

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155812	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/17/2015
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NAME OF PROVIDER OR SUPPLIER  WELLBROOKE OF CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 517 CONCORD ROAD CRAWFORDSVILLE, IN 47933
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: December 10, 11, 14, 15, 16, and 17, 2015</p> <p>Facility number: 013107 Provider number: 155812 AIM number: 201279670</p> <p>Census bed type: SNF: 40 SNF/NF: 13 Residential: 29 Total: 82</p> <p>Census payor type: Medicare: 26 Medicaid: 13 Other: 14 Total: 53</p> <p>Quality review completed December 22, 2015 by 29479.</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The submission of this plan of correction does not indicate an admission by WellBrooke of Crawfordsville that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to our residents of WellBrooke of Crawfordsville. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance of this facility. It is thus submitted as a matter of statute only. All corrections have been submitted to this POC. We respectfully request from the department paper compliance.</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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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and record review, the facility failed to maintain dignity for 1 of 1 random observation. (Resident #65)</p> <p>Finding includes:</p> <p>On 12/10/15 at 11:50 a.m., RN #3 was observed coming out of Resident #65's room. In the middle of the hallway the RN yelled to a Certified Nursing Assistant (CNA) half way down the hall, that Resident (name) #65 needed to go to the bathroom. Other residents were in the area in a small group, or individual activity.</p> <p>A Minimum Data Set (MDS) assessment, dated 9/25/15, coded the resident without cognitive impairment.</p> <p>The facility policy, titled "Residents Rights," identified as current and provided by the Administrator on 12/16/15 at 10:35 a.m. indicated, "...You have the right to confidentiality of your personal and clinical records...."</p>	F 0241	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p><i>Resident # 65 has not experienced any negative effects from the deficient action.</i></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p><i>The facility has determined that all residents requiring care have the potential to be affected.</i></p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient</b></p>	01/16/2016

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	3.1-3(t)		<p><b>practice does not recur:</b></p> <p><i>Staff responsible for providing assistance to residents will be in-serviced on Resident's Rights and and Respect specific to the proper procedures for requesting and notifying other staff of the need for care</i></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><i>The Director of Nursing Services (DNS), or designee, will conduct observations of staff providing care on various shifts 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance.</i></p> <p><i>Observation reports and validation checklists will be reviewed by the Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee.</i></p>	

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F 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure the resident's preferences were obtained and/or followed pertaining to showers for 1 of 3 residents reviewed for choices. ( Resident # 34)</p> <p>Finding includes:</p> <p>During an interview on 12/10/15 at 2:30 p.m., Resident # 34 indicated she had not been asked by staff what her personal preferences were for frequency of showers.</p> <p>During an interview on 12/15/15 at 2:19 p.m., Resident # 34 indicated she was</p>	F 0242	<p>Corrective action completion date: January 16, 2016</p> <p><b><u>The facility respectfully requests paper compliance.</u></b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p><i>The shower preference for Resident #34 was addressed and the plan of care was updated.</i></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p>	01/16/2016

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	<p>asked by staff if she preferred a morning or night shower, but she was not asked about how many times a week she wanted a shower and was just placed on a two times a week schedule.</p> <p>During an interview on 12/15/15 at 2:35 p.m., Activities Director indicated her staff did not ask residents what their preferences were for frequency of showers per week. The activities director further indicated the staff used a form when a resident is newly admitted called, "New Admission Resident Preferences".</p> <p>Resident #34's clinical record was reviewed on 12/15/15 at 10:00 a.m. The admission Minimum Data Set (MDS), dated 10/31/15, indicated the resident had no cognitive impairment and required assistance of one person for bathing.</p> <p>A copy of the "New Admission Resident Preferences" sheet for Resident #34 was provided by the Director of Health Services on 12/15/15 at 3:17 p.m. The preferences sheet did not indicate the resident's preferences for frequency of showers.</p> <p>A copy of the shower schedule for Resident # 34, dated 10/26/15, was provided by the Director of Health Services on 12/16/15 at 11:18 a.m. The</p>		<p><i>The facility has determined that other residents have the potential to be affected.</i></p> <p><i>Social Service Director or designee will interview current residents to ensure that bathing, and other preferences are being honored and update plans of care as indicated.</i></p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><i>Life enrichment Director or designee will obtain resident preferences on admission. Resident Preferences including showers will be further discussed and care planned during the Resident First meeting which includes the resident and designated family members.</i></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p>		

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F 0244 SS=D Bldg. 00	<p>sheet indicated the resident was to receive showers on Tuesdays and Fridays weekly.</p> <p>A copy of Resident # 34's Activities of Daily Living record was provided by the Nurse Consultant on 12/16/15 at 11:30 a.m. The record lacked documentation the resident received two showers a week during the period of 11/27/15 to 12/11/15.</p> <p>The facility policy titled, "Resident Rights," identified as current by the Administrator on 12/16/15 at 10:35 a.m., indicated "...You have the right to make choices about aspects of your life in the facility...2. The facility will allow you to make choices about what you wear, how you are groomed, with whom you eat, etc...."</p> <p>3.1-3(u)(3)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p>		<p><i>The Director of Nursing Services (DNS), or designee, will conduct audits of 3 residents 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance.</i></p> <p><i>Observation reports and validation checklists will be reviewed by the Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee.</i></p> <p>Corrective action completion date: January 16, 2016</p> <p><b><u>The facility respectfully requests paper compliance.</u></b></p>		

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	<p>Based on interview and record review, the facility failed ensure Resident #67's concerns discussed in monthly Resident Council meetings were addressed when employment of designated responsible staff was terminated for 3 of 4 Resident Council minutes reviewed. This affected Resident #67, Finding includes:</p> <p>On 12/11/15 at 9:45 a.m., Resident #67 was interviewed. The resident indicated sometimes she did not receive pain medications in time when she had requested them. She indicated it had taken up to two hours at times and she got upset with the nurse. The resident indicated she had reported the concern to the managers.</p> <p>Resident Council minutes were provided by the Administrator on 12/15/15 at 11:25 a.m. The area of concern of not getting requested pain medication on multiple occasions was noted by Resident #67 in the minutes of the meetings in July, September, and November 2015. No meetings were held in August and October.</p> <p>The facility responses that addressed the concern was noted for July, September, and November was noted of "will talk to the nurse on duty." On 12/16/15 at 2:00</p>	F 0244	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p>Resident #67 has had no further issues or concerns voiced regarding the timeliness of pain medications.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p><i>All resident's that receive PRN pain medications have the potential to be affected.</i></p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p><i>The Facility will listen to the views and act upon grievances and recommendations of residents which affect the residents care and overall well being in the campus.</i></p>	01/16/2016			

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F 0279 SS=D Bldg. 00	<p>p.m., the Director of Nursing (DON) provided a report that addressed concerns about the timeliness of medication administration by Licensed Practical Nurse (LPN) #13, dated 12/7/15. The report indicated the nurse indicated she was unable to get medications passed timely due to being too busy. The DON asked for an accounting of her time. The report indicated the concerns would be monitored and followed up by the DON.</p> <p>The Administrator was interviewed on 12/15/15 at 11:30 a.m. The Administrator indicated the concerns had not been addressed because changes in staff.</p> <p>The Administrator provided a policy titled "Resident Council Meeting Requirements," (no date) on 12/15/15 at 11:25 a.m. The policy included, but was not limited to, "Purpose The primary purpose of the resident council is to provide an organized meeting to determine and act on resident's needs and concerns in relation to their care and facility (campus) services..."</p> <p>3.1-3(l)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p>		<p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p><i>The Executive Director or designee will review and audit all Resident Council Meeting Minutes and resident concerns 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance.</i></p> <p><i>Audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</i></p> <p>Corrective action completion date: January 16, 2016</p> <p><u>The facility respectfully requests paper compliance.</u></p>				

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	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a plan of care was developed for the assessment of a dialysis fistula (arteriovenous access) and intravenous dialysis port for 1 of 1 resident reviewed for dialysis. (Resident #111)</p> <p>Finding includes:</p> <p>Registered Nurse (RN) #3 was interviewed on 12/14/15 at 2:02 p.m. She indicated Resident #111 had an intravenous catheter for hemodialysis and a fistula (dialysis access site) not mature enough for use in dialysis. The nurse indicated the facility did not assess either</p>	F 0279	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p><i>The care plan of the resident # 111 was reviewed and updated to include monitoring of the resident's fistula per facility protocol.</i></p> <p><b>Identification of other residents having the potential to be affected by the same alleged</b></p>	01/16/2016

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	<p>site for patency, bleeding, or signs of infection.</p> <p>The Director of Nursing (DON) was interviewed on 12/15/15 at 11:10 a.m. The DON indicated nursing should have assessed the fistula even if currently not being used. She thought there had been an order for it, but after checking there was not.</p> <p>Resident #111's clinical record was reviewed on 12/14/15 at 11:00 a.m. A physician's order was noted on readmission to the facility on 11/16/15, for the resident to go to the dialysis center on Tuesday, Wednesday, and Saturday at 10:00 a.m.</p> <p>A plan of care that addressed monitoring of the devices had not been implemented.</p> <p>On 12/15/15 at 11:30 a.m., LPN #1 provided a printed report from the electronic health record to "check dialysis port site q (every) shift et (and) post dialysis for bleeding redness or swelling document site condition in progress note with each observation. Documentation was noted it had begun on 12/14/15. At the same time, another report was provided to check fistula every shift for redness, swelling, bleeding, bruit (audible blood flow) and thrill (pulsation). Chart</p>		<p><b>deficient practice and corrective actions taken:</b></p> <p><i>The facility has determined that no other residents were affected.</i></p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><i>Interdisciplinary team members responsible for writing care plans will be re-educated on the facility's policy and procedure for developing Comprehensive Care Plans.</i></p> <p><i>Licensed staff will be in-serviced on the monitoring of dialysis fistulas per the facility's protocol.</i></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p>		

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	<p>in progress note.</p> <p>The facility policy titled "GUIDELINE FOR DIALYSIS PROVIDER COMMUNICATION," (no date) included, but was not limited to, "...5. Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring of the shunt site for signs of complication b. Review the Dialysis Provider paperwork for any necessary follow up requirements...."</p> <p>3.1-35(a) 3.1-35(b)(1)</p>		<p>Physician orders will be reviewed in the AM meeting 5 days a week and care plans developed for all medical, nursing, mental and psychosocial needs.</p> <p><i>The Director of Nursing Services (DNS), or designee, will complete weekly audits of 3 residents care plans 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance.</i></p> <p><i>Audit records will be reviewed by the /Quality Assurance until such time consistent substantial compliance has been achieved as determined by the committee.</i></p> <p>Corrective action completion date: January 16, 2016 <i>Committee</i></p> <p><b><u>The facility respectfully requests paper compliance.</u></b></p>	

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure the assessment of a dialysis fistula (arteriovenous access) and intravenous dialysis port for 1 of 1 resident reviewed for dialysis. (Resident #111)</p> <p>Finding includes:</p> <p>Registered Nurse (RN) #3 was interviewed on 12/14/15 at 2:02 p.m. She indicated the Resident #111 had an intravenous catheter for hemodialysis and a fistula (dialysis access site) not mature enough for use in dialysis. The nurse indicated the facility did not assess either site for patency, bleeding, or signs of infection.</p> <p>The Director of Nursing (DON) was interviewed on 12/15/15 at 11:10 a.m. The DON indicated nursing should assess the fistula even if currently not being used. She thought there was an order for it, but after checking there was not.</p>	F 0309	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p><i>Resident #111 was assessed immediately, and appropriate interventions were implemented.</i></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p><i>The facility determined that no other residents were at risk</i></p>	01/16/2016			

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	<p>Resident #111's clinical record was reviewed on 12/14/15 at 11:00 a.m. A physician's order was noted on 11/16/15 for the resident to go to the dialysis center on Tuesday, Wednesday, and Saturday at 10:00 a.m.</p> <p>A plan of care that addressed monitoring of the devices had not been implemented.</p> <p>On 12/15/15 at 11:30 a.m., LPN #1 provided a printed report from the electronic health record to "check dialysis port site q (every) shift et (and) post dialysis for bleeding redness or swelling document site condition in progress note with each observation. Documentation was noted it had begun on 12/14/15. At the same time, another report was provided to check fistula every shift for redness, swelling, bleeding, bruit (audible blood flow) and thrill (pulsation). Chart in progress note.</p> <p>The facility policy titled "GUIDELINE FOR DIALYSIS PROVIDER COMMUNICATION," (no date) included, but was not limited to, "...5. Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring of the shunt site for signs of complication b. Review the Dialysis Provider paperwork for any necessary</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p><i>Licensed nursing staff will be in-serviced on the facility's Guidelines for Dialysis Communication and monitoring of Dialysis fistulas per the facilities policy and procedure</i></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><i>The Director of Nursing Services (DNS), or designee, will complete audits for current dialysis patients and new dialysis residents upon admission 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance</i></p> <p><i>Audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by</i></p>	

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F 0329 SS=D Bldg. 00	<p>follow up requirements...."</p> <p>3.1-37(a)</p> <p>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.</p> <p>Based on a comprehensive assessment of a 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><i>the committee.</i></p> <p>Corrective action completion date: January 16, 2016</p> <p><b><u>The facility respectfully requests paper compliance.</u></b></p>		

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	<p>Based on observation, interview, and record review, the facility failed to identify and monitor patterns and frequency of behaviors associated with atypical psychosis for which an antipsychotic was prescribed as well as failed to ensure a gradual dose reduction was attempted when recommended for 1 of 5 residents reviewed for unnecessary medications. (Resident #58)</p> <p>Finding includes:</p> <p>On 12/11/15 at 11:00 a.m., Resident #58 was observed with his eyes closed and not interacting with peers while seated in the 100 Hall lounge area, in a small group activity.</p> <p>On 12/11/15 at 2:32 p.m., the resident was in a low bed in his room. The resident indicated he was "okay" but provided minimal responses and did not engage in conversation when asked questions.</p> <p>On 12/16/15 at 11:20 a.m., Resident #58 was observed with his eyes closed and not interacting with peers while seated in the 100 Hall lounge area in a small group.</p> <p>Resident #58's clinical record was</p>			F 0329	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p><i>The Physician wrote an order for a dose reduction for Resident #67 during the survey.</i></p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p><i>All residents on psychoactive medications have the potential to be affected.</i></p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p><i>All residents receiving psychoactive medications will be audited by the Social Service Director and or designee by January 15th to ensure that the facility is meeting the required dose reduction guidelines.</i></p>		01/16/2016

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	<p>reviewed on 12/16/15. Physician orders were noted for the Antipsychotic medication Olanzapine 10 mg (milligrams) po (by mouth) every hour of sleep for atypical psychosis. An order date was noted of 3/20/15. A side effect of the medication, found in the Lippincott Nursing Drug Handbook, 34th edition, copy right, 2014, included but was not limited to, somnolence.</p> <p>Pharmacy recommendations were reviewed on 12/16/15 at 11:15 a.m. The report for record review completed between 10/1/15 and 10/21/15, included a recommendation to attempt a reduction of Olanzapine from 10 mg to 5 mg daily. The physician's response on 9/15 was noted of "per progress note: resident stable, can try dosage reduction, but he is doing well on this regimen...dosage reduction will only put him at risk for falling bc (because) he gets agitated and tries to get up out of wc (wheelchair) and fall."</p> <p>The physician was interviewed on 12/16/15 at 11:59 a.m. The physician indicated he had cared for the resident prior to admission to the facility 10/10/14. He indicated he had placed the resident on the medication due to falls at home, which resulted in a fracture. The physician indicated the resident had</p>		<p><i>Behavior observation documentation will be implemented for residents on psychoactive medications to determine if the need for said medication remains warranted.</i></p> <p><i>Licensed staff will be in-serviced by the DHS or designee on the Behavior Documentation Observation Procedure and the facility police for tracking GDR's.</i></p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>Behavior Tracking documentation will be reviewed 5 days a week in the AM meeting to ensure appropriate interventions and care plans are in place.</p> <p><i>The Pharmacy will conduct monthly audits of all psychoactive medications and make recommendations based on use and supporting documentation.</i></p> <p><i>The Social Service</i></p>	

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	<p>fallen after admission to the facility and had another fracture. A pharmacy recommendation for a dosage reduction was made in July, 2015 and declined. The physician indicated he was afraid the resident might become agitated and fall and fracture again if the dose was decreased, but was not entirely opposed to an attempt. Later on 12/16/15 an order was written to "reduce the medication to 5 mg and closely monitor for agitation and wandering."</p> <p>LPN #2 was interviewed on 12/16/15 at 11:37 a.m. He was not aware of the resident every having behaviors and did not know where to document behaviors, or what the behavior was for use of the medication. After the interview, LPN #2 consulted with the Social Service Director (SSD) and was informed behaviors would be documented in the event tab of the electronic record.</p> <p>The SSD was interviewed on 12/16/15 at 2:00 p.m. She indicated she had reviewed the events documentation for several months and no behaviors were noted.</p> <p>On 12/17/15 at 10:46 a.m., the DON provided a facility policy titled "PSYCHOACTIVE DRUG MONITORING," LAST REVISION 9/17/12. The policy included, but was</p>		<p><i>Director/designee will audit behavior tracking, GDR's and pharmacy recommendations of 3 residents 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance with the plan of care.</i></p> <p><i>Audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</i></p> <p>Corrective action completion date: January 16, 2016</p> <p><u>The facility respectfully requests paper compliance.</u></p> <p>-</p> <p>-</p> <p>- -</p>		

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	<p>not limited to, "Procedures a) Residents receive a psychoactive medication only if designated medically necessary b the prescriber. The medical necessity is documented in the resident's medical record and in the care planning process."</p> <p>b) The continued need for the psychoactive medication is reassessed regularly by the prescriber and the care planning team. If continuation is deemed necessary, this is indicated in the medical record. Effects of the medications are documented, as a part of the care planning process. Unless medically contraindicated, periodic dosage reductions are attempted and the results documented..."</p> <p>The DON also provided a document titled "GUIDELINES FOR BEHAVIOR OBSERVATIONS," She indicated it had been approved for use on December 15, 2015, and would begin to be implemented. She also indicated, after investigation, the section of the electronic record that should have been used for tracking of behaviors had not been "turned on" in the facility.</p> <p>The guidelines included but were not limited to, "...Each resident currently on a Mental Health Wellness/Behavior Management Program shall have a behavior Monitoring Record either in</p>			

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F 0371 SS=E Bldg. 00	<p>paper form or via the Electronic Health Record (EHR). ...If no behaviors occur during the staff member's shift it is not necessary to document. ...Documenting behaviors in EHR, an order set may be chosen regarding targeted behaviors. A description of the behavior shall be described for shiftly (sic) documentation...."</p> <p>3.1-48(a)(3) 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 meals were prepared and served under sanitary conditions. This had the potential to effect 52 of 53 residents receiving meals from the kitchen and 30 of 53 residents served in the main dining room.</p> <p>Findings include:</p> <p>1. On 12/10/15 at 10:12 a.m., during a</p>	F 0371	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p>No residents experienced any negative outcomes.</p>	01/16/2016

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	<p>kitchen observation, Dietary Assistant #6 was observed walking through the food preparation area with uncover facial hair. At the same time, Dietary Assistant #7 was observed with uncovered facial hair as he carried clean dishes from the dishwashing area.</p> <p>On 12/10/15 at 11:28 a.m., Dietary Manager was observed with uncovered facial hair, removing plastic wrap from the steam table pans prior to the lunch meal service in the main dining room.</p> <p>On 12/15/15 at 11:45 a.m., Dietary Manager was observed during pureed preparation. The employee's beard restraint failed to cover his moustache.</p> <p>A document titled, "Food Production Guidelines-Sanitation &amp; Safety," dated 2009, was provided by the Administrator on 12/17/15 at 10:15 a.m. The document indicated, "Guideline: ...Procedure: ...3. Approved hairnets,... or other effective hair restraints shall be used by employees who engage in the preparation and service of food..."</p> <p>A document titled, "Beard Restraint Guideline," dated March 2013, was provided by the Administrator on 12/17/15 at 10:15 a.m. The document indicated, "Guideline: ...Beard restraints</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p>The facility has determined that all residents could have experienced negative outcomes.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>The Director of Dining Services will hold a Formal In-Service with the entire Dining Services Staff to review Trilogy's Facial Hair Restraint Policy.</p> <p>To ensure we are utilizing proper Facial Hair Restraints, we have established a Checks &amp; Balance Verification System. The Director of Dining Services and/or Designee will verify &amp; document that all Employees with Facial Hair are wearing the Proper Restraints while in a Food Production or Food</p>	

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	<p>are required in any food production area. Facial hair is not exempt from the hair restraint standard...." The document included an illustrated example of the proper method for the beard restraint to be used. The illustration indicated the beard restraint should cover the face from under the nose to under the chin and be held in place by straps behind the ears.</p> <p>The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-Title 410 IAC 7-24," dated November 13, 2004, indicated under "410 IAC 7-24-138: Effectiveness of hair restraint., Sec. 138.... (b) food employees shall wear hair restraints, such as...beard restraints,...that are designed and worn to effectively keep hair from contacting: (1) exposed food; (2) clean equipment, utensils...."</p> <p>2. During a dining observation on 12/10/15 at 11:37 p.m., Dietary Manager served twelve residents in the dining room plates of food. The employee carried the plates with his thumb in contact with the interior surface area of the plates where food was placed.</p> <p>On 12/10/15 at 11:57 a.m., Business Office Employee #8 was observed chewing bubble gum in the dining room, while she pushed the dessert cart, served spiced cake with her thumb on the</p>		<p>Service Area.</p> <p>The Director of Dining Services will hold a Formal In-Service with the entire Campus Staff to review the Facility Hand washing Policy.</p> <p>To ensure we are following the proper Hand washing Policy, we have established a Checks &amp; Balance Verification System. The Director of Dining Services and/or Designee will verify &amp; document that all Employees are properly following the Hand washing Policy during Meal Service(s).</p> <p>The Director of Dining Services will hold a Formal In-Service with the entire Campus Staff to review the proper Handling of Meal Plates.</p> <p>To ensure we are utilizing proper plate-handling techniques, we have established a Checks &amp; Balance Verification System. The Director of Dining Services and/or Designee will verify &amp; document that all Employees are properly handling plates during Meal Service.</p>		

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	<p>interior surfaces of four plates given to residents, without any hand sanitation.</p> <p>Administrator was observed, without any hand sanitation, on 12/10/15 at 12:13 p.m., while waiting for a plate of food to be dished out, to touch her hair, scratch her forehead, adjust her necklace, and then serve the plate of food to a resident. While waiting in line to retrieve another plate of food, Administrator was observed to adjust her shirt, then proceeded to serve a plate of food to a resident. She then patted the back of another resident, served a dish of ice cream to a resident, scratched her forehead, then served an additional two dishes of ice cream to residents.</p> <p>On 9/4/15 at 9:22 a.m., Administrator indicated staff serving food to residents should sanitize their hands prior to serving the food, staffs' hands were not to be in contact with the interior surfaces of the plated food, and staff were not to chew gum while serving food to the residents in the dining room.</p> <p>Documentation, identified as a current facility policy titled, "Retail Food Establishment Sanitation Requirements," provided by Administrator on 12/17/15 at 1:40 p.m., indicated, "...When to wash hands...Food employees shall clean their</p>		<p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p>The Director of Dining Services and/or Designee will verify &amp; document that all employees with facial hair are wearing the Proper Hair Restraints 2 x Per Day for 5 Days a then Weekly for 5 Weeks then monthly times 4 months to ensure compliance.</p> <p>The Director of Dining Services and/or Designee will verify &amp; document that all employees are following the Hand washing Policy during meal Service(s) 2 x Per Day for 5 Days and then Weekly for 5 Weeks then monthly times 4 months to ensure compliance</p> <p>The Director of Dining Services and/or Designee will verify &amp; document that all employees are handling plates properly during meal Service 2 x Per Day for 5 Days a then Weekly for 5 Weeks then monthly times 4 months to ensure compliance</p> <p><i>Audits will be reviewed by the</i></p>	

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R 0000  Bldg. 00	<p>hands...before touching food or food-contact surfaces...an employee shall chew gum, eat and drink food, or use any form of tobacco only in designated areas where the contamination of: exposed food...cannot result..."</p> <p>3.1-21(i)(3)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 29 Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IC 16.2-2.5.</p>	R 0000	<p><i>Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</i></p> <p>Corrective action completion date January 16, 2016</p> <p><b><u>The facility respectfully requests paper compliance.</u></b></p> <p>The submission of this plan of correction does not indicate an admission by WellBrooke of Crawfordsville that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to our residents of WellBrooke of Crawfordsville. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation</p>		

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R 0055 Bldg. 00	<p>410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.</p> <p>Based on observation, interview, and record review the facility failed to ensure privacy during physical examination for 4 of 5 residents observed. (Residents 1, 2, 8, and 9)</p> <p>During an observation on 12/17/15 at 10:00 a.m., RN # 3 performed a head to toe assessment on Resident # 1 with the door to her apartment wide open. Resident # 1 was in plain view for anyone to see or hear walking down the hallway.</p> <p>During an observation on 12/17/15 at 10:06 a.m., RN # 3 performed a head to toe assessment on Resident # 2 with the door to her apartment wide open.</p>	R 0055	<p>of compliance of this facility. It is thus submitted as a matter of statute only. All corrections have been submitted to this POC. We respectfully request from the department paper compliance.</p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> <i>Residents # 1, 2, 8, and 9 have voiced no concerns.</i> <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> <i>All other residents have the potential to be affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Staff # 3 and other staff responsible for providing care will be in-serviced on Resident Rights and Dignity. How the corrective measures will be</i></p>	01/16/2016

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	<p>Resident # 2 was in plain view for anyone to see or hear walking down the hallway.</p> <p>During an observation on 12/17/15 at 10:16 a.m., RN # 3 performed a head to toe assessment on Resident # 9 with the door to her apartment wide open. Resident # 9 was in plain view for anyone to see or hear walking down the hallway.</p> <p>During an observation on 12/17/15 at 11:34 a.m., RN # 3 performed a head to toe assessment on Resident # 8 with the door to his apartment wide open. Resident # 8 was in plain view for anyone to see or hear walking down the hallway.</p> <p>During an interview on 12/17/15 at 2:00 p.m., LPN # 1 indicated when performing any kind of assessment the resident's doors should be closed.</p> <p>A policy titled, "Resident Rights", identified as current and provided by the Administrator on 12/16/15 at 10:35 a.m., included but not limited to "...You have the right to personal privacy...2. When you are undergoing an examination or treatment, the staff should conduct the examination and treatment in a manner that maintains the privacy of your body</p>		<p><b>monitored to ensure the alleged deficient practice does not recur:</b> <i>The Director of Nursing Services (DNS), or designee, will conduct random observations of staff providing care once per week on various shifts 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Observation reports and validation checklists will be reviewed by the Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: January 16, 2016 <u>The facility respectfully requests paper compliance.</u></i></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155812		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/17/2015	
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R 0414  Bldg. 00	<p>(i.e., room door should be closed, privacy curtain should be pulled around the bed, etc)...."</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review the facility failed to ensure staff washed their hands after direct contact with the residents for 4 of 5 residents observed during medication pass. (Resident # 1, 2, 8, and 9).</p> <p>During an observation on 12/17/15 at 10:00 a.m., RN # 3 entered Resident # 1's apartment and performed a head to toe assessment and gave resident her medications. RN# 3 exited the apartment when tasks were completed and was observed returning to medication room. RN # 3 proceeded to prepare medication for another resident without washing her hands.</p> <p>During an observation on 12/17/15 at 10:06 a.m., RN # 3 entered Resident # 2's apartment and performed a head to toe assessment and gave resident her medications. RN # 3 exited the apartment when tasks were completed and was</p>	R 0414	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p><i>Residents #1, 2, 8, and 9 have experienced no negative effects.</i></p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b></p> <p><i>Other residents receiving Medication have the potential to affected.</i></p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p>	01/16/2016			

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	<p>observed returning to medication room. RN # 3 proceeded to prepare medication for another resident without washing her hands.</p> <p>During an observation on 12/17/15 at 10:16 a.m., RN # 3 entered Resident # 9's apartment and performed a head to toe assessment and gave resident her medications. RN # 3 exited the apartment when tasks were completed and was observed returning to medication room. RN # 3 proceeded to prepare medication for another resident without washing her hands.</p> <p>During an observation on 12/17/15 at 11:34 a.m., RN # 3 entered Resident # 8's apartment and performed a head to toe assessment and gave resident his medications. RN # 3 exited apartment and went to a sink in hallway. RN # 3 washed her hands for 5 seconds and turned off faucet with bare hands. RN # 3 was observed returning to medication room and began to prepare medication for another resident.</p> <p>During an interview on 12/17/15 at 2:00 p.m., LPN # 1 indicated staff should wash their hands after coming in contact with residents.</p> <p>A policy titled, "Guideline for</p>		<p><i>Staff #3 and licensed staff will be in-serviced on the Hand washing, and Medication delivery protocols per the facility guidelines.</i></p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b></p> <p><i>The Director of Nursing Services (DNS), or designee, will conduct random observations of staff providing care once per week on various shifts 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance.</i></p> <p><i>Observation reports and validation checklists will be reviewed by the Quality Assurance Committee monthly until such time consistent substantial compliance has been achieved as determined by the committee.</i></p> <p>Corrective action completion date: January 16, 2016</p>				

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	Handwashing/Hand Hygiene" dated 8/2014 and provided by Administrator on 12/17/15 at 1:30 p.m., included but not limited to, "...3. Healthcare workers shall wash hands at times such as ...c. Before/After having direct physical contact with residents ...8. Wash well for 20 seconds, using a rotary motion and friction ...11. Turn of faucet with a dry paper towel to avoid recontaminating hands from faucet...."		<u>The facility respectfully requests paper compliance.</u>		