STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING 00 B. WING	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	52565 STATE ROAD 933 SOUTH BEND, IN 46637

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00393796. Complaint IN00393796- Unsubstantiated due to lack of evidence Survey dates: December 7, 8, 9, 12, 13, 14 and 15, 2022 Facility number: 013302 Provider number: 155824 AIM number: 201281730 Census Bed Type: SNF/NF: 15 SNF: 29 Residential: 37 Total: 81 Census Payor Type: Medicare: 16 Medicaid: 14 Other: 14 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/29/22.	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of South Bend Assisted Living that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of South Bend Assisted Living. The 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 skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rayne Wise	Executive Director	01/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of			

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	comfortable sound levels. Based on observation and interview, the facility failed to ensure resident rooms and 1 kitchenette were maintained in a clean safe environment (Room 106, 116, 127, 129, 230 and unit 200 kitchenette) Findings include: 1.During a tour of the facility with the Maintenance Director and Housekeeping Supervisor, conducted on 12/13/2022 between 10:30 A.M. and 12:15 P.M., the following was noted: Room 106 had exposed plaster on the walls and loose vinyl baseboards at the corners. Room 116 has exposed plaster on the walls. Room 127 had exposed plaster on the walls and loose baseboards. Room 129 had exposed plaster on the walls. Room 230 had exposed plaster on the walls. 2. 200 Hall Kitchenette had a drawer that was missing a face plate that was housed inside the cabinet. During an interview, conducted with the Housekeeping Supervisor, at that time, she indicated she would tell the housekeepers to put in a work order for exposed plaster or loose baseboards when they are cleaning resident rooms. During an interview, conducted with the Maintenance Director, at that time, he indicated he	F 0584	F 584 1. Room 106 had exposed plaster on the walls and loose vinyl baseboards at the corners. Room 116 had exposed plaster on the walls. Room 127 had exposed plaster on the walls and loose baseboards. Room 129 had exposed plaster on the walls. Room 230 had exposed plaster on the walls. 200 Hall Kitchenette had a drawer that was missing a face plate that was housed inside the cabinet. All rooms areas were addressed 1/9/2023. No ill effects due to this alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. DPO or Designee will conduct an A) Inspection to be completed on all residents' rooms to ensure rooms are in good repair and B) Inspection of cabinetry on the halls to ensure they are in good repair. 3. DPO or designee will re-educate the Licensed Nursing Staff and IDT on the following campus policy on "Walls Preventive Maintenance and Furniture Maintenance," and ensuring inspection of resident rooms, furniture and generating work orders as needed. 4. The following audits will be conducted for 5 residents by the DPO or designee 2 times per	01/11/2023

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	is the only person to maintain the building and if staff doesn't put in a work order he is unaware of what needs fixed as these items would have been corrected. A current policy, titled " Walls Preventative Maintenance and Furniture Maintenance" was provided by the Regional Nurse on 12/14/22 at 3:44 P.M. The policy states it is the facilities policy to inspect common areas and corridor walls monthly, "...resident room walls are inspected during routine semi-annual preventative maintenance....". The furniture maintenance policy states "...Furniture is to be cleaned and organized daily, purpose is to provide guidelines for cleaning and caring for furniture...Procedure: generate work orders for furniture in need of repairs or touch up painting...." 3.1-18(a)		week times 8 weeks, then monthly times 2 months to ensure compliance: A) Inspection to be completed on resident's rooms to ensure rooms are in good repair and B) Inspection of cabinetry on the halls to ensure they are in good repair.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide assistance for removal of facial hair for 1 of 4 residents reviewed for activities of daily living. (Resident 34) Finding includes: A clinical record review was completed, on 12/9/2022 at 10:26 A.M., diagnoses included but not limited to: encephalopathy, unspecified, nontraumatic intracranial hemorrhage, contusion and laceration of cerebrum, unspecified, with loss	F 0677	F677 1. Resident number 34 was affected. Resident was offered to be shaven 12/14/22. Resident did refuse ADL care and then discharged to home on 12/15/22. 2. All male residents have the potential to be affected. All male residents have been reviewed for the need of ADL care of facial hair with no further concerns noted. All nursing staff to be educated on	01/11/2023

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	of consciousness, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, other pulmonary embolism without acute cor pulmonale, hemiplegia, unspecified affecting left nondominant side, and aphasia. During an observation, on 12/12/2022 at 10:21 A.M., Resident 34 was sitting up in bed, he had hair growth on his cheeks, chin, and neck. During an observation, on 12/13/2022 at 9:55 A.M., resident was unshaved sitting up in bed. During an observation, on 12/14/2022 at 8:39 A.M., resident was sitting up in bed a staff member was assisting him with his breakfast, and he was unshaved. During an interview, on 12/13/22 at 10:45 A.M., the resident indicated, if they had time he would like to be shaved, he shaved at home, does not recall if he received a shower last night. During an interview, on 12/13/2022 at 3:40 P.M., CNA 2 indicated that they tried to give him a shower before, he refuses, he prefers a bed bath. Shower protocol is to make sure peri area is clean, nail care and to shave him. Since he is an evening shower they are always usually shaved. He would shave them if they were not. During an interview, on 12/14/2022 at 11:36 A.M., CNA 1 (certified nurse aide) indicated activity of daily living care that she provides in the morning: clean the peri-area, get ready for the day, make the bed, shut blinds and doors, check skin for hot spots, make room nice and clean and organized, make sure they are comfortable and give them a shower or if they want one. She does not do anything differently for a male's care compared to		ADL care to maintain resident preference related to facial hair. 3. As a measure of ongoing compliance, the DHS or designee will complete rounding to ensure ADL care of facial hair is completed per resident preference on 5 male residents weekly for 4 weeks, then twice per month for 2 months, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	a female except to wipe from front to back. When asked if she offered to shave Resident 34 she indicated she did not, and she should have. On 12/14/2022 at 11:55 A.M., a policy was requested, and one was not provided. 3.1-38(a)(3)(D)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to implement their interventions to prevent pressure ulcers for 1 of 3 reviewed for pressure ulcers. (Resident 15) Finding includes: A clinical record was completed, on 12/9/2022 at 2:30 P.M., for Resident 15, diagnosis included but not limited to: metabolic encephalopathy, acute kidney failure, rhabdomyolysis, right knee chondrocalcinosis and osteoarthritsis of right hip.	F 0686	F 686 1. Resident #15 pressure ulcer plan of care and orders was reviewed and is up to date. 2. All nurses in serviced on following treatment orders and proper documentation. 3. Licensed nursing staff have been re-educated on admission skin assessment, measurement, staging, proper interventions, and care plans for pressure ulcers.	01/11/2023

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	The record indicated the resident was admitted on 10/15/2022. An Admission Minimum Data Set (MDS) Assessment, dated 10/17/2022. indicated under section GG, Mobility-Admission Performance indicated: A. Roll left to right - substantial/maximal assistance, B. Sit to lying: The ability to move from sitting on side of bed to lying flat in bed and C. Lying to sitting on the side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, with no back support indicated substantial/maximal assistance - Helper does MORE THAN HALF the effort. A Baseline Care Plan, dated 10/17/2022, indicated the Skin Integrity Goal: Resident will have intact skin or has current skin condition. Resident is at risk for compromised skin condition. Check history of or observed triggers and proceed to approaches: Resident requires assistance to reposition. Check desired approaches check all that apply: pressure reducing cushion to chair, pressure reducing mattress to bed, nutritional/hydration interventions for skin integrity issues, encourage resident to float heels while in bed, monitor adequate nutritional and hydration intake and consult dietician, observe for issues around casts, splints, immobilizers and provide padding as needed, notify MD if unaware of any adverse findings in skiintegrity, inspect skin when repositioning, toileting, and assisting with ADL's , notify nurse of adverse findings, dressing per MD order and treatments per MD order, turn and reposition for comfort with care, applications of ointments and creams. A Skin Integrity Event, dated 10/26/2022, indicated unstageable pressure ulcer on right heel,		Baseline Care Plans for all new admits will be checked for Pressure Ulcer Prevention and Plan of Care will be put into place. 4. Audits will be completed on new admissions for skin assessments, and preventative skin measure for pressure ulcers. DHS or designee will review skin preventative orders on new admissions weekly x4 weeks, then every other week x2 months, then monthly x3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus quality assurance meetings. The plan will be revised as warranted.	

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	length 3.5 (cm)centimeters, width 3.5 cm. Present on admission? No. NEW INTERVENTIONS: float heels, turn with care interventions, avoid positioning resident directly on skin breakdown. On 12/13/2022 at 11:49 A.M., the Director of Nursing indicated that an Event was not opened for the left heel it was place on wound management. An Admission Observation, dated 10/15/2022, indicated Resident 15's Braden Scale for pressure ulcer predictability, with a score of 15 which indicated at risk. The Braden's indicated: Activity: Mobility Resident's ability to change and control body position: 2. Very limited- Make occasional slight changes in body or extremity position, but unable to make frequently or significant changes independently. Friction and Shear: Describe any problems related to friction and shear: 2. Potential Problem - Moves feebly or requires minimum assist. During a move, skin probably slides to some extent, against sheets, chair, restraints or other device. Maintains relatively good position in chair and bed most of the time but occasionally slides down. A Treatment Administration History dated 10/1/2022 - 10/31/2022, indicated she had an order for Incontinence care- cleanse with personal cleanser and apply protective ointment/cream as needed after each incontinence episode, three times a day. Nystatin powder; 100,000 unit/gram; amount to administer: 1 application; topical, twice a day, apply to perineal area three times a day after the area has been cleansed and dried, and weekly skin assessment: 0=no impairment, 1= new impairment, 2=old impairment Other Test:, once a day on Thu.			

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	During an interview, on 12/13/2022 at 3:14 P.M., Resident 15 indicated, "My heels were not put on a pillow right away. There was nothing done. It would have been nice if they came in more and helped me when I got here." During an interview on 12/14/2022 at 2:55 P.M., the Director of Nursing indicated the orders should have been put into place when plan of care was initiated. On 12/15/2022 at 10:02 A.M., the Regional Nurse provided a policy titled, "Guidelines for Pressure Prevention," revised 12/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...PURPOSE To maintain good skin integrity and avoid development of pressure ulcers. PROCEDURES Care plan interventions shall be implemented based on risk factors identified in the nursing assessment. Interventions may include but not limited to: Activity/Mobility Elevate heels off the bed-avoid use of "heel protectors". Place on pressure relief mattress. Place on pressure reduction support surface (such as wheelchair cushion). Establish an individualized turning schedule if resident is immobile or compromised. Frequency of position change is individualized. Diagnosis: Assess diagnosis for impact on skin condition and healing process such as diabetes, PVD, etc...." 3.1-37(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources			

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	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure kitchen utensils, pots, colanders and dishes were covered and inverted, extra powder thickener was not poured back into its origional container, and clean thermometers were stored in a sanitary maner until reuse after cleaning with probe wipe, this effected 44 of 44 residents who received their meals from the kitchen. Findings include: 1. During an observation, on 12/9/2022 at 10:43 A.M., Cook 4 over filled the measuring cup with thickener and poured some of it back into the container. During an interview, on 12/9/2022 at 10:49 A.M., Cook 4 indicated she should not have poured it back in the container. 2. During an observation, on 12/9/2022 at 11:01	F 0812	F 812 1. There were no residents found to be affected by the stated deficient practice, however 100% of the residents have the potential to be affected. 2. An in-service was conducted for the dietary staff with focus on policy and procedure related to food storage. The Dietary Manager or designee will conduct random audits of food storage to ensure that food is stored in a safe and sanitary manner. An in-service was conducted for the dietary staff with focus on policy and procedure related on how to properly take food temperatures. An in-service was conducted for the dietary staff with focus on policy and procedure related to informing on if there is any over filling of the measuring	01/11/2023

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	A.M., observed Cook 5 temp the rice then clean the thermometer with a probe wipe and set the thermometer on the countertop behind him, he removed his gloves, washed his hands donned gloves picked the meter up and temped the vegetables. He continued the same steps after temping the vegetable and the fish. During an interview, on 12/9/2022 at 11:08 A.M., the Cook 5 indicated that they do sanitize the counter several times a day, but should have put it on a plate. 3. During the tour of the kitchen on 12/9/2022 at 11:10 A.M., observed the dishes on shelves on the side of the steam table facing up, uncovered with dust and crumbs on the shelf. The bottom shelf was approximately 12 inches from the floor. During an interview, on 12/9/2022 at 11:12 A.M., the Dietary Manager indicated that the dishes should have been turned over. On 12/13/2022 at 9:26 A.M., the Administrator provided a policy titled, "Food Temperatures-Serving Line", revised 7/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Proper procedures are used so that measured temperatures are accurate and contamination is prevented: B. Thermometers are clean, rinsed, and santized before, after, and in between use. An alcohol swab may be used to sanitize according to the manufactures instructions."... And she provided a policy titled, " Safety Guidelines", revised 3/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...J. 5. China or glasses will not be mixed with pots and pans when washing or stored in food preparation areas. K. Work Areas 3.		utensils, we cannot pour the excess food thickener back into the container. 3. To ensure the issue does not reoccur, beginning on (date) daily for 7 days, and weekly for 4 weeks, and then monthly. The dietary director or cook will verify that all kitchen utensils, pots, colanders, and dishes will be covered and inverted. All dishware, plates, utensils, pots, and pans will be clean and crumb free. To ensure the issue does not reoccur, beginning on (date) daily for 7 days, and weekly for 4 weeks, and then monthly. The dietary director or cook will verify that all while temping food takes place the thermometer cannot be placed on the table in between using it to take temperatures. To ensure the issue does not reoccur, beginning on (date) daily for 7 days, and weekly for 4 weeks, and then monthly. The dietary director or cook will verify that excess food thickener will not be poured back in the container. 4. The state audits will be conducted by DFS or designee at a rate of 2 times per week for 4 weeks and then every other week times 4 weeks for 3 months and then monthly for 2 months. The results of the audits will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus	

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	Keep cupboard, closet doors and drawers closed...." 3.1-21(i)3		Quality Assurance Committee (QA) for a minimum of 6 months then randomly thereafter for further recommendations.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review and interviews, the facility failed to ensure a glucometer was disinfected thoroughly by 1 of 1	F 0880	F 880 1. 1 resident was affected.	01/11/2023

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	nursing staff observed assessing blood sugar levels. (LPN 10) Finding includes: During an observation of a medication administration pass, conducted on 12/13/2022 at 12:20 P.M., LPN 10 was observed to gather supplies to obtain the blood sugar of Resident 41. LPN 10 then washed her hands, donned gloves and carried the supplies to the resident and obtained the blood glucose level for the resident. After completing the blood glucose test, LPN 10 disposed of the used lancet and test strip, removed her gloves and washed her hands. She then donned another pair of gloves and wiped the glucometer machine with an alcohol wipe. When asked if this was the "normal" way she disinfected the glucometer, LPN 10 did not answer. After pushing the medication cart back to the nurse's station area, LPN 10 proceeded to chart on the computer for a few minutes. After a few minutes, LPN 10 verbally stated, "I'm done." LPN 10 made no attempt to disinfect the glucometer. Review of the facility policy and procedure, titled "Glucometer Cleaning and Control Test Guidelines" provided by the Regional Nurse Consultant, RN 14 on 12/14/2022 at 2:00 P.M. included the following instructions: "Procedures: 1. If glucometers are used from one resident to another, they should be cleaned and disinfected after each use. 2. Clean glucometer surface when visible blood or bloody fluids are present by wiping with a cloth dampened with soap and water or isopropyl alcohol to remove any visible organic material prior to disinfecting. 3. See manufacture guidelines for cleaning an disinfecting...."		Glucometer was sanitized per manufacturer's guidelines immediately. Employee was educated immediately. 2. All residents with an order for blood glucose checks have the potential to be affected 1. All staff education completed. 2. 100% audit completed of all residents with an order for blood glucose checks. 3. As a measure of ongoing compliance, the Director of Health Services (DHS) or designee will complete random audits to ensure glucometer machines are being disinfected per manufacturer's guidelines weekly x4 weeks, then every other week x2 months, then monthly x 3 months. All findings from the current audit will result in additional audits if warranted. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	Review of an additional facility policy and procedure, titled "Guidelines for performance of blood glucose monitoring and glucometer maintenance" provided by the Administrator on 12/15/2022 at 10:37 A.M. included the following procedures: "...7. Glucometer machines shall be cleaned between residents according to manufacture recommendations as needed...." A second form, untitled included the following information: "Option 2 Clean the outside of the blood glucose meter with a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%), Disinfect the meter by diluting 1 ml of household bleach (5-6%) sodium hypochlorite solution) in 9 ml water to achieve a 1:10 dilution. Use a lint-free cloth dampened with the solution to thoroughly wipe down the meter...Cleaning and Disinfecting Procedures: "Note Two disposable wipes are needed for each cleaning and disinfecting procedure, wipe for cleaning and a second wipe for disinfecting...Disinfecting Step 5 Pull out 1 new towelette and wipe the entire surface of the meter horizontally and vertically to remove bloodborne pathogens. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. This prevents disinfectant liquid from entering the meter...Step 6 Treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions...." During an interview with the Administrator, conducted on 12/15/2022 at 10:37 A.M., she indicated the facility's policy indicated it was acceptable to clean the glucometer with an alcohol wipe." During an interview with the Director of Nursing, conducted on 12/15/2022 at 11:00 A.M., she indicated LPN 10 was new and could not locate			

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	the "purple wipes" (disinfecting wipes) She indicated the nurse, after being assisted to locate the correct wipes, had disinfected the glucometer. 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit incuded the investigation of Nursing Home Complaint IN00393796. Complaint IN00393796- Unsubstantiated due to lack of evidence Survey dates: December 7, 8, 9, 12, 13, 14 and 15, 2022 Facility number: 013302 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 12/29/22.	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of South Bend Assisted Living that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of South Bend Assisted Living. The 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 skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interviews, the facility failed to ensure service plans were signed and dated by the resident for 3 of 7 residential clinical records reviewed. (Resident 5 and 4) Findings include:	R 0217	R 0217 1. Two Residents were affected, service plans were immediately signed. 2. Any resident that admits to Residential has the potential to be affected. Education was provided	01/11/2023

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	1. The closed clinical record for Resident 5 was reviewed on 12/15/2022 at 12:00 P.M. Resident 5 was admitted to the facility assisted living on 9/16/2022 from the facility health care campus. The Eval and Service plan for Resident 5, dated 9/16/2022 was not signed by the resident. The signature section on the form was left blank and was not dated. 2. A clinical review was completed, on 12/15/22 at 3:00 P.M., for Resident 4, the diagnoses included, but not limited to: type 2 diabetes, hypertension, seizures, and nontraumatic intracranial hemorrhage. During an interview on 12/15/2022 at 1:29 P.M.,, the Director of Nursing indicated that the residents service plan, dated 10/12/2022 was not signed by the resident or responsible party and should have been. On 12/15/2022 at 1:44 P.M., the Regional Nurse provided a policy titled, "Assisted Living Evaluation and Service Plan Guidelines," revised 3/24/2022, and indicated this is the policy currently used by the facility. The policy did not indicate that the service plan needs to be dated or signed by the resident.		to Director of Assisted Living on ensuring that service plans were signed upon admission. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 service plans for signatures weekly for four weeks, then every other week for two months, then monthly for three months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.			

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	Based on record review and interview, the facility failed to ensure authorizations for as needed medications administered by a qualified medication aide were documented in the medical record in 1 of 7 residents reviewed for medications. (Resident 4) Findings include: A clinical record was reviewed, on 12/15/2022 at 10:30 A.M., and indicated Resident 4 diagnoses included, but not limited to: type 2 diabetes, hypertension, seizures, and nontraumatic intracranial hemorrhage. Resident 4's Physician Orders, dated 11/28/2022, indicated she was receiving lorazepam 1 mg (milligram) tablet, oral, every 4 hours as needed for anxiety/restlessness. A Medication Administration Record, dated 11/30/2022 indicated Resident 4 had received the anxiolytic medication on 11/30/2022 which was administered by a QMA 11 (qualified medication aide). During an interview, on 12/15/2022 at 1:30 P.M, the Director of Nursing indicated that the as needed lorazepam was administered for anxiety by a QMA, the documentation should have been in the progress notes or an observation if it had been authorized by a nurse and the documentation was not available. On 12/15/2022 at 1:44 P.M., the Regional Nurse provided a policy titled," ADMINISTRATION OF PRN MEDICATIONS", dated 5/10/2016, and indicated the policy was the one currently used by the facility. The policy indicated "...SOP DETAILS 1. Prior to administration of PRN	R 0246	1. One resident was affected. QMA immediately educated in writing that documentation of nurse assessment of resident's need of prn medication prior to administration. 2. Any resident receiving prn medication has the potential to be affected. All CRMA's who administer prn medication have been educated. 3. As a measure of ongoing compliance, the DHS or designee will monitor 3 prn administrations for documentation of nurse approval two times weekly for four weeks, then every week for two months, then monthly for three months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	01/11/2023

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	medications, the nurse shall review the orders and note any parameters for administration. 2. Non-pharmacological interventions shall be attempted and documented prior to administration of PRN medications. 3. Documentation should reflect the reason for administering the PRN medication. a. i.e.: c/o of headache, symptoms of anxiety such as pacing, wringing hands, c/o of hip pain r/t recent ORIF. 4. If PRN medication is to be administrated by a QMA the Standard of Practice for PRN, medication administration by a Qualified Medication Assistant shall be observed under the direction of a licensed nurse. 5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects...." On 12/15/2022 at 2:05 P.M., the Director of Nursing provided the Qualified Medication Aide Scope of Practice, the scope indicated, "...The following tasks are within the scope of practice for the QMA unless prohibited by facility policy: (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the residents record symptoms indicating the need for the medication symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty...."			

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R 0273 Bldg. 00	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. Based on observation and interview, the facility failed to ensure kitchen utensils, pots, colanders and dishes were covered and inverted, and thermometer was placed on the counter after cleaned with probe wipe this effected 37 of 37 residents who received their meals from the kitchen. Findings include: 1. .During an observation, on 12/9/2022 at 11:01 A.M., observed Cook 5 temp the rice then cleaned the thermometer with probe wipe set the thermometer on the countertop behind him, removed his gloves, washed his hands donned gloves picked the meter up and temped the vegetables. He continued the same steps after temping the vegetable and the fish. During an interview, on 12/9/2022 at 11:08 A.M., the Cook 5 indicated that they do sanitize the counter several times a day, but should have put it on a plate. 2. During the tour of the kitchen, on 12/9/2022 at 11:10 A.M., observed the dishes on shelves on the side of the steam table facing up, uncovered with dust and crumbs on the shelf. The bottom shelf is approximately 12 inches from the floor. During an interview, on 12/9/2022 at 11:12 A.M., the Dietary Manager indicated that the dishes should have been turned over.	R 0273	R 0273 1. 37 residents had the potential to be affected. 2. Any resident that admits to Residential has the potential to be affected. Education was provided to Cooks regarding the placement of the thermometer on a plate after temping food, and not placing it back on the counter. Education was also provided to dietary staff on proper storage of dishes, keeping them inverted, and covered to ensure a safe and sanitary manner. 3. As a measure of ongoing compliance, the DFS or designee will audit thermometer placement on a plate and proper storage of dishes weekly for four weeks, then every other week for two months, then monthly for three months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	01/11/2023

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	On 12/13/2022 at 9:26 A.M., the Administrator provided a policy titled, "Food Temperatures-Serving Line", revised 7/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Proper procedures are used so that measured temperatures are accurate and contamination is prevented: B. Thermometers are clean, rinsed, and santized before, after, and in between use. An alcohol swab may be used to sanitize according to the manufactures instructions."... And she provided a policy titled, " Safety Guidelines", revised 3/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...J. 5. China or glasses will not be mixed with pots and pans when washing or stored in food preparation areas. K. Work Areas 3. Keep cupboard, closet doors and drawers closed...."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review and interviews, the facility failed to ensure 1 of 3 nursing staff administering medication to 1 of 5 residents observed receiving medications followed the facility policy and manufacturer's instructions regarding insulin injections from an insulin pen. (QMA 11, Resident 6) Finding includes: During an observation of medication administration, conducted on 12/14/2022 at 11:35	R 0296	R0296 1. One resident was affected. QMA immediately educated in writing on proper insulin priming. Return demonstration completed with no concerns noted. 2. Any diabetic resident who receives insulin via pen has the potential to be affected. All employees who administer insulin have been educated. 3. As a measure of ongoing	01/11/2023

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	A.M., QMA 11, retrieved Resident 6's Humalog insulin pen from the top drawer of the medication cabinet. After placing the needle onto the end of the pen, she then proceeded to move the dial end of the pen to "3." She indicated the resident was supposed to get 5 units and she would give him 3 units with the pen from the drawer and then she would have to go get a "new" pen for the resident. She then proceeded to approach Resident 6, obtained his permission to administer the insulin, swabbed the resident's left lower abdominal area, pinch the skin with her thumb and forefinger and administered the insulin, via the pen, with her other hand. She did not prime the insulin pen prior to administering the medication. She then disposed of the empty insulin pen, and obtained a new pen from the medication room, located on the health care 200 hall. She then, after cleaning the end of the new insulin pen with alcohol, placed a new needle onto the end, moved the dial to the "2" on the dial, swabbed the resident left lower abdomen with alcohol, pinched his skin and administered the insulin via the pen. She again, did not prime the insulin pen prior to the administration of the insulin. When queried regarding the need to prime the insulin pen, QMA 11 indicated she knew what priming was but thought it was only required for other types of injections. Review of the facility policy and procedure, titled, "Specific Medication Administration Procedures," provided by the Regional Nurse Consultant on 12/14/2022 at 2:50 P.M., included the following: "...Pen Devices: Dial dose as instructed by pen manufacturer..." Review of the manufacturer's instructions for use of the Humalog KwikPen, provided by the Director of Nursing on 12/15/2022 at 9:05 A.M.,		compliance, the DHS or designee will observe insulin administration three times weekly for four weeks, then every other week for two months, then monthly for three months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	included the following: "...Priming your Pen Prime before each injection. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6. To prime you Pen, turn the Dose Knob to select 2 units. Step 7. Hold you pen with the needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8 Continue holding your pen with needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in he Dose Window. Hold the Dose Knob in and count to 5 slowly. Your should see insulin at he tip of the needle....."			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility	R 0356	R 0356	01/11/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING 00 B. WING	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	52565 STATE ROAD 933 SOUTH BEND, IN 46637

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	failed to ensure that all the required information was provided in the Emergency Information File for 3 out of 7 records reviewed. (Residents 1, 2, 3) Findings include: 1. A clinical record review was conducted, on 12/14/2022 at 11:15 A.M., for Resident 1, diagnoses included but not limited to: type 2 diabetes, anxiety disorder, hypertension, hyperlipodemia, cerebral infarction D/T occlusion or stenosis. Resident 1 was admitted to the facility on 9/21/2022. A review of the Emergency Information File indicated that the hospital preference was not included. During an interview on 12/15/2022 at 11:25 A.M., the Administer indicated that the hospital preference should have been included in the Emergency Information File. 2. On 12/14/2022 at 1:45 P.M., a clinical record review of Resident 3 was conducted. Review of the Emergency Information File indicated that a hospital preference had not been identified 3. On l2/15/2022 at 2:10 P.M., a clinical record review of Resident 2 was conducted. Review of the Emergency Information File indicated that a hospital preference had not been identified. On 12/15/2022 at 11:20 A.M., during an interview with the Director of Nursing, she indicated the required information for residents should be available in their Emergency Information File. Review of the facility policy and procedure, titled AL (Assisted Living) Emergency Assistance Guidelines" provided by the Director of Nursing		1. Resident number 1, 2, and 3 were affected. QMA immediately educated in writing on proper insulin priming. Return demonstration completed with no concerns noted. 2. All residents have the potential to be affected. 100% audit completed and all deficiencies corrected immediately. 3. As a measure of ongoing compliance, the DHS or designee will audit 5 charts to ensure preferences are in place three times weekly for four weeks, then every other week for two months, then monthly for three months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	on 12/15/2022 at 10:24 A.M. included the following procedures: "...2. The file shall contain the following information:...b. The resident's hospital preference...."			