STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155808	A. BUILDING 00 B. WING	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

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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 also included the Investigation of Nursing Home Complaint IN00394060. Complaint IN00394060 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: January 23, 24, 25, 26, 27 and January 30, 2023. Facility number: 012937 Provider number: 155808 AIM number: 201208220 Census Bed Type: SNF/NF: 22 SNF: 29 Residential: 28 Total: 79 Census Payor Type: Medicare: 22 Medicaid: 16 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 6, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield 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 Westfield. 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 0554 SS=D	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roger Piotrowicz	Executive Director	02/14/2023

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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Bldg. 00	§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure residents had been assessed for self-administration of medications before leaving medications unattended for 2 of 2 residents reviewed for self-administration of medication. (Resident 26 and C) Findings include: 1. During an observation, on 01/24/23 at 8:49 a.m., Resident 26 was observed in bed. A medication cup with pills was found on the bedside table. There was no nursing staff present in the room. The record for Resident 26 was reviewed on 01/24/23 at 5:02 p.m. Diagnoses included, but were not limited to, acute kidney failure, unspecified lung disease, and acute and chronic respiratory failure. There was no self-administration of medications assessment, order, or care plan found in the resident's record. During an interview, on 01/24/23 at 8:54 a.m., LPN 1 indicated the medications were not to be left at the bedside, she left the medications on the table. She was returning to check on the resident. 2. The record for Resident C was reviewed on 01/30/23 at 09:53 a.m. Diagnoses included, but were not limited to, spinal stenosis lumbar region, disorder of the urinary system unspecified, and unspecified abdominal pain.	F 0554	. Residents 26 and “C” were affected. No adverse occurrences noted. LPN #1 was educated regarding leaving meds at bedside and the self administration policy. 2. All residents have the potential to be affected. An audit was conducted to ensure no medications left at bedside without “may keep at bedside” orders and observations in place. Education was provided to nurses and qualified medication aides on the Self administration of medications policy. 3. As a measure of ongoing compliance, the Director of Health Services or designee will complete an audit to ensure appropriate medication administration observation. Audits to be completed on 5 residents weekly for 4 weeks, then every other week for 2 months, and 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.	02/23/2023

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	A nursing note, dated 12/03/22 at 12:31 a.m., indicated "...Resident asked writer to leave meds with her that she will take them in a few. Writer left meds with Resident...." There was no self-administration of medications assessment, order, or care plan found in the resident's record. During an interview, on 01/25/23 at 10:08 a.m., the Director of Nursing indicated the facility was to do a self-administration of medications assessment, get orders from the physician to self-administer, and update the care plan prior to allowing residents to self-administer their medications. A facility policy, titled "Guidelines for Self-Administration of Medications," dated as revised on 05/22/18 and provided by the Corporate Support Nurse on 01/24/23 at 10:37 a.m., indicated "...Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed...Results of the assessment will be presented to the physician for evaluation and an order for self-medication...." 3.1-11(a)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the			

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	resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure all residents were free from abuse, including but not limited to physical abuse or intimidation for 2 of 2 residents alleging such incidents of abuse. (Resident 17 and 40) Findings include: 1. During the initial tour of the facility, on 01/23/2023 at 10:30 a.m., Resident 17 indicated a staff member had "choked" her till she "almost passed out". She indicated the incident occurred in the resident's bathroom when the staff member was assisting her from the commode to her chair. Prior to the event, there had been an argument and "yelling" between her and the staff member. The resident was unable to remember what the argument was about but recalled the staff member said to her, "I'll show you" and proceeded to choke the resident. The resident indicated she had talked with "the man in charge" and he stated the staff member would no longer care for her. The record for Resident 17 was reviewed on 01/23/2023. Diagnosis included, but were not limited to, fracture of T9-T10 vertebrae, diabetes mellitus, encephalopathy (a brain disease), and depressive disorder. Documentation was lacking in the progress notes of any event. On 01/24/2023 at 3:40 p.m., Resident 17 was	F 0600	1. Residents 17 and 40 were affected without adverse occurrences noted. An investigation was initiated immediately and allegations were reported through the Gateway survey report system immediately. Education was provided to ED, DHS, ADHS on abuse policy and procedure as well as reportable guidelines per IDOH. 2. All residents have the potential to be affected. All staff educated on the Abuse and Neglect policy as well as reportable guidelines. Clinical staff educated on transfers and appropriate gait belt use. 3. As a measure of ongoing compliance, ED or designee to complete random audits of abuse policy comprehension of 5 employees weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months. DHS or designee will audit transfers of 5 residents weekly x4 weeks, then biweekly x 8 weeks, then monthly x3 months to ensure compliance.	02/23/2023

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	interviewed by a different surveyor regarding the allegation. The resident again indicated "an aide" was transferring her from the commode to her chair and indicated she was choked and "almost passed out". During an interview, on 01/24/2023 at 3:56 p.m., the Executive Director (ED) indicated he had been made aware of the allegation by a therapy staff member. The aide indicated her "arms slipped" upwards towards the resident's throat area and added he did not believe this was abuse. The aide told him she and Resident 17 had "yelled at each other" but added he didn't "know anything about that". The CRCA was reassigned to the 200 unit. Documentation regarding the investigation of the allegation was requested at that time. An "Investigation Summary" was received from the ED on 01/24/2023 at 3:56 p.m. The summary indicated the alleged incident had occurred on 01/11/2023 and had been reported on 01/11/2023 at 11:45 a.m. The description of the allegation indicated "Resident stated staff grabbed her and she felt she was being choked. Notified by therapist" The timeline of event indicated "Happened during resident transfer from toilet" The Critical Factors indicated "Staff member stated she was helping her up and grabbed around chest to help transfer" Summary of Investigation indicated "It was a simple transfer and staff asked to transfer different unit in facility". During an interview, on 01/26/2023 at 10:17 a.m., the Therapy Director indicated a therapy aide reported to her when she arrived at Resident 17's room, she alleged she was "choked" in the bathroom. The aide immediately placed the resident in a wheelchair and brought her to the		4. As a quality measure, the ED 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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	therapy room. She immediately reported to the ED, who came to the therapy room to interview the resident privately. The Therapy Director indicated she was aware of an entry in the therapy notations regarding the allegation. The occupational therapy note, dated 1/11/2023, indicated "...found in pt (patient) restroom reporting CNA (Certified Nursing Assistant) had physically assaulted her by choking her after an argument between pt and CNA. CNA walked be (sic) the room to get pt for lunch w (with) pt stating 'and this is her'..." During an interview with the ED and CSN (Corporate Support Nurse), on 01/26/23 at 2:14 p.m., the ED indicated he didn't feel the allegation was an "intentional act of abuse". CNA 23 was assisting the resident from the commode to her chair. He denied having knowledge of an "argument" or yelling prior to the event. 2. During a room visit with Resident 40, on 01/26/2023 at 4:50 p.m., a resident family member was present and indicated a couple of weeks ago she had received a phone call very early in the morning the resident had fallen from his bed. When she arrived at the facility, the resident told her the night nurse had been "very rude and short" when she came to the room to help the resident following the fall. The room was in disarray, with the over-the-bed table across the room and not in reach and the bed was pulled out from its original position. The resident told her, following the fall, the over-the-bed table was overturned, and personal items were strewn across the floor. When he asked for these items, RN 18 picked up his phone and threw it at the resident, striking him in the stomach. RN 18 allegedly also threw the tv remote and a full box of Kleenex at the resident. The resident indicated the			

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	information the family member relayed was correct and he was not injured, and it was "over". The family member also indicated RN 18 would frequently place the resident's remote to his electric bed out of the resident's reach, after telling the resident he had his bed up too high. On 01/26/2023 at 6:40 p.m., an email was received from a family member. The email indicated the following: "On the morning of Saturday, January 14th, I received a call from the night shift nurse (RN 18) informing me that my dad had fallen out of bed. She said he was not injured. When I arrived to his room, it was still not back in order. He then told me that (RN 18) was very rude and upset with him. He said, "she went bananas on me because I asked her to move my tray back so I could reach my things". She told him she was too busy for that. She proceeded to throw his cell phone hitting him in the stomach. She then threw his TV remote and a box of tissues at his stomach. She stormed out of the room and told him she hoped he didn't need anything else. (His remote had been jarred to the point the TV would not come on until I reset it) I immediately went to the nurses station to report the incident." During an interview, on 01/27/2023 at 9:19 a.m., the ADNS (Assistant Director of Nursing Services) indicated she recalled the family member alleging the night shift staff were "not being nice" to Resident 40. She was aware of the nurse throwing the resident's phone, the tv remote, and a box of tissues at the resident. Resident 40 was "very impatient at night" and the resident was "very particular" regarding the arrangement of his room, such as he wanted "the wheelchair a certain way" and the "over-the-bed table right next to the bed." She investigated "the throwing of the items" and			

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	sent a note to the ED. The response of the ED was to not allow RN 18 to care for Resident 40. The record for Resident 40 was reviewed on 01/25/2023 at 1:26 p.m. Diagnosis included, but were not limited to, pneumonia, bronchitis, chronic pulmonary disease, and emphysema. The resident's MDS (Minimum Data Set) assessment, dated 12/20/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 11 which indicated a minimal cognitive deficit. During an interview, on 01/27/2023 at 2:23 p.m., the DNS (Director of Nursing Services) indicated she was informed of the incident by the ADNS through an email to herself and the ED. All allegations were investigated by the ED, and she followed his instruction regarding any corrective action which needed to be taken. A current policy, titled "Abuse and Neglect Procedural Guidelines," dated as last reviewed on 10/24/2022 and received at the time of entrance, indicated "...developed and implemented processes, which strive to ensure the preventions and reporting of suspected or alleged resident abuse and neglect...Physical abuse - Includes, but is not limited to hitting, slapping punching, biting and kicking. It also includes controlling behavior through corporal punishment. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to...hitting with an object...Reporting/response - Any staff member, resident visitor or resident representative may report known or suspected abuse, neglect, exploitation or misappropriation to local or state agencies...Ensure that all alleged			

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	violations involving abuse, exploitation, neglect, or misappropriation of mistreatment immediately, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made...or not later than 24 hour if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures...A written report of the investigation outcome, including resident response and/or condition, final conclusion, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days...." 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the			

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	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure alleged violations of abuse were reported to the State Survey Agency as required for 2 of 2 allegations of abuse reviewed for reporting. (Resident 17 and 40) Findings include: 1. During the initial tour of the facility, on 01/23/2023 at 10:30 a.m., Resident 17 indicated a staff member had "choked" her till she "almost passed out". She indicated the incident occurred in the resident's bathroom when the staff member was assisting her from the commode to her chair. Prior to the event, there had been an argument and "yelling" between her and the staff member. The resident was unable to remember what the argument was about but recalled the staff member said to her, "I'll show you" and proceeded to choke the resident. The resident indicated she had talked with "the man in charge" and he stated the staff member would no longer care for her. The record for Resident 17 was reviewed on 01/23/2023. Diagnosis included, but were not	F 0609	1. Residents 17 and 40 were affected without adverse occurrences noted. An investigation was initiated immediately and allegations were reported through the Gateway survey report system immediately. Education was provided to ED, DHS, ADHS on abuse policy and procedure as well as reportable guidelines per IDOH 2. All residents have the potential to be affected. All staff educated on the Abuse and Neglect policy as well as reportable guidelines 3. As a measure of ongoing compliance, ED or designee to complete random audits of abuse policy comprehension of 5 employees weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months 4. As a quality measure, the	02/23/2023

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	limited to, fracture of T9-T10 vertebrae, diabetes mellitus, encephalopathy (a brain disease), and depressive disorder. Documentation was lacking in the progress notes of any event. During an interview, on 01/24/2023 at 3:56 p.m., the Executive Director (ED) indicated he had been made aware of the allegation by a therapy staff member. The aide indicated her "arms slipped" upwards towards the resident's throat area and added he did not believe this was abuse. The aide told him she and Resident 17 had "yelled at each other" but added he didn't "know anything about that". The CRCA was reassigned to the 200 unit. Documentation regarding the investigation of the allegation was requested at that time. An "Investigation Summary" was received from the ED on 01/24/2023 at 3:56 p.m. The summary indicated the alleged incident had occurred on 01/11/2023 and had been reported on 01/11/2023 at 11:45 a.m. The description of the allegation indicated "Resident stated staff grabbed her and she felt she was being choked. Notified by therapist" The timeline of event indicated "Happened during resident transfer from toilet" The Critical Factors indicated "Staff member stated she was helping her up and grabbed around chest to help transfer" Summary of Investigation indicated "It was a simple transfer and staff asked to transfer different unit in facility". The allegation occurred on 01/11/2023 and was not reported to the State Agency until 1/25/2023. During an interview with the ED and CSN (Corporate Support Nurse), on 01/26/23 at 2:14		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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	p.m., the ED indicated he didn't feel the allegation was an "intentional act of abuse". CNA 23 was assisting the resident from the commode to her chair. He denied having knowledge of an "argument" or yelling prior to the event. 2. During a room visit with Resident 40, on 01/26/2023 at 4:50 p.m., a resident family member was present and indicated a couple of weeks ago she had received a phone call very early in the morning the resident had fallen from his bed. When she arrived at the facility, the resident told her the night nurse had been "very rude and short" when she came to the room to help the resident following the fall. The room was in disarray, with the over-the-bed table across the room and not in reach and the bed was pulled out from its original position. The resident told her, following the fall, the over-the-bed table was overturned, and personal items were strewn across the floor. When he asked for these items, RN 18 picked up his phone and threw it at the resident, striking him in the stomach. RN 18 allegedly also threw the tv remote and a full box of Kleenex at the resident. The resident indicated the information the family member relayed was correct and he was not injured, and it was "over". The family member also indicated RN 18 would frequently place the resident's remote to his electric bed out of the resident's reach, after telling the resident he had his bed up too high. The record for Resident 40 was reviewed on 01/25/2023 at 1:26 p.m. Diagnosis included, but were not limited to, pneumonia, bronchitis, chronic pulmonary disease, and emphysema. The resident's MDS (Minimum Data Set) assessment, dated 12/20/2022, indicated the resident had a BIMS (Brief Interview for Mental			

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	Status) score of 11 which indicated a minimal cognitive deficit. During an interview, on 01/27/2023 at 9:19 a.m., the ADNS (Assistant Director of Nursing Services) indicated she recalled the family member alleging the night shift staff were "not being nice" to Resident 40. She was aware of the nurse throwing the resident's phone, the tv remote, and a box of tissues at the resident. Resident 40 was "very impatient at night" and the resident was "very particular" regarding the arrangement of his room, such as he wanted "the wheelchair a certain way" and the "over-the-bed table right next to the bed." She investigated "the throwing of the items" and sent a note to the ED. The response of the ED was to not allow RN 18 to care for Resident 40. During an interview, on 01/27/2023 at 2:23 p.m., the DNS (Director of Nursing Services) indicated she was informed of the incident by the ADNS through an email to herself and the ED. All allegations were investigated by the ED, and she followed his instruction regarding any corrective action which needed to be taken. The allegation occurred on 01/14/2023 and was not reported to the State Agency until 1/25/2023. A current policy, titled "Abuse and Neglect Procedural Guidelines," dated as last reviewed on 10/24/2022 and received at the time of entrance, indicated "...developed and implemented processes, which strive to ensure the preventions and reporting of suspected or alleged resident abuse and neglect...Physical abuse - Includes, but is not limited to hitting, slapping punching, biting and kicking. It also includes controlling behavior through corporal punishment. Corporal punishment, which is physical punishment, is			

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	used as a means to correct or control behavior. Corporal punishment includes, but is not limited to...hitting with an object...Reporting/response - Any staff member, resident visitor or resident representative may report known or suspected abuse, neglect, exploitation or misappropriation to local or state agencies...Ensure that all alleged violations involving abuse, exploitation, neglect, or misappropriation of mistreatment immediately, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made...or not later than 24 hour if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures...A written report of the investigation outcome, including resident response and/or condition, final conclusion, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days...." 3.1-28(c)			
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-			

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	(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure the bed hold policy was provided to residents who transferred to the hospital or within 24 hours of the transfer to the hospital for 4 of 4 residents reviewed for notice of bed hold policy. (Residents 8, 15, 19 and 47) Findings include: 1. The record for Resident 8 was reviewed on 01/23/23 at 10:10 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and muscle weakness. A nursing note, dated 10/11/22 at 11:18 a.m., indicated Resident 8 was sent to the hospital for right sided weakness. There was no scanned or written documentation	F 0625	1. Residents 8, 15, 19 and 47 were affected without adverse occurrences noted. 2. All residents have the potential to be affected. An audit was conducted to ensure all residents whom had discharged from facility at time of discovery had been issued a bed hold policy. Education provided to nurses on Bed Hold Policy. 3. As a measure of ongoing compliance, the DHS or designee will audit to ensure bed hold policies had been issued to discharged residents. Audits to occur on 5 discharged residents	02/23/2023

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	in the record to show the bed hold policy was provided to the resident or responsible party. 2. The record for Resident 15 was reviewed on 01/23/23 at 10:04 a.m. Diagnoses included, but were not limited to, hematuria (blood in urine), vascular dementia, and anemia. A nursing note, dated 11/06/22 at 10:29 a.m., indicated the family was notified the resident was to be sent to the hospital. There was no note to indicate the bed hold policy was provided to the resident or responsible party. A nursing note, dated 11/06/22 at 10:42 a.m., indicated the resident was sent out to the hospital. There was no note to indicate the bed hold policy was provided to Resident 15. There was no scanned or written documentation in the record to show the bed hold policy was provided to the resident or responsible party. 3. The record for Resident 19 was reviewed on 01/23/23 at 10:22 a.m. Diagnoses included, but were not limited to, anemia, chest pain, and chronic obstructive pulmonary disease. A nursing note, dated 08/23/22, indicated the resident was sent out to the hospital for a decreased hemoglobin. There was no note to indicate the bed hold policy was provided to the resident or responsible party. A nursing note, dated 11/01/22, indicated the resident was sent out to the hospital for an increased heart rate. There was no note to indicate the bed hold policy was provided to the resident or responsible party.		weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 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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	There was no scanned or written documentation in the record to show the bed hold policy was provided to the resident or responsible party. 4. The record for Resident 47 was reviewed on 01/24/23 at 3:48 p.m. Diagnoses included, but were not limited to, hypertensive kidney disease, type 2 diabetes mellitus, and heart block. A nursing note, dated 12/27/22, indicated the resident was sent to the hospital due to unresponsiveness. There was no note to indicate the bed hold policy was provided to the resident or responsible party. There was no scanned or written documentation in the record to show the bed hold policy was provided to the resident or responsible party. During an interview, on 01/26/23 at 9:25 a.m., LPN 1 indicated the bed hold information was in the resident record under Events. During an interview, on 01/26/23 at 9:29 a.m., the Director of Nursing indicated she was not able to find bed holds under the Event tab in the residents' records. The bed hold document was to be provided by the social worker or business office within 24 hours. During an interview, on 01/27/23 at 8:31 a.m., Social Worker 22 indicated the nursing staff provides the bed hold policy when a resident went out to another provider, but if a resident discharged then she provided it, and it was put in the resident documents. During an interview, on 01/27/23 at 8:47 a.m., the Director of Nursing indicated she needed to look up how the bed hold policy worked.			

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	During an interview, on 01/27/23 at 9:51 a.m., the Director of Nursing indicated she was unable to find any notes or documents to show the residents had been provided with a bed hold policy. A facility policy, titled "Bed Hold Notification," dated as revised on 09/19/2018 and provided by the Director of Nursing on 01/27/23 at 10:10 a.m., indicated "...Before transferring a resident to a hospital...the Nursing designee or other designated staff member should provide written information to the resident and a family member or legal representative of the bed hold and admission policies...In cases of emergency transfers, the notice of bed hold policy under the state plan and facility's bed hold policy should be provided to the resident or resident's representative by nursing designee within 24 hours of the transfer. This may be sent with other papers accompanying the resident to the hospital...." 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)			
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 interview and record review, the facility failed to timely provide incontinence care to a dependent resident for 1 of 1 resident reviewed for Activities of Daily Living (ADLs). (Resident C) Finding includes:	F 0677	1. Resident C was affected without adverse occurrences noted. Incontinence care was provided. 2. All residents have the potential to be affected.	02/23/2023

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	During an interview, on 01/24/23 at 3:07 p.m., Resident C indicated she had pain around her bladder area and urine was taken for a urinalysis. About 20 minutes ago the nurse came to answer her call light, she informed the nurse she needed her brief changed. The nurse told her the CNA had gone on break. The nurse turned off the resident's call light and exited the room. The nurse did not change the resident. The record for Resident C was reviewed on 01/30/23 at 9:53 a.m. Diagnoses included, but were not limited to, spinal stenosis lumbar region, disorder of the urinary system unspecified, and unspecified abdominal pain. A care plan, initiated on 02/11/18, indicated "...Resident experiences episodes of bowel and bladder incontinence...." The interventions included, but were not limited to, "...Observe for signs and symptoms of UTI...Offer and assist with toileting as needed and per resident request...Provide incontinence care as needed...." A Minimum Data Set assessment, dated 12/3/22, indicated the resident was frequently incontinent and required total dependence from 1 staff member from toileting needs. A nursing note, dated 01/24/23 at 12:14 p.m., indicated the resident had complaints of abdominal pain and was concerned it could be a urinary tract infection. The urine was collected and sent out for a urinalysis along with a culture and sensitivity test (a test to check for a urinary tract infection, the type of bacterial growth, and the antibiotic which could be used to treat the infection). During an interview, on 01/24/23 at 3:14 p.m., LPN		Education provided to clinical staff regarding incontinence care. 3. As a measure of ongoing compliance, the DHS or designee will audit call light responses from nursing staff to ensure incontinence needs are met. Audits to occur on 5 residents weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 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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	14 indicated he did respond to the call light for Resident C. The resident wanted to be changed, but he did not change her. He did turn off the call light and left the room. During an interview, on 01/24/23 at 3:21 p.m., the Director of Nursing indicated the nurse could assist the resident with changing a brief. A facility job description, titled "Licensed Practical Nurse (LPN)," provided by the Corporate Support Nurse on 01/24/23 at 3:15 p.m., indicated "...Provide direct nursing care...." A facility policy, titled "Guidelines for Answering Call Lights," dated as revised on 05/11/16 and provided by the Director of Nursing on 01/25/23 at 3:00 p.m., indicated "Provide the service the resident requested and turn off the call light...If the service is unable to be provided do not turn off the call light until the appropriate staff is available to assist...." This Federal Tag relates to Complaint IN00394060. 3.1-38(a)(2)(C)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility	F 0684	1. Resident 21 was affected	02/23/2023

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	failed to provide the necessary care and services for a resident who had a change of condition and required hospitalization for 1 of 1 resident reviewed for quality of care. (Resident 21) Finding includes: The record for Resident 21 was reviewed on 01/23/23 at 2:30 p.m. Diagnoses included, but were not limited to, hemiplegia, cerebral infarction, diabetes, epilepsy, neuropathy, and contracture of the left shoulder, elbow, and hand. A Minimum Data Set (MDS) assessment, dated 07/25/22, indicated the resident was cognitively intact and had impairment on the left side of his upper body and lower body. A care area assessment (CAA), dated 07/25/22, indicated the resident required extensive assist with bed mobility, toileting, dressing, personal hygiene, and maximum assist with bathing and assist with all transfers. A care plan, dated 01/23/18 and updated on 01/24/23, indicated the resident had a potential for cardiovascular distress related to a diagnosis of hypertension and hyperlipidemia. Interventions included, but were not limited to, observe for signs and symptoms of cardiovascular distress and report as needed. An Occupational Therapy progress note, dated 01/17/23, indicated the resident was able to tolerate stretches and strengthening exercises with two-pound weighs for two sets of 20 on his right upper extremity. A Physical Therapy progress note, dated 01/18/23, indicated the resident had new signs and		without adverse occurrences noted. Education was provided on Change of Condition policy including resident assessment to nurse that sent resident 21 to hospital. 2. All residents have the potential to be affected. Education provided to nurses regarding assessment and change of condition, with MD and responsible party notification. 3. As a measure of ongoing compliance, the DHS or designee will audit change in condition events with notification to MD and responsible party for 5 residents weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 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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	symptoms of having difficulty opening his hand to retrieve a Kleenex and wipe his eye. He demonstrated an absence of right wrist and finger extension. The resident reported he had been dropping things and noticed a tremor in his hand. The progress notes further indicated the Director of Nursing and day shift nurse was notified. A progress note, dated 01/18/23 at 3:10 p.m., indicated therapy notified staff the resident required assistance to feed, and he had difficulty using his right wrist. A progress note, dated 01/18/23 at 10:41 p.m., indicated the resident had trouble using his right hand. A family member was in the facility and called the physician. The physician and family requested the resident be sent out to the hospital. A progress note, dated 01/18/23 at 3:57 p.m., recorded as a late entry on 1/25/23 at 8:01 a.m., indicated the physician gave order to send to the hospital for a neuro evaluation. Paramedics were called and arrived within five minutes. Vitals and assessment completed by paramedics. During an interview, on 01/24/23 at 3:24 p.m., a family member indicated she had concerns when she visited Resident 21 on 01/18/23. She observed the resident, he had weakness, and his right hand was drooping. The facility had not assessed the resident or contacted the physician on the change of condition. During an interview, on 01/24/23 at 4:00 p.m., the physician's office representative indicated the family member contacted office with a concern of a drop in the resident's right hand. During an interview, on 01/25/23 at 11:00 a.m.,			

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	Physical Therapist (PT) 8 indicated she observed the resident was different than normal. She first found him sleeping in the bathroom in his chair and he had a right-hand droop. She notified the nursing staff just before lunch, on 01/18/23 around 12:15 p.m., of the new change in condition. During an interview, on 01/25/23 at 11:27 a.m., the Director of Health Services (DHS) indicated no assessment had been completed for Resident 21, on 01/18/23, when he had a change of condition. Staff should have completed an assessment immediately when they were notified of the concern with the right wrist drop and it was a change of condition. During an interview, on 01/25/23 at 3:39 p.m., Registered Nurse (RN) 12 indicated she was not aware of a change in condition until shift change report in the afternoon. She was notified by RN 6 who indicated she did not assess the resident but did assist in feeding the resident at mealtime. RN 12 indicated the family member contacted the physician for recommendations and no assessment had been completed by facility staff. A current facility policy, titled "Notification of Change of Condition," dated as last reviewed on 12/1/21, indicated "...the facility must inform the resident, consult with the physician, and notify the resident's legal representative when a significant change in the resident's physical status... A reason included but not limited to a suspected cardiac or neurological event...." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer			

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	§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 provide treatment and services to adequately assess for pressure ulcers and to ensure physician's orders were followed for 1 of 1 resident reviewed for pressure ulcers. (Resident 43) Finding includes: During the initial tour of the facility, on 01/24/2023 at 9:20 a.m., Resident 43 was observed lying in bed, on her back, with a low air loss mattress on the bed. The resident's spouse, who was present in the room at the time of the observation, indicated the mattress was "new" and was placed on the bed on 01/19/2023. When asked about the resident's skin condition, the spouse indicated the resident had "a new wound" on her coccyx, adding "it took them some time to see the open area" due to the location. The area was small, and treatment included "packing" in the wound. The record for Resident 43 was reviewed on 01/23/2023 at 3:09 p.m. Diagnosis included, but were not limited to, pneumonia, diabetes mellitus,	F 0686	1. Resident 21 was affected without adverse occurrences noted. 2. All like residents have the potential to be affected. An audit was conducted to ensure all like residents are turned and repositioned per policy. In addition, an audit was conducted to ensure weekly skin assessments were entered for all residents. Nurses educated on following MD orders for treatments. An audit was also conducted to ensure any resident with a wound dressing had correct treatment in place. 3. As a measure of ongoing compliance, the DHS or designee will audit to ensure weekly skin assessments are completed. Audits to occur on 5 residents	02/23/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

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	hypertension, Hodgkin's lymphoma, and anorexia. A MDS (Minimum Data Set) assessment, dated 12/02/2022, section M indicated the resident was "at risk" for pressure ulcer development and had no pressure ulcers at the time of admission. A care plan, dated 12/03/2022, identified a problem of being at risk for skin breakdown related to needing assistance with ADLs (activities of daily living) and was incontinent. Interventions included, but were not limited to, conduct weekly skin assessments, pay particular attention to bony prominences, and to encourage and assist to turn and reposition. A progress note, dated 12/29/2022 at 10:10 a.m., by the wound nurse indicated "...Skin Sweep: No skin issues...." A progress note, dated 01/18/2023 at 12:21 p.m., indicated "...Noted pinpoint area on coccyx. Writer notified management of area and opened event. Applied preventative dressing...." A progress note, dated 01/19/2023 at 2:55 p.m., indicated " ...presents with newly identified PI (pressure injury) to sacrum at this time. According to self as well as spouse, resident has had PI to area in the past, has healed and re-opened...." A Wound Management Detail Report, dated 01/19/2023, described the location of the pressure ulcer to be on the resident's coccyx, and it was not present on admission. The wound was measured to be 1.1 cm (centimeters) in length, 1.1 cm wide with a depth of 0.6 cm. Comments included "Circular. Able to put cotton applicator 0.6 cm. Shin bridge present at 6 o'clock. Documentation was lacking the stage of the wound on this date.		weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 months. The DHS or designee will also audit for correct treatment application. Audit to occur on 5 residents weekly x4 weeks, then 5 residents bi-weekly x8 weeks, then 5 residents monthly x3 months. Furthermore, DHS or designee will audit to ensure like residents are turned and repositioned per skin tolerance for 5 residents weekly x4 weeks, then bi-weekly x8 weeks, then 5 residents monthly x3 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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The resident's Treatment Administration Record (TAR) from the time of the resident's admission, on 12/01/2022 through the present, indicated nurse skin assessments were completed on 12/06/2022, 12/08/2022, 12/15/2022, 12/22/2022, 12/29/2022, 01/05/2023, 01/12/2023, 01/19/2023 and 01/27/2023. "Old impairment" had been coded on the dates of 12/22/2022, 12/29/2022, 01/19/2023 and 01/26/2023. All other dates the resident was coded to have "no impairment". During an interview, the CSN (Clinical Support Nurse) indicated she was unaware why the resident was coded to have "old impairment" on these dates.

On 01/24/2023 at 2:07 p.m., the treatment to the area was observed with LPN 10, assisted by the ADNS (Assistant Director of Nursing Services). When the resident was rolled to her left side, a foam border dressing was observed to be securely in place on the resident's coccyx area. The dressing was dated 01/23/2023, with illegible initials. When LPN 10 removed the dressing, there was no packing observed in the resident's wound and none was found in the dressing. When questioned about the missing Iodoform strip, LPN 10 indicated she did not know why there was no packing found in the wound. The wound appeared circular in appearance, clean and without drainage. The wound was measured by LPN 10 to be 0.8 cm by 1.0 cm with a measurable depth of 0.5 cm. LPN 10 packed the wound with an Iodoform strip as ordered by the resident's physician and the wound was covered with a foam border dressing.

During an interview, on 01/23/2023 at 3:31 p.m., LPN 10, identified by the DNS (Director of Nursing) as the "wound nurse" indicated the pressure ulcer was a "stage 3" and indicated the

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	wound was discovered at that stage on 01/18/2023. During an interview, on 01/27/2023 at 2:06 p.m., the DNS indicated CRCAs (Certified Resident Care Assistants) were "supposed to do skin assessments" when bathing the residents and "if anything was found", they were "responsible to call the nurse" for evaluation. She indicated the nurse would then complete the assessment and open "an event" and notify the wound nurse. A current facility policy, titled "Guidelines for Weekly Skin Observation," dated as last reviewed on 03/16/2022 and provided by the CSN on 01/30/2023 at 11:00 a.m., indicated "...To monitor the effectiveness of intervention for pressure reductions, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated...A full body observations shall be completed week by the licensed nurse...In addition to the Weekly Observation by the licensed nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and peri care and notify the nurse if an area is identified...." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is			

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	unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to ensure a resident received assistance with mobility who was dependent on staff for ambulation for 1 of 1 resident reviewed for mobility. (Resident 25) Finding includes: During an observation and interview, on 01/24/23 at 10:36 a.m., Resident 25 was observed seated, in her recliner, in her room. She indicated she was blind but was able to ambulate in her room because she was familiar with the layout. She indicated "I need to get out of my room, I feel secluded." She was unable to walk in the hallways alone because she was unable to see obstacles, but the staff were too busy to walk with her. She enjoyed walking to keep up her strength. The record for Resident 25 was reviewed on 01/24/23 at 11:30 a.m. Diagnoses included, but were not limited to, legal blindness, and severe bilateral glaucoma. A visual Care Area Assessment, dated 05/24/22, was triggered due to blindness related to glaucoma.	F 0688	1. Resident 25 was affected without adverse occurrences noted. Initiated a walk to dine program for resident. 2. All like residents have the potential to be affected. An audit was conducted to ensure all like residents have been assessed for restorative programming. 3. As a measure of ongoing compliance, the DHS or designee will audit to ensure like residents being offered ambulation. Audits to occur on 5 residents weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 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	02/23/2023

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	A Minimum Data Set assessment, dated 11/28/22, indicated Resident 25 required the supervision of one staff for all activities of daily living except she was independent to walk in her room. A care plan, dated as updated on 01/25/23, indicated Resident 25 was at risk for falling related to a history of falls, high risk medications, blindness, essential tremor, and chronic pain. Interventions included, but were not limited to, use a rollator to walk long distances, and ambulate with family. The care plan lacked indication staff was to assist the resident with ambulation out of her room, in the hallways, of the facility. During an interview, on 01/25/23 at 9:30 a.m., the Director of Health Services indicated Resident 25 could leave her room by herself with the use of a walking stick. During an interview, on 01/25/23 at 10:42 a.m., the Director of Therapy indicated Resident 25 did not use a vision stick and required staff assistance to walk in the hallways for her safety due to the obstacles. The therapy department recommended Resident 25 have staff assist her to guide the walker due to her vision problems. Resident 25 was able to ambulate 400 feet with only staff assistance for guidance of her walker upon her therapy discharge. A policy was not provided before exit. 3.1-42(a)(2)		will be reviewed and updated as warranted.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including			

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	tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to store nebulizer masks/equipment in a sanitary manner and failed to ensure cautionary and safety signs indicating the use of oxygen were posted or 3 of 3 residents reviewed for respiratory care. (Resident 26, 4 and 3) Findings include: 1. During an observation, on 01/23/22 at 8:49 a.m., Resident 26 was observed in bed, the nebulizer mask (a mask used for the delivery of a breathing treatment) was found to be stored on top of the nebulizer machine. The mask was not stored in a bag. The record for Resident 26 was reviewed on 01/24/23 at 5:02 p.m. Diagnoses included, but were not limited to, acute kidney failure, unspecified lung disease, and acute and chronic respiratory failure. A physician's order, dated 09/16/22, indicated to give ipratropium-albuterol (a medication combination used to help control the symptoms of lung diseases, such as asthma, chronic bronchitis, and emphysema) solution for nebulization; 0.5 mg-3 milligrams/3 milliliters every six (6) hours as needed.	F 0695	1. 1. Resident 3, 4, and 26 was affected without adverse occurrences noted. Nebulizer order discontinued and the machine was removed from the room of resident 26. Resident 4's Oxygen tubing was replaced and date added to new tubing. Oxygen identified magnet was added to door entry of resident 3. 2. All like residents have the potential to be affected. An audit was conducted to ensure all like residents had respiratory tubing dated, all nebulizers cleaned and stored in labeled bag per policy and oxygen magnets on entry of every room utilizing O2. 3. As a measure of ongoing compliance, DHS or designee will audit 5 residents with respiratory equipment to have proper labeling and storage per policy. Oxygen magnets to be audited for placement per policy. Audits to occur weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months. 4. As a quality measure, the DHS or designee will	02/23/2023

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	2. During an observation, on 01/23/23 at 2:21 p.m., Resident 4's nebulizer mask was found to be stored on top of the nebulizer machine. The mask was not stored in a bag and the tubing had not been labeled with a date it was put into use. The record for Resident 4 was reviewed on 01/24/23 at 10:36 a.m. Diagnoses included, but were not limited to, senile degeneration of the brain, emphysema, and pneumonia. A physician's order, dated 06/04/22, indicated to give ipratropium-albuterol solution for nebulization; 0.5 mg-3 milligrams/3 milliliters every six (6) hours as needed. During an interview, on 01/24/23 at 8:54 a.m., LPN 1 indicated the nebulizer masks were to be washed and air dried, then stored in a bag.3. During an observation, on 01/23/23 at 9:27 a.m., Resident 3 was observed seated, in her recliner, in her room. The oxygen concentrator was on, and the nasal cannula was curled up on the resident's bed. No "oxygen in use" signage was on the door. During an observation, on 01/25/23 at 12:16 p.m., Resident 3 was seated, in her recliner, in her room wearing the nasal cannula with the oxygen concentrator on. No "oxygen in use" signage was on the door. During an observation, on 01/26/23 at 8:22 a.m., no signage was on the door of Resident 3 to indicate oxygen was in use. The record for Resident 3 was reviewed on 01/23/23 at 2:31 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic kidney disease, sleep apnea, cardiomegaly, and dementia.		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 care plan, dated 12/23/22, indicated Resident 3 had a potential for shortness of breath while lying flat related to COPD. Interventions included, but were not limited to, administer oxygen per physician's order and as needed.

A physician's order, dated 01/4/23, indicated to apply oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath.

A physician's progress note, dated 01/17/23 at 7:21 a.m., indicated Resident 3 had been seen for pneumonia and remained on oxygen at 2 liters per minute (LPM).

During an interview, on 1/25/23 at 1:35 p.m., the Director of Health Services indicated the use of oxygen for a resident would be identified by a magnet on the door.

During an interview, on 01/26/23 at 8:45 a.m., Licensed Practical Nurse (LPN) 10 indicated she was not aware Resident 3 was on oxygen.

A facility policy, dated as revised in May 2018 and provided by the Corporate Support Nurse on 01/24/23 at 10:37 a.m., indicated "...Place an "Oxygen in Use" sign on the outside of the room entrance door...."

A facility policy, titled "Respiratory Equipment," dated as revised on 05/11/16 and provided by the Corporate Support Nurse on 01/24/23 at 10:37 a.m., indicated "...Medication Nebulizers/Continuous Aerosol...Store circuit in plastic bag, marked with date and resident's name, between uses...."

3.1-47(a)(6)

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F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observations, interview and record review, the facility failed to appropriately assess a resident's pain who received scheduled and as needed narcotic pain medications for 1 of 1 resident reviewed for pain. (Resident 9) Finding includes: During an observation and interview, on 01/23/23 at 10:57 a.m., Resident 9 was seated in her Broda chair in her room. She was observed to have facial grimacing and moaning. Resident 9 indicated she had pain in her back. The record for Resident 9 was reviewed on 01/26/23 at 11:30 a.m. Diagnoses included, but were not limited to, ventral hernia, diabetic neuropathy, Parkinson's disease, and spinal stenosis. A Minimum Data Set assessment, dated 12/08/22, indicated Resident 9 had moderate cognitive impairment and required extensive assistance from staff for all activities of daily living. A Care Area Assessment, dated 12/08/22, was triggered due to pain and indicated to use routine and as needed medication as ordered. A care plan, dated 10/07/21, indicated Resident 9 was at risk for pain related to ventral hernia.	F 0697	1. Resident 9 was affected. As needed analgesics orders clarified to add tasks to record: pain scale, location, prior interventions as well as effectiveness. 2. All like residents have the potential to be affected. An audit was conducted to ensure as needed analgesics have appropriate tasks to record in health record: pain scale, pain location, prior interventions and effectiveness. Education provided to nurses regarding entering appropriate pain assessment when entering as needed analgesics. Education also provided on assessment of pain documentation prior to administration of as needed analgesics. 3. As a measure of ongoing compliance, DHS or designee will audit new as needed analgesics to determine appropriate tasks are in place (prior interventions, scale, location and effectiveness). 4. 4. As a quality measure, the DHS or designee will review	02/23/2023

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	Interventions included, but were not limited to, observe and record verbal and non-verbal signs of pain, reposition as needed, notify the physician of increased pain, administer medications as order and notify the physician for any side effects observed or lack of effectiveness, and attempt non-pharmacological interventions. Physician's orders included, but were not limited to: a. Dated 11/26/21, diclofenac sodium 1% gel. Apply to the right shoulder for pain. b. Dated 12/4/22, acetaminophen suppository 650 milligrams (mg) every four hours as needed for pain. c. Dated 12/4/22, Hydrocodone-acetaminophen tablet 5-325 mg by mouth three times day for pain. d. Dated 12/4/22, Hydrocodone-acetaminophen tablet 5-325 mg by mouth every four hours. e. Dated 12/4/22, morphine concentrate 100 mg/5 milliliters (ml) (20 mg/ml) give 5 mg/0.25 mg every two hours pain and shortness of breath. Resident 9's record lacked indication her pain severity was documented. During an interview, on 01/23/23 at 12:06 a.m., Licensed Practical Nurse (LPN) 1 indicated Resident 9 received scheduled and as needed pain medication to control her pain. During an interview, on 10/25/23 at 10:08 a.m., LPN 10 indicated staff should document a pain assessment once a shift. If a patient received an as needed pain medication staff should document a pain rating and the effectiveness of the medication in the administration record. During an interview, on 01/26/23 at 11:57 a.m., the Corporate Support Nurse (CSN) indicated staff		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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	had not been documenting a pain rating or location for the as needed medication. The order did not have the triggers for pain location and rating. Nursing should have been assessing and documenting the pain, location, and effectiveness when the pain medication was given. A current policy indicated each resident's pain induced its origin, location, severity, alleviating and exacerbating factors, current treatment and response would be observed and documented. 3.1-37(a)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record	F 0700	1. Resident 39 was affected	02/23/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

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	review, the facility failed to complete a bed rail assessment per an intervention by the Interdisciplinary Team (IDT) for 1 of 1 resident reviewed for accident hazards. (Resident 39) Finding includes: During an observation of Resident 39's room, on 01/23/23 at 11:43 a.m., side rails/mobility bars were found on the bed. The record for Resident 39 was reviewed on 01/25/23 at 11:39 a.m. Diagnoses included, but were not limited to, cerebral atherosclerosis, atrial fibrillation, and repeated falls. A nursing note, dated 12/29/22 at 3:30 p.m., indicated the resident was found on the floor. Resident "...may have climbed over the side rail after turning the bed on high position...." A nursing note, dated 12/30/22 at 10:24 a.m., indicated "...IDT Note: Resident had another fall on 12/29/22 @ 330pm. Patient had unwitnessed fall. Observed on the bedroom floor. Assessed for injury, none noted. Re-evaluate if bedrail is being used appropriately for bed mobility...." A care plan indicated the resident was at risk for falling. The interventions included, but were not limited to, re-evaluate if the bedrail was being used appropriately for bed mobility. A bed rail assessment, dated 12/30/22, was found in the record. The assessment was not filled out. During an interview, on 01/27/23 at 9:21 a.m., the Assistant Director of Nursing indicated if the bed rails were to be assessed, then the rails should have been assessed per the IDT note. The		with no adverse effects. Assessment for bed rails was completed and bed rails were removed. 2. All like residents have the potential to be affected. An audit was conducted for bed rail assessments. Education was provided to nurses on bed rail assessments. An order will be placed to complete bed rail observation/assessment for residents with orders for bed rails quarterly. 3. As a measure of ongoing compliance, DHS or designee will audit 5 residents with bed rails to ensure observation compliance. Audit to be completed weekly x4 weeks, then biweekly x8 weeks then monthly x3 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. F761 1. No residents were affected by the deficient practice. Medication and treatment storage carts were locked upon discovery. 2. All residents have the potential to be affected. An audit was conducted to ensure all	

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	assessment should have been completed. A facility policy, titled "Guidelines for the Use of Bed Rails," dated 10/09/17 and provided by the Assistant Director of Nursing on 01/27/23 at 10:33 a.m., indicated "...the resident is assessed for the use of bed rails...The campus must also assess the resident's risk from using bed rails...An event should be completed within the residents EHR (record)...." 3.1-45(a)(1)		medication and treatment storage carts were locked when unattended. Education was provided to clinical staff on medication storage policy. 3. As a measure of ongoing compliance, DHS or designee will round to ensure medication and treatment carts are locked when unattended. Audits to be conducted weekly x4 weeks, then bi-weekly x8 weeks, then monthly x3 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.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and			

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	permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored in accordance with professional standards in 1 of 1 medication cart and 1 of 1 treatment cart reviewed for medication storage. (200 Hall) Findings include: During an observation and interview, on 01/23/23 at 9:12 a.m., to 9:16 a.m., a medication cart located in the 200-unit hallway, 15 feet away from nurses' station was unlocked and unsecured. No staff were observed in the hallway or at the nurse's station. Registered Nurse (RN) 7 exited a resident's room and indicated she went to answer a call light. During an observation and interview, on 01/23/23 at 2:30 p.m., a medication cart was found unlocked and unsecured in the 200 Unit hallway. Licensed Practical Nurse (LPN) 14 exited Room 225 at 2:35 p.m. LPN 14 indicated he heard Resident 11 yelling for help. He should have secured the medication cart prior to leaving. During an observation, on 01/24/23, from 8:25 a.m.,	F 0761	1. Residents 200 and 900 were affected by alleged deficient practice. Medications were removed from residents' room at dining table. 2. All residents have the potential to be affected. An audit was conducted to ensure no medications left at bedside without "may keep at bedside" orders and observations in place. Education was provided to nurses and qualified medication aides on the Self administration of medications policy. 3. 3. As a measure of ongoing compliance, the Director of Health Services or designee will complete an audit to ensure appropriate medication administration observation. Audits to be completed on 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. 4. As a quality measure, the DHS or designee will review any	02/23/2023

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	to 8:45 a.m., the followed was observed: At 8:25 a.m., a treatment cart was observed unlocked and unsecured. Four unidentified residents were seated at a table near the nurse's station and a visitor exited Room 224. At 8:32 a.m., CNA 13 walked past the treatment cart carrying a breakfast tray for a resident. At 8:33 a.m., RN 12 exited Room 228 and walked past the treatment cart toward the nurse's station. At 8:34 a.m., an unidentified dietary aide passed the unlocked treatment cart and entered Room 224. At 8:36 a.m., CNA 13 walked past the treatment cart carrying a breakfast tray for Resident 226. At 8:37 a.m., CNA 13 walked past the treatment cart carrying a breakfast tray to Resident 13. During an interview, on 1/24/23 at 8:46 a.m., LPN 10 indicated the treatment cart was unlocked and unsecured. She indicated the treatment carts should be locked and secured when not in use. LPN 10 indicated the following biologicals were within the treatment cart: a. A container of Vanicream b. A tube of Diclofenac cream (a nonsteroidal anti-inflammatory drug (NSAID) used to treat mild-to-moderate pain) c. A tube of hydrocortisone cream (a topical used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) d. A tube of hemorrhoid cream (used for hemorrhoid symptoms) e. A tube of Anti-fungal cream (used to treat fungal skin infections) f. A container of Butt cream (used to provide protective layer on the most sensitive of skin for incontinence rash relief) g. A container of Aquaphor ointment (used to soothes and help protect skin) h. Eucerin cream: a moisturizer to treat or prevent		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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	dry, rough, scaly, itchy skin and minor skin irritations i. A tube of lidocaine ointment (used to numb or help with loss of feeling for patients having certain medical conditions) j. A tube of zinc oxide cream (used to treat or prevent minor skin irritations) A facility policy, titled "Medication storage in the facility," dated 1/17, indicated medications and biological are stored safely, securely, and properly, following manufactures recommendations of the supplier. 3.1-25(m)			
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 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			

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	standards for food service safety. Based on observation, interview and record review, the facility failed to ensure masks were worn correctly in the kitchen, failed to keep boxes off the floor of the freezer, failed to ensure foods were kept closed in the freezer and failed to ensure foods which had been opened were labeled with open dates. This deficient practice had the potential to affect 51 of 51 residents receiving food from the kitchen. Findings include: 1. a. During an observation of the kitchen with the Dietary Manager, on 01/23/22 beginning at 9:30 a.m., Cook 24 was observed working over a bowel of potatoes, which was prepared for all residents, with his face mask below his nose and chin. At that time, the Dietary Manager indicated the mask was to be worn over the nose and mouth. b. In the cooler, three (3) boxes were found stored on the floor. The Dietary Manager indicated the boxes should not have been stored on the floor, they were just put there. 2. a. During a follow up visit to the kitchen with the Dietary Manager in attendance, on 01/24/23 at 2:26 p.m., a box of hamburger patties was found in the freezer. The box was not sealed, and the patties were left open to air. b. A rectangular plastic container full of onion rings was found exposed to air due to the lid was resting on top of the container and not sealed. The container was over-filled, and the lid was not secured. c. A 40-ounce bag of onion rings approximately 1/8 full was found open and without an open date. d. A one gallon container of milk was found in the cooler. The container was half full and did not	F 0812	1. No residents were affected by the deficient practice. Education provided to cook #24 on face mask policy. Food storage boxes were removed from the floor in the walk in cooler. All open food boxes were closed. Open food items were labeled with open dates or discarded as appropriate. 2. All residents have the potential to be affected. Education provided to dietary staff on food storage policy, label and dating policy as well as face mask policy. An audit was conducted to ensure food items were properly dated and stored. 3. As a measure of ongoing compliance, the DFS (Director of Food Service) or designee will audit food storage areas to ensure proper labeling, dating and storage. Audits to be conducted 3x/week x 4 weeks, then weekly x4 weeks, then monthly x3 months. IP or designee to ensure proper face mask use daily. 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.	02/23/2023

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	have an open date. At that time, the Dietary manager indicated it should have had an open date on the container. e. A box containing 16 large Italian sausages was found open to air in the freezer. At that time, the Dietary Manager indicated it should not have been left open to air. f. A ten (10) pound box of catfish fillets, approximately 1/8 full was found open to air with ice crystals on the fillets. The Dietary Manager indicated the boxes were supposed to be closed after getting food items out of the boxes. g. A bag of mixed vegetables, 1/4 full, was found to be opened and sealed with plastic wrap. There was no date to indicate when the bag had been originally opened. A facility policy, titled "POLICY," dated as approved on 01/02/23 and provided by the Corporate Support Nurse on 01/30/23 at 12:42 p.m., indicated "...REFRIGERATED STORAGE...Food is covered, dated and stored loosely to permit air circulation...FROZEN STORAGE...All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn...Items are labeled and dated..." The policy did not address storing boxes on the floor of the freezer. A facility policy, titled "Food labeling and Dating Policy," dated as revised on 04/26/22 and provided by the Corporate Dietary Manager on 01/24/23 at 3:15 p.m., indicated "...Foods in production need both a production date AND a use by date...Foods are considered to be in production when they have been taken out of the original container AND the seal has been broken...All foods must be properly covered (not exposed to air)...."			

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	3.1-21(i)(3)			
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 communicable disease or infections should be reported; (iii) Standard and transmission-based			

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	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, interview and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure staff were wearing face	F 0880	Resident 104 was affected. Staff were immediately educated face mask policy. All residents have the potential to be affected. All staff to be	02/23/2023

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	masks correctly in the kitchen and while interacting with residents in the dining room for 2 of 2 staff members observed for infection control practices. (Cook 24 and Speech Therapist 17) Findings include: 1. During an observation of the kitchen with the Dietary Manager, on 01/23/22 beginning at 9:30 a.m., Cook 24 was observed working over a bowel of potatoes, which was prepared for all residents, with his face mask below his nose and chin. At that time, the Dietary Manager indicated the mask was to be worn over the nose and mouth. 2. During an observation of the breakfast service, on 01/27/23 at 8:36 a.m., Speech Therapist 17 was observed standing over Resident 104. Resident 104 was eating breakfast and the Speech Therapist was within 2 feet of the resident, her mask was worn under her chin. During an interview, on 01/27/22 at 8:36 a.m., Speech Therapist 17 indicated the resident was hard of hearing and she needed to take her mask down to let the resident read her lips, and masks were to be worn at all times in the facility. During an interview, on 01/27/22 at 8:38 a.m., Resident 104 indicated her oatmeal was cold and the dining staff did get her a new bowl. The resident did not appear to have an issue hearing the conversation when spoken to while using a mask properly covering the nose and mouth. Immediately following the interview, with Resident 104, another staff member was observed to stop and speak with the resident. The staff member was wearing a face mask correctly, over her nose and mouth, and Resident 104 did not appear to have		educated, following CDC and facility policy, on face mask policy. The Executive Director (ED), Director of Health Services (DHS), Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained. Monitoring/auditing of this plan of correction will occur on all shifts: Face masks to be worn per policy by employees while interacting with residents and in the kitchen. All findings from the RCA, if different from current audit, will result in additional audits. The ED, campus IP, or designee will round the campus daily to ensure appropriate infection control practices are maintained and for any needs as determined from	

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	any difficulty hearing the conversation. A facility policy, titled "COVID-19 Health Care Staff Vaccination," revised 09/08/22 and provided by the Corporate Support Nurse at 11:00 a.m., indicated "...always wear a well-fitting face mask...regardless of whether...providing direct care to a resident...." 3.1-18(b)		RCA findings for a minimum of 6 weeks and will continue thereafter until compliance is maintained.	
F 0888 SS=A Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.			

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	§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;			

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	155808	A. BUILDING 00 B. WING	01/30/2023

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	(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on interview and record review, the facility failed to ensure 100% of staff were fully vaccinated or obtained reasonable accommodation, such as a religious or medical exemption, as evidenced by 1 of 1 partially vaccinated staff member failed to complete the second step of a two-step Covid-19 vaccination as required. (CNA 23) Finding includes: During a review of the facility staff vaccination records, on 01/30/2023 at 1:24 p.m., the records indicated the following: CNA 23 had received the first dose of the Pfizer	F 0888	No POC needed	02/23/2023

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	Covid-19 vaccination on 04/26/22. The second dose of the vaccine was not recorded. During an interview, on 01/30/2023 at 11:23 a.m., LPN 10 indicated CNA 23 had only received one Covid-19 vaccine and should have received the second dose in April 2022. The facility's current policy, titled "COVID-19 Health Care Staff Vaccination," dated 02/01/2022, indicated "...As a condition of employment, each current employee shall receive the vaccinations required under this policy or obtain an approved accommodation and will comply with the following on an annual basis...Provide proof of vaccination for Influenza and COVID...or...Obtain an approved accommodation...due to employee's inability to receive the vaccination because such employee is disabled or has a qualifying medical condition that contraindicates the vaccination...or due to the employee's sincerely held religious practice of belief...All facility staff shall complete and maintain COVID-19 vaccination unless granted an exemption/accommodation to the vaccination requirements or those whose vaccination has been temporarily delayed, as recommended by the CDC, due to clinical precautions and consideration...." 3.1-18(b)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure resident care equipment was kept in a sanitary condition and	F 0921	1. Resident 22 was not affects by deficient practice. Pillow case was replaced at time of discovery.	02/23/2023

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	failed to ensure clean linens were provided for 1 of 1 hallway and 1 of 1 resident randomly observed for environment. (200 Hallway and Resident 22) Finding includes: 1. During an observation, on 01/24/23 at 8:17 a.m., in the 200-unit hallway the resident lift equipment was observed dirty and soiled. Three electric Hoyer lifts were found to be soiled with brown and white colored dry dirt. The Sit to Stand's handles were observed dirty with black and white substance. The footrest had food crumbs and the support strap mesh was frayed. During an interview, on 01/24/23 at 8:26 a.m., Licensed Practical Nurse (LPN) 3 indicated the resident lift transfer equipment was not cleaned and indicated she was unsure when the equipment was last cleaned. The night shift was responsible for cleaning the equipment, but staff should clean equipment if observed dirty. During an interview, on 01/24/23 at 8:50 a.m., LPN 10 indicated the process of when the equipment was to be cleaned was still being worked on. The night shift should clean the equipment, or any staff should be cleaning when it was observed soiled. 2. During an observation, on 01/23/23 at 1:52 p.m., Resident 22 was resting in bed. The pillowcase had brownish red stains to the right side of the resident's head. During an observation, on 01/24/23 at 2:49 p.m., the resident was observed resting in bed. The pillowcase was observed to have brownish red stains to the left of the resident's head.		All lifts were cleaned and disinfected at time of discovery. 2. All residents have the potential to be affected. Education provided to staff on cleaning equipment policy as well as linen changing. 3. As a measure of ongoing compliance, DHS or designee will audit lifts and bed linens for visible signs of soilage randomly 5x weekly x 4 weeks, then biweekly x8 weeks then monthly x 3months. 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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	During an observation, on 01/25/23 at 9:56 a.m., the resident was observed resting in bed, the pillowcase had brownish red stains on it. During an interview, on 01/25/23 at 10:03 a.m., CNA 19 indicated the linens were to be changed on shower days and when soiled. A facility policy, titled" Standard Precautions," dated as revised on 05/11/16, indicated equipment in the environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner to prevent transmission of infectious agents, example properly clean and disinfect reusable equipment before use on another equipment. A facility policy, titled "Guidelines for Handling Linen," dated as revised on 05/11/16 and provided by the Corporate Support Nurse on 01/30/23 at 11:00 a.m., indicated "...PURPOSE...To provide clean, fresh linen to each resident...." 3.1-19(f)(5)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00394060. Complaint IN00394060 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: January 23, 24, 25, 26, 27 and	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield 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 Westfield. The facility recognizes its obligation to provide legally and	

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	January 30, 2023 Facility number: 012937 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 6, 2023.		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.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview and record review, the facility failed to ensure residents had a self-administration assessment for medications and failed to ensure a resident had an order for a medication for 2 of 2 residents reviewed for	R 0216	1. Residents 200 and 900 were affected by alleged deficient practice. Medications were removed from residents' room at dining table.	02/23/2023

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	self-administration. (Resident 900 and 200) Findings include: 1. During a medication administration observation, on the Assisted Living Memory Care Unit, on 01/24/23 at 8:19 a.m., QMA 25 had placed a cup of medications in front of Resident 900 while she was sitting at the table with four (4) other residents. The QMA, who was standing at the medication cart, told Resident 900 not to forget to take her medications. She indicated the resident did not have a self-administration assessment or order. Upon inquiry, the QMA went to Resident 900 and assisted her to take her medications. The record for Resident 900 was reviewed on 01/24/23 at 9:40 a.m. Diagnoses included, but were not limited to, Parkinson's psychosis, torticollis (a twisting of the neck which caused the head to rotate and tilt at an odd angle) and constipation. There was no self-administration of medication assessment or order found in the record. During an interview, on 01/30/23 at 8:41 a.m., the Corporate Support Nurse indicated medications should not be left in a cup at the breakfast table with memory care residents sitting at the table. 2. During an observation of Resident 200's medications, stored in his room, with the Interim Assisted Living Director, on 01/25/23 at 9:26 a.m., the resident was found to have Flonase (a nasal spray for allergies) 27.5 mcg (micrograms) and famotidine (a medication for reflux and heartburn) 20 milligram tablets on his refrigerator. His door was not locked. The record for Resident 200 was reviewed on		2. All residents have the potential to be affected. An audit was conducted to ensure no medications left at bedside without “may keep at bedside” orders and observations in place. Education was provided to nurses and qualified medication aides on the Self administration of medications policy. 3. 3. As a measure of ongoing compliance, the Director of Health Services or designee will complete an audit to ensure appropriate medication administration observation. Audits to be completed on 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. 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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	01/23/23. Diagnoses included, but were not limited to, schizophrenia, bipolar disorder, and allergic rhinitis. A physician's order, dated 08/17/22, indicated to give Flonase 50 mcg, one spray each nostril twice a day. The resident did not have an order for Flonase 27.5 mcg. The resident did not have an order for famotidine 20 mg. The resident did not have a self-administration assessment. The resident did not have a self-administration order for the medications found in his room. During an interview, on 01/25/23 at 9:37 a.m., Resident 200 indicated he did take the Flonase and heart burn medications himself. During an interview, on 01/25/23 at 10:08 a.m., the Director of Nursing indicated the facility was supposed to do a self-administration assessment, get orders from the physician to self-administer and update the service plan prior to allowing residents to self-administer their medications. She was not aware the resident did not have an order for the famotidine. A facility policy, titled "AL Self-Administration of Medications Guidelines" dated as revised on 08/11/16 and provided by the Director of Nursing on 01/25/23 at 10:08 a.m., indicated "...Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed for safety by a licensed nurse...Results of the			

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	assessment will be presented to the physician for evaluation and an order for self-medication...." 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.			
R 0273 Bldg. 00	Based on observation, interview and record review, the facility failed to ensure masks were worn correctly in the kitchen, failed to keep boxes off the floor of the freezer, failed to ensure foods were kept closed in the freezer, to ensure foods which had been opened were labeled with open dates, and failed to ensure the dishwasher in the second-floor kitchen was reaching the appropriate wash temperatures. This deficient practice had the potential to affect 28 of 28 residents receiving food from the kitchen and 16 of 28 residents which used the dishes in the second-floor dining room. Findings include: 1. a. During an observation of the kitchen with the Dietary Manager, on 01/23/22 beginning at 9:30 a.m., Cook 24 was observed working over a bowel of potatoes, which was prepared for all residents, with his face mask below his nose and chin. At that time, the Dietary Manager indicated the mask was to be worn over the nose and mouth. b. In the cooler, three (3) boxes were found stored on the floor. The Dietary Manager indicated the boxes should not have been stored on the floor, they were just put there. 2. a. During a follow up visit to the kitchen with the Dietary Manager in attendance, on 01/24/23 at	R 0273	1. No residents were affected by the deficient practice. Education provided to cook #24 on face mask policy. Food storage boxes were removed from the floor in the walk in cooler. All open food boxes were closed. Open food items were labeled with open dates or discarded as appropriate. Dishwasher allowed to time to bring up to proper temperature (recommended guidelines) prior to use. 2. All residents have the potential to be affected. Education provided to dietary staff on food storage policy, label and dating policy as well as face mask policy. Additionally, dietary staff were educated on the dish machine policy. An audit was conducted to ensure food items were properly dated and stored. 3. As a measure of ongoing compliance, the DFS (Director of Food Service) or designee will audit food storage areas to ensure proper labeling, dating and storage. Audits to be conducted	02/23/2023

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	2:26 p.m., a box of hamburger patties was found in the freezer. The box was not sealed, and the patties were left open to air. b. A rectangular plastic container full of onion rings was found exposed to air due to the lid was resting on top of the container and not sealed. The container was over-filled, and the lid was not secured. c. A 40-ounce bag of onion rings approximately 1/8 full was found open and without an open date. d. A one gallon container of milk was found in the cooler. The container was half full and did not have an open date. At that time, the Dietary manager indicated it should have had an open date on the container. e. A box containing 16 large Italian sausages was found open to air in the freezer. At that time, the Dietary Manager indicated it should not have been left open to air. f. A ten (10) pound box of catfish fillets, approximately 1/8 full was found open to air with ice crystals on the fillets. The Dietary Manager indicated the boxes were supposed to be closed after getting food items out of the boxes. g. A bag of mixed vegetables, 1/4 full, was found to be opened and sealed with plastic wrap. There was no date to indicate when the bag had been originally opened. 3. During the initial observation of the dishwasher in the second-floor kitchen, on 01/25/23 at 8:55 a.m., Dietary Aide 16 loaded dishes (plates, cups, and glasses) and ran the cycle. The dishwasher reached a temperature of 148 degrees Fahrenheit and then dropped steadily to 137 degrees. The rinse cycle reached 174 degrees. The wash temperature posted on the machine indicated wash at 150-165 degrees and the rinse temperature needed to be at 180-195 degrees.		3x/week x 4 weeks, then weekly x4 weeks, then monthly x3 months. IP or designee to ensure proper face mask use daily. An additional audit was conducted by the DFS (Director of Food services) or designee on dishwasher temperatures 3x weekly x4 weeks then weekly x 4 weeks then monthly x3 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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	At that time, Dietary Aide 16 indicated some days the machine reached 150 degrees. When the machine had been sitting (not used) it would be low. At 8:57 a.m., Dietary Aide 16 ran the dishwasher again. The highest temperature reached for the wash cycle was 136 degrees. The machine did rinse at 183 degrees. During a third run of the dishwasher operation with only silverware loaded, on 01/25/23 at 9:18 a.m., Dietary Aid 16 indicated the machine was not reaching the correct wash temperature. She did contact the Dietary Manager and report the machine was not working. She ran the dishwasher with plates, glasses, and cups in first load and silverware in second load, but never pulled items for proper washing and instead returned them to storage even after being aware the dishwasher was not washing properly. She indicated they were clean because there was steam. During an interview, on 01/27/23 at 9:40 a.m., the Dietary Manager indicated the dishes were not cleaned properly if the dishwasher was not reaching the correct temperature. He had the pipes looked at and indicated he was told the pipes were in the ceiling and when it was cold outside the dishwasher may need to be ran a couple times first to get it operating at the correct temperature for washing dishes. The staff did not inform him there was an issue with the dishwasher, so he was not aware of the issue. A facility policy, titled "POLICY," dated as approved on 01/02/23 and provided by the Corporate Support Nurse on 01/30/23 at 12:42 p.m., indicated "...REFRIGERATED STORAGE...Food is covered, dated and stored			

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	loosely to permit air circulation...FROZEN STORAGE...All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn...Items are labeled and dated..." The policy did not address storing boxes on the floor of the freezer. A facility policy, titled "Food labeling and Dating Policy," dated as revised on 04/26/22 and provided by the Corporate Dietary Manager on 01/24/23 at 3:15 p.m., indicated "...Foods in production need both a production date AND a use by date...Foods are considered to be in production when they have been taken out of the original container AND the seal has been broken...All foods must be properly covered (not exposed to air)...." A facility policy, titled "Dish Machine," dated as revised on 11/22/27 and provided by the Corporate Dietary Manager on 01/26/23 at 10:29 a.m., indicated "...High-Temperature Dishwasher recommended guideline...Wash 150-165 degrees F (Fahrenheit)...Final Rinse...180 degrees F...."			
R 0300 Bldg. 00	410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review, the facility failed to ensure an open date was place on an insulin pen when it was opened for 1 of 1 resident reviewed for insulin storage. (Resident 800) Finding includes:	R 0300	1. Resident 800 was not affected by the alleged deficient practice. Insulin bottle was discarded and replaced by new vial with open date added per policy. 2. Multi dose vials/pens	02/23/2023

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	During a medication administration observation, on 01/24/23 at 11:11 a.m., QMA 25 was preparing Novolog (an insulin) via flex pen for Resident 800. The insulin pen did not have an open date. At that time, QMA 25 indicated there was no open date on the insulin and indicated there should have been an open date on the pen. The record for Resident 800 was reviewed on 01/30/23. Diagnoses included, but were not limited to, type 2 diabetes, hypertension, and hyperlipidemia (high cholesterol). A physician's order, dated 01/04/23, indicated to give Humalog insulin per the sliding scale (a scale of dosing based on the blood sugar result) four times a day. A physician's order, dated 01/04/23, indicated to give Humalog insulin 15 units before meals. A facility policy, titled "LABELING OF MEDICATIONS AND BIOLOGICALS," dated as revised on 11/28/17 and provided by the Corporate Support Nurse on 01/30/23 at 11:00 a.m., indicated "...If a multi-dose vial has been opened or accessed...the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date...."		audited for open dates. Education was provided to nurses and qualified medication aides on labeling of medications and biologicals policy. 3. As a measure of ongoing compliance, the DHS or designee will randomly audit medication carts for open dates on multi dose vials/pens 5x weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 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 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155808	A. BUILDING 00 B. WING	01/30/2023

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	including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to ensure staff were wearing masks correctly while interacting with residents during their meal and failed to ensure oxygen tubing was dated and nebulizer masks were stored in a sanitary manner for 1 of 1 staff and 1 of 1 resident observed for infection control. (Dietary Aid 16 and Resident 100) Findings include: 1. During an observation, on 01/25/23 at 8:09 a.m., Dietary Aid 16 was observed in the 2nd floor dining area assisting residents with meals, her mask was noted to be worn under her chin. During an interview, on 01/25/23 at 8:10 a.m., Dietary Aid 16 indicated she wore her mask in the facility all the time, but she had asthma, so she took it down. 2. During an observation, on 01/25/23 at 8:37 a.m., a nebulizer mask for Resident 100 was found stored on top of the nebulizer machine. The resident was also using oxygen via nasal cannula and the oxygen tubing did not have a date. During an interview, on 01/25/23 at 8:42 a.m., LPN 10 indicated the oxygen tubing needed to be dated, and the nebulizer mask should be stored in a bag. A facility policy, titled "COVID-19 Health Care Staff Vaccination," dated as revised on 09/08/22	R 0407	1. Resident 100 was not affected by the alleged deficient practice. Oxygen tubing was replaced with newly labeled tubing and nebulizer was replaced and stored in labeled bag per policy when not in use. Education was provided to dietary aide 16 on mask use policy. 2. All like residents have the potential to be affected. An audit was conducted at time of occurrence to ensure all respiratory equipment properly labeled and stored. Education was provided to clinical staff on respiratory storage and labeling. Education provided to staff on face mask policy. 3. As a measure of ongoing compliance, DHS or designee will audit 5 residents with respiratory equipment to have proper labeling and storage per policy. Oxygen magnets to be audited for placement per policy. Audits to occur weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months. . IP or designee to ensure proper face mask use daily. 4. As a quality measure, the DHS or designee will review any findings and corrective action at	02/23/2023

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	and provided by the Corporate Support Nurse at 11:00 a.m., indicated "...always wear a well-fitting face mask...regardless of whether...providing direct care to a resident...." A facility policy, titled "Respiratory Equipment," dated as revised on 05/11/16 and provided by the Corporate Support Nurse on 01/24/22 at 10:37 a.m., indicated "...Medication Nebulizers/Continuous Aerosol...Store circuit in plastic bag, marked with date and resident's name, between uses...." A facility policy, titled "Administration of Oxygen," dated as revised on 05/18 and provided by the Corporate Support Nurse on 01/24/23 at 10:37 a.m., indicated "...Date the tubing for the day it was initiated...."		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	