

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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: August 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12, 2015.</p> <p>Facility number: 012937 Provider number: 155808 AIM number: 201208220</p> <p>Census bed type: SNF: 27 SNF/NF: 24 Residential: 30 Total: 81</p> <p>Census payor type: Medicare: 16 Medicaid: 14 Other: 21 Total: 51</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on August 12, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview and record review, the facility failed to follow their abuse policy guidelines for reporting suspected abuse for 1 of 4 residents being reviewed regarding the abuse policy procedures. (Resident #58)</p> <p>Findings include:</p> <p>Resident #58's record was reviewed on 8/7/15 at 3:40 p.m. Diagnoses included, but were not limited to, anxiety disorder, depressive disorder, macular degeneration, hearing loss and generalized pain.</p> <p>On 8/3/15 at 8:20 a.m., during an interview, Resident #58 indicated "someone beat me up and this is where these bruises came from." She was observed at that time, to raise both her long sleeves up and she had medium sized purple and port wine (red) colored bruises to her bilateral forearms and tops of her hands.</p> <p>The Executive Director was notified of</p>	F 0226	<p><b>F 226</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident 58 - An investigation for the allegation of mistreatment was investigated and reported to the ISDH by the Executive Director.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to</b></p>	09/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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 resident's bruises and the allegations someone beat her up on 8/3/15 at 8:45 a.m.</p> <p>A statement provided by RN #9 on 8/7/15 at 5 p.m., indicated the Director of Health Services (DHS) on 8/3/15 at 9:30 a.m., measured the bruises on Resident #58's bilateral forearms. The right forearm measured 8.0 cm (centimeters) x 6.0 cm and the left forearm measured 10.0 cm x 7.5 cm.</p> <p>A "Questionnaire: Investigation of Unknown Bruising" form dated 8/5/15 at 4 p.m., provided by RN #9 on 8/7/15 at 5 p.m., indicated RN #12 indicated she had noticed bruises to the residents bilateral wrists on 8/2/15 on the 2 p.m. to 10 p.m., shift while providing care for the resident. She indicated she had not seen the resident bump into things or fall into her seat because she was an assist of two persons with her ADL's (Activity of Daily Living).</p> <p>A "Questionnaire: Investigation of Unknown Bruising" form dated 8/5/15 at 12:00 p.m., provided by RN #9 on 8/7/15 at 5 p.m., indicated CNA #13 indicated she had noticed bruising on the resident when she got her up in the morning, but she did not specify the location of the bruises. She indicated the resident was</p>		<p><b>ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate campus staff on the following guidelines: Abuse and Neglect - reporting of allegations</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interview of residents and staff regarding any allegations/reporting of abuse/neglect/ mistreatment.</p> <p>The campus will continue the process to screen employees prior to hire for history of abuse, train the new employees and on going for current employees on abuse prevention, including training on protection of the resident, investigation of the alleged abuse and reporting the suspected abuse.</p> <p>For any allegations identified, ED or designee will ensure the following occurs: Identification: appropriate MD/family notification, completion of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>an assist of 2 persons.</p> <p>During an interview on 8/7/15 at 4:29 p.m., RN #9 indicated if a CNA noticed a bruise on a resident, the CNA was to report it to the nurse immediately, so the nurse could report the bruise of unknown origin to a manager and an investigation was to be started. He indicated he would have expected the CNA who noticed Resident #58's bruises to report those to the nurse and the nurse who noticed the bruises to have started an event report and reported those bruises to the manager. He indicated CNA #13 noticed the bruises on the resident on the morning of 8/3/15 when she got her up even though her statement was dated 8/5/15. He indicated 8/5/15, was the date she was interviewed.</p> <p>A current policy titled "Abuse And Neglect Procedural Guidelines" dated 9/16/2011, provided by the Campus Clinical Support staff member on 8/11/15 at 3:45 p.m., indicated "Purpose: [name of company] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedure: ... 3. Definitions: ... i. Injuries of Unknown Source-means an injury that occurs when both of the following conditions are met: i. The</p>		<p>accident / incident report, notification to the State Department of Health. Protection: suspension of suspected employee(s) pending outcome of investigation. Investigation: initiate and complete.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0248 SS=D Bldg. 00	<p>source of the injury is not observed by any person or the source of the injury could not be explained by the resident and ii. The injury is suspicious in nature because of the extent of the injury or the location of the injury. 1. (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time of the incidence of injuries over time... d. Identification: ii. Any person with knowledge or suspicion of suspected violations shall report immediately without fear of reprisal...."</p> <p>3.1-28(c)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to provide ongoing activities as the resident desired for 1 of 3 residents reviewed for activities. (Resident #10)</p> <p>Findings include:  Resident #10's record was reviewed on 8/10/15 at 9:54 a.m. Diagnoses included,</p>	F 0248	<p><b>F 248</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #10- personal preference for activities and care plan was updated to reflect the</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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, acute cerebrovascular disease, depressive disorder, anxiety disorder, aphasia, insomnia and acute pain</p> <p>The Admission MDS (Minimum Data Set) assessment dated 11/4/14, indicated Preference for Customary Routine and Activities indicated it was very important for the resident to listen to music she liked. It was very important for her to be around pets and animals. It was somewhat important for her to do things with groups of people. It was somewhat important for her to do her favorite activities. It was very important for her to go outside to get fresh air when the weather was good and it was very important for her to participate in religious services or practices.</p> <p>The resident had a Care Plan dated 5/7/15, which addressed the problem she had a diagnosis of acute cerebrovascular accident and had difficulty communicating at times because of it. She would usually decline group programs unless her husband took her, but she enjoyed music and being with her husband. She preferred going to group programs with her husband. She enjoyed watching movies in her room. Approaches included, "5/20/15- -Encourage my husband to attend group</p>		<p>resident's current interests. Resident need for 1:1 programming was re-evaluated.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents' activity personal preference and care plans will be reviewed to ensure they reflect the resident's current interests. Resident need for 1:1 programming will also be re-evaluated.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The Life Enrichment Director (LED)/ Designee will provide re-education to the staff in Nursing, Social Service, Environmental Services and Life Enrichment regarding the need to provide ongoing activities as the resident desires.</p> <p>The Life Enrichment Support Team will re-educate the campus LED and designees on participation and documentation</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>programs with me. Provide me with a monthly activity of events. Provide my husband and I with movies as desired or needed."</p> <p>An Activity Progress Note dated 5/7/15 at 12:47 p.m., indicated the resident continued to participate in group programs such as; music weekly. The resident's husband came in almost daily and ate with her. Activities provided the resident and her spouse with movies, which they watched at night in her room together. The one on one assessment was completed and the resident did not meet the one on one programing at that time.</p> <p>An Activities Progress note dated 8/5/15 at 4:22 p.m., indicated the resident continued to decline group programs unless her husband was with her. The resident's spouse visited daily and took her on outdoor strolls and watched movies with her each evening. She participated well in group programs such as; music when her spouse was present. Activities provided the resident with one on one visits such as; doing her nails as needed.</p> <p>On 8/5/15 at 9:49 a.m., Resident #10 was observed sitting in her wheelchair in her room by the foot of the bed, with her back to the hallway door and the front of</p>		<p>of 1:1 programming.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the LED or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review of activity personal preference and care plan to ensure they reflect the resident's current interests. Observe the residents to ensure they are involved in the activities of their interest, per their careplan and personal preference.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>her body was facing the window. She was staring at the windows. The window blinds were pulled three-fourths of the way down the window and she was unable to see out the windows. She had a compact disc (CD) player sitting on her nightstand, which was not playing and her T.V. was off.</p> <p>On 8/8/15 at 10:00 a.m., the resident was observed sitting in her wheelchair in her room by the foot of the bed, with her back to the hallway door and the front of her body was facing the windows. She was staring at the windows. The window blinds were pulled three-fourths of the way down the window and she was unable to see out the windows. She had a CD player sitting on her nightstand, which was not playing and her T.V. was off.</p> <p>On 8/10/15 at 10:05 a.m., the resident was observed sitting in her wheelchair in her room by the foot of the bed, with her back to the hallway door and the front of her body facing the windows. She was staring at the windows. The window blinds were raised half-way up and an empty bird feeder was visible outside the resident's windows. She indicated at that time she enjoyed watching the birds come to the bird feeder and eat out of the bird feeder. The resident did not have</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>fingernail polish on her fingernails at that time. The CD player was off.</p> <p>On 8/11/15 at 10:25 a.m., the resident was laying in her recliner with her eyes closed. Her fingernails did not have fingernail polish on them.</p> <p>During an interview on 8/10/15 at 1:28 p.m., CNA #13 indicated Resident #10 liked music. She indicated the resident did not attend the activity programs at the facility. She indicated the resident had a CD player in her room and she liked to listen to music on her own CD player.</p> <p>During an interview on 8/12/15 at 9:18 a.m., the Activities Director indicated Resident #10 was not currently on a one on one activity program, but she received them as needed. She indicated the resident came to group music activities if her husband was here because she did better if he was with her. She indicated the resident's husband checked out movies from the activity department, so the resident and him could watch movies in her room every evening. She indicated the CNA's played music for her on her CD player. She indicated the resident did not like every staff member doing tasks for her, so if she did not like someone she would not allow them to do something for her and she had days where she would</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0279 SS=E Bldg. 00	<p>not allow anyone to do things for her.</p> <p>She indicated the resident got her fingernails polished once in awhile, but she did not know when the last time was she had them done. She indicated the nail activity was not on the calendar as an activity, but resident's nails were done a couple times a month for a couple of the residents. She indicated the facility used to do the residents' nails as an activity until the Manicurist, who came in once or twice a week could no longer come. She indicated she could try to do the resident's nails today. She indicated she did not have a form, which documented the as needed one on one activities the activity department had done with Resident #10 because she did not think she needed to keep track of those activities because they were as needed.</p> <p>3.1-33(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to have a plan of care for constipation, weight loss and depression for 4 of 25 residents reviewed for Care Plan implementation. (Residents #10, #46, #27 and #96)</p> <p>Findings include:</p> <p>1. Resident #10's record was reviewed on 8/10/15 at 9:54 a.m. Diagnoses included, but were not limited to, acute cerebrovascular disease, aphasia, depressive disorder, anxiety disorder and acute pain.</p> <p>The resident did not have bowel movements (BM's) documented for the following days: 6/11/15 through 7/17/15 for 35 days 7/27/15 through 8/2/15 for 6 days 8/4/15 through 8/7/15 for 3 days</p> <p>No constipation Care Plan was found in the resident's record</p>	F 0279	<p><b>F 279</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The following resident plans of care have been reviewed/revised: #10 for constipation and depression, #46 for nutrition/weight and depression, #27 for constipation and #96 for constipation.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents with diagnosis of constipation, depression and with nutritional / weight change concerns to ensure a plan of care has been developed.</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074		
(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 8/11/15 at 3:45 p.m., the Campus Clinical Support staff member indicated the resident did not have a constipation care plan.</p> <p>2. Resident #46's record was reviewed on 8/8/15 at 10:29 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbances, debility, oral cancer in situ, Diabetes Mellitus, depression, nausea with vomiting and gastroesophageal reflux disease.</p> <p>The following were the residents weights: 4/15/15--251 5/8/15--296 7/3/15--247 8/6/15--262</p> <p>No Care Plan was found in the residents record to address nutrition or weight changes.</p> <p>During an interview on 8/11/15 at 3:45 p.m., the Campus Clinical Support staff member indicated there was no Care Plan for nutrition or weight changes.</p> <p>3. On 8/10/15 at 1:28 p.m., the record review for Resident #27 was completed. Diagnoses included, but were not limited to, hypothyroidism, constipation, Type 2</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits will be conducted for 5 residents by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: residents with diagnosis of constipation, depression and with nutritional / weight change concerns have a plan of care developed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>Diabetes, constipation and history of a colon resection.</p> <p>The resident did not have a bowel movement (BM) for more than 72 hours on following dates: 6/27/15 through 7/3/15 for 6 days. 7/10/15 through 7/20/15 for 10 days.</p> <p>There was no Care Plan documentation found.</p> <p>On 8/10/15 at 4:10 p.m., RN #10 indicated the documentation showed Resident #27 went several days without a BM. RN #10 also indicated there were no as needed bowel medications given in the month of June 2015. She also indicated if a resident did not have a bowel in 72 hours they were to follow their bowel program protocol.</p> <p>4. On 08/10/2015 at 11:20 a.m., the record review for Resident #96 was completed. Diagnoses included, but were not limited to, dementia, fracture of hip, constipation, and mood disorder.</p> <p>The nurses notes were reviewed from 6/12/15 through 8/11/15 and there was no documentation of bowel movements.</p> <p>The documentation for bowels indicated the resident had gone without a bowel</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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=D Bldg. 00	<p>movement for 72 hours or more on the following dates: 6/17/15 through 6/21/15 for 4 days. 7/1/15 through 7/5/15 for 4 days. 7/9/15 through 7/14/15 for 5 days.</p> <p>The Care Plans were reviewed and no Care Plan for constipation was found.</p> <p>On 8/11/15 at 11:51 a.m., the Campus Clinical Support staff member indicated the residents should have a BM every 72 hours (3 days) and if not, follow their bowel protocol. A resident having a diagnosis of constipation should have a Care Plan for constipation.</p> <p>3.1-35(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 observation, interview and record review, the facility failed to ensure bowel movements were monitored and bowel assessments were completed for 4 of 5 residents reviewed for bowel</p>	F 0309	<b>F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> 1). Resident #27, #96, #10, #64- bowel protocol is	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>monitoring ( Residents #27, #96, #10, and #65). The facility also failed to ensure staff were trained and following proper procedure who performed peritoneal dialysis for 1 of 1 residents being reviewed for dialysis. (Resident #11)</p> <p>Findings include:</p> <p>1. On 8/10/15 at 1:28 p.m., the record review for Resident #27 was completed. Diagnoses included, but were not limited to, hypothyroidism, constipation, Type 2 Diabetes, constipation and history of a colon resection.</p> <p>The admission orders from the hospital indicated the resident was to get 17 grams of Polyethylene glycol (medication that assists with bowel movements) in 8 ounces of fluid daily.</p> <p>The Physician's Orders recapitulation for August 2015, indicated: 6/9/15--Senekot (a laxative medication) 8.6 milligrams 1 tablet by mouth every evening. 7/28/15--Miralax 17 grams by mouth twice daily.</p> <p>The electronic physician's orders dated 6/10/15, indicated the physician had discontinued Polyethylene Glycol and the</p>		<p>in place for monitoring, assessment and intervention.</p> <p>2). Resident #11 - Licensed Nurses will be trained on proper procedure for performing Peritoneal Dialysis (PD), including infection control. A new, clean copy of PD Step by Step procedure will be placed at resident's bedside and at the nurses station. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p>1). DHS or designee will complete a ongoing review during daily clinical meeting (5 times per week) of all residents with no recorded bowel movement in 72 hours to ensure the bowel protocol is in place for monitoring, assessment and intervention.</p> <p>2). DHS or designee will coordinate Licensed Nurse training on proper procedure for performing PD, including infection control. Training to be completed by Peritoneal Dialysis Company. A new, clean copy of PD Step by Step procedure will be placed at resident's bedside and at the nurses station. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> 1). DHS or designee will re-educate the Licensed Nurses and CNAs on the following campus guidelines: Guideline for Bowel Protocol. 2). Peritoneal Dialysis Company will train</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074		
(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>order was changed to as needed.</p> <p>The nurses notes indicated: 7/23/15: The resident was complaining of left flank pain, stated she thought it was gas pain. 7/24/15: The resident's abdomen was non distended, the bowel sounds were active in all four quadrants and the abdomen was soft and non-tender to touch. 7/25/15: The resident was complaining of dizziness to the CNA and the CNA had just gotten the resident off of the toilet. The resident became sweaty and weak. The resident appeared very pale and sweaty at that time. In talking with the resident she indicated she was very weak and complained of nausea. Fluids were given and the resident was placed back into bed. The resident complained of abdominal pain and stated, "I pushed so hard and almost threw up and still didn't have a bowel movement" At 2:12 p.m., A KUB (kidney ureter bladder xray) was requested and the results showed "mild colonic dilatation consistent with ileus (a painful obstruction of the ileum or other part of the intestine).</p> <p>The Physician's Progress notes indicated: 6/9/15 and 7/16/15 the physician's progress notes indicated no concerns with bowels. 7/21/15: The patient was seen per</p>		<p>Licensed Nurses on proper procedure for performing PD, including infection control. Training to be completed by Peritoneal Dialysis Company. A new, clean copy of PD Step by Step procedure will be placed at resident's bedside and at the nurses station. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> 1). The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: residents with no recorded bowel movement in 72 hours to ensure the bowel protocol is in place for monitoring, assessment and intervention. 2). The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observe License Nurse during PD procedure, including infection control practices. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 request for complaints of pain to LUQ (left upper quadrant) for the past few days, the patient denied constipation, but complained of possible gas.</p> <p>7/27/15: The chief complaint: follow up of resident's flank pain, the KUB showed an ileus. The patient had 2 BM's today that were formed. The resident had good oral intake of clear liquids. The resident's pain had persisted 3-4 days. The pain had improved since her last visit, the location of the pain problem is LUQ.</p> <p>7/30/15: History of partial bowel resection. Gastrointestinal area positive for bowel sounds, abdomen was soft, non tender and nondistended.</p> <p>The KUB dated 7/25/15, indicated a mild colonic ileus. Findings are new from 10/13/14.</p> <p>7/28/15: indicated mild ileus, which is slightly improved since prior study. There are prominent large and small bowel loops consistent with mild ileus.</p> <p>The resident did not have a BM for more than 72 hours on following dates: 6/27/15 through 7/3/15 for 6 days. 7/10/15 through 7/20/15 for 10 days.</p> <p>On 8/10/15 at 4:10 p.m., RN #10 indicated the documentation showed Resident #27 went several days without a BM. RN #10 indicated there were no as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 bowel medications given in the month of June. She also indicated if a resident did not have a bowel movement in 72 hours they were to follow their bowel program protocol.</p> <p>2. On 08/10/2015 at 11:20 a.m., the record review was completed for Resident #96. Diagnoses included, but were not limited to, dementia, fracture of hip, constipation, and mood disorder.</p> <p>The physician's orders indicated no medications for constipation.</p> <p>The nurses notes were reviewed from 6/12/15 through 8/11/15 and there was no documentation of bowel movements.</p> <p>The bowel movement documentation indicated the resident did not have a BM for more than 72 hours on following dates: 7/1/15 through 7/5/15 for 4 days. 7/9/15 through 7/14/15 for 5 days.</p> <p>On 8/11/15 at 11:51 a.m., the Campus Clinical Support staff member indicated the resident should have a BM every 72 hours (3 days) and if not, follow their bowel protocol. A resident having a diagnosis of constipation should have an as needed medication for constipation.</p> <p>3. Resident #10's record was reviewed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 8/10/15 at 9:54 a.m. Diagnoses included, but were not limited to, acute cerebrovascular disease, aphasia, depressive disorder, anxiety disorder and acute pain.</p> <p>The resident's Electronic Medication Administration Record (EMAR) dated August 2015, included, but were not limited to, the following orders: 3/3/15--Dulcolax suppository (laxative medication) 10 mg (milligrams) given rectally daily as needed 3/3/15--Miralax powder (laxative medication) 17 grams/dose with 8 oz (ounces) water by mouth daily 3/3/15--Milk of Magnesia Suspension (laxative medication) 400 mg/5 ml (milliliter) give 30 ml by mouth daily as needed</p> <p>The resident did not have bowel movements (BM's) documented for the following days: 6/11/15 through 7/17/15 for 35 days 7/27/15 through 8/2/15 for 6 days</p> <p>Resident #10's record lacked documentation to indicate as needed laxatives were administered when she went without a BM longer than 3 days except on 8/5/15, she was given Miralax at 3:58 p.m., but had no BM results until 8/8/15 at 9:58 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>No further abdominal assessments found in the resident's record.</p> <p>During an interview on 8/11/15 at 2:32 p.m., CNA #18 indicated he documented the residents BM's in the computer under the vitals area. He indicated if he noticed a resident had not had a BM for 3 days he would notify the resident's nurse, so she could give the resident something for their bowels. He indicated when documenting the resident's BM status there had to be either the size of the stool documented in the computer or none had to be documented in the computer. He indicated when the CNA's were charting in the computer they could not leave the BM area blank.</p> <p>During an interview on 8/11/15 at 2:36 p.m., RN #12 indicated almost all the residents have an as needed medication for their bowels. She indicated if the resident did not have a BM for three days she would give the resident their as needed medication and if the resident did not have an as needed medication, then as a nursing measure she would give the resident prune juice. She indicated any resident that did not have an as needed medication for their bowels, she would call the doctor and get one ordered. She indicated she knew the facility had a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>bowel protocol, but the protocol was not listed in each residents standing orders. She indicated she documented the bowel sounds in the nurses notes if the resident had not had a bowel movement for three days. RN #12 indicated she made sure the nurse following her knew to watch for BM results after she gave a bowel medication, then if it was not effective she called the doctor or if the resident had another as needed bowel medication such as; Milk of Magnesia or a Dulcolax suppository she would give that to the resident. She indicated a bowel report was printed out every morning by the nurse manager and it was the nurses responsibility to give the as needed laxatives to the residents who had not had a BM for 3 days and were on the bowel report.</p> <p>During an interview on 8/12/15 at 11:30 a.m., the Director of Health Services (DHS) indicated there were no other abdominal assessments found documented for this resident during the above listed dates without a bowel movement.</p> <p>4. Resident #65's record was reviewed on 8/8/15 at 1:09 p.m. Diagnoses included, but were not limited to, Alzheimers disease, irritable bowel syndrome and constipation.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 resident's EMAR dated August 2015, included, but were not limited to, the following orders:</p> <p>5/6/15--Metamucil (laxative) one packet oral Mix one packet in eight ounces of water daily.</p> <p>5/6/15--Miralax powder 17 grams mix in 8 oz of water and give daily as needed.</p> <p>The resident did not have bowel movements (BM's) documented for the following days:</p> <p>6/9/15 through 6/15/15 for 7 days 6/17/15 through 6/23/15 for 6 days 6/25/15 through 7/8/15 for 13 days 7/10/15 through 7/18/15 for 8 days 7/21/15 through 8/1/15 for 11 days</p> <p>No abdominal assessments were found documented for the days the resident did not have a BM.</p> <p>Resident #65's record lacked documentation to indicate as needed laxatives were administered when she went without a BM for longer than 3 days.</p> <p>During an interview on 8/11/15 at 3:45 p.m., the Campus Clinical Support staff member indicated there were no as needed medications given during the times when the resident did not have</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>documented BM's. She indicated she was not able to find any other BM's documented.</p> <p>During an interview on 8/12/15 at 11:30 a.m., the DHS indicated there were no abdominal assessments found documented for the days this resident had no BM's over 3 days.</p> <p>A current policy titled "Guidelines Bowel Protocol" dated 2/17/15, provided by the Assistant Director of Health Services (ADHS) at 1:15 p.m., indicated "Purpose: To provide guidance for the use of bowel stimulants for residents with constipation. Procedure: ... 5. The Bowel and Bladder Circumstance form or Ineffective Bowel Pattern form shall be initiated for any resident not having a BM with 72 hours (unless this has been determined to be a usual bowel pattern for the individual). a. The 72 Hour follow up on the B &amp; B Circumstance from [sic] should be completed until the resident has a BM or the bowel pattern returns to normal for the resident. b. The Ineffective Bowel Pattern form should be completed each shift until the resident has a BM or bowel pattern has returned to 'normal' for the resident. c. The assessment of the abdomen shall be completed each shift that includes abdominal distention, pain and bowel sounds. 6. Nursing shall</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>assess for effectiveness within 24 hours of the first step before proceeding to the next level. 7. If at any time there are indications of a bowel blockage the physician should be notified to receive instruction to proceed with the protocol or to intervene with further testing...."</p> <p>A current policy titled "Bowel Protocol" dated 2/17/15, provided by the ADHS at 1:15 p.m., indicated "If a resident/patient has indication of constipation-hard stool, complaints of constipation, no bowel movement within 72 hours (unless this has been determined to be a usual pattern for the individual then this protocol should be implemented in accordance with the individual elimination pattern) -the following bowel protocol may be implemented: 2 Tablespoons (30 cc [cubic centimeters]) of 'Natural Laxative' (mixture of bran, applesauce and prune juice) BID [twice daily]. This mixture may also be given daily in place of a stool softener. Dosage and frequency may be adjusted as needed. If no results within 24 hours of above give 30 cc of Milk of Magnesia and continue Natural Laxative as above. If no results within approximately 12 hours of above MOM [Milk of Magnesia] administration give Dulcolax suppository. If results of suppository are not satisfactory within 2 hours give Fleets enema [laxative given</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>rectally]. Assess for signs and symptoms of bowel obstruction-bowel sounds all quadrants of abdomen, blood pressure changes, abdominal distention and/or pain...."</p> <p>5. Resident #11's record review was completed on 8/10/15 at 10:45 a.m. Diagnoses included, but were not limited to Diabetes Mellitus and End Stage Renal Disease.</p> <p>On 8/7/15 at 4:20 p.m., RN #9 provided the document titled "Check Off List" dated 4/7/15, that indicated all of the nurses which were trained to do Peritoneal Dialysis (PD).</p> <p>The Electronic Medication Administration Record (EMAR) for Resident #11 was reviewed and indicated the nurses who had completed Peritoneal Dialysis for the last 14 days.</p> <p>The list of nurses trained to do PD and the nurses who documented they had done Peritoneal Dialysis were compared. There were six nurses who had performed the PD, which were not on the list of nurses that were trained.</p> <p>On 8/7/15 at 2:24 p.m., the Executive Director provided a document signed and dated on 3/27/15 titled, "Skilled Nursing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>Facility/Nursing Home Agreement for Certain Home Peritoneal Dialysis Related Services" indicated,"...The Nursing Facility agrees that if a trained Nursing Facility Staff member is not available to serve as the Caregiver, the Nursing Facility shall not initiate treatment on any of the HERD [End Stage Renal Disease] Residents and shall make arrangements to provide alternative dialysis treatments for the HERD Residents..."</p> <p>In an observation of peritoneal dialysis on 8/7/15 at 3:28 p.m., LPN #19 had not washed or sanitized her hands before donning gloves and putting on a mask. LPN #19 put alcohol sanitizer on her gloves, then grabbed Alcavis solution (bleach solution) and cleaned the blue end hooked into the machine and opened clamps hooked up to the dialysis solution bag and Resident #11's port, which she was holding with the solution soaked gauze. LPN #19 hung her mask on the hanger where the solution was hung. She indicated she reuses her mask as to not be so wasteful and indicated she would give the resident about 9 minutes and then come back.</p> <p>On 8/7/15 at 3:43 p.m., during an interview the resident indicated the staff usually use the alcohol rub and put it on their hands.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>There was an undated laminated version of the PD training manual titled , "Stay Safe Step by Step Procedure" in the resident's room. There were several notes handwritten on the Dialysis instruction sheet "hand sanitize and glove" According to LPN #17, this was the reference tool the nurses use. The document indicated, "... Set Up...12. Mask 13. Wash hands for 1 full minute and put on gloves...."</p> <p>On 8/7/15 at 4:18 p.m., LPN #19 referred to the reference tool at that time, then she indicated they did not wash their hands, they sanitized their hands with sanitizer after donning clean gloves as the PD trainer told them to do. She indicated they were trained to use hand sanitizer with gloves on due to the exchanges being awkward and there was no drainage during the exchanges. LPN #17 also indicated the trainer told them during training they could use hand sanitizer or wash their hands before putting on gloves.</p> <p>On 8/7/15 at 4:26 p.m., RN #9 who had completed the PD training indicated they were trained they could wash their hands or sanitize their hands, but that putting on gloves and then hand sanitizing was not the way they were trained. RN #9 also</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 if there was a nurse who had not been trained, they would have another nurse do the transfusion. RN#9 indicated whoever did the transfusion would sign off on the EMAR.</p> <p>During an interview on 8/11/15 at 3:34 p.m., LPN #17 indicated the PD company had trained her and indicated that she washed her hands, then cleaned the white port on the pole and bleached the port down and changed gloves. She indicated she would hand wash and glove and was not under the impression that you used alcohol gel instead of handwashing.</p> <p>During an interview on 8/11/15 at 3:45 p.m. LPN #18 indicated the PD company had trained her and she washed her hands before she donned gloves, but she understood the PD company to say they could use alcohol sanitizer once they had gloves on.</p> <p>During an interview on 8/11/2015 at 3:46 p.m., LPN #11 indicated they were trained by (name of the dialysis company) and she understood she had to wash her hands before she donned her gloves, then after her gloves were on she could use hand sanitizer.</p> <p>On 8/11/15 at 2:15 p.m., the Campus Clinical Support (CCS) staff member was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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=D Bldg. 00	<p>notified of variances on the EMAR and training list. A request was made to ensure all of the trained staff names were provided. The CCS indicated she would contact the dialysis center to see if some of the documentation had been left out when sent to the facility. As of exit on 8/11/15 at 4:46 p.m., no other documentation had been provided,.</p> <p>On 8/11/2015 at 3:00 p.m., the ADHS (Assistant Director of Health Services) indicated he took training and he understood he could use hand sanitizer, however handwashing was required during the PD process. The Campus Clinical Support staff member indicated she would expect the staff to wash their hands as well as this was documented on the procedure list they are to follow.</p> <p>3.1-37(a)</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to put pressure prevention interventions in place for 1 of 3 residents reviewed for pressure ulcers. (Resident #16)</p> <p>Findings include:</p> <p>On 8/7/15 at 3:58 p.m., Resident #16's record review was completed. Diagnoses included, but were not limited to, pneumonia, Congestive Heart Failure, and high blood pressure.</p> <p>A Skin Integrity Event dated 7/20/15, indicated the resident had a new pressure area noted to his right heel. It was described as a DTI (Deep Tissue Injury) right heel noted to be a deep reddened area that measured 2 cm (centimeters) x 1 cm. The treatment was to apply skin prep and float heels in bed.</p> <p>A Care Plan dated 6/17/15, at risk for pressure ulcers indicated to use pressure reducing mattress for pressure reduction when resident was in bed. Use moisture barrier product to perineal area. Report any signs of skin breakdown (sore, tender red, or broken areas.) Keep clean and dry as possible. Minimize skin exposure to</p>	F 0314	<p><b>F 314 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #16 - pressure prevention interventions are in place per plan of care. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Review of all residents who currently have a pressure area or are at risk for developing to ensure pressure prevention interventions are in place per plan of care. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses and CNAs on the following campus guidelines: Pressure Prevention <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: residents who currently have a pressure area or are at risk for developing have</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074		
(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 0318 SS=D Bldg. 00	<p>moisture.</p> <p>On 8/7/15 at 9:48 a.m., the resident was in bed with his heels against the mattress and the head of his bed was up. The resident was very lethargic and unable to move himself.</p> <p>On 8/7/15 at 9:50 a.m., CNA # 21 indicated the resident should have had his heels floated and indicated she needed to find more pillows.</p> <p>On 8/10/15 at 3:44 p.m., RN #10 indicated the interventions the resident had for pressure was a pressure relieving mattress and a cushion for his wheelchair. A request was made for pressure prevention intervention measures for his heels. As of the exit conference on 8/12/15 at 4:46 p.m., no other information was provided.</p> <p>3.1-40(a)(1)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to ensure</p>	F 0318	<p>pressure prevention interventions are in place per plan of care. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	09/11/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>interventions were followed to prevent possible worsening of contractures for 1 of 2 residents reviewed for range of motion. (Resident #64)</p> <p>Findings include:</p> <p>Resident #64's record was reviewed on 8/10/15 at 8:45 a.m. Diagnoses included, but were not limited to, dementia, tremor, chronic pain, and anxiety state.</p> <p>The Electronic Medication Administration Record (EMAR) dated August 2015, included, but was not limited to, the following order: 3/18/15--"Place foam grips to hands every morning, to prevent any further contracture, and to prevent skin break down, check skin on inside of palm Q [every] shift for s [signs] / sx [symptoms] of skin break down, and remove foam grips from hand every night at HS [bedtime]." three times a day</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment dated 4/23/15, indicated the resident had functional limitations on both sides for the upper and lower extremities.</p> <p>The resident had a Care Plan dated 3/18/15, that addressed the problem she required a splint to her right hand and a</p>		<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #64 - interventions are in place to prevent possible worsening of contractures, per plan of care.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents with contractures to ensure interventions are in place to prevent worsening, per plan of care.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: Contracture Prevention and Management Program</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>rolled up wash cloth to her left hand to be placed in her hands every morning and removed every evening to prevent contractures. Approaches included "...3/18/15--Please assist me to apply my splint and wash cloth to my hands every morning, report any signs of worsening contractures."</p> <p>On 8/3/15 at 4:18 p.m., Resident #64 was observed sitting at the table at the 200 unit nurses station in her broda chair with bilateral hand contractures. She had a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/4/15 at 9:56 a.m., the resident was observed sitting at the table at the 200 unit nurses station in her Broda chair. She had a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/4/15 at 11:10 a.m., the resident was observed sitting at table at the 200 unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/4/15 at 12:21 p.m., the resident was observed sitting at the table at the 200 unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand.</p>		<p><b>not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: residents with contractures have interventions are in place to prevent worsening, per plan of care.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 8/5/15 at 11:05 a.m., LPN #5 indicated Resident #64 had bilateral hand and arm contractures. She indicated the resident was supposed to have two palm pads in place, but hospice had not brought the other one in yet. She indicated she was going to have to call and check on the palm pad for the resident's left hand.</p> <p>A nursing progress note dated 8/5/15 at 11:33 a.m., indicated "Res. [resident] only has one foam grip pad...."</p> <p>A nursing progress note dated 8/5/15 at 1:50 p.m., indicated "... [name of company] will receive it's shipment on Tuesday and they will bring res. another foam hand grip."</p> <p>On 8/7/15 at 10:25 a.m., the resident was observed sitting at the table at the 200 unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/7/15 at 11:34 a.m., the resident was observed sitting at the table at the 200 unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/7/15 at 1:20 p.m., the resident was observed sitting at the table at the 200</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/8/15 at 9:58 a.m., the resident was observed sitting at the table at the 200 unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/8/15 at 12:10 p.m., the resident was observed sitting at the table at the 200 unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/8/15 at 1:25 p.m., the resident was observed being transferred to bed with a Hoyer lift and she had a blue foam palm grip pad in her right hand and nothing in her left hand.</p> <p>On 8/10/15 at 1:50 p.m., the resident was observed sitting at the table at the 200 unit nurses station with a blue foam palm grip pad in her right hand and nothing in her left hand. RN #15 indicated at that time Resident #64 was to have a palm splint in her left hand, but she had not received one from hospice as of yet. She indicated the resident was supposed to have a rolled up washcloth inside her hand until the palm splint arrived from hospice.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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=D Bldg. 00	<p>On 8/11/15 at 3:40 p.m., the resident was observed sitting in the 200 Southeast hallway in her Broda chair with the blue foam palm pad in her right hand and nothing in her left hand.</p> <p>On 8/12/15 at 2:18 p.m., the Program Director indicated the resident had bilateral contractures and therapy had not seen her for her contractures in the past, but she had foam splints that were to be worn.</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to prevent a resident at risk for elopements from eloping from the facility and failed to ensure medication was not left unattended in a resident's room for 2 of 5 residents reviewed for supervision. (Residents #72 and #11)</p> <p>Findings include:</p>	F 0323	<p><b>F 323</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p>1). Resident #72 has been</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>1. Resident #72's record was reviewed on 8/7/15 at 9:00 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbances, anxiety disorder, insomnia, depressive disorder, mood disorder and altered mental status.</p> <p>The resident's Physician Recapitulation orders dated August 2015, included, but were not limited to, the following orders: 3/2/15--Up in wheelchair with assist of one 3/2/15--Elopement pendant-check placement every shift 3/19/15--Elopement pendant-check function daily</p> <p>The resident had a Care Plan report dated 8/4/14, which indicated "... Cont [continues] to wander about ECF [Extended Care Facility]...."</p> <p>The resident had a Care Plan report dated 9/4/14 at 2:00 p.m., which indicated "Discussed concerns r/t [related / to] wandering + [and] exit seeking. Wanderguard remains in place. Encouraged family to look into memory care secondary security + programming...."</p> <p>The resident had a Care plan report dated</p>		<p>discharged.</p> <p>2). Resident #11 - medications are not left unattended in resident's room.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p>1). Review of all residents identified as a risk for elopement to ensure preventions interventions are in place to prevent elopement, per plan of care.</p> <p>2). All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>1). DHS or designee will re-educate the campus staff on the following campus guidelines: Elopement Risk Reduction</p> <p>At any time a resident is identified</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>11/3/14, which indicated "Episodes of wandering continue...."</p> <p>An Event report dated 3/14/15 at 4:45 p.m. indicated the resident had attempted to leave the facility out the front door right before dinner. She had made it through the first set of doors with her wanderguard on before she was brought back into the facility.</p> <p>A Fax Transmittal cover sheet dated 3/14/15, indicated "This is just notification the [name of resident] was caught trying to wander out of the building she made it through the first set of doors with her wanderguard on but was stopped before getting through the second set...."</p> <p>A progress note dated 3/14/15 at 11:28 p.m., indicated "[name of resident] was caught exiting the first set of front doors around 4:45 this evening with her wanderguard on. She did not make it through the second set. She was brought back to the dining room for dinner but later went to the doors again to try and let some people in who were locked out... I offered to take her to her room to watch tv and she wanted to go to the billiards room to watch TV on the big screen. She was not in there on her next 15 minute check and writer searched the whole first</p>				<p>with significant risk factors that are beyond the facility's environmental capabilities, he/she will be evaluated for possible transfer to a more secure facility, per policy.</p> <p>The campus will continue to conduct routine door alarms checks.</p> <p>2). DHS or designee will re-educate the Licensed Nurses and QMAs on the following campus guideline: Medication Administration General Guidelines</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>1). The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: a). residents identified as a risk for elopement to ensure preventions interventions are in place to prevent elopement, per plan of care. b). staff verbalizes knowledge of appropriate interventions to implement if a</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>floor. She came out of the elevator at this point and was taken to her room...."</p> <p>A progress note dated 4/12/15 at 5:46 a.m., indicated the resident got herself up and dressed and wheeled herself down towards the 100 unit hallway.</p> <p>A progress note dated 4/17/15 at 5:44 p.m., indicated the resident attempted to enter another resident's room on the 100 hallway, but was not easily redirected.</p> <p>A Psychiatry progress note dated 5/6/15, indicated the resident needed someone to be with her if she was going to be outside the facility and she was not to be outside the facility without supervision.</p> <p>A progress note dated 5/8/15 at 9:18 a.m., indicated "[name of resident] was evaluated by [name of Psychiatrist] on 5/6/15, due to noted agitation, exit-seeking... She could be physically redirected away from exits for short periods only...."</p> <p>An IDT (Intradisciplinary Team) progress note dated 5/8/15 at 10:14 a.m., indicated "IDT met this day to discuss resident risks. Resident is an increased risk for elopement... throughout this week resident has been observed multiple times exit seeking. She does have a</p>		<p>resident is exit seeking. c). door alarms are checked for functioning</p> <p>2). The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observation of resident's room directly after medication pass to ensure medication was not left unattended.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>wandergard [sic] in place and is frequently left in common areas to observe by staff... Most time [name of resident] is easily redirected, but this week has been more difficult at times. Weather has improved and more independent residents are observed outside by resident, contributing to the frequency...."</p> <p>A progress note dated 5/18/15 at 11:26 a.m., indicated the Psychiatrist was notified of the resident's seeking behavior she displayed today and he indicated there was nothing else he could do with her medication and she should be transferred to a locked dementia unit...."</p> <p>An event report dated 5/8/15 at 12:34 p.m., indicated the resident was found in the grand lobby exit seeking. She had exit seeking attempts in the past, which were unsuccessful. The report indicated she was agitated. The resident's wandering placed her at a significant risk of getting to a potentially dangerous place such as; stairs or outside the building. The interventions were her clothes were labeled with identification, a personal alarm was placed, a resident elopement risk profile was completed and a Psychiatry referral was complete. The root cause was she observed other resident's outside.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 progress note dated 5/18/15 at 12:54 p.m., indicated the resident continued to exit-see and the Executive Director (ED) was concerned about her elopement risk.</p> <p>A progress note dated 5/18/15 at 9:44 p.m., indicated the resident attempted to leave the building four times on that particular shift.</p> <p>A progress note dated 5/24/15 at 11:05 a.m., indicated the resident had been wandering around that shift. She wandered around the unit, lobby, dining room and she had put herself in the elevator one time.</p> <p>A progress note dated 5/24/15 at 9:47 p.m., indicated the resident attempted to leave through the front door twice on that shift.</p> <p>A progress note dated 6/2/15 at 6:26 p.m., indicated the resident had tried to exit the facility through the front doors that evening.</p> <p>A Psychiatry progress note dated 6/4/15, indicated she had exit seeking behavior on 5/30/15. She told the staff she wanted to go outside and she had a wanderguard in place at that time.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>An Event report dated 7/25/15 at 10:18 p.m., indicated the resident eloped from the front entrance of the building. She was found by a staff member on the sidewalk in the front of the building propelling herself away from the building. The report indicated the resident was found propelling herself in her wheelchair at 7:15 p.m. The following behaviors the resident exhibited prior to the elopement was she had unsuccessful and successful elopements in the past, repeatedly opening doors and setting off alarms of secured doors, resisting redirection from staff, verbal statements about leaving, wandering with no rational purpose and attempted to open doors observing entrances and exits. The wandering presence and and frequency indicated the behavior of this type occurred daily. The measures taken to prevent this behavior again were a door alarm (wanderguard was applied).</p> <p>A progress note dated 7/25/15 at 10:28 p.m., indicated "Staff noted the front door alarm sounding. Staff reset alarm and noted res [resident] to be sitting in front lobby. Staff returned to unit then heard front door alarm sounding again. Staff returned to front door. Res was seen propelling self in w/c [wheelchair] along</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>sidewalk in front of building. Staff caught up to and approached res...."</p> <p>A progress note dated 7/26/15 at 1:33 p.m., indicated "Resident followed another resident who is A &amp; O [Alert and Oriented] x [times] 3 out of door onto front porch area. Resident did not pass the sidewalk near the front door of the facility and resident was playing with flowers. Resident had just been in dining room eating breakfast and 2 nurses had eye contact with resident. Fellow resident reported that he opened the door for resident which is how she got out...."</p> <p>A "Field Work Order" dated 7/26/15, was provided by the ED on 8/10/15 at 2:48 p.m. The work order indicated "Wanderguard at front door activating because of interference... Also found incorrect wiring on a newly added 3rd antenna that cold possibly be a cause of sporadic interference...." The ED indicated at that time the facility had been having trouble with the front door wanderguard system, which had been installed two weeks prior to this date. She indicated (Name of the Company) was at the facility on 7/26/15, due to the wanderguard system did not alarm when Resident #72 exited the building with another resident earlier that morning on 7/26/15, and before that it was going off</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>sporadically for no reason. She indicated when the company left that day the wanderguard system was functioning without problems and the facility had not had problems with the system since that day.</p> <p>During an interview on 8/10/15 at 2:49 p.m., the Executive Director (ED) indicated the resident had exited the facility the night before on 7/25/15, and was propelling herself down the sidewalk when a nurse found her after the door alarm sounded. She indicated she would have expected the nurse who found her after the door alarm sounded the first time to have taken her back to the nursing unit with that nurse. She indicated the second time she eloped out the front doors on 7/26/15, a resident let her out the front doors, but the doors did not alarm. She indicated LPN #16 saw the resident leave out the front doors with the other resident from the second floor residential area looking through the glass and she notified staff on the first floor.</p> <p>A current policy titled "Procedure Guidelines: Elopement Risk Reduction" dated 10/19/2007 and revised 9/16/2011, was provided by the Assistant Director of Health Services on 8/10/15 at 1:15 p.m., indicated "Elopement Overview: Elopements occur when a resident leaves</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 premises or a safe area with authorization (I.e., an order for discharge or leave of absence) and/or any necessary supervision to do so... Procedure:...2. Residents identified with significant risk factors that are beyond the facility's environmental capabilities (unsecured facilities should be evaluated for transfer to a more secure facility. 3. A plan of care will be developed and implemented for each resident identified as having the potential to leave the facility unauthorized, requiring supervision for off ground privileges or wandering to an unsafe area... 6. Facilities with door alarms should place a 'wander guard bracelet' on the resident and have the alarms activated at all times. 7. A check will be completed of alarmed doors and resident alarms to ensure proper functioning...."</p> <p>2. On 8/7/15 at 3:06 p.m., an observation was made of a bubble pack medication card of Zithromycin (an antibiotic) 225 milligrams with 4 tabs enclosed in bubbles. This was found lying underneath of a peritoneal dialysis book in Resident #11's room.</p> <p>On 8/7/15 at 3:07 p.m., RN #9 indicated the medication should not have been left in the resident's room</p> <p>3.1-45(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0325 SS=D Bldg. 00	<p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to implement or continue weight loss prevention interventions to prevent a significant weight loss for 2 of 4 residents reviewed for weight loss. (Residents #46 and #65)</p> <p>Findings include:</p> <p>1. Resident #46's record was reviewed on 8/8/15 at 10:29 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbances, debility, oral cancer in situ, Diabetes Mellitus, nausea with vomiting and gastroesophageal reflux disease.</p> <p>The resident's Electronic Medication</p>	F 0325	<p><b>F 325</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #46 and #65 - weight obtained and recorded in the medical record.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents weights. If the weight is</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>Administration Record (EMAR) dated August 2015, included, but were not limited to, the following orders: 7/14/14--Regular diet 12/30/14--Weight daily on Monday</p> <p>The following were the residents weights: 4/15/15--251 5/8/15--296 7/3/15--247 8/6/15--262</p> <p>Resident #46 had a documented 49 pound or 19.8% significant weight loss in 90 days.</p> <p>The dietary progress note dated 4/1/15, indicated the resident weighed 235 pounds on 3/2/15. There was no significant weight change. He ate a regular diet with a hard boiled egg every meal for added protein. His Albumin was 3.1 on 3/24/15, which was mildly low. The Registered Dietician (RD) recommended the hard boiled egg with every meal be discontinued and a weight was requested.</p> <p>A dietary progress note dated 7/7/15, indicated the resident's weight was 247 on 7/3/15. His May 2015, weight was 297 and was likely inaccurate, but no reweight was documented. He weighed</p>		<p>out of normal range, a re-weight will be obtained/recorded to determine the accuracy of the original weight.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: Weight Tracking</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review resident weights. If the weight is out of normal range, a re-weight should be obtained/recorded to determine the accuracy of the original weight.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074		
(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>251 on 4/15/15 with no significant change. His weight loss was 7.4% weight loss in 180 days. He had some cellulitis at the end of may and was ordered an antibiotic and presently had edema. He ate well and tolerated a regular diet. Recommendation was to discontinue the Promod supplement.</p> <p>During an interview on 8/11/15 at 4:01 p.m., RN #9 indicated the inaccurate weight gain was most likely due to the staff member who weighed the resident did not subtract his wheelchair, then it appeared the next time he was weighed he had a significant weight loss.</p> <p>2. Resident #65's record was reviewed on 8/8/15 at 1:09 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, mood disorder, senile dementia, anxiety state, mood disorder, depressive disorder, and chronic pain.</p> <p>The resident's EMAR dated August 2015, included, but was not limited to, the following order: 5/6/15--Finger food and pleasure foods</p> <p>The following were the resident's weights: 5/25/15--166 6/18/15--191</p>		recommendation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>7/8/15--178</p> <p>A Nutrition progress note dated 7/15/15 at 9:59 a.m., indicated the resident's weight on 7/15/15, was 178 times two attempts. Her weight on 6/18/15, was 191, which seemed to be an inaccurate weight, but no reweight was completed. Her admission weight in May 2015, was 170. No recommendation at that time. Regular diet with finger foods in place. BMI is 30.5.</p> <p>During an interview on 8/11/15 at 4:30 p.m., the Director of Health Services (DHS) indicated he expected the nursing staff to reweigh the residents if the weight they obtained was inaccurate. He indicated the Registered Dietician (RD) had a list, which had residents names with weights who she would tell nursing management required a reweight. He indicated both these residents should have been reweighed when their weights were seen by the RD. He indicated the nurses documented the residents weights in the computer as data, so the weights did not always get recognized as an inaccurate weight for the residents to have them get reweighed immediately, but the RD should catch the inaccurate weights when reviewing the weights and ask for a reweight.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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
	A current policy titled "Guidelines For Weight Tracking" dated 11/2007 and revised 05/2014, was provided by the Campus Clinical Support staff member at 3:45 p.m., indicated "Purpose: To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration. Procedure: ... 3. The facility dietician or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted. 4. Scales shall be properly maintained and calibrated to ensure accuracy of weight. 5. To the extent possible the same scale, same person, same wheelchair (if applicable) should be used to ensure consistency. 6. The weight should be recorded in the individual resident medical record utilizing the monthly weight tracking form and in the computerized system to provide an "at a glance" report for the dietician. 7. Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight. This should be completed when the discrepancy is noted and not wait until the dietician recommends a re-weigh. The re-weigh should be documented in the medical record as well as the original weight...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0327 SS=D Bldg. 00	<p>3.1-46(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview and record review, the facility failed to ensure to offer residents alternative methods to assist in hydration for 2 of 3 residents reviewed for hydration (Resident #16 and Resident #41)</p> <p>Findings include:</p> <p>1. Resident #16's record was reviewed on 8/7/15 at 3:58 p.m. Diagnoses included, but were not limited to, Congestive Heart Failure, edema, acute pain and pneumonia.</p> <p>The physician's orders dated 6/17/15, was for a Mechanical soft diet with nectar thickened liquids.</p> <p>The Care Plan dated 6/17/15, indicated the resident was at risk for dehydration and indicated here was a Care Plan dated 6/17/15, indicating the resident was at risk for dehydration "... Assist with fluids as needed. assess for dehydration</p>	F 0327	<p><b>F 327</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #16 and #46 are being offered alternative methods to assist in hydration.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: Hydration Management</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>(dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry/cracked lips, dry mucus membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance...."</p> <p>The Nutrition Assessment dated 6/16/15, indicated the fluid consumption need of 1,000-1,499 cc day</p> <p>The Care Plan for nutrition dated 6/17/15, indicated to provide diet/supplements/medications as ordered Please assist me with meals as needed. Offer alternate food and beverage items as needed.</p> <p>Obtain my weight as ordered/needed. I am on daily weights presently.</p> <p>The fluid documentation in milliliters indicated: 7/7/15--240 x 3 = 720 ml 7/8/15--240 x 2 + 360 = 840 ml 7/10/15--240 ml 7/11/15--360 + 480 = 840 ml 7/12/15--240 + 240 = 480 ml 7/13/15--120 ml 7/14/15--240 x 2 = 480 ml 7/15/15--240 x 2 = 480 ml 7/16/15--240 x 2 = 480 ml 7/17/15--360 ml 7/18/15--240 + 240= 480 ml 7/19/15--none documented</p>		<p>Interventions</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Resident observation for fluids available and within reach in room, alternative hydration options offered to meet the dietary fluid intake need, fluids are being documented.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>7/20/15--240 x 2 = 480 ml 7/21/15--240 x 2 = 480 ml 7/22/15--240 x 2 = 480 ml 7/24/15--240 x 3 = 720 ml 7/25/15--240 x 2 = 480 ml 7/27/15--240 x 2 = 480 ml 7/28/15--240 x 2 = 480 ml 7/29/15--240+ 360 +120 = 720 ml 7/30/15--240 x 2 = 480 7/31/15--360 ml 8/1/15--240 x 2+ 360 = 840 ml 8/2/15--360+ 480 = 840 ml 8/3/15--480+ 240 + 240 = 960 ml 8/4/15--240+ 240 + 240 = 720 ml 8/5/15--240+ 240 = 480 ml 8/6/15--240 + 240 = 480 ml 8/7/15--240 ml + 120 ml +240 ml = 600 ml 8/8/15--240 ml 8/9/15--240 ml</p> <p>The resident progress notes indicated: 8/7/15 at 6:31 a.m., indicated the resident was incontinent of a moderate amount of urine . 8/6/15 at 1:20 p.m., indicated a new order for Augmentin (an antibiotic) 875/125 milligrams x 7 days for Pneumonia. 1:50 p.m. the resident had a medium amount of urine. 8/5/15 at 11:11 a.m., indicated the resident was not very talkative this day, the resident had a minimal amount of lethargy noted. The resident was leaning</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>in the wheelchair at breakfast and was assisted to lay down in bed after the meal. 8/4/15, indicated the resident only urinated once during night. 8/3/15, indicated the resident's Oxybutinin medication for overactive bladder was discontinued today. 8/2/15, indicated the resident was up in the recliner at 9:45 a.m., awake and alert to self. The resident tolerated med administration and thickened liquids continue.</p> <p>On 8/7/15 at 9:04 a.m., the resident was observed to have 1 cup of coffee at breakfast.</p> <p>On 8/7/15 at 1:35 p.m., the resident and his spouse were sitting in recliners. Resident #16 had his shoes on with a pillow underneath. There was a small Styrofoam cup with ice water in it and a large tan cup with water, which was half full. The spouse indicated they have 2 other cups with lids on them that help keep the fluids cold. The fluids were on a table, which was not in reach of either resident.</p> <p>There was no documentation found in the record of offering alternative hydration options, such as popsicles or ice cream, to the resident to meet the dietary fluid intake need.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>2. Resident #41's record was reviewed on 8/09/15 at 4:17 p.m. Diagnoses included, but were not limited to, edema, stroke, and gastro reflux disease.</p> <p>On 8/09/15 at 4:14 p.m., the resident was sitting in her room in her wheelchair. There were two Styrofoam cups that were empty sitting on her bedside table. There were no fluids in her room, no water pitcher visible.</p> <p>The resident order dated 4/15/15, had an order for nectar thick liquids and to encourage fluids every shift. The resident also had order for Lasix (a diuretic medication) 40 milligrams daily dated 4/15/15.</p> <p>The Care Plan dated 5/4/15, indicated I receive diuretic medication related to high blood pressure. 5/14/15--1) Administer diuretic per MD order. Observe and report effectiveness. Report adverse drug reaction. 5/14/15-- Observe/report dehydration (dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucous membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance.)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 Care Plan dated 6/11/15, indicated: I would like to meet my nutritional and hydration needs to support my overall metabolic conditions.</p> <p>Interventions included but were not limited to, offer alternate food and beverage as needed.</p> <p>The nutritional assessment dated 4/22/15 had no indication of swallowing disorders and the oral/nutritional intake-fluids need was 1,500-2,000 cc/day.</p> <p>Fluids documented in milliliters as indicated: 8/8/15--480 milliliters (ml) 8/7/15--240 ml + 240 + 300 = 780 ml 8/6/15--240 + 360 + 360 = 960 ml 8/5/15--120 + 240 (X 2) + 60 = 660 ml 8/4/15--360 ml 8/3/15--360 + 300 = 660 ml 8/2/15--240 + 240 = 480 ml 8/1/15--240 + 300 = 540 ml 7/31/15 --240 + 400 + 300 = 940 ml</p> <p>There was no documentation found in the record of offering of alternative hydration options, such as popsicles or ice cream, to the resident to meet the dietary fluid intake need.</p> <p>A request was made on 8/11/15 at 3:30 p.m., of alternative hydration options for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0328 SS=E Bldg. 00	<p>Resident #16 and Resident #41. As of the exit conference on 8/12/15 at 4:46 p.m., no other information was provided.</p> <p>3.1-46(b)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was monitored during a respiratory treatment for 1 of 1 residents reviewed for respiratory needs. (Resident #60). The facility also failed to ensure respiratory equipment was changed in a timely manner and stored appropriately for 5 of 5 residents observed for respiratory equipment storage . (Residents #10, #27, #64, #69 and #85)</p> <p>Findings include:</p> <p>1. On 8/8/14 at 1:18 p.m., Resident #60 was observed laying in bed taking his breathing treatment without a staff</p>	F 0328	<p><b>F 328 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> 1). Resident #60 - resident is being monitored by Licensed Nurse during respiratory treatments. 2). Residents #10, #27, #64, #69, #85 - respiratory equipment in place was changed in a timely manner and is stored appropriately. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p>1). DHS or designee will observe all residents receiving respiratory treatments to ensure they are monitored by Licensed Nurse during respiratory</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074		
(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>member present. The resident was observed having trouble holding the nebulizer mouthpiece in his mouth and it was falling over to the right side of his mouth and he was not able to reach up and hold it. A family member of the resident was instructing him to take a deep breath. CNA #6 entered the room and indicated she would find the resident's nurse.</p> <p>On 8/8/15 at 1:19 p.m., LPN #11 was observed entering the resident's room. She held the nebulizer mouthpiece for the resident as he finished his breathing treatment.</p> <p>Resident #60's record was reviewed on 8/10/15 at 9:31 a.m. Diagnoses included, but were not limited to, leukocytosis, acute bronchitis, edema, asthma, and heart failure.</p> <p>The resident's Electronic Medication Administration Record dated August 2015, included, but was not limited to, the following order: 8/3/15--Duonebs (a bronchodilator medication that is inhaled) aerosol 0.5 mg (milligrams) /3 mg one vial inhalation four times daily times five days from 8/3/15 to 8/9/15 for acute bronchitis.</p> <p>The EMAR dated August 2015, indicated</p>		<p>treatments. 2). DHS or designee will observe all respiratory equipment in place to ensure it was changed in a timely manner and is stored appropriately <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: 1). Nebulizer Administration, Cleaning, and Storage 2). Respiratory Infection Control <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). resident is being monitored by Licensed Nurse during respiratory treatments. 2). respiratory equipment in place was changed in a timely manner and is stored appropriately. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 8/8/15 for the 12:00 p.m.-2:00 p.m. Duoneb treatment the following was documented:</p> <p>The resident had wheezes before and after the nebulizer treatment. The resident's oxygen saturation before the breathing treatment was 91% on room air and 90% on room air after the breathing treatment. The treatment lasted 15 minutes.</p> <p>The resident's record lacked a self medication administration assessment.</p> <p>During an interview on 8/8/15 at 1:42 p.m., LPN #11 indicated she should have stayed with Resident #60 after she started the breathing treatment. She indicated she left the resident's room to go to another resident's room and got "caught up" with another resident. She indicated this resident had family members in the room, so she thought he would be "all right" to stay in the room with his family while she went to another resident's room. She indicated he had a change of condition recently and the physician thought he may have Congestive Heart Failure. She indicated he was not supposed to be self administering his breathing treatments.</p> <p>During an interview on 8/11/15 at 3:45 p.m., the Campus Clinical Support staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>member indicated the resident did not have a Self Medication Administration Assessment or order in his record.</p> <p>2. On 8/5/15 at 9:52 a.m., Resident #10's nasal cannula oxygen tubing was connected to her oxygen concentrator, which she was wearing had a piece of clear tape wrapped around it dated 7/19, with 10-6 documented in black marker. The nasal cannula oxygen tubing attached to the oxygen portable tank hanging on the back of her wheelchair was wrapped around the handles of the wheelchair. The tubing had a piece of clear tape wrapped around it dated 7/10, with a black marker.</p> <p>During an interview on 8/5/15 at 10:29 a.m., RN #8 indicated the oxygen tubing on the oxygen concentrator was dated 7/19/15 and the oxygen tubing wrapped around the wheelchair handles connected to the portable tank was dated 7/10/15.</p> <p>The resident's record was reviewed on 8/10/15 at 9:54 a.m. Diagnoses included, but were not limited to, acute cerebrovascular disease, convulsions, aphasia, and anxiety disorder.</p> <p>The resident had a Physician order dated 3/3/15, which indicated the oxygen tubing was to be changed once weekly on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>Sundays on the 10 p.m. to 6 a.m., shift.</p> <p>The resident's EMAR dated August 2015, indicated the resident's oxygen tubing was not changed on 8/2/15 due to pending supply delivery.</p> <p>3. On 8/5/15 at 10:21 a.m., Resident #27's nasal cannula oxygen tubing was observed connected to an oxygen concentrator, but was laying over the concentrator and was not in a plastic bag. The oxygen tubing had a clear piece of tape wrapped around it dated 7/13, with a black marker. The resident indicated at that time she only used the oxygen at night.</p> <p>During an interview on 8/5/15 at 10:31 a.m., RN #8 indicated the oxygen tubing attached to the oxygen concentrator was dated 7/13/15 and was not in a bag.</p> <p>The resident's record was reviewed on 8/10/15 at 9:46 a.m. Diagnoses included, but were not limited to, obstructive sleep apnea, Congestive Heart Failure, and hypertension.</p> <p>The resident lacked an order in her record to have her oxygen tubing changed routinely or as needed.</p> <p>During an interview on 8/10/15 at 1:15</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>p.m., RN #10 indicated the resident did not have an order to change her oxygen tubing weekly on Sundays.</p> <p>4. On 8/5/15 at 10:45 a.m., RN #9 was observed opening Resident #64's bedside top drawer and pulled a plastic bag out with a nebulizer mask which was dated 4/22/15, in black marker on the outside of the plastic bag and on the cup part of the nebulizer equipment. He was observed to pick up the nasal cannula oxygen tubing off the floor laying over an oxygen concentrator and was unable to locate a date on the oxygen tubing.</p> <p>Resident #64's record was reviewed on 8/10/15 at 8:45 a.m. Diagnoses included, but were not limited to, dementia, anxiety state, pneumonia and wheezing.</p> <p>The EMAR dated April 2015, indicated the resident had an order dated 4/30/15, for duoneb inhaler (bronchodilator medication used to open the lungs when inhaled) 0.5 mg (milligrams) / 3 mg / 3 ml (milliliters). Administer 3 ml's three times a day for three days then resume the as needed medication. The resident received this medication on these dates: 4/30/15</p> <p>The EMAR dated May 2015, indicated the resident had an order dated 4/30/15,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>for duoneb inhaler 0.5 mg / 3 mg / 3 ml. Administer 3 ml's three times a day for three days then resume the as needed medication. The resident received this medication on these dates: 5/1/15 and 5/2/15</p> <p>The EMAR dated July 2015, indicated the resident had an order dated 7/24/15, Ipratropium-Albuterol Solution 0.5 mg-3 mg (2.5 mg base)/3 ml 1 ampule given four times a day from 7/24/15 to 7/27/15. The resident received this medication on these dates: 7/24/15 to 7/27/15</p> <p>The EMAR dated August 2015, indicated the resident had an order dated 10/20/2014, Ipratropium-Albuterol Solution 0.5 mg-3 mg (2.5 mg base)/3 ml 1 ampule given three times a day as needed.</p> <p>The resident's record lacked an order to change the nebulizer equipment or the oxygen tubing routinely or as needed.</p> <p>During an interview on 8/10/15 at 1:15 p.m., the RN #10 indicated there was no order to change the resident's oxygen tubing or nebulizer equipment.</p> <p>5. On 8/5/15 at 9:15 a.m., Resident #69's nasal cannula oxygen tubing was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>observed connected to her concentrator with a piece of clear tape wrapped around it dated 7/19 with 10-6 documented on it with a black marker. The resident was sitting in her recliner wearing her oxygen at that time. The nasal cannula oxygen tubing connected to the portable tank on the back of the resident's wheelchair had a clear piece of tape wrapped around it dated 7/19, with 10-6 documented on it with black marker. It was stored in a plastic bag.</p> <p>During an interview on 8/5/15 at 10:48 a.m., RN #9 indicated Resident #69's nasal cannula oxygen tubing connected to her oxygen concentrator and portable oxygen tank was dated 7/19/15.</p> <p>The resident's record was reviewed on 8/10/15 at 4:31 p.m. Diagnoses included, but were not limited to, hypertension, Congestive Heart Failure and asthma.</p> <p>The resident's EMAR dated August 2015, indicated she had an order dated 12/17/14, change oxygen tubing daily on Sundays from 12 a.m. to 5 a.m.</p> <p>The resident's EMAR dated August 2015, indicated the oxygen tubing was not changed on the scheduled date 8/2/15, without an explanation as to why the tubing was not changed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>6. On 8/5/15 at 9:47 a.m., Resident #85's nasal cannula oxygen tubing was observed connected to the oxygen concentrator stored in the plastic bag and the nasal cannula oxygen tubing connected to the portable tank on the back of her wheelchair had a piece of clear plastic tape wrapped around it dated 7/20 with 10-6 documented on it with black marker.</p> <p>During an interview on 8/5/15 at 10:47 a.m., RN #9 indicated Resident #85's nasal cannula oxygen tubing connected to the oxygen concentrator and the portable tank was dated 7/20/15.</p> <p>The resident's record was reviewed on 8/10/15 at 9:17 a.m. Diagnoses included, but were not limited to, bacterial pneumonia, acute respiratory failure, wheezing and congenital subortic stenosis.</p> <p>The resident's EMAR dated August 2015, indicated an order dated 5/27/15, for oxygen tubing change weekly on Sundays from 10 p.m. to 6 a.m.</p> <p>The resident's EMAR dated August 2015, indicated the resident's oxygen tubing was not changed on the scheduled date 8/2/15, without an explanation as to why</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 tubing was not changed.</p> <p>During an interview on 8/5/15 at 10:47 a.m., RN #9 indicated oxygen tubing and nebulizer equipment should be changed weekly. He indicated the oxygen tubing should be placed in a plastic bag to be stored after use.</p> <p>A current policy titled "Guidelines For Administration of Oxygen" dated April 4, 2014, was provided by ADHS #2 on 8/10/15 at 1:15 p.m., indicated "Purpose: To provide guidelines for safe oxygen administration when insufficient oxygen is being carried by the blood to the tissues... Procedure: ... 14. Date the tubing for the date it was initiated. a. Tubing should be changed weekly and PRN [as needed]...."</p> <p>A current policy titled "Nebulizer Administration, Cleaning, and Storage" dated March 2012, provided by the Associate Director of Health Services #2 on 8/10/15 at 1:15 p.m., indicated "... Throughout the treatment encourage the resident to take deep breath's and exhale normally. Remain with the resident unless the resident has been assessed and authorized to self administer. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup... Store completely dry equipment in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0332 SS=D Bldg. 00	<p>a plastic bag with the resident's name and date on it (the bag and equipment should be changed every 7 days)...."</p> <p>3.1-47(a)(6)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview the facility failed to ensure they were free of a medication error rate of 5% or greater for 2 of 3 resident's during the observation of the medication pass. This deficient practice resulted in a medication error rate of 6.976 % for 3 errors out of 43 opportunities for error. (Residents #110 and #105).</p> <p>Findings include:</p> <p>1. Resident #110's record was reviewed on 08/05/15 at 10:30 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus, neuropathy, restless legs syndrome, edema, pain, and hypertension. These diagnoses remained current at the time of the record review.</p> <p>A review of the current admission physician orders dated August 2015,</p>	F 0332	<p><b>F 332</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #110 an #105 - A observation of medication administration was conducted to ensure the medication error rate is less than 5%.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice</p> <p><b>Measures put in place and</b></p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>instructed the nursing staff to administer Levemir solution (insulin) 100 units/ml (milliliters) - 70 units subcutaneously.</p> <p>The resident also had physician orders for Novolog FlexPen (insulin) at 100 units/ml per sliding scale: "If blood sugar is 150 to 199, give 2 units, if blood sugar is 200 to 249, give 4 units, if blood sugar is 250 to 299, give 6 units, if blood sugar if 300 to 349, give 8 units, if blood sugar is 350 to 400 give 9 units. Special Instructions: Call MD/NP [Medical Director/Nurse Practitioner] if blood sugar is greater than 400. Before meals and at Bedtime 8:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m."</p> <p>During the Medication Administration Pass observed on 08/05/15 at 8:30 a.m., Licensed Nurse #1, prepared medications for Resident #110. The Licensed Nurse indicated the resident received Levemir subcutaneously as "scheduled" and based on the resident's Accucheck the nurse would administer the scheduled amount of the Novolog Sliding Scale Insulin at the same time.</p> <p>The Licensed Nurse indicated the resident's blood sugar was 175 prior to eating breakfast.</p> <p>The Licensed Nurse drew up 70 units of</p>		<p><b>systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following guideline: Specific Medication Administration Guideline. .</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for Medication Administration will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Conduct a medication administration observation to ensure the medications are administered in a safe and effective manner and the medication error rate is less than 5%.</p> <p>Throughout the audit / observation period, all 3 shifts will be observed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 scheduled Levemir, and then indicated he needed to draw up 11 units of Novolog Sliding Scale Insulin into a separate syringe based upon the resident's blood sugar result.</p> <p>After the Nurse drew up the medications he proceeded to the resident's room, informed the resident he had the insulin and administered the Levemir insulin subcutaneously into the resident's abdomen, and the measured amount of Novolog Sliding Scale Insulin into the resident's right upper arm.</p> <p>During the reconciliation of the resident's medications the physician orders for the amount of insulin in regard to the sliding scale insulin should have been 2 units.</p> <p>During an interview on 08/05/15 at 11:15 a.m., the Unit Manager Licensed Nurse #3, indicated after she reviewed the Medication Administration Record she realized the Licensed Nurse reviewed the Medication Administration Record from the evening before and saw where a Licensed Nurse gave 9 units of the Novolog Insulin based on a blood sugar of 388 mg/dL (milligrams/deciliter). "He should have only drawn up 2 units."</p> <p>At 11:00 a.m., and after the reconciliation of the resident's medications, a request</p>		randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>was made to perform an Accucheck on the resident. The result was 130 mg/dL.</p> <p>2. Resident #105's record was reviewed on 08/05/15 at 10:30 a.m. Diagnoses included, but were not limited to, Encephalopathy, hemiplegia, hypertension, depressive disorder, constipation, glaucoma, arterial disease, and hemiplegia. These diagnoses remained current at the time of the record review.</p> <p>At the time of admission the resident had physician orders dated 07/13/15, for Lisinopril (an antihypertensive medication) 20 mg once a day and Omeprazole (an anti-ulcer medication) 20 mg once daily.</p> <p>A review of the current physician orders for August 2015, also indicated the resident had physician orders to continue the Lisinopril 20 mg once a day and the Omeprazole 20 mg once daily.</p> <p>During the observation of the medication administration pass on 08-05-15 at 8:00 a.m., Licensed Nurse #1 failed to administer the daily medications of Lisinopril and Omeprazole.</p> <p>A review of the facility policy on 08/07/15 at 11:45 a.m., titled "Specific</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0333 SS=D Bldg. 00	<p>Medication Administration Procedures," and dated as "effective date "02/1/0 [sic], indicated the following:</p> <p>"Policy: To administer medication in a safe and effective manner."</p> <p>"Procedures - ... E. Check MAR [Medication Administration Record] for order.... G. Read medication label three (3) times: 1.) prior to removing the medication package/container from the cart/drawer, 2.) prior to removing the medication from the package/container: 3.) as the package/container is returned to the cart/drawer. Compare label to MAR."</p> <p>3.1-25(b)(9)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, facility failed to ensure medications were administered without a significant medication error for 1 of 25 records being reviewed for medication administration. (Resident #62)</p> <p>Finding includes:</p>	F 0333	<p><b>F 333 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #62 has been discharged. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to</p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074		
(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 8/10/15 at 3:20 p.m., the record review for Resident #62 was completed. Diagnoses included, but were not limited to, trigeminal neuralgia (facial nerve pain), pneumonia and sepsis.</p> <p>The physicians orders indicated: 3/2/15--Carbamazepine (an anti seizure medication) 100 milligrams po (orally) once daily 8 p.m. 3/2/15--Carbamazepine 200 milligrams (mg) po tablet twice daily 8 a.m. and 12 p.m. through 3/6/15. 3/6/15--Carbamazepine 200 mg tablet 1 tab po 8 a.m. and 12 p.m. 3/6/15--Carbamazepine 200 mg oral; special instructions give 2 tabs=400 mg and at 8 a.m. and 12 p.m. 3/11/15--Carbamazepine 200 milligrams po give 1 tab 2 x day 8 am, 12 p.m.</p> <p>Nurses notes indicated:  3/8/15 at 6:22 p.m., RN #22 indicated the resident's temperature was re-assessed at that time and the resident was sitting in bed and appeared lethargic and slightly confused. The resident was slow to respond to questions. The resident was noted to have involuntary twitching in face, hands and legs. The resident was not making eye contact with the writer at that time. The resident was not able to state his name and city of where resident</p>		<p>be affected by this alleged deficient practice. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Nursing Team on the following campus guidelines: 1). Medication Orders 2). Medication Administration - General Guidelines <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits / observations will be conducted by the DHS or designee daily (5 x per week) during Clinical Review Meeting: Review of all previous days prescribed orders. Any dose or order that appears inappropriate considering the resident's age, condition, allergies or diagnosis will be verified with the MD. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>was residing, but not able to answer any other questions. The resident's temperature was 100 degrees at that time. The resident's pupils were reactive, but sluggish and the left eyelid seemed to be slightly edematous. The right arm had a drop noted when assessed and the resident had a very weak grip to his right arm. The resident's vital signs were assessed and the Nurse Practitioner(NP) was notified,and was awaiting a return call at that time. At 6:35 p.m., the writer spoke to the NP and new orders were obtained. The writer contacted the spouse and notified her of the new orders. At 7:30 p.m., the Rocephin (antibiotic) was administered in the right deltoid (muscle) and the resident tolerated the shot well. The resident appeared more alert and lucid when talking with staff. The resident's intravenous medication was infusing at that time and bolus was tolerated well. The resident's blood pressure was slightly improved and would continue to monitor.</p> <p>3/9/15 at 1:14 p.m., a Speech Therapist reported slurring of the speech, and nonresponsiveness. The nurse assessed the resident and he was unable to put words together and was unable to keep his eyes open. The NP was at the facility assessed the resident. A new order was received to send to the resident to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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=F Bldg. 00	<p>emergency room for evaluation and treatment.</p> <p>3/10/15 at 11:40 p.m., indicated the resident's family refused Carbamazepine and Rocephin in the evening related to concerns that the meds might have caused side effects of confusion, lethargy, and generalized edema in the left hand.</p> <p>On 8/10/15 at 3:45 p.m., RN #10 indicated the resident's Carbamazepine level was within normal range at the emergency room. RN #10 indicated a staff member did not transcribe the order for the Carbamazepine correctly and inadvertently changed the order to two 200 milligram tablets twice daily, causing the resident to have a medication error.</p> <p>3.1-48(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to maintain a sanitary environment in the kitchen. This had the potential to affect 51 of 51 residents who received food</p>	F 0371	<b>F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The following areas were completed in the kitchen:	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>from the kitchen.</p> <p>Findings include:</p> <p>The kitchen tour was done on 8/3/15 at 7:10 a.m., with the Dining Services Manager (DSM) in attendance.</p> <p>On 8/3/15 at 7:13 a.m., there was a cart with cookie sheets stacked on them and two of the cookie sheets were uncovered. The DSM indicated at that time the food that was stacked on a cart that was uncovered such as 12 pieces of pie, and 12 pieces of cake were there from yesterday and were to be thrown away.</p> <p>The DSM indicated there was no sanitation bucket prepared as of yet and that they usually prepared it first thing in the morning.</p> <p>RN #8 was in the kitchen without a hair net. The DSM indicated on 8/3/15 at 7:20 a.m., they liked the staff to use a hair net and pointed to a rack on the wall with several hairnets enclosed in cardboard wrappers. RN #8 was observed with a beard and mustache as well that were uncovered. He was observed standing by the area where the cook was serving food and had no hair net or beard net on.</p> <p>On 8/3/15 at 7:22 a.m., the walk in</p>		<p>1). Observed food is kept covered during transport/when not in use 2). Sanitation bucket is prepared at the start of the shift 3). Hair nets are in place (for hair, beards, and mustaches) 4). The walk in refrigerator floor is free of debris 5). No food is stored on the floor 5). The meat slicer is clean and covered 6). A cleaning schedule is in place</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: 1). Food storage 2). Sanitation (bucket) 3). Hair Restraints (to include hair, beards, mustaches) 4). Sanitation of walk in refrigerator 5). Cleaning / storage of equipment 6). Cleaning schedule <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1).</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>refrigerator was observed to have debris scattered on the floor. The dry storage area was observed to have yellow dried debris on the floor. There were food particles scattered about the floor as well. At that time, the DSM indicated it usually got swept daily and mopped when the deliveries came in. He indicated the last delivery they had received was Friday and he had not had time to stack the 2 boxes of potatoes that were on the floor on the shelf. He indicated the potatoes should not be on the floor.</p> <p>On 8/3/15 at 7:30 a.m., the meat slicer and the mixer were observed uncovered. The slicer had debris on the bottom surface underneath the blade that was offwhite and pink colored. The DSM indicated it should be cleaned after every use and there were no covers for the mixer or the slicer.</p> <p>On 8/13/15 at 9:54 a.m., the DSM provided a document titled, "Cleaning List" All of the boxes and dates were blank. The DSM indicated this was a form he had created, but he had not gotten around to using, but it was the only cleaning list he had.</p> <p>3.1-21(i)(3)</p>		<p>Observed food is kept covered during transport / when not in use 2). Sanitation bucket is prepared at the start of the shift 3). Hair nets are in place (for hair, beards, and mustaches) 4). The walk in refrigerator floor is free of debris 5). No food is stored on the floor 6). Equipment is clean and covered 7). A cleaning schedule is in place The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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: 30 Sample: 7</p> <p>These state findings were cited in accordance with 410 IAC 16.2-5.</p>			R 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on August 12, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>		
R 0273  Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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>standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to maintain a sanitary environment in the kitchen. This had the potential to affect 30 of 30 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>The kitchen tour was done on 8/3/15 at 7:10 a.m., with the Dining Services Manager (DSM) in attendance.</p> <p>On 8/3/15 at 7:13 a.m., there was a cart with cookie sheets stacked on them and two of the cookie sheets were uncovered. The DSM indicated at that time the food that was stacked on a cart that was uncovered such as 12 pieces of pie, and 12 pieces of cake were there from yesterday and were to be thrown away.</p> <p>The DSM indicated there was no sanitation bucket prepared as of yet and that they usually prepared it first thing in the morning.</p> <p>RN #8 was in the kitchen without a hair net. The DSM indicated on 8/3/15 at 7:20 a.m., they liked the staff to use a hair net and pointed to a rack on the wall with several hairnets enclosed in cardboard wrappers. RN #8 was observed with a</p>	R 0273	<p><b>F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The following areas were completed in the kitchen:</p> <p>1). Observed food is kept covered during transport/when not in use 2). Sanitation bucket is prepared at the start of the shift 3). Hair nets are in place (for hair, beards, and mustaches) 4). The walk in refrigerator floor is free of debris 5). No food is stored on the floor 5). The meat slicer is clean and covered 6). A cleaning schedule is in place</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: 1). Food storage 2). Sanitation (bucket) 3). Hair Restraints (to include hair, beards, mustaches) 4). Sanitation of walk in refrigerator 5). Cleaning / storage of equipment 6). Cleaning schedule <b>How the corrective measures will be monitored to</b></p>	09/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>beard and mustache as well that were uncovered. He was observed standing by the area where the cook was serving food and had no hair net or beard net on.</p> <p>On 8/3/15 at 7:22 a.m., the walk in refrigerator was observed to have debris scattered on the floor. The dry storage area was observed to have yellow dried debris on the floor. There were food particles scattered about the floor as well. At that time, the DSM indicated it usually got swept daily and mopped when the deliveries came in. He indicated the last delivery they had received was Friday and he had not had time to stack the 2 boxes of potatoes that were on the floor on the shelf. He indicated the potatoes should not be on the floor.</p> <p>On 8/3/15 at 7:30 a.m., the meat slicer and the mixer were observed uncovered. The slicer had debris on the bottom surface underneath the blade that was offwhite and pink colored. The DSM indicated it should be cleaned after every use and there were no covers for the mixer or the slicer.</p> <p>On 8/13/15 at 9:54 a.m., the DSM provided a document titled, "Cleaning List" All of the boxes and dates were blank. The DSM indicated this was a form he had created, but he had not</p>		<p><b>ensure the alleged deficient practice does not recur:</b> The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Observed food is kept covered during transport / when not in use 2). Sanitation bucket is prepared at the start of the shift 3). Hair nets are in place (for hair, beards, and mustaches) 4). The walk in refrigerator floor is free of debris 5). No food is stored on the floor 6). Equipment is clean and covered 7). A cleaning schedule is in place The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0351 Bldg. 00	<p>gotten around to using, but it was the only cleaning list he had.</p> <p>410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on observation, interview and record review, the facility failed to ensure medical records were safeguarded from loss, destruction, or unauthorized use for 2 of 2 units and 25 of 25 clinical records.</p> <p>Findings include:</p> <p>During an interview on 08/07/15 at 9:45 a.m., Licensed Nurse #7 indicated the Residents Clinical Records were kept in a bookcase in the common area where residents worked on jigsaw puzzles.</p> <p>The nurse indicated the records were kept in the lower section of the cabinetry.</p> <p>Upon observation, the records were not safe guarded and the doors were unlocked. The two doors to one section</p>	R 0351	<p><b>R 351</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Medical records are safeguarded from loss, destruction or unauthorized use.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice</p> <p><b>Measures put in place and</b></p>	09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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 0414	<p>of the bookcase contained 15 resident clinical records for the 400 hall, and 10 clinical records for the residents who resided on the 300 hall.</p> <p>A review of the facility policy on 08/07/15 at 11:45 a.m., titled "Health Insurane [sic] Portability Accountability Act (HIPPA)," and dated December 2011, indicated the following:</p> <p>"Purpose - To establish clear expectations regarding all aspects of confidentiality."</p> <p>"Policy - ... Trilogy places significant trust in all who have access to sensitive information and with that trust comes a high level of responsibility. Any breach of these confidentiality rules and expectations listed below is considered extremely serious and may result in the immediate termination of the violator."</p> <p>"Storage and Security: Hardcopies of the medical record located in resident care areas shall be house in physically secure areas and all other medical records are house in physically secure areas within the Medical Record Department."</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency</p>		<p><b>systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the campus staff on the following guideline: HIPAA</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations of medical records will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Resident's medical records are in a secured area to safeguard from loss, destruction, or unauthorized use.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/12/2015	
NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD				STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074			
(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			
Bldg. 00	<p>(k) 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>Based on observation and record review, the facility failed to ensure licensed nursing staff performed handwashing or sanitization after direct resident contact for 4 of 4 resident observations during 1 of 1 medication administration pass. (Residents #29, #30, #23 and #18)</p> <p>Findings include:</p> <p>During the Medication Pass Observation on 08/07/15 at 8:30 a.m., Licensed Nurse #7 prepared the medication for Resident #29. The nurse placed each medication into a plastic cup, and then proceeded to the resident's apartment. The nurse knocked on the door and entered the apartment. The nurse instructed the resident to take the medications. After the resident completed taking his medications, the nurse left the apartment and then returned to the medication cart and began to prepare the medications for Resident #30. The licensed nurse placed each medication into a plastic cup, proceeded to the resident apartment, knocked on the door, entered the apartment and explained to the resident the medications in the cup were the morning medications. After the resident took the medications the licensed nurse</p>	R 0414	<p><b>R 414</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> All residents have the potential to be affected by this alleged deficient practice. Nurse was educated regarding handwashing or sanitization after direct resident contact.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: 1). Specific Medication Administration Procedures 2). Handwashing / Hand Hygiene</p>	09/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>returned to the medication cart. She then started to prepare medication for Resident #23. The nurse placed each medication into the plastic cup, and proceeded to the resident's apartment. The licensed nurse knocked on the door to the apartment, entered the apartment only to find the resident was not there. The licensed nurse proceed to the dining room. The resident was eating breakfast and the nurse explained to the resident he needed to take his morning medications. Upon completion of the resident taking the medications, the licensed nurse returned to the medication cart and prepared medications for Resident #18. The nurse placed each medication into a plastic cup and proceeded to the resident apartment. The nurse instructed the resident the need to take his morning medications. The licensed nurse assisted the resident to a sitting position on the side of the bed and the resident proceeded to take the medications.</p> <p>Throughout the observation period the licensed nurse failed to wash or sanitize her hands.</p> <p>A review of the facility policy on 08/07/15 at 11:45 a.m., titled "Specific Medication Administration Procedures," dated "2/1/0 [sic]," indicated the following:</p>		<p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Handwashing or sanitization complete after direct resident contact.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155808	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF WESTFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074
---	--

(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>"Policy: To administer medication in a safe and effective manner."</p> <p>"Procedure: ... J. Cleanse hands using antimicrobial soap and water or facility approved hand sanitizer before beginning a med. [medication] pass, before handling medication, and before contact with resident."</p> <p>A review of the facility policy on 08/07/15 at 11:45 a.m., titled "Guidelines for Handwashing/Hand Hygiene," and dated 10/2004, indicated the following:</p> <p>"Purpose - Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF [Long Term Care Facilities]."</p> <p>"Procedure: 1. All health care workers shall wash their hands frequently and appropriately. ... 3. Health Care Workers shall wash hands at times such as: ... c. Before/after having direct physical contact with residents."</p>			