

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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.</p> <p>Survey dates: February 8, 9, 10, 11, 12, and 15, 2016.</p> <p>Facility number: 012993 Provider number: 155806 AIM number: 201208210</p> <p>Census bed type: SNF: 24 SNF/NF: 20 Residential: 28 Total: 72</p> <p>Census payor type: Medicare: 14 Medicaid: 19 Other: 39 Total: 72</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on February 16, 2016.</p>	F 0000	<p>This plan of correction has been prepared and executed because the law requires it. This plan does not constitute an admission that any of the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Wellbrooke of Wabash reserves all rights to raise all possible contestations and defenses in any civil or criminal claim, action, or proceeding. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 15, 2016. Please accept this Plan of Correction as the provider's credible allegation of 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: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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>be taken.</p> <p>Based on interview and record review, the facility failed to report an allegation of verbal abuse made by a resident against another resident to the Indiana State Department of Health (ISDH) for 1 of 3 residents reviewed for abuse (Resident #58).</p> <p>Findings include:</p> <p>A review of the medical record for Resident #58 began on 02/12/2016 at 9:29 a.m., and indicated Resident #58's diagnoses included, but were not limited to, unspecified dementia, pseudobulbar affect, Chronic Obstructive Pulmonary Disease [COPD], major depressive disorder, and anxiety disorder. Her cognitive status was listed as not assessable as the Resident #58 only gave nonsensical answers.</p> <p>During an interview with the daughter of Resident #58, on 02/10/2016 at 11:21 a.m., she indicated that she felt her mother had been verbally abused on April 2, 2015. She indicated that another resident got into her mother's face resulting in her mother feeling threatened. The facility told the daughter that her mother was out of control and that the facility felt it was best for her to leave, As a result of the incident,</p>	F 0225	<p>F 225 – The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? Current residents residing in the facility have the potential to be affected by the alleged deficient practice.</p>	03/04/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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 #58 was transferred to an area in-patient psychiatric hospital.</p> <p>During an interview with the Director of Nursing (DON), on 02/12/2016 at 10:14 a.m., she read the nursing progress note, dated 4/2/2015. It indicated that this was the first time she read or heard about this incident. She then indicated that she assumed the other resident referred to in the note did not hear the verbal threats from Resident #58 and that this would not be considered a reportable event.</p> <p>During an interview with the Executive Director (ED), on 02/12/2016 at 10:22 a.m., she indicated that she did not report this incident because the verbal threats of harm from Resident #58 had not affected any other resident in any way. The ED indicated that PT (physical therapist) #12 and LPN #75 were both at work and involved in the incident that day. She indicated that PT #12 was a known trigger for Resident #58. She indicated that, as the situation escalated, PT #12 had to hide in another resident's room until the other staff members could calm Resident #58.</p> <p>During an interview with PT #12 on 02/12/2016 at 10:36 a.m., she indicated that on 4/2/2015 there had been an emergency with another resident on the</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The Executive Director and DHS will be provided inservicing by clinical support staff on March 1, 2016 on the guidelines for reporting allegations of abuse. An inservice education program will be conducted by the Director of Health Services and the Executive Director with direct care staff addressing circumstances that require reporting including appropriate timeframes.</p> <p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur? The Executive Director and/or designee will conduct a random audit of 5 residents, residents will be assessed and interviewed to ensure that any allegations are identified, properly investigated and reported weekly for 4 weeks then</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>200 hall. She indicated that she could not remember what room or the name of the other resident. PT #12 indicated that Resident #58 was irritated that day and that she was asked to stay with Resident #58 while staff attended to the emergency. PT #12 indicated that Resident #58 was trying to enter the room where the emergency was taking place. She indicated she was trying to intervene by walking Resident #58 to the nurses station on the 200 hallway because that was where Resident #58 liked to sit. Upon arrival to the nurses station, PT #12 indicated Resident #58 grabbed a stapler and began chasing her around the nurses' station, swinging her arm and trying to hit the therapist with it. PT #12 indicated there was no available staff to help her on the 200 hall because they were all attending to the emergency. She indicated after a few minutes of being chased by Resident #58, she was able to get to a phone and page for help. She indicated LPN #75 then arrived to assist her with Resident #58. PT #12 indicated, when LPN #75 arrived, PT #12 went into another resident room and closed the door.</p> <p>During an interview with LPN #75, on 2/12/2016 at 10:40 a.m., she indicated she was the staff member who responded to PT #12's call on 4/2/2015. LPN #75</p>		<p>monthly times 5 months to ensure reporting of allegations. Results of audits will be reported by the Executive Director and/or designee to the campus Quality Assurance Committee for 6 months or until 100% compliance is achieved and randomly thereafter for further recommendations.</p> <p>Date of completion: March 4, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 that Resident #58 was very upset that day. LPN #75 indicated that she was usually able to calm Resident #58 down when she was agitated. LPN#75 indicated Resident #58 had "amazing strength" when she was having an episode. She indicated that she was able to get the stapler and a tape dispenser out of the hands of Resident #58. LPN #75 indicated Resident #58 was pacing up and down the hallways, stating she was going to "kill the residents."</p> <p>A review of the nursing progress notes for Resident #58 began on 02/11/2016 at 11:07 a.m., and indicated an incident recorded on 4/2/2015 at 3:16 p.m. "Res [resident] agitated and pacing the halls with a stuffed animal. Took clipboard and swinging it at writer threatening to kill writer. States 'You fat and stupid, I'm gonna kill ya.' attempts made to redirect. Res [resident] was throwing writers papers off desk. Writer got another staff member and a therapy staff to come redirect with re-approach from different staff. Offered liquids and snack and ineffective. Res screaming 'yeah...yeah' however refused chips and drink. Threw a chair at therapist. Writer and CNA [certified nursing assistant] attempt to go to another res room. CNA and writer kept door closed to keep resident safe</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>that we were assisting. [Resident #58's name] threatened to kill the resident and states 'I'll get em' staff had to stand in front of the door with door closed with all writers weight against door as resident was wiggling handle and pushing against. States 'if I get a gun and find one I'll kill them all.' Looking for items off nursing desk to hit staff with writer quickly removed stapler and tape as res was trying to grab items. 1:1 care given at all times currently to keep all residents safe. PRN Ativan gel given to back of the neck. NP, [Daughter Name], updated. New order received: may send resident to [name of area hospital]. Several attempts made to call daughter, [Daughter Name] without success. Message left with [Daughter Name] to call facility ASAP. Other daughter, [Daughter Name] called as well to notify of mother condition/behavior/threats and updated of new order to send to ER."</p> <p>During a review of the Daily Census Report provided by the DON on 2/15/2016 at 9:58 a.m., it indicated there were 24 residents residing on the 200 hallway on 4/2/2016.</p> <p>During a review of the Behavior/Mood Symptom Tracking Tool provided by the SSD on 2/15/2016 at 10:07 a.m., it indicated the behaviors for Resident #58</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 4/2/1015 were hitting, yelling, throwing things and verbally threatening in the hallway and lounge with an unknown cause. Interventions documented included but were not limited to: "taken to the bathroom, removed from the area and changed position" with the outcomes being: "behavior got worse, resident became combative, resident became louder and resident became agitated."</p> <p>A review of the policy titled, "ABUSE AND NEGLECT PROCEDURAL GUIDELINES", provided by the DON on 2/11/2016 at 10:15 a.m., indicated the following:</p> <p>"...Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...</p> <p>...DEFINITIONS: ...a. ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known or alleged)... ...b. VERBAL ABUSE- may include oral, written or gestured language that includes disparaging and derogatory terms to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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/ patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability...</p> <p>...ii. Resident to resident verbal threats of harm...</p> <p>...d. IDENTIFICATION</p> <p>...vii. The Executive Director is responsible for:</p> <p>1. Notification to the State Department of Health (per state guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies as indicated...</p> <p>...f. INVESTIGATION</p> <p>i. The executive director is accountable for investigating and reporting...</p> <p>...g. REPORTING</p> <p>i. Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, or misappropriation to local or state agencies.</p> <p>ii. Immediately and not more than 24 hours complete an initial report to applicable state agencies....</p> <p>...iv. A written report of the investigation outcome, including resident response</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>and/ or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days.</p> <p>...v. ...if the event does not result in bodily injury, it must be reported no later than 24 hours..."</p> <p>3.1-13(g)(1) 3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow their abuse policy in regards to investigation and timely reporting to the state agency for a verbal threat of harm between resident to resident abuse for 1 of 3 residents reviewed for abuse (Resident #58). This deficient practice had the potential to affect 24 residents residing on the 200 Hall.</p>	F 0226	<p>F-226 - It is the policy of Wellbrooke of Wabash to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.</p> <p>What corrective action will</p>	03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>Findings include:</p> <p>A review of the medical record for Resident #58 began on 02/12/2016 at 9:29 a.m. and indicated Resident #58's diagnosis included but were not limited to Unspecified Dementia, Pseudobulbar affect, Chronic Obstructive Pulmonary Disease [COPD], Major Depressive Disorder, Anxiety disorder. Her cognitive status was listed as not assessable as Resident #58 only gave nonsensical answers during the assessment.</p> <p>During an interview with a family member of Resident #58 on 02/10/2016 at 11:21 a.m., she indicated that she felt her mother had been verbally abused on April 2, 2015. She indicated that another resident got into her mother's face resulting in her mother feeling threatened. The facility told the daughter that her mother was out of control and that the facility felt it was best for her to leave the facility. As a result of the incident, Resident #58 was transferred to an area in-patient psychiatric hospital.</p> <p>During an interview with the Director of Nursing [DON] on 02/12/2016 at 10:14 a.m., she read the nursing progress note, dated 4/2/2015, and indicated that this was the first time she read or heard about</p>		<p>be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? Current residents residing in the facility have the potential to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? The Executive Director and DHS were provided inservice by clinical support staff on March 1, 2016 on policy and procedures for reporting allegations of abuse. An inservice education program will be conducted by the Director of Health Services and the Executive Director with direct care staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>this incident. She then indicated that she assumed the other resident referred to in the note did not hear the verbal threats from Resident #58 and that this would not be considered a reportable event.</p> <p>During an interview with the Executive Director [ED] on 02/12/2016 at 10:22 a.m., she indicated that she did not report this incident because the verbal threats of harm from Resident #58 had not affected any other resident in any way. The ED indicated that PT (physical therapist) #12 and LPN #75 were both at work and involved in the incident that day. She indicated that PT #12 was a known trigger for Resident #58. She indicated that as the situation escalated PT #12 had to hide in another resident's room until the other staff members could calm Resident #58.</p> <p>During an interview with PT #12 on 02/12/2016 at 10:36 a.m., she indicated, on 4/2/2015, there had been an emergency with another resident on the 200 hall. She indicated that she could not remember what room or the name of the other resident. PT #12 indicated that Resident #58 was irritated that day and she was asked to stay with Resident #58 while staff attended to the emergency. PT #12 indicated that Resident #58 was trying to enter the room where the</p>		<p>addressing circumstances that require reporting.</p> <p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur? The Executive Director and/or designee will conduct a random audit of 5 residents, residents will be assessed and interviewed to ensure that any allegations are identified, properly investigated and reported, weekly for 4 weeks then monthly times 5 months to ensure reporting of allegations. Results of audits will be reported by the Executive Director and/or designees to the campus Quality Assurance Committee for 6 months or until 100% compliance is achieved and randomly thereafter for further recommendations.</p> <p>Date of completion: March 4, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>emergency was taking place. The therapist indicated she was trying to intervene by walking Resident #58 to the nurses station on the 200 hallway because that was where Resident #58 liked to sit. Upon arrival to the nurses station PT #12 indicated Resident #58 grabbed a stapler and began chasing her around the nurses' station swinging her arm trying to hit her with the stapler. PT #12 indicated there was no available staff to help her on the 200 hall because they were all attending to the emergency. She indicated after a few minutes of being chased by Resident #58 she was able to get to a phone and page for help. She indicated LPN #75 then arrived to assist her with Resident #58. PT #12 indicated, when LPN #75 arrived, PT #12 went into another resident room and closed the door.</p> <p>During an interview with LPN #75 on 2/12/2016 at 10:40 a.m., she indicated she was the staff member who responded to PT #12's call on 4/2/2015. LPN #75 indicated that Resident #58 was very upset that day. LPN #75 indicated that she was usually able to calm Resident #58 down when she was agitated. LPN#75 indicated the Resident #58 had "amazing strength" when she was having an episode. She indicated that she was able to get the stapler and a tape dispenser out of the hands of Resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>#58. LPN #75 indicated Resident #58 was pacing up and down the hallways stating she was going to kill the residents.</p> <p>A review of the nursing progress notes for Resident #58 began on 02/11/2016 at 11:07 a.m., indicated an entry of the incident on 4/2/2015 at 3:16 p.m. "Res [resident] agitated and pacing the halls with a stuffed animal. Took clipboard and swinging it at writer threatening to kill writer. States 'you fat and stupid, I'm gonna kill ya.' attempts made to redirect. Res was throwing writers papers off desk. Writer got another staff member and a therapy staff to come redirect with re-approach from different staff. Offered liquids and snack and ineffective. Res screaming 'yeah...yeah' however refused chips and drink. Threw a chair at therapist. Writer and CNA [certified nursing assistant] attempt to go to another res room. CNA and writer kept door closed to keep resident safe that we were assisting. [Resident #58's name] threatened to kill the resident and states 'I'll get em' staff had to stand in front of the door with door closed with all writers weight against door as resident was wiggling handle and pushing against. States 'if I get a gun and find one I'll kill them all.' Looking for items off nursing desk to hit staff with writer quickly removed stapler and tape as res was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>trying to grab items. 1:1 care given at all times currently to keep all residents safe. PRN Ativan gel given to back of the neck. NP, [Daughter Name], updated. New order received: may send resident to [Name of in-patient psychiatric care center]. Several attempts made to call daughter, [Daughter Name] without success. Message left with [Daughter Name] to call facility ASAP. Other daughter, [Daughter Name] called as well to notify of mother condition/behavior/threats and updated of new order to send to ER."</p> <p>During a review of the Daily Census Report provided by the DON on 2/15/2016 at 9:58 a.m., it indicated there were 24 residents residing on the 200 hallways on 4/2/2016.</p> <p>During a review of the Behavior/Mood Symptom Tracking Tool, provided by the SSD on 2/15/2016 at 10:07 a.m., it indicated the behaviors for Resident #58 on 4/2/1015 were "hitting, yelling, throwing things and verbally threatening in the hallway and lounge with an unknown cause." Interventions documented included but were not limited to: "taken to the bathroom, removed from the area and changed position" with the outcomes being "behavior got worse, resident became</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>combative, resident became louder and resident became agitated."</p> <p>A review of the policy titled "ABUSE AND NEGLECT PROCEDURAL GUIDELINES" provided by the DON on 2/11/2016 at 10:15 a.m., indicated the following:</p> <p>"Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.</p> <p>...DEFINITIONS:</p> <p>a. ABUSE means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known or alleged).</p> <p>b. VERBAL ABUSE- may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/ patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability...</p> <p>...ii. Resident to resident verbal threats of harm.</p> <p>...d. IDENTIFICATION</p> <p>vii. The Executive Director is responsible</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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:</p> <p>1. Notification to the State Department of Health (per state guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies as indicated...</p> <p>...f. INVESTIGATION</p> <p>i. The executive director is accountable for investigating and reporting.</p> <p>...g. REPORTING</p> <p>i. Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect, or misappropriation to local or state agencies</p> <p>ii. Immediately and not more than 24 hours complete an initial report to applicable state agencies....</p> <p>...iv. A written report of the investigation outcome, including resident response and/ or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days</p> <p>v. "...if the event does not result in bodily injury, it must be reported no later than 24 hours...."</p> <p>3.1-28(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed for 1 of 5 residents whose clinical records were reviewed for unnecessary medications. (Resident #37)</p> <p>Findings include:</p> <p>Review of Resident #37's clinical record began on 02/12/2016 at 11:05 a.m. Diagnoses included, but were not limited to, diabetes and hypertension.</p> <p>Resident #37 had a current physician's order, dated 09/25/2015, for Coreg (hypertension medication) 3.125 mg (milligrams) one tablet, one time per day. The special instructions included with the order indicated, "call if BP [blood pressure] is greater than 170/100 or less than 100/60".</p>	F 0282	<p>F282 – It is the practice of Wellbrooke of Wabash to provide or arrange services provided by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice? Resident #37's blood pressures for last 3 months were sent to residents Dr for review including current medication list. No negative outcomes noted.</p> <p>How other residents having the potential to be affected</p>	03/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>Review of Resident #37's medication administration history for December, 2015 indicated a blood pressure reading of 93/62 was obtained on December 18, 2015. It also indicated the Coreg was not administered "Due to condition".</p> <p>Review of Resident #37's medication administration history for January, 2016 indicated on January 19, 2016 Coreg was not administered because it was "on hold". No blood pressure reading was indicated. A blood pressure reading of 94/63 was obtained on January 21, 2016 and Coreg was not administered "Due to condition".</p> <p>Review of Resident #37's care plan for diabetes, dated 07/08/2015, included the following: "Administer medications as ordered...Notify doctor and family prn..."</p> <p>During an interview on 02/15/2016 at 1:55 p.m., the D.O.N. indicated the physician should have been notified of any blood pressure readings less than 100/60. She also indicated there was no documentation of notification having been done.</p> <p>3.1-35(g)(2)</p>		<p>by the same deficient practice will be identified and what corrective actions will be taken? Current residents residing at the campus have the potential to be affected by the alleged practice. Current residents who have blood pressure parameters for medications have been reviewed to ensure physician notification has been followed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Licensed nursing staff will be re-educated to notify MD of blood pressure parameters higher or lower than set parameter. An audit of 5 residents weekly during CCM will be completed to ensure MD notification of blood pressures above or below set blood pressure parameters for 4 weeks, then five residents will be audited monthly times 5 months to ensure physician notification regarding blood</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a		pressure parameter for medications. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? DHS and or designee will forward the results of the audit and or observations to be reported, reviewed, and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: March 16, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from psychotropic medications (Resident #68) and antibiotics (Resident #6) without indication for 2 of 5 residents reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>1. On 2/08/16 at 11:21 a.m., Resident #68 was observed sleeping in her bed with a talk show playing on the TV.</p> <p>On 2/08/16 2:32 p.m., Resident #68 was observed sleeping in bed. Two of her daughters were at her bedside and indicated the resident had slept through much of their visit.</p> <p>On 2/09/16 at 9:18 a.m., Resident #68 was observed in bed sleeping. The room was dark.</p> <p>On 2/10/16 at 8:45 a.m., Resident #68</p>	F 0329	<p>F-329 It is the practice of Wellbrooke of Wabash that each resident's drug regimen is free from unnecessary drugs.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice?</p> <p>Resident #6 has been discharged from the facility. Resident #68 medical record has been reviewed related to her psychotropic medications and the physician has made no changes to resident #68's drug regimen. Nursing staff did request therapy to screen resident #68 on 1/15/16 and OT picked up resident #68 on 1/18/16 for w/c positioning and decline in self care.</p>	03/16/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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 observed in bed sleeping. The room was dark.</p> <p>On 2/10/16 at 2:22 p.m., Resident #68 was observed in bed sleeping. The room was dark.</p> <p>On 2/11/16 at 9:21 a.m., Resident #68 was observed in bed sleeping. The room was dark with a talk show playing on the TV.</p> <p>02/11/16 at 11:10 a.m., Resident #68 was observed in bed sleeping. A talk show was playing on the TV.</p> <p>On 2/11/16 at 12:26 p.m., Resident #68 was observed in the dining room, slowly eating spaghetti with a fork. The spaghetti was falling from the fork onto her lap and her eyes were closed.</p> <p>On 2/12/16 at 8:22 a.m., Resident #68 was observed in the dining room, eating toast with her eyes closed. At 8:33 a.m., the resident was observed in bed with her eyes closed.</p> <p>On 2/15/16 at 8:23 a.m., Resident #68 was observed in the dining room, being assisted with breakfast by a staff member. The resident's eyes were closed and her head was down.</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? Any resident residing at the campus that receives a psychotropic medication has the potential to be affected by the alleged practice. The consultant pharmacist had reviewed all psychoactive medications as of 2-12-16 and continues to review these medications monthly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Licensed nursing staff inserviced regarding psychotropic medications and unnecessary medications. Newly admitted residents or readmissions will be reviewed during CCM(clinical care meeting) for psychoactive medications. In addition, a monthly behavioral meeting will be held to address any changes</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>Review of Resident #68's clinical record began on 2/9/16 at 10:13 a.m.</p> <p>Diagnoses included, but were not limited to, dementia with behavioral disturbance, pseudobulbar affect, and chronic pain.</p> <p>Resident #68's medications, included, but were not limited to, Risperdal 0.125 mg (an anti-psychotic) twice daily for major depression (ordered to begin on 1/21/16), mirtazapine 7.5 mg (an anti-depressant) daily for appetite stimulation (ordered to begin on 12/12/15), Lexapro 10 mg (an anti-depressant) daily for depression (ordered to begin on 11/13/15), Depakote 250 mg (a mood stabilizer) twice daily for depression (ordered to begin on 1/11/16), and Namzaric ER (a dementia medication) 28-10 mg daily.</p> <p>A "Progress Note", dated 1/7/16, and signed by the psychiatric nurse practitioner, indicated Resident #68's behaviors were due to her advancing dementia and no medication changes were needed at that time.</p> <p>A "Progress Note", dated 1/11/16, and signed by the resident's primary care physician, indicated Resident #68 complained of increased back pain and felt down some days. A new order was written for Depakote 250 mg twice daily.</p>		<p>in behavior or the introduction of a psychoactive medication. During this meeting, the medication, as well as the care plan and behavior monitoring will be reviewed. Residents who have had any new psychoactive medication will be audited at the addition of the medication and then monthly times 5 months to ensure the resident is not receiving any unnecessary medications.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? DHS and or designee will forward the results of the audit and or observations to be reported, reviewed, and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 new order was received on 1/28/16 to decrease the resident's Risperdal at the recommendation of the facility pharmacist, due to the Depakote being added to the resident's "extensive" list of psychotropic medications.</p> <p>A consult note from a psychologist, dated 2/10/16, indicated Resident #68's energy remained decreased, and may have been due to her general cognitive deterioration.</p> <p>An "Observation Report", dated 12/4/15, signed by the Director of Social Services (DSS), indicated Resident #68 exhibited behaviors such as crying and hallucinations, but was not exhibiting any behaviors at that time.</p> <p>An "Observation Report", dated 1/14/16, signed by the DSS, indicated Resident #68 had been started on Depakote for mood stabilization, but was not exhibiting any behaviors at that time.</p> <p>An "Observation Report", dated 1/21/16, signed by the DSS, indicated Resident #68 had an episode of tearfulness on 1/14/16, but had not exhibited any behaviors.</p> <p>An "Observation Report", dated 2/4/16, signed by the DSS, indicated Resident #68 was tearful on 2/3/16, and had been</p>		<p>Completion Date: March 16, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>yelling out and refused her medications.</p> <p>An "Event Report", dated as beginning on 1/11/16 indicated the following: On 1/12/16, the resident had been tired and somewhat lethargic that day. On 1/14/16, Resident #68 was in her wheelchair resting her head on her hand. The note further indicated she was not looking around or interacting with anyone around her. On 1/15/16, Resident #68 was sitting in the commons area with her head down and was not talking to anyone around her. On 1/21/16, Resident #68 was noted to be lethargic, listless, and leaning forward to one side in her wheelchair.</p> <p>An "Event Report", dated as beginning on 1/28/16, indicated the following: On 1/28/16, Resident #68 had been sleepy all day. On 2/3/16, at 11:06 p.m., Resident #68 had one episode of yelling out, due to having to use the bathroom. On 2/4/16 at 4:01 a.m., Resident #68 had one episode of yelling out, due to having to use the bathroom. On 2/7/16, Resident #68 was assessed as being "pretty 'out of it' today", and had to be assisted with breakfast. On 2/8/16, Resident #68 kept her head down, did not talk, and kept her eyes closed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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 2/12/16 at 8:37 a.m., LPN #11 indicated Resident #68 had become more lethargic after the Depakote had been started. She further indicated the Risperdal had been reduced shortly after starting the Depakote, which had helped, but she was "not so alert anymore" and had not had any behaviors for a long time.</p> <p>During an interview, on 2/12/16 at 8:42 a.m., CNA #17 indicated Resident #68 had not been herself for around a month and had preferred to stay in bed.</p> <p>During an interview, on 2/12/16 at 10:36 a.m., the Administrator and DSS indicated the physician had started the Depakote due to the resident being tearful at times.</p> <p>2. Review of Resident #6's clinical record began on 2/11/2016 at 1:51 p.m.. Diagnoses included, but were not limited to, history of urinary tract infection (UTI) and chronic kidney disease.</p> <p>Resident #6 had a current, 12/2/15, quarterly Minimum Data Set assessment (MDS), which indicated the resident was frequently incontinent of bladder and required extensive assistance for ADLs.</p> <p>Resident #6's current medications</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>included, but were not limited to, Macrobid (antibiotic) 100 mg (milligrams) once an evening for UTI prophylaxis indefinitely.</p> <p>A review of an urinalysis, dated 12/13/2015, provided by the DON on 2/12/2016 at 8:50 a.m., included abnormal findings in the following: urine protein, urine blood, leukocyte esterase, white blood cells (WBC), bacteria, epithelial cells, and yeast. The culture of the urine indicated it was resistant to Macrobid.</p> <p>A prescription order, provided by the DON on 2/11/2016 at 3:44 p.m., indicated the order for Macrobid 100 mg once an evening for UTI prophylaxis indefinitely was started on 08/11/2014 and ordered by the attending physician. It also indicated a discontinue date of 12/20/2015 ordered by a NP.</p> <p>A second prescription order, provided by the D.O.N. on 2/11/2016 at 3:44 p.m., indicated the order for Macrobid 100 mg once an evening for UTI prophylaxis indefinitely was started again on 12/20/2015 ordered by the NP who had discontinued the medication.</p> <p>During an interview, on 2/12/2016 at 9:35 a.m., with the ordering NP, she indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0371 SS=E Bldg. 00	<p>she did not remember writing the order for Macrobid for Resident #6. She also indicated that she would not normally prescribe an prophylactic antibiotic unless the family or the patient wanted it.</p> <p>3.1-48(a)(4)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure sanitary serving practices were followed during 2 of 2 meal service observations for 1 of 2 dining rooms observed (Wells Dining Room). This practice potentially affected 5 of 5 healthcare residents being served in this dining room.</p> <p>Findings include:</p> <p>1. During a dining observation in the Wells Dining Room on 2/8/16 beginning at 11:53 a.m., the following was observed:</p>	F 0371	<p>F 371 - It is the practice of Wellbrooke of Wabash to procure food from sources approved by Federal, State or local authorities; and to store, prepare and distribute food under sanitary conditions.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by the alleged deficient practice.</p>	03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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>Cook #4 entered the kitchenette and approached the sink. She washed her hands by rubbing her palms together for 5 seconds. She then applied a pair of gloves and proceeded to set up the steam table. Cook #4 removed the gloves and washed her hands by rubbing her palms together for 5 seconds. She applied another pair of gloves. Cook #4 then removed a paper towel from the dispenser and obtained a thermometer from under the counter area. She placed the thermometer into each compartment of food on the steam table, wiping the thermometer with the paper towel after testing each food item. Cook #4 replaced the thermometer under the counter area.</p> <p>Cook #4 then began preparing plates of food with the following concerns observed during the meal service:</p> <p>Cook #4 placed a plate in her right hand and reached into a metal pan with her gloved left hand and removed pieces of fried hot shrimp, placing them on the plate.</p> <p>Cook #4 picked up a small bowl containing cubed honeydew melon and removed the plastic wrap. Cook #4 then picked up the bowl with the fingers of her right hand inside the bowl and placed it on a tray on the counter.</p>		<p>Cook #4 and the CDM will be re-educated by the facility dietician regarding hand washing, appropriate glove use, thermometer sanitation, and food handling.</p> <p>How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? Current residents residing in the facility have the potential to be affected by the alleged deficient practice. On March 2, 2016 dining services personnel will be re-educated on the Proper Glove Use Fact Sheet, Guidelines for Hand washing and the Food Temperatures-Serving Line Policy. All staff will be re-educated on the Guidelines for Hand washing.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? Dining services</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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>Cook #4 picked up a hamburger bun with tongs and placed it on a plate. She placed the tongs onto the counter top. She then picked the bun up with her gloved hands and split the bun in half, laying each half onto the plate. She placed a hamburger patty onto the bun, and placed the top of the bun on the sandwich with the tongs.</p> <p>The CDM (Certified Dietary Manager) entered the kitchenette and washed his hands at the sink for three seconds, rubbing only his palms together. After drying his hands, the CDM began cutting a cake sitting in the corner of the kitchenette. The CDM then washed his hands for six seconds, rubbing only his palms together, and touching the sensor light on the faucet to turn the water back on. The Activity Director then handed the CDM a glass she had obtained from a resident's table, reaching over the steam table from the serving side of the counter. The CDM filled the glass with soda and handed it back over the steam table to the Activity Director. The CDM then began placing pieces of cake onto plates. He then rubbed his right eye with his right hand, and washed his hands for seven seconds by rubbing only his palms together, and touching the light sensor on the faucet with his hands to turn the water flow back on. After drying his hands, the</p>		<p>personnel were re-educated on the Proper Glove Use Fact Sheet, Guidelines for Hand washing and the Food Temperatures-Serving Line Policy. A hand washing return demonstration was successfully performed. The Registered Dietician will conduct reeducation on March 2, 2016 on safe food handling with dining services personnel and will re-educate quarterly. The re-education will include proper hand washing, glove use, handling of plates/utensils, and preparation and serving food.</p> <p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur? The Director of Food Services or designee is conducting quality improvement audits of hand washing, glove usage, and proper food handling. The Director of Food Services and/or designee will perform observations of personnel during meal preparation and serving 3 times weekly for 1</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>CDM placed the paper towel into the trash, and repositioned the trash can with his hands. He then washed his hands for seven seconds, rubbing his palms together, and touching the light sensor on the faucet to turn the water on. He then placed two serving trays into the dishwasher. The CDM then placed a piece of cake onto a plate, wrapped it with plastic wrap, and handed it to another staff member. He then washed his hands again for 5 seconds, rubbing his palms together, and touching the light sensor on the faucet. The CDM then removed five drinking glasses from a cabinet, holding one of the glasses against his chest with his right arm, and filled them with iced tea.</p> <p>2. During a second dining observation in the Wells Dining Room, beginning on 2/11/16 at 11:49 a.m., the following was observed:</p> <p>Cook #4 washed her hands for 3 seconds, rubbing only her palms together, and applied gloves. She removed a paper towel from the dispenser and obtained a thermometer from under the counter. She placed the thermometer into each compartment of food on the steam table, wiping the thermometer with the paper towel after testing each food item. She then removed the gloves and washed her</p>		<p>month then weekly for 1 month then monthly for 6 months. In addition, the Registered Dietician is conducting monthly food sanitation audits including hand washing, glove usage and proper food handling.</p> <p>Additional quality improvement audits will be completed based upon the level of compliance. The results of all audits will be reported to the Quality Assurance Committee monthly for additional recommendations as necessary.</p> <p>Date of completion: March 4, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>hands for five seconds, rubbing her palms together, and touching the light sensor on the faucet to turn the water back on to rinse her hands. Cook #4 then proceeded to prepare plates of food. After removing her gloves, she retrieved a plate of pureed food from the refrigerator and removed the plastic wrap covering the plate. She placed a small bowl of food on the plate. Cook #4 then washed her hands, rubbing her palms together for five seconds, touching the light sensor to turn the water back on. She reapplied gloves after drying her hands. She placed the plate in the microwave and heated the food. She obtained a thermometer from under the counter and placed it in each food item on the plate, wiping the thermometer with a paper towel, and replacing the thermometer under the counter. Cook #4 then resumed preparing plates of food.</p> <p>During an interview, on 2/12/16 at 10:04 a.m., the CDM indicated handwashing should last for at least 2 rounds of singing the "Happy Birthday" song. He further indicated the food thermometer should be sanitized between testing each food item and that wiping it with a paper towel was not acceptable practice.</p> <p>Review of a document, "Proper Glove Use Fact Sheet", received from the Dietary Manager on 2/12/16 at 10:52</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 0425 SS=D Bldg. 00	<p>a.m., indicated the following: "...When using gloves, you should: Wash your hands before putting them on and when changing to a fresh pair...."</p> <p>Review of a policy, "GUIDELINES FOR HANDWASHING", dated 10/2014, and received from the Dietary Manager on 2/12/16 at 10:52 a.m., indicated the following: "...7. Wet hands with running water. Apply liquid soap and work into a lather. 8. Wash well for 20 seconds (ABC or Happy Birthday song.), using a rotary motion and friction. 9. Rinse hands well under running water...."</p> <p>Review of a policy, "Food Temperatures-Serving Line", dated 7/2013, and received from the Dietary Manager on 2/12/16 at 10:52 a.m., indicated the following: "...B. Thermometers are clean, rinsed, and sanitized before, after, and in between use. An alcohol swab may be used to sanitize the thermometer between uses at one meal...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure an antidepressant medication was available for 1 of 5 residents reviewed for unnecessary medications (Resident #37).</p> <p>Findings include:</p> <p>Review of Resident #37's clinical record began on 02/12/2016 at 11:05 a.m. Diagnoses included, but were not limited to, depression and anxiety.</p> <p>Resident #37 had a current physician's order, dated 08/04/2015, for Zoloft (antidepressant) 100 mg (milligrams) once a morning.</p>	F 0425	<p>F-425 – It is the practice of Wellbrooke of Wabash to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.75.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice? Resident #37 did not have any negative effects related to this practice. The physician was notified related resident not</p>	03/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>Review of Resident #37's medication administration history for November, 2015 indicated that Zoloft 100 mg was not administered on November 16, 2015 and November 17, 2015. It also indicated "Drug/Item unavailable".</p> <p>Review of Resident #37's medication administration history for February, 2016 indicated Zoloft 100 mg was not administered on February 8, 2016 and February 9, 2016. It also indicated "Drug/Item unavailable".</p> <p>During an interview on 02/15/2016 at 1:55 p.m., the D.O.N. indicated Resident #37 should have received Zoloft every day. She also indicated there was no further documentation to indicate why the medication had not been given.</p> <p>3.1-25(a)</p>		<p>receiving the prescribed medication November 16 & 17, 2015 and February 8 & 9, 2016.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents who receive medications have the potential to be affected. All resident medications have been audited to ensure medication is available for each medication ordered for each resident residing in the facility.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Licensed Nursing staff and CRMA's will be re-educated regarding medication administration. Medication Pass Observation will be conducted with Licensed Nursing Staff and CRMA's weekly for 4 weeks and then at least monthly for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.		5 months to ensure proper medication administration, alternating between different staff and shifts so different staff will be monitored. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? DHS and or designee will forward the results of the audit and or observations to be reported, reviewed, and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: March 16, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure linens were stored and handled in a sanitary manner for 1 of 2 nursing units (200 Hall). This practice had the potential to affect 26 of 26 residents residing on the 200 Hall.</p> <p>Findings include:</p>	F 0441	F-441 – It is the practice of Wellbrooke of Wabash to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Corrective actions accomplished for those	03/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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 linen cart was observed on the east wing of the 200 hall at 8:14 a.m. The cover was lifted and folded over the top of the cart. The cart contained, but was not limited to, bed sheets, pillowcases, a pillow, and resident gowns. There were no staff members observed in the area. A towel and 2 washcloths were observed to be wedged in the handrail outside of room #205. On the south wing of the 200 hall, piles of linen containing a towel and two washcloths were observed wedged in the handrail outside of rooms #222, #221, and #216.</p> <p>During an interview, on 2/15/16 at 9:17 a.m., QMA #3 indicated linens were to be covered and were not to be placed in the hand rails.</p> <p>Review of a document, titled, "GUIDELINES FOR HANDLING LINEN", dated 8/2014 and received from the ADON on 2/15/16 at 9:33 a.m., indicated the following: "...PURPOSE: To provide clean, fresh linen to each resident. To prevent contamination of clean linen...PROCEDURE: Clean Linen 1. Clean linen should be transported...in a clean, covered cart...5. Linen should be made available for each room but should not be stored in the resident room...."</p>		<p>residents found to be affected by the alleged deficient practice? No residents were affected by the alleged deficient practice. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken? Current residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not re-occur? Nursing staff will be re-educated related to linen storage and handling. An audit will be conducted for weekly for 4 weeks, then monthly times 5 months to ensure linen carts are covered and linen is not any handrail in the corridor. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur? The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. Completion Date: March 16, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>3.1-19(g)(1)(2)(3)</p> <p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.</p> <p>Survey dates: February 8, 9, 10, 11, 12, and 15, 2016.</p> <p>Facility number: 012993 Provider number: 155806 AIM number: 201208210</p> <p>Residential Census: 28</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>This plan of correction has been prepared and executed because the law requires it. This plan does not constitute an admission that any of the citations are either legally or factually correct. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Wellbrooke of Wabash reserves all rights to raise all possible contestations and defenses in any civil or criminal claim, action, or proceeding. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on February 15, 2016. Please accept this Plan of Correction as the provider's credible allegation</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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 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 standards, including 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sanitary serving practices were followed during meal service for 1 of 2 dining rooms observed (Wells Dining Room). This practice potentially affected 22 of 22 residential residents eating in this dining room.</p> <p>Findings include:</p> <p>1. During a dining observation in the Wells Dining Room on 2/8/16 beginning at 11:53 a.m., the following was observed:</p> <p>Cook #4 entered the kitchenette and approached the sink. She washed her hands by rubbing her palms together for 5 seconds. She then applied a pair of gloves and proceeded to set up the steam table. Cook #4 removed the gloves and washed her hands by rubbing her palms together for 5 seconds. She applied another pair of gloves. Cook #4 then removed a paper towel from the</p>			R 0273	<p>of compliance.</p> <p>R273 - It is the practice of Wellbrooke of Wabash to maintain food preparation and serving areas in accordance with state and local sanitation and safe food handling standards.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by the alleged deficient practice. Cook #4 and the CDM have been re-educated by the facility dietician regarding hand washing, appropriate glove use, thermometer sanitation, and food handling.</p> <p>How other residents having the potential to be affected</p>		03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>dispenser and obtained a thermometer from under the counter area. She placed the thermometer into each compartment of food on the steam table, wiping the thermometer with the paper towel after testing each food item. Cook #4 replaced the thermometer under the counter area.</p> <p>Cook #4 then began preparing plates of food with the following concerns observed during the meal service:</p> <p>Cook #4 placed a plate in her right hand and reached into a metal pan with her gloved left hand and removed pieces of shrimp, placing them on the plate.</p> <p>Cook #4 picked up a small bowl containing cubed honeydew melon and removed the plastic wrap. Cook #4 then picked up the bowl with the fingers of her right hand inside the bowl and placed it on a tray on the counter.</p> <p>Cook #4 picked up a hamburger bun with tongs and placed it on a plate. She placed the tongs onto the counter top. She then picked the bun up with her gloved hands and split the bun in half, laying each half onto the plate. She placed a hamburger patty onto the bun, and placed the top of the bun on the sandwich with the tongs.</p> <p>The CDM (Certified Dietary Manager)</p>		<p>by the same alleged deficient practice will be identified and what corrective action will be taken? Current residents residing in the facility have the potential to be affected by the alleged deficient practice. On March 2, 2016 dining services personnel will be re-educated on the Proper Glove Use Fact Sheet, Guidelines for Hand washing and the Food Temperatures-Serving Line Policy. All staff will be re-educated on the Guidelines for Hand washing.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? Dining services personnel were re-educated on the Proper Glove Use Fact Sheet, Guidelines for Hand washing and the Food Temperatures-Serving Line Policy. A hand washing return demonstration was successfully performed. The Registered Dietician will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>entered the kitchenette and washed his hands at the sink for three seconds, rubbing his palms together. After drying his hands, the CDM began cutting a cake sitting in the corner of the kitchenette. The CDM then washed his hands for six seconds, rubbing only his palms together, and touching the sensor light on the faucet to turn the water back on. The Activity Director then handed the CDM a glass she had obtained from a resident's table, reaching over the steam table from the serving side of the counter. The CDM filled the glass with soda and handed it back over the steam table to the Activity Director. The CDM then began placing pieces of cake onto plates. He then rubbed his right eye with his right hand, and washed his hands for seven seconds by rubbing only his palms together, and touching the light sensor on the faucet with his hands to turn the water flow back on. After drying his hands, the CDM placed the paper towel into the trash, and repositioned the trash can with his hands. He then washed his hands for seven seconds, rubbing his palms together, and touching the light sensor on the faucet to turn the water on. He then placed two serving trays into the dishwasher. The CDM then placed a piece of cake onto a plate, wrapped it with plastic wrap, and handed it to another staff member. He then washed</p>		<p>conduct reeducation on March 2, 2016 on safe food handling with dining services personnel and will re-educate quarterly. The re-education will include proper hand washing, glove use, handling of plates/utensils, and preparation and serving food.</p> <p>How the corrective action will be monitored to ensure the alleged deficient practice will not recur? The Director of Food Services or designee is conducting quality improvement audits of hand washing, glove usage, and proper food handling. The Director of Food Services and/or designee will perform observations of personnel during meal preparation and serving 3 times weekly for 1 month then weekly for 1 month then monthly for 6 months. In addition, the Registered Dietician is conducting monthly food sanitation audits including hand washing, glove usage and proper food handling.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>his hands again for 5 seconds, rubbing his palms together, and touching the light sensor on the faucet. The CDM then removed five drinking glasses from a cabinet, holding one of the glasses against his chest with his right arm, and filled them with iced tea.</p> <p>2. During a second dining observation in the Wells Dining Room, beginning on 2/11/16 at 11:49 a.m., the following was observed:</p> <p>Cook #4 washed her hands for 3 seconds, rubbing only her palms together, and applied gloves. She removed a paper towel from the dispenser and obtained a thermometer from under the counter. She placed the thermometer into each compartment of food on the steam table, wiping the thermometer with the paper towel after testing each food item. She then removed the gloves and washed her hands for five seconds, rubbing her palms together, and touching the light sensor on the faucet to turn the water back on to rinse her hands. Cook #4 then proceeded to prepare plates of food. After removing her gloves, she retrieved a plate of pureed food from the refrigerator and removed the plastic wrap covering the plate. She placed a small bowl of food on the plate. Cook #4 then washed her hands, rubbing her palms together for five seconds,</p>		<p>Additional quality improvement audits will be completed based upon the level of compliance. The results of all audits will be reported to the Quality Assurance Committee monthly x 6 months or until 100% compliance is achieved.</p> <p>Date of completion: March 4, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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>touching the light sensor to turn the water back on, and reapplied gloves after drying her hands. She placed the plate in the microwave and heated the food. She obtained a thermometer from under the counter and placed it in each food item on the plate, wiping the thermometer with a paper towel, and replacing it under the counter. Cook #4 then resumed preparing plates of food.</p> <p>During an interview, on 2/12/16 at 10:04 a.m., the CDM indicated handwashing should last for at least 2 rounds of singing the "Happy Birthday" song. He further indicated the food thermometer should be sanitized between each food item and that wiping it with a paper towel was not acceptable practice.</p> <p>Review of a document, "Proper Glove Use Fact Sheet", received from the Dietary Manager on 2/12/16 at 10:52 a.m., indicated the following: "...When using gloves, you should: Wash your hands before putting them on and when changing to a fresh pair...."</p> <p>Review of a policy, "GUIDELINES FOR HANDWASHING", dated 10/2014, and received from the Dietary Manager on 2/12/16 at 10:52 a.m., indicated the following: "...7. Wet hands with running water. Apply liquid soap and work into a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
--	--

(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 0410 Bldg. 00	<p>lather. 8. Wash well for 20 seconds (ABC or Happy Birthday song.), using a rotary motion and friction. 9. Rinse hands well under running water...."</p> <p>Review of a policy, "Food Temperatures-Serving Line", dated 7/2013, and received from the Dietary Manager on 2/12/16 at 10:52 a.m., indicated the following: "...B. Thermometers are clean, rinsed, and sanitized before, after, and in between use. An alcohol swab may be used to sanitize the thermometer between uses at one meal...."</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(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>repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure residents received a tuberculin skin test prior to, or upon, admission for 2 of 7 residents reviewed (Residents #R2 and #R6).</p> <p>Findings include:</p> <p>Record review for Resident #R2 began on 02/12/2016 at 2:32 p.m.. Diagnoses included, but were not limited to, diabetes and acute respiratory failure.</p> <p>The admission date for Resident #R2 was 02/06/2016.</p> <p>Review of a document titled "Preventive Health Care", dated 2/15/2016, provided by the D.O.N. on 02/15/2016 at 8:54 a.m., indicated Resident #R2 received a TB (tuberculin skin test) on 02/08/2016, two days after admission.</p> <p>Record review for Resident #R6 began on 02/11/2016 at 10:42 a.m.. Diagnoses included, but was not limited to, diabetes and hyperlipidemia.</p>	R 0410	<p>R410 – It is the practice of Wellbrooke of Wabash to conduct a tuberculin skin test within 3 months prior to admission or upon admission and read at 48 or 72 hours. If the first step is negative, a second test should be performed within 1 to 3 weeks after the first test.</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice? Resident #2 and #6 have current tuberculin skin testing completed and documented in the electronic health record. No negative outcomes occurred.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will</p>	03/16/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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 admission date for Resident #R6 was 09/03/2015.</p> <p>Review of a document titled "Immunization Record", undated, provided by the D.O.N on 02/15/2016 at 8:54 a.m., indicated Resident #R6 received a Tuberculosis testing on 09/12/2015, nine days after admission.</p> <p>During an interview with the D.O.N., on 02/12/2016 at 2:45 p.m., she indicated that tuberculin skin testing should be done prior to admission into an assisted living facility.</p> <p>Review of a document titled "Assisted Living Guidelines Chest Xray and Mantoux Testing", dated 12/2010, provided by the D.O.N on 02/15/16 at 8:45 a.m., included: "...Procedure:... b. Indiana - within 3 months of admission or upon admission...."</p>		<p>be taken? Current residents' tuberculin tests have been reviewed and are current.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Nursing staff will be re-educated in regards to ensuring residents are given a tuberculin skin test upon admission and read at 48 hours to 72 hours if TB hasn't been administered prior to admission. Residents will be monitored weekly to ensure TB skin testing has been administered properly and documented. DHS/designee will review all new admissions weekly for 4 weeks then monthly times 5 months related to the tuberculin tests being administered properly.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? DHS and or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2016
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH			STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992		
(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>designee will forward the results of the audit and or observations to be reported, reviewed, and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months or until 100% compliance is achieved.</p> <p>Completion Date: March 16, 2016</p>		