of total hours worked.</p>		<p>has been in-serviced on the new sign that includes total hours and process to maintain records for 18 months.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the Executive Director/Designee will check staffing sign placement with total hours and verify records are maintained. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
F 0371 SS=E Bldg. 00	<p>On 12/16/15 at 9:19 a.m., staff posting was observed as follows: Days RNs 7a-3:30p - 4; LPNs 7a-3:30p - 4; CNAs 7a-3p - 5 Evenings RNs 3p-11:30p - 2; LPNs 3p-11:30p - 2; CNAs 3p-11p - 4 Nights RNs 11p-7:30a - 2; LPNs 11p-7:30a - 1; CNAs 11p-7a - 3 The posting lacked indication of total hours worked.</p> <p>During an interview on 12/16/15 at 10:21 a.m., the Staff Development Coordinator indicated she was unaware she was to post the number of hours worked.</p> <p>During an interview on 12/16/15 at 1:40 p.m., the Administrator indicated he was unaware staff posting should include the actual hours worked. He Indicated he could not provide a policy for staff posting.</p> <p>3.1-13(i)(4)</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure clean and sanitary conditions related to hand washing, hair restraints and soiled equipment for 2 of 2 dining observations (Resident #60, Resident #55, Resident #214, Resident #58, Resident #29, Resident #74).</p> <p>Findings include:</p> <p>1. On 12/10/15 at 11:40 a.m., Registered Nurse (RN) #4 was observed going behind the serving line to fill a glass with a beverage from the dispenser without a hair net on. This drink was served to Resident #60. As Certified Nurse Aide (CNA) #5 was observed behind the serving line, with her hair not fully restrained and long loose hair hung from her neck to the middle of her back. Next, the Social Service Director with was observed washing her hands for 6 seconds. She then loaded the desserts on to 2 trays and served 1 tray herself. After she loaded and dispensed several deserts from the tray, she was observed to rinse the same tray off with water and continued serving on the same tray. Nine desserts on the tray were observed to be served to residents, including Resident</p>	F 0371	<p>F 371</p> <p>It is the practice of Wellbrooke of Avon to store, prepare, distribute and serve food under sanitary conditions.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 214 has been discharged from the facility. Residents #60, 55, 58, 29 and 74 will be served under sanitary conditions.</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>Residents will be served using proper hand washing, hair restraints, and linen handling. The facility has discontinued use of service trays.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Staff has been in-serviced on hand washing, when hair restraints are</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>#55 and Resident #214.</p> <p>On 12/14/15 at 9:14 a.m., Food Service Aide #6 was observed carrying a clean table cloth up against her uniform. This table cloth was placed on a table for lunch preparation. Next, Food Service Aidr #7 was observed picking up and carrying a soiled table cloth next to her uniform before dispensing into the soiled linen cart. She was then observed to continue setting the tables. At the same time during an interview, Food Service Aide #6 indicated she was unaware of any precautions carrying linen.</p> <p>On 12/14/15 at 12:12 p.m., CNA #8 was observed to wet her hands, applied soap and without scrubbing, she immediately rinsed her hands and partially dried them. With partially wet hands she was observed to serve a glass of milk to Resident #58. Next after CNA #8 used alcohol sanitizer, she was observed with wet hands from the hand sanitizer to serve Resident #29 her meal tray and assist her with her food. Then RN #9 was observed to remove soiled dishes from a serving tray which was used to serve Resident #74 her meal tray.</p> <p>During an interview on 12/16/2015 at 10:01 a.m., CNA #2 indicated during hand washing one should scrub their</p>		<p>required, and linen handling. DFS/designee will verify and document that food is served under sanitary conditions according to federal and state regulations.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed daily by the ED/designee including each meal service monitored-five days a week x 3 weeks, then weekly x 5 weeks, then monthly x 3 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>hands for 20 seconds. She indicated hands should be washed when going in resident's rooms and before and after resident care, when delivering trays and after every 5 residents.</p> <p>During an interview on 12/16/15 1:31 p.m., the Social Service Director indicated she would hand wash between clearing soiled dishes and serving clean dishes. She indicated she would use alcohol sanitizer after every 3 residents and she would hand wash when going from kitchen to dining room, and between patient care. She indicated her practice for hand washing was to scrub while singing happy birthday 1 or 2 times, about 20 seconds. She indicated she should use a hair net when she goes behind the serving line, with all of her hair covered.</p> <p>During an interview on 12/16/15 at 1:25 p.m., the Food Service Director indicated a hair net would be worn when behind the serving line and when entering the kitchen. He indicated the behind the serving line included the drink dispenser and sink for hand washing. He also indicated he was unaware of the sanitation with the use and reuse of a serving tray. At this same time the policy for serving tray use was requested.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>On 12/16/15 at 2:43 p.m., the Food Service Director indicated he did not have a policy for serving trays. During a dining observation on 12/10/2015 from 12:03 p.m. to 12:06 p.m., Certified Nursing Assistant (CNA) #5 was observed to enter the kitchen twice without her hairnet fully covering all of her hair. Her long hair was observed lying against her neck and down her mid-back without a hairnet covering.</p> <p>A policy titled "Guideline for Handwashing/Hand Hygiene", identified as current by the Executive Director on 12/15/2015 at 2:25 p.m., indicated, "Handwashing is the single most important factor in preventing transmission of infections...Health care workers shall wash hands at times such as before/after preparing/serving meals, drinks, tube feedings, etc. and before/after having direct physical contact with residents...wash well for 20 seconds (ABC or Happy Birthday song.), using a rotary motion and friction...."</p> <p>A policy titled "Guidelines for Handling Linen", identified as current by the Executive Director on 12/15/2015 at 2:25 p.m., indicated, "Purpose: To provide clean, fresh linen to each resident. To prevent contamination of clean linen...linens should be carried away</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 12/17/2015
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	
F 0441 SS=E Bldg. 00	<p>from the body to prevent contamination from clothing...do not place soiled linen on furniture or floor...."</p> <p>A policy titled "Dining Room In-Service", identified a current by the Dietary Manager on 12/16/2015 at 10:25 a.m., indicated, "...Clean, sanitize and reset table for next meal service...."</p> <p>A policy titled "Dietary Hair Restraint Policy and Procedures", identified as current by the Dietary Manager on 12/16/2015 at 10:25 a.m., indicated, "All Dining Service employees will be required to wear hair restraints as required by the 2009 Federal Food Code...food employees shall wear hair restraints to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles...tray-line, dishwashing, cooking, and walk-in cooler areas are restricted to personnel with hair restraints...."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure staff adequately sanitized hands before delivering cups of ice water to residents for 3 of 4 staff observations of hand sanitation and failed to ensure a resident's</p>	F 0441	F 441 It is the practice of Wellbrooke of Avon to provide a safe, sanitary and comfortable environment and to prevent the development and	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>linens were not placed on the floor for 1 of 5 resident's rooms observed for linen handling (Resident # 203).</p> <p>Findings include:</p> <p>On 12/10/15 at 12:45 p.m., during an observation of Resident # 203 at 1:40 p.m., Resident #203's room was observed to have his blankets and pillows on the floor.</p> <p>On 12/16/2015 at 9:58 a.m. CNA #1 was observed to hand wash for 10 seconds and then was observed to assist Resident #29 at the resident's table at the nurses ' station. CNA #2 was observed to hand wash for 10 seconds, and then filled 10 cups of ice water for resident distribution. She was observed delivering all 10 cups to residents down the Renaissance 1 hall. After RN #3 was observed to hand wash for 15 seconds, she then returned to her med cart.</p> <p>During an interview on 12/16/2015 at 10:01 a.m., CNA #2 indicated during hand washing one should scrub their hands for 20 seconds. She would hand wash when going in resident's rooms and before and after resident care.</p> <p>The "GUIDELINES FOR HANDLING LINEN" policy was provided by the</p>		<p>transmission of disease and infection.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Resident # 203 has been discharged from the facility. Resident #29 will be assisted by staff following appropriate hand washing technique.</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>Residents will be provided care following appropriate hand washing and linen handling techniques.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Nursing staff has been in-serviced on hand washing and linen handling. DHS or designee will observe linen handling and handwashing on various shifts 3 times per week for 4 weeks then weekly for 4 weeks then monthly times 4 times months.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>administrator on 12/15/15 at 2:25 p.m. This current policy indicated, "...PURPOSE: To provide clean, fresh linen to each resident. To prevent contamination of clean lines. PROCEDURE: Clean Linen...4. Linens should be carries away from the body to prevent contamination from clothing...Dirty Linen... 4. Do not place soiled linen on furniture or floor...."</p> <p>The "Guidelines for Handwashing/Hand Hygiene" policy was provided by the administrator on 12/15/15 at 2:25 p.m. This current policy indicated the following: "...Purpose: Hand washing is the single most important factor in preventing transmission of infections...Procedure" ,,3. Health Care Workers shall wash hands at times such as:...b. Before/after preparing/serving meals, drinks, tube feedings, etc. c. Before/after having direct physical contact with residents...8. Wash well for 20 seconds (ABC or Happy Birthday song.), using a rotary motion and friction...."</p> <p>3.1-18(l) 3.1-19(g)(1)</p>		<p>QAA monitoring tool will be completed by the DHS/Designee on hand washing and linen handling daily with monitoring for each shift at least weekly. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
R 0000 Bldg. 00	<p>This Visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 17 Sample: 7</p> <p>The following Residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>R092</p> <p>It is the practice of Wellbrooke of Avon to maintain a written fire and disaster plan.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>No residents were identified in the deficiency.</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>Current residents will participate in monthly fire drills that include fire department participation at least twice per year.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Director of Plant Operations has been in-serviced on the need for fire drills that include local fire</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals		department participation at least twice per year. The campus has invited the city fire department to participate in our next monthly fire drill. How the corrective action will be monitored to ensure the deficient practice does not reoccur? QAA monitoring tool will be completed by the Executive Director/Designee to review fire drills including local fire department participation. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved. Date to be completed 1/14/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to document the attempt to hold fire drills with the local fire department for 12 of 12 months of fire drills reviewed.</p> <p>Finding includes:</p> <p>On 12/17/15 at 1:58 p.m., the facility fire drills from 12/29/14 to 11/14/15 were reviewed. The "Record of Drills" forms indicated fire drills were conducted without fire department participation on the following dates: 12/29/14, 1/29/15, 2/26/15, 3/11/15, 4/8/15, 5/5/15, 6/24/15, 7/14/15, 8/20/15, 9/16/15, 10/20/15, and 11/14/15.</p> <p>During an interview on 12/17/15 at 11:29 a.m., the Facility Services Supervisor indicated he routinely requested the fire department's involvement in fire drills, but the fire department always declined. He indicated he did not have</p>	R 0092	<p>R092</p> <p>It is the practice of Wellbrooke of Avon to maintain a written fire and disaster plan.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>No residents were identified in the deficiency.</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>Current residents will participate in monthly fire drills that include fire department participation at least twice per year.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the</p>	01/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/17/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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>documentation of his requests for the fire department's participation or the fire department's denial of participation.</p> <p>On 12/17/15 at 3:31 p.m., the Director of Nursing provided the facility's fire drill policy. The policy did not address the state requirement for the local fire department's participation in fire drills twice a year.</p>		<p>deficient practice does not reoccur?</p> <p>Director of Plant Operations has been in-serviced on the need for fire drills that include local fire department participation at least twice per year. The campus has invited the city fire department to participate in our next monthly fire drill.</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the Executive Director/Designee to review fire drills including local fire department participation. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>1/14/16</p>	