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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155808 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/12/2015 |
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| NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WESTFIELD | STREET ADDRESS, CITY, STATE, ZIP CODE 937 E 186TH STREET WESTFIELD, IN 46074 |
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| F 000 Bldg. 00 | <p>This visit was for the Investigation of Complaint IN 00168477.</p> <p>Complaint IN00168477-substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F431.</p> <p>Survey date: March 12, 2015</p> <p>Facility number: 012937 Provider number: 155808 AIM number: 201208220</p> <p>Survey Team: Maria Pantaleo, RN-TC Bobette Messman, RN</p> <p>Census bed type: SNF: 19 SNF/NF: 30 Residential: 25 Total: 74</p> <p>Census payor type: Medicare: 18 Medicaid: 14 Other: 16 Total: 48</p> <p>Sample: 3</p> | F 000 | <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00168477) on March 12, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| F 225 SS=D Bldg. 00 | <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on March 17, 2015.</p> <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</p> | | | |

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| | <p>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 be taken.</p> <p>Based on record review and interview, the facility failed to notify the Indiana State Department of Health- Long Term Care Division of an alleged violation of misappropriation of property. This affected 1 of 3 residents reviewed for misappropriation of narcotics. (Resident C)</p> <p>Findings include:</p> <p>During a review of clinical records for the date 2/26/15 at 1:50 p.m., of Resident C, the record indicated the narcotics count sheet and the medication card containing Vicodin were missing. In total six tablets of Vicodin were missing.</p> <p>During an interview on 3/12/15 at 3:00 p.m., with the Executive Director (ED), the Director of Health Services (DHS), and the Assistant Director of Health (ADHS), the ED stated an investigation into missing narcotics was started on</p> | F 225 | <p>F 225</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: An investigation for the allegation of misappropriation of property (narcotics) for Resident C was investigated by the ED and DHS starting 2/27/15. In addition, the local police department was contacted and they initiated a investigation into the missing narcotics. The ED will notify the Indiana State Department of Health - Long Term Care Division of the alleged violation of misappropriation of property.</p> <p>Identification of other residents having the potential to be affected by the same alleged</p> | 04/11/2015 |

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| | <p>2/27/15 at 1:30 p.m.. She was notified by the DHS that 6 pills of Hydrocodone-APAP 10-325 mg (a narcotic pain reliever) were missing from the Monon South Hall medication cart. The ED called the Human Resources Representative of the parent corporation and the police. A police investigation into the missing pills was started. She indicated she did not call or communicate with the Indiana State Department of Health- Long Term Care Division.</p> <p>This Federal tag relates to complaint IN00168477.</p> <p>3.1-28(c)</p> | | <p>deficient practice and corrective actions taken: all residents have the potential to be affected by the same alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The ED will educate the leadership team on the campus guideline for State Reportable Events.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the ED or designee 1 times per week times 8 weeks, then monthly times 4 months to ensure compliance: The Indiana State Department of Health-Long Term Care Division is notified of all alleged violations of misappropriation of property.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then</p> | |

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| F 431 SS=E Bldg. 00 | <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the</p> | F 431 | randomly thereafter for further recommendation. | 04/11/2015 |

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| | <p>facility failed to provide an accurate accounting method for narcotic count at change of shift. This deficient practice affected 4 of 5 medication carts reviewed for narcotics count.</p> <p>Findings include:</p> <p>1. During a narcotics count on 3/12/15 at 9:40 a.m., on Monon Hall North with RN#1, a narcotics count was completed. The narcotics count sheet for the month of March was reviewed and found to have 10 of 68 spaces unsigned.</p> <p>During an interview with RN#1 on 3/12/15 at 9:45 a.m., he indicated the ongoing and off going nurse were to sign the narcotic count sheet at the end of the narcotic reconciliation process. This happened at end and start of every shift.</p> <p>2. During a narcotics count on 3/12/15 at 9:55 a.m., on the Monon Hall South with LPN #1, a narcotics count was completed. The narcotics count sheet for the month of March was reviewed and found to have 4 of 68 spaces unsigned.</p> <p>3. During a narcotics count on 3/12/15 at 10:20 a.m., on the Boardwalk North Hall with RN#2, a narcotics count was completed. The narcotics count sheet for the month of March was reviewed and</p> | | <p>F 431</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Audit of all narcotics to ensure an accurate accounting method is in place.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Audit of all narcotics to ensure an accurate accounting method is in place.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and QMAs on the following guideline: Shift to Shift Narcotics Count</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee 2 times per week times</p> | | | | |

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| | <p>found to have 8 of 68 spaces unsigned.</p> <p>4. During a narcotics count on 3/12/15 at 10:40 a.m., on the Boardwalk South Hall with LPN#2, a narcotics count was completed. The narcotics count sheet for the month of March was reviewed and found to have 6 of 68 spaces unsigned.</p> <p>During an interview with Director of Health Services on 3/12/15 at 2:00 p.m., he indicated the procedure for signing the narcotics count sheet was expected of every nurse.</p> <p>A review of the policy titled "Guidelines for Shift to Shift Narcotics Count" dated with revision date of 8/29/14, stated "...5. Both staff members shall sign that the narcotics count is accurately reconciled."</p> <p>This Federal tag relates to complaint IN00168477.</p> <p>3.1-25(e)(2)</p> | | <p>8 weeks, then monthly times 4 months to ensure compliance: Audit of all narcotics to ensure an accurate accounting method is in place.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation</p> | | |