

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 01/26/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 20, 21, 22, 23 and 26, 2015</p> <p>Facility number: 012993 Provider number: 155806 AIM number: 201208210</p> <p>Survey team: Angela Selleck, RN, TC Debora Barth, RN Shelley Reed, RN Jason Mench, RN</p> <p>Census bed type: SNF/NF: 32 Total: 32</p> <p>Census payor type: Medicare: 13 Medicaid: 9 Other: 10 Total: 32</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 28,</p>	F000000	<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 January 26,2015. Please accept this Plan of Correction as the provider's credible allegation of compliance.</p> <p>Wellbrooke of Wabash respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. We appreciate your consideration of this request.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000282 SS=D	<p>2015 by Randy Fry RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to implement the Care Plan and physician order for 2 of 23 residents whose Care Plans or physician orders were reviewed. (Resident #23 and #13)</p> <p>Findings include:</p> <p>1. During a staff interview on 1/21/15 at 9:41 a.m., LPN #2 indicated Resident #23 had an unwitnessed fall within the past 30 days.</p> <p>During record review on 1/22/15 at 8:33 a.m., the Quarterly Minimum Data Set (MDS), dated 1/5/15, indicated Resident #23 was severely cognitively impaired. Resident #23's diagnoses included, but were not limited to, congestive heart failure, lack of coordination, hypertension, diabetes mellitus and muscle weakness.</p> <p>A Nursing Note, dated 1/2/15 at 6:10 a.m., indicated a bruise to the right hand</p>	F000282	F282 - It is the practice of Wellbrooke of Wabash to provide services by qualified persons in accordance with each resident's written plan of care. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Res #23's care plan was updated after IDT review of incidents. Staff aware of care plan interventions. Res #13 no longer resides in campus. 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? Residents with the potential to be affected are those who have had a fall or had a change in condition requiring a physician order that changes the plan of care. When care plan interventions are changed or a physician order is obtained the IDT will review the plan of care and interventions will be updated in the electronic health record including an area	02/25/2015			

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	<p>was noted by a CNA during care. The resident stated he fell on second shift, but did not tell anyone he had fallen. He indicated he was able to pick himself up off the floor and move back into bed.</p> <p>A Nursing Note, dated 10/26/14 at 8:19 p.m., indicated Resident #23 was heard yelling from his room that he had fallen. The resident indicated he got out of his chair to answer the phone, tripped on the chair and landed on the floor. Resident #23 denied any pain and a full skin check was completed.</p> <p>A Nursing Note, dated 3/17/14 at 12:36 a.m., indicated Resident #23 was found lying on his side between the two rooms in his apartment. Resident #23 denied any pain and indicated he did not hit his head. A skin assessment indicated no injuries were noted.</p> <p>A current Care Plan, dated 11/4/14, indicated Resident #23 had a problem with unsteady gait and fall risk. Interventions to the problem included, but were not limited to, "staff to round on resident every 2 hours with reminders not to get up without assistance, keep phone in reach and fall risk assessment quarterly and as needed."</p> <p>During an interview on 1/22/15 at 1:40</p>		<p>where staff must document intervention in place. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? All nursing staff will be re-in serviced on the requirement that they must acknowledge the intervention for plan of care and document in the electronic medical record by February 13, 2015. How the corrective action will be monitored to ensure the alleged deficient practice will not recur? Fall interventions that have been changed or updated post incident will be monitored for documentation in the electronic medical record 3 times weekly for 4 weeks. Findings will be reviewed by campus QAA committee to review trends x 6 months or until 100% compliance is achieved. Addendum: Audits will be conducted by the DHS or designee 3 times weekly x 4 weeks; then weekly x 1 month; then monthly x 4 months. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved. Date of completion: February 25, 2015</p>		

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	<p>p.m., CNA #4 indicated staff checked on the resident whenever they were in the back hall and reminded him to put on his call light for assistance.</p> <p>A Fall Risk Assessment, dated 1/2/15, indicated Resident #23 had a calculated fall risk score of 14. A score higher than 10 indicated the resident represented a high risk for falls.</p> <p>Review of the November 2014, December 2014 and January 2015 Flow Sheets, provided by the Director of Nursing on 1/23/15 at 11:24 a.m., indicated a Care Plan for staff to round on Resident #23 every 2 hours with reminders not to get up without assistance. No initials were noted on any of the three months, except 1/22/15.</p> <p>During an interview on 1/23/15 at 11:24 a.m., the Director of Nursing indicated her staff were not signing the Flow Sheet indicating they checked on Resident #23. She indicated she was unaware the information was in the system. She indicated she had since re-educated staff to document they checked on the resident every 2 hours.2. The clinical record for Resident #13 was reviewed on 1/23/15 at 10:00 a.m. Diagnoses for the resident included, but were not limited to, congestive heart failure, hypertension,</p>			

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F000309 SS=D	<p>diabetes mellitus type II, chronic obstructive pulmonary disease and muscle weakness.</p> <p>A review of a Physician's telephone order, dated 10/12/14, indicated the resident had orders that included, "U/A (urinalysis) C&S (culture and sensitivity), CXR (chest x-ray) [for] SOB (shortness of breath) STAT (immediately) ...2 views, Tylenol 650 mg (milligrams) p.o. (by mouth) NOW...."</p> <p>A review of the "October 2014 Medications" Administration for Resident #13 indicated Tylenol 650 mg was not administered on 10/12/14.</p> <p>During an interview with the Director of Nursing (DON) on 1/26/15 at 2:19 p.m., she indicated there was no documentation of the administration of Tylenol 650 mg on 10/12/14.</p> <p>No further information was provided upon exit on 1/26/15.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p>			

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	<p>services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure the monitoring of a fistula site for 1 of 1 residents on dialysis was completed. (Resident #83)</p> <p>Findings include:</p> <p>The clinical record for Resident #83 was reviewed on 1/22/15 at 2:24 p.m. Diagnoses for the resident included, but were not limited to, congestive heart failure, end stage renal disease, diabetes mellitus type II and hypertension.</p> <p>During an observation of Resident #83's fistula on 1/26/15 at 2:19 p.m. with the DON, she indicated the dialysis fistula was located on Resident #83's left inner forearm, the thrill was present and the dressing was dry and intact.</p> <p>The review of Resident #83's clinical record from 1/15/15 through 1/23/15, indicated no dialysis fistula assessment for five of nine days reviewed on the following dates: 1/15/15, 1/16/15, 1/19/15, 1/20/15 and 1/21/15.</p> <p>The review of the "January 2015</p>	F000309	<p>F 309 - It is the practice of Wellbrooke of Wabash to provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #83's treatment record was updated to include monitoring A-V fistula daily for edema,thrill, and bruit. 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? No other residents on hemodialysis reside on campus at this time. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? Licensed nursing staff will be re-in serviced by Director of Health Services or designee on A-V fistula monitoring and documentation requirements on the treatment record by February 25, 2015. How the corrective action will be monitored to ensure the alleged deficient</p>	02/25/2015

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	<p>Treatments" indicated with an electronic signature, the dialysis access - fistula, bruit, edema and thrill was first completed on 1/23/15.</p> <p>During an interview with the Director of Nursing (DoN) on 1/23/15 at 10:50 a.m., she indicated a fistula of a dialysis resident should be assessed once a day.</p> <p>During an interview with the DON on 1/23/15 at 11:25 a.m., she indicated the 24 hour reports are not part of the clinical record but rather the staff's worksheet. She indicated she had instructed the nurses to complete late entries for the assessments missed related to resident #83's fistula.</p> <p>During an interview with the DON on 1/23/15 at 3:17 p.m., she indicated Registered Nurse #1 had completed late entries on 1/22/15 for the assessments of Resident #83's fistula for the following dates: 1/16/15, 1/19/15 and 1/21/15. The DoN indicated all the late entries were completed from the nurse's worksheets. These worksheets were not part of the clinical record.</p> <p>During an interview with the DON on 1/26/15 at 1:05 p.m., she indicated LPN #2 had completed a late entry on 1/23/15 for the assessment of Resident #83's</p>		<p>practice will not recur? The DHS or ADHS will monitor A-V Fistula for documentation in the electronic medical record 3 times weekly for 4 weeks. Findings will be reviewed by campus QAA committee to review trends x 6 months or until 100% compliance is achieved. Addendum: Audits will be conducted by the DHS or designee 3 times weekly x 4 weeks; then weekly x 1 month; then monthly x 4 months. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved. Date of Completion: February 25, 2015</p>				

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	<p>fistula for the date of 1/20/15. The DON indicated the late entry was completed from the nurse's worksheet. The DON further indicated the initial admission assessment completed by LPN #5 did not address Resident #83's dialysis fistula.</p> <p>A review of the policy titled "GUIDELINES FOR MONITORING SHUNT: HEMODIALYSIS ARTERIOVASCULAR ACCESS (AV) (Fistula, Graft or Central Venous Catheter), dated January 2014, and provided by the Administrator on 1/23/15 at 12:45 p.m., indicated the following:</p> <p>"PURPOSE: To effectively provide monitoring of vascular access utilized for hemodialysis.</p> <p>PROCEDURE:</p> <p>1. Monitor AV shunt daily for:</p> <p>redness swelling signs and or symptoms of infections complaints of pain local warmth exudate tenderness numbness tingling extremity swelling distal to access</p>			

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F000322 SS=D	<p>list not all inclusive</p> <p>2. Monitor the AV shunt daily for thrill and bruit.</p> <p>thrill - is done by touch bruit - sound via stethoscope "whooshing around" (if sound changes to a "whistle like sound it could indicate a clot and or narrowing. If this occurs, notify physician...</p> <p>...6. Document assessment findings in resident medical record nursing notes and or in designated area on treatment administration record (TAR)..."</p> <p>No further information was provided upon exit on 1/26/15.</p> <p>3.1-37(a)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate</p>						

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	<p>treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review the facility failed to check placement before utilizing the gastrostomy tube (g-tube) for 1 of 1 residents with a g-tube. (Resident #85)</p> <p>Findings include:</p> <p>RN # 1 was observed for medication pass on 1/22/15 at 3:00 p.m. The nurse entered Resident # 85's room. She washed her hands and drew 60 milliliters (ml) into the syringe for the flush. She donned gloves. She attached the syringe to the gastrostomy tube and proceeded to push the fluids into the tube. She marked the syringe and replaced it into the storage container. She removed her gloves and then washed her hands and left the room.</p> <p>The clinical record for Resident #85 was reviewed on 1/22/15 at 3:30 p.m. The resident's diagnosis included, but was not limited to myasthenia gravis. There was a physician's order for a "water flush- 60 ml - every shift."</p> <p>The Director of Nursing was interviewed on 1/23/15 at 2:30 p.m. She indicated the</p>	F000322	<p>F 322 – It is the practice of Wellbrooke of Wabash to ensure that a resident who is fed by a gastrostomy tube receives the appropriate treatment and services to prevent aspiration, pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #85 continues to reside on the campus. On February 4, 2015, his g-tube was successfully removed. 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? No other residents have the potential to be affected by this practice related to, no resident in campus have G-tubes. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? DHS and/or designee will re-educate licensed nursing staff and QMAs on "guidelines for the safe administration of</p>	02/25/2015	

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F000323 SS=D	<p>nurse should have checked for placement before administering the water through the g tube.</p> <p>The undated policy for "guidelines for administering gastric tube medications" was provided by the Director of Nursing on 1/23/15 at 2:30 p.m. It indicated:</p> <p>"Purpose: To provide guidelines for the safe administration of medications through gastric tube.</p> <p>Procedure: ...34. Check placement in the stomach and residual gastric contents...."</p> <p>3.1-44(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to assure 1 of 8 residents observed during</p>	F000323	<p>medications through gastric tube." How the corrective action will be monitored to ensure the alleged deficient practice will not recur? DHS and/or designee will monitor residents with g-tube (if any reside in campus), that placement was verified prior to flushing g-tube and/or medication administration per the documentation in the electronic medical record. RN #1 will have a return demonstration on campus guideline completed by DHS before February 25, 2015. Findings will be reviewed by campus QAA committee to review trends x 6 months or until 100% compliance is achieved. Addendum: Audits will be conducted by the DHS or designee 3 times weekly x 4 weeks; then weekly x 1 month; then monthly x 4 months. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved. Date of completion: February 25, 2015</p> <p>F-323 – It is the practice of Wellbrooke of Wabash to ensure that the resident environment remains as free of hazards as</p>	02/25/2015			

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	<p>medication pass was administered his medications with a nurse present. (Resident #85)</p> <p>Findings include:</p> <p>RN #1 was observed during medication pass on 1/22/15 at 3:00 p.m. The nurse was using the telephone and finished her conversation at 3:05 p.m. Upon entering Resident # 85's room, there was a medication cup observed on his bedside table. There were 3 pills in the medication cup. Another medication cup had a thick yellow substance, identified as yogurt by the resident, next to the medication cup. There was also an opened container of yogurt on the table with a spoon in it.</p> <p>The resident indicated he needed more yogurt to eat to take his pills than the little cup. He had asked the nurse for more yogurt and she had brought him a container to eat with his pills. Two other people were in the room and were introduced by the resident as his brother and sister-in-law. The resident continued to take his pills as the nurse prepared to flush his gastrostomy tube.</p> <p>The resident completed taking his medications as the nurse was leaving the room. The resident indicated this was the</p>		<p>possible. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #85 did not have any negative effects related to practice; he did take the medication per current physician order. RN#1 will be counseled by the DHS, before February 25, 2015 related to the potential for a negative outcome if medications left at bedside. 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? All Residents have the potential to be effected if medication are left at bedside and not witnessed by the nurse to be taken. RN #1 will be counseled by the DHS, before February 25, 2015 related to the potential for a negative outcome if medications left at bedside. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? DHS and/or designee will re-educate licensed nursing staff and QMAs on campus medication administration guideline, specifically that medications cannot be left at bedside unsupervised. During monitoring, if a licensed nurse and/or QMA are noted to leave medication at bedside unsupervised, a counseling form</p>		

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F000441 SS=D	<p>way he always took his pills.</p> <p>Interview with RN # 1, on 1/22/15 at 3:20 p.m., indicated she had taken the resident his medications before she had answered the phone call. She had not been present during the time she left the pills at his bedside.</p> <p>Interview with the Director of Nursing, on 1/23/15 at 2:30 p.m., indicated the nurse should not have left the pills at the resident's bedside.</p> <p>3.1-45(a)(2)</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>		<p>and/or discipline will be given. How the corrective action will be monitored to ensure the alleged deficient practice will not recur? DHS and/or designee will monitor medication pass 3 times a week for 4 four weeks, alternating staff so different staff will be monitored. RN #1 will have a return demonstration on campus guideline completed by DHS before February 25, 2015. Findings will be reviewed by campus QAA committee to review trends x 6 months or until 100% compliance is achieved. Addendum: Audits will be conducted by the DHS or designee 3 times weekly x 4 weeks; then weekly x 1 month; then monthly x 4 months. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved. Date of completion: February 25, 2015</p>		

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	<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>Based on observation, interview, and record review, the facility failed to assure the staff followed infection control procedures regarding handwashing and glove use during the medication pass for 3 of 4 staff observed concerning 5 of 8 residents observed during medication pass. (RN #1, LPN #2, QMA #3; Residents # 84, 85, 23, 15, & 61)</p> <p>Findings include:</p> <p>1. RN # 1 was observed during medication pass on 1/22/15 from 8:50</p>	F000441	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. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident were affected by the alleged deficient practice. How other residents having the potential	02/25/2015

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	<p>a.m. till 10:00 a.m. She passed medication to Resident # 84 and Resident # 15 during this time. She was also observed doing a gastrostomy flush at 3:00 p.m. on 1/22/15 for Resident # 85. During these observations, between residents, she did not use hand sanitizer. She also did not wash her hands for more than 15 seconds during the five observations of handwashing.</p> <p>2. QMA # 3 was observed during medication pass on 1/23/15 from 7:50 a.m. till 8:45 a.m. When she completed passing medications to Resident # 61, she washed her hands at the sink in the nurses station for five seconds.</p> <p>3. The Director of Nursing was interviewed on 1/23/15 at 1:10 p.m. She indicated the policies should have been followed. The Administrator provided policies for "Guidelines for Handwashing", dated 10/2004, on 1/23/15 at 1:10 p.m., which indicated the following:</p> <p>"Purpose: Handwashing is the single most important factor in preventing transfusion of infections...</p> <p>Procedures: ...7. Wet hands with running water. Apply liquid soap and work into a lather.</p>		<p>to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? All Residents residing at the campus have the potential to be affected by the alleged deficient practice. 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 campus has guidelines in place indicating how hand washing should be performed and when glove use is indicated for administrating medications. DHS and/or designee will re-educate nursing staff on campus these guidelines by February 25, 2015. How the corrective action will be monitored to ensure the deficient practice will not recur? DHS and/or designee will perform observations of hand washing and glove use during medication pass, 3 times a week for four weeks, alternating staff so different staff will be monitored. Findings will be reviewed by campus QAA committee to review trends x 6 months or until 100% compliance is achieved. Addendum: Audits will be conducted by the DHS or designee 3 times weekly x 4 weeks; then weekly x 1 month; then monthly x 4 months. DHS or designee will report findings to QA&A for 6 months or until 100% compliance is achieved. Date of</p>				

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R000000	<p>8. Wash well for 20 seconds..., using rotary motion and friction.</p> <p>9. Rinse hands well under running water, allowing water to flush from wrist to fingertips....."</p> <p>4. LPN # 2 was observed giving an insulin injection to Resident # 23 at 8:00 a.m. on 1/23/15. The LPN did not wear gloves during the time she administered the insulin.</p> <p>A policy titled "Subcutaneous medication administration procedures" was provided by the Director of Nursing on 1/23/15 at 1:10 p.m. The policy, dated 9/17/12, indicated the following:</p> <p>"Procedures: a) Prepare medication as follows:... b) Apple (sic) gloves and select an appropriate site for injection...."</p> <p>3.1-18(b)(1)</p> <p>This survey was for a State Residential Licensure Survey.</p> <p>Survey dates: January 26, 2014.</p> <p>Facility number: 012993</p>	R000000	<p>completion: February 25, 2015</p> <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,</p>	

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	<p>Provider number: 155806 AIM number: 201208210</p> <p>Survey team: Angela Selleck, RN TC Debora Barth, RN Shelley Reed, RN Jason Mench, RN</p> <p>Census bed type: Residential: 15 Total: 15</p> <p>Census payor type: Other: 15 Total: 15</p> <p>Sample: 7</p> <p>Wellbrooke of Wabash was found to be in compliance with 410 IAC 16.2-5 in regard to State Residential Licensure Survey.</p>		<p>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 January 26,2015. Please accept this Plan of Correction as the provider's credible allegation of compliance.</p> <p>Wellbrooke of Wabash respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. We appreciate your consideration of this request.</p>				