STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155812	A. BUILDING 00 B. WING	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF CRAWFORDSVILLE	517 CONCORD ROAD CRAWFORDSVILLE, IN 47933

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included an Investigation of Complaint IN00409672. This visit included a State Residential Licensure Survey. Complaint IN00409672 - No deficiencies related to the allegations are cited. Survey dates: July 10, 11, 12, 13, 14, and 17, 2023 Facility number: 013107 Provider number: 155812 AIM number: 201279670 Census Bed Type: SNF/NF: 18 SNF: 25 Residential: 26 Total: 69 Census Payor Type: Medicare: 16 Medicaid: 18 Other: 9 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 27, 2023.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rebeccah Garza | RN Clinical Support | 08/13/2023

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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	and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure that contracted staff completed a resident assessment and vital	F 0550	**F550: Resident Rights/Exercise of Rights** **1) Immediate actions taken for**	08/14/2023

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	signs in privacy for 1 of 1 resident randomly observed (Resident 32). Finding includes: During a dining observation, on 7/10/23 at 11:43 a.m., Resident 32 was sitting at a table in his Geri chair (large, padded chair with wheeled bases) waiting for lunch to be served. Two contracted hospice nurses entered the dining room and went to where Resident 32 was sitting. Registered Nurse (RN) 4 obtained vital signs on the resident. The RN obtained a temporal (forehead) temperature, pulse oximeter reading, heart rate, manual blood pressure, and auscultated (listened) his lungs with her stethoscope. There were several other residents in the dining room at that time along with dietary staff and other facility staff. During an interview, on 7/10/23 at 11:48 a.m., RN 4 indicated she was not told that she could not obtain a resident's vital signs while they were in the dining room. Resident 32's record was reviewed on 7/11/23 at 9:42 a.m. The profile indicated the resident diagnoses included, but were not limited to, Rhabdomyolysis (a breakdown of muscle tissue that releases damaging protein in the blood), unspecified dementia (group of conditions characterized by impairment of at least two brain functions such as memory and judgment), and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). A quarterly Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was severely impaired cognitively and was on		**those residents identified:** No Residents were affected. No adverse effects noted. Residents 32 was assessed for psycho/social distress, and none noted by DHS/Designee. **2) How the facility identified other residents:** All Residents in house on Hospice Services were reviewed and ensured those nurses had training completed regarding assessing a Resident in a private setting and outside the dining rooms. **3) Measures put into place/ System changes:** Staff Nurses and all Hospice Providers were re-educated Resident Rights Guidelines and Clinical Standards by DHS/designee ensured that all clinical staff providing assessment for the Resident to be completed in a private area and cannot be completed in the dining room. DHS/Designee to complete Resident Privacy QAPI Audit Tool. **4) How the corrective actions will be monitored:** As a measure of ongoing	

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	hospice services. During an interview, on 7/12/23 at 9:39 a.m., the Executive Director (ED) indicated that staff should not be performing assessments and/or vital signs in the dining room on any resident. During an interview, on 7/12/23 at 9:53 a.m., the ED indicated that hospice staff had been told before not to do assessments and vital signs in the dining room. On 7/12/23 at 9:50 a.m., the ED provided a document, with a revised date of 5/11/17, titled, "Resident Rights Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...2. Our residents have a right to: a. Be treated with dignity and respect ...d. Privacy ...." 3.1-3(t)		compliance, the DHS/Designee, will complete audits during mealtime to ensure that no clinician is assessing a Resident in the dining room and it is completed in a private area 2x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including			

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	the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure a privacy curtain was installed for 1 of 1 resident reviewed for privacy (Resident 29). Findings include: During an observation on 7/11/23 at 10:36 a.m., Resident 29 was lying on her bed and there was no privacy curtain on the resident's side of the room. During an observation on 7/12/23 at 10:32 a.m., the resident was lying on her bed and no privacy curtain for the resident's side of the room. The resident indicated she asked for a curtain when she was moved into the room, but none had been provided. She would go into the bathroom for care	F 0583	**F583 Personal Privacy/ Confidentiality of Records** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. Resident 29 was not affected by this practice. The Privacy Curtain was replaced once laundered by Director of Environmental Services. **2) How the facility identified other residents:** All like residents have the potential to be affected. ED/Designee will complete visual	08/14/2023

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	from the staff, whenever she needed privacy. The privacy curtain for the other resident was pushed aside against the far wall next to the other resident's bed. During an observation on 7/12/23 at 10:35 a.m., the resident was lying on her bed. The roommate's privacy curtain was pulled out and around the roommate. The curtain did not provide privacy for Resident 29. On 7/13/23 at 9:34 a.m., the Director of Nursing (DON) indicated all residents in a double occupancy room should have their own privacy curtain. On 7/13/23 at 9:39 a.m., Licensed Practical Nurse (LPN) 8 indicated all residents in double occupancy rooms should have their own privacy curtain. LPN 8 indicated she would close the door when providing care for a resident, if a person walked in, she would cover the resident with a blanket. On 7/13/23 at 9:53 a.m., during the room observation no privacy curtain was on the resident's side of the room. On 7/13/23 at 10:00 a.m., the Executive Director (ED) indicated the privacy curtain had been removed due to it being soiled by the previous roommate and the housekeepers had not replaced it yet. During the room observation on 7/13/23 at 3:00 p.m., the resident was lying on her bed, a privacy curtain was hanging on Resident 29's side of the room. The roommate's privacy curtain was pushed back against the far wall against the roommate's bed.		observations to ensure all residents in semi-private rooms privacy curtains are up and replacements are in house to changed out for cleaning/damaged purposes. **3) Measures put into place/ System changes:** All staff educated by ED/Designee on Privacy Curtain Policy for residents in a semi-private room. As a measure of ongoing compliance, the ED/designee will complete Resident Privacy Curtain QAPI audit. **4) How the corrective actions will be monitored:** As a measure of ongoing compliance, the ED/Designee will complete audits of 3 semi-private rooms to ensure privacy curtains are in place per policy 2x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted.	

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	Resident 29's record was reviewed on 7/13/23 at 10:24 a.m. A quarterly Minimum Data Set (MDS) assessment (a standardized assessment tool that measures health status in nursing home residents), dated 6/16/23, indicated the resident was cognitively intact and required limited assistance of one person for toileting and dressing. The resident's care plan, dated 12/8/22, indicated the resident was at risk for incontinence and needed assistance of one person with toileting as needed. On 7/12/23 at 9:50 a.m., the DON provided a document, with a revised date of 5/11/17, titled, "Resident Rights Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated," ...2. Our residents have a right to...a. be treated with dignity and respect...d. privacy ...." 3.1-3(o)		Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) assessment for 1 of 16 residents' MDS assessments reviewed (Resident 5). Finding includes: Resident 5's record was reviewed on 7/12/23 at 10 :57 a.m. The profile indicated the resident's diagnoses included but were not limited to depression unspecified (when symptoms of	F 0641	No POC needed	08/14/2023

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	depression cause significant distress or impairment in social, occupational, or other important areas of functioning but do not meet the full criteria for any of the depressive disorder diagnoses). A care plan, dated 1/26/22, indicated the resident was at risk for adverse consequences related to receiving an antipsychotic medication for depression. Section N0410 of the resident's annual Minimum Data Set (MDS) assessment, dated 10/23/22, indicated the resident had received an antipsychotic medication all 7 days during the look-behind period (the time period over which the resident's condition or status is captured by the MDS assessment). Section N0450 of the annual MDS assessment indicated antipsychotics were not received during the assessment look-behind period. A historical review of the resident's October 2022 medication administration record (MAR) indicated the resident had received the antipsychotic medication aripiprazole (used to treat certain mental/mood disorders) related to the diagnosis of depression unspecified. During an interview, on 7/13/23 at 12:13 p.m., the Executive Director (ED) indicated a mistake had been made on the resident's annual MDS assessment. The Resident had been on an antipsychotic medication at that time, but the specific section of the MDS assessment had been coded incorrectly. On 7/13/23 at 12:13 p.m., the ED provided a document titled, "CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment			

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	Instrument) Version 3.0 Manual," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...N0450: Antipsychotic Medication Review (cont.)...Coding Instructions for N0450: Code 0, no: if antipsychotics were not received...Code 1, yes: if antipsychotics were received on a routine basis...." 3.1-31(a)(13)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on interview, observation, and record review, the facility failed to ensure that staff used the assistance of two people when providing care and staff had the proper knowledge of the use of a low air loss mattress to prevent a resident's fall out of bed, which resulted in harm when the resident obtained a fractured femur (thigh bone) that required surgery for 1 of 14 residents reviewed for accidents (Resident 27). B. Based on interview, observation, and record review, the facility failed to ensure hot water temperatures were maintained within safe range for 3 of 14 residents reviewed for accidents (Residents 11, 40, and 26). Findings include:	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** **1) Immediate actions taken for those residents identified:** Residents 27 was assessed by DHS/Designee and ensured all current fall interventions were in place. No adverse reactions were noted. Resident 40 and Resident 26 were not affected, and no adverse reactions were noted. **2) How the facility identified other residents:**	08/14/2023

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	A. During an interview, on 7/11/23 at 10:06 a.m., Resident 27 indicated on 5/2/23 Certified Resident Care Aide (CRCA) 18 was providing incontinence care while she was in bed. CRCA 18 rolled her over to the right side of the bed and just kept rolling until she rolled her out of bed. She fractured her femur and had to have surgery. There was only one staff member who provided incontinence care at that time. Resident 27's record was reviewed on 7/13/23 at 1:31 p.m. The profile indicated the resident diagnoses included, but were not limited to, nondisplaced spiral fracture (fracture due to torsion or twisting force that produces a fracture that circles or spirals around the shaft) of shaft of left femur (thigh bone, the longest strongest bone in the body) and multiple sclerosis (a disease in which the immune system eats away at the protecting covering of nerves). An annual Minimum Data Set (MDS) assessment, dated 1/6/23, indicated the resident was cognitively intact and required assistance of two persons for bed mobility, transfers, and toileting. The MDS indicated she was dependent on the assistance of 2 or more staff for lower body dressing. A quarterly MDS assessment, dated 4/8/23, indicated the resident was cognitively intact and required assistance of two persons for bed mobility, transfers, toileting, and lower body dressing. A care plan, dated 7/1/2020 and revised 5/3/23, indicated the resident was at risk for falls related to weakness to all extremities, use of anti-depressant medication, and impaired mobility.		All Residents that have fallen have the potential to be affected and have been assessed by DHS/Designee to ensure all current fall interventions are in place and effective at this time. All Residents have the potential to be affected by increased water temperatures. All Rooms have been checked by the Director of Plant Operations to ensure the hot water temperature is between 100- and 120-degrees Fahrenheit. **3) Measures put into place/ System changes:** All staff educated by DHS/ED/Designee on Fall Management Program Guidelines and Water Temperature Testing Policies. As a measure of ongoing compliance, the DHS/designee will complete a Fall Management QAPI Audit and ED/designee will complete Water Temperature Log. **4) How the corrective actions will be monitored:** As a measure of ongoing compliance, the DHS/Designee will complete audits of 5 residents to ensure that all fall interventions are in place 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. ED/designee will complete audits of 5 resident's	

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	Interventions included but were not limited to provide two caregivers to give assistance while providing care. Review of the Occupational Therapy (OT) plan of treatment note, dated 1/2/23, indicated the resident was referred to therapy due to a decline of active range of motion (AROM) to her left upper extremity (arm). The therapy note indicated, Resident 27 was dependent for toileting hygiene, lower body dressing, and transfers. A progress note, dated 5/2/23 at 12:52 p.m., indicated Resident 27 was lying on her side when staff was changing her brief. Staff was standing behind the resident providing peri-care when the resident began to slide out of the bed, legs first, away from staff. Staff were able to grab the resident around her torso and assisted to her to the floor with the resident's left knee bent. A progress note, dated 5/2/23 at 3:00 p.m., indicated Resident 27 had a stat (immediately) x-ray and had an acute fracture of distal femur with a small lipohemarthrosis (mixture of fat and blood in a joint cavity following trauma). The Nurse Practitioner was notified, and the resident transported to the emergency room. An Interdisciplinary Team (IDT) note, dated 5/3/23 at 8:43 a.m., indicated Resident 27 was lying on her side while staff was changing her brief. The staff person was standing behind the resident providing peri-care when the resident began to slide out of bed, legs first, away from the caregiver. The intervention was to provide two caregivers while care was provided to the resident. An episodic event form, dated 5/3/23, indicated a		rooms to ensure that water temperature is within range 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	root cause of the fall to be the air mattress. A plan of action was to ensure that the air mattress was to be firm during care and to have two staff members when care was provided while resident was in bed. The facility was to ensure the safety of all residents who receive care while in bed on an air mattress. An in-service sheet, dated 5/3/23 and 5/4/23, indicated staff attended an in-service on bed mobility, transfer, and care. There were 29 staff members in attendance. A hospital discharge report, dated 5/8/23, indicated Resident 27 had surgery, on 5/3/23, on the intramedullary retrograde nail femur (surgeon will make two small incisions near the knee joint to insert two flexible titanium rods through the femur). An undated investigation summary, indicated the resident was holding on to the mobility bar during incontinence care and was not strong enough to prevent herself from sliding off the bed. During an interview, on 7/14/23 at 10:17 a.m., Resident 27 indicated she had required the use of a mechanical lift for a long time, and she needed the assistance of two persons for incontinence care, transfers, showers, and turning side to side while in bed, and had been that way for a long time prior to the fall. During an interview, on 7/14/23 at 10:19 a.m., Registered Nurse (RN) 11 indicated Resident 27 required a mechanical lift for transfers and was two person assist for turning and repositioning. During interview, on 7/14/23 at 11:21 a.m., Qualified Medication Aide (QMA) 14 indicated			

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	155812	A. BUILDING 00 B. WING	07/17/2023

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	Resident 27 had a low air loss mattress, and the low air loss mattress had a machine that contained a button and could be pushed to firm the mattress while staff was providing care. During an interview, on 7/14/23 at 11:59 a.m., CRCA 18 indicated that when Resident 27 had her fall, incontinence care was being provided. She indicated the resident was turned onto her side and began to slide off her mattress. The CRCA 18 was able to help assist the resident as she fell to the floor with her left leg bent. She was unable to explain what a low air loss mattress was and was not aware there was a firm button that could be used while providing care when the resident was in bed. Review of the low air loss mattress manufacturer guidelines indicated a mode of operation was an auto firm mode and provided maximum air inflation designed to assist both resident and caregivers during resident transfer and treatment. On 7/14/23 at 1:29 p.m., the Regional Clinical Support provided a document, dated 5/10/16, titled, "Nursing ADL Documentation Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Procedures: ...2. ADL services will be conducted and documented by the Certified Nurses Aide (CNA) each shift ....6 ...The paper format shall be submitted to the MDS Coordinator ...." On 7/14/23 at 1:46 p.m., the Executive Director (Ed) provided a document, dated 5/31/17, titled, "Fall Management Program Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Procedure: ...a. Identified risk factors should be evaluated for the			

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	contribution they may to the resident's likelihood of falling ...." B1. During an observation, on 7/10/23 at 11:23 a.m., Resident 11's bathroom sink hot water was too hot to hold hands under the water for more than a few seconds without burning the skin. The Director of Plant Operations (DPO) checked the hot water temperature, on 7/10/23 at 12:08 p.m., and indicated Resident 11's bathroom sink hot water temperature was too warm, at 127.4 degrees Fahrenheit (F), per the facility's thermometer and the hot water temperature should be between 100 F to 120 F. Resident 11's record was reviewed, on 7/13/23 at 10:15 a.m., with diagnoses included, but were not limited to, hypertension (high blood pressure), cognitive communication deficit, and difficulty in walking. An admission Minimum Data Set (MDS) assessment, dated 6/20/23, indicated the resident was cognitively intact, required extensive assistance of two persons for bed mobility, transfer, and toilet use, and was a total dependence of one person for personal hygiene. B2. During an observation with the DPO, on 7/10/23 at 12:11 p.m., the hot water temperature in Resident 40's bathroom sink was 122.0 F per the facility's thermometer. The DPO indicated, the hot water temperature in Resident 40's bathroom was too warm and the facility had recently purchased a new hot water boiler. Resident 40's record was reviewed, on 7/11/23 at 3:06 p.m., with diagnoses included, but were not limited to, dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and malignant neoplasm of unspecified part of unspecified			

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	bronchus or lung (lung cancer). An admission MDS assessment, dated 5/8/23, indicated the resident had a severe cognitive impairment and required extensive assistance of one person for bed mobility, transfer, toilet use, and personal hygiene. B3. During an observation with the DPO, on 7/10/23 at 12:15 p.m., the hot water temperature in Resident 26's bathroom sink was 125.6 F per the facility's thermometer. The DPO indicated the hot water temperature in Resident 26's bathroom was too warm, and he checked random resident bathrooms water temperatures daily, kept a temperature log, and had not had any water temperatures in the facility more than 120 degrees Fahrenheit. Resident 26's record was reviewed, on 7/14/23 at 10:07 a.m., with diagnoses included, but were not limited to, hypertension (high blood pressure) and altered mental status. An annual MDS assessment, dated 6/24/23, indicated the resident was cognitively intact, required extensive assistance of two persons for bed mobility, transfer, and toilet use, and was an extensive assistance of one person for personal hygiene. On 7/11/23 at 9:05 a.m., the Executive Director (ED) indicated, all the hot water temperatures in the residents' rooms should be between 100 F to 120 F, the DPO had turned down the hot water temperature in the boiler because the hot water temperature was too warm, and the DPO was checking the water temperatures throughout the day to make sure that the water was not too hot in any of the residents' rooms. The ED indicated, there had been no reported burns or scalding's as a result of the hot water temperatures.			

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	On 7/13/23 at 8:55 a.m., the ED indicated the mixing valve had been changed out in the hot water system and the DPO had been checking the hot water temperatures in the facility to ensure the hot water temperature was maintained between 100 F to 120 F. The ED, on 7/10/23 at 12:29 p.m., provided and identified a document as a current facility policy, titled "Water Temperature Testing Life Safety," dated 8/20/2018. The policy indicated, "...It is Trilogy policy to test water temperatures daily...Required Water Temperatures...Patient room temperatures are specified by state requirements...Indiana 100 F-120 F...." 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter			

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	as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident's indwelling urinary catheter (a catheter which is inserted into the bladder and remains in to drain urine) tubing was kept from contact with the floor for 1 of 2 residents reviewed for urinary catheters (Resident 198). Finding includes: During a random observation, on 7/10/23 at 11:36 a.m., Certified Occupational Therapist Assistant (COTA) 9 was pushing Resident 198 in the hallway, in his wheelchair. The resident's indwelling catheter tubing was observed dragging the floor. During the initial pool observation, on 7/10/23 at 11:54 a.m., Resident 198 was observed in his room sitting in front of his television. His indwelling urinary catheter tubing was in contact with the floor. During a random observation, on 7/11/23 at 10:33	F 0690	**F690 Bowel/Bladder Incontinence, Catheter, UTI** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. Resident 198 catheter was placed in a dignity bag and was unable to drag the ground. **2) How the facility identified other residents:** All Residents in house with indwelling catheters were reviewed and ensured residents had dignity bags were in place and the catheter bag did not touch the floor by DHS/Designee. **3) Measures put into place/ System changes:**	08/14/2023

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	a.m., Resident 198 was sitting next to his bed in his room. His indwelling catheter tubing was in contact with the floor. During a random observation, on 7/11/23 at 10:55 a.m., Resident 198 was observed in therapy. His indwelling catheter tubing was in contact with the floor. Resident 198's record was reviewed on 7/13/23 at 2:37 p.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional) and benign prostatic hyperplasia with lower urinary tract symptoms (needing to urinate frequently [during the day and night], a weak urine stream, and leaking or dribbling of urine). A care plan, dated 7/10/2023, indicated the resident used a catheter for the diagnosis of obstructive and reflux uropathy. Interventions included, but were not limited to, observe tubing. During an interview, on 7/12/23 at 2:57 p.m., the Director of Nursing (DON) indicated catheter tubing should never come into contact with the floor, as it could create and infection risk. On 7/12/23 at 3:12 p.m., the Regional Clinical Support provided a document, dated 5/11/2016, titled, "Preserving Dignity with Indwelling Catheter," and indicated it was the policy currently being used by the facility. The policy indicated, "...1. General guidelines: ...e) Urinary drainage bags and catheter tubing should be kept from touching the floor surface." 3.1-41(a)(2)		All nursing staff educated by DHS/Designee on Guidelines for use of an indwelling catheter. As a measure of ongoing compliance, the DHS/designee, will complete a Urinary Catheter Review QAPI Audit. **4) How the corrective actions will be monitored:** As a measure of ongoing compliance, the DHS/Designee, will complete Urinary Catheter audits of 2 residents to ensure that the Catheter Dignity Bag is in place and Catheter Bag is not touching the ground 2x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure a pharmacy recommendation was addressed timely for 1 of 5 residents reviewed for unnecessary medications (Resident 5). Finding includes: Resident 5's record was reviewed on 7/12/23 at 10:57 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified atrial fibrillation (AFIB-the heart's upper chambers beat chaotically and irregularly -	F 0757	**F757 Drug Regimen is Free from Unnecessary Drugs** **1) Immediate actions taken for those residents identified:** No residents were affected. No adverse effects noted. Resident 5 medications were assessed and reviewed with the physician and pharmacy recommendations were reviewed and completed. **2) How the facility identified other residents:**	08/14/2023

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	out of sync with the lower chambers of the heart) and hypertension (high blood pressure). A physician's order, dated 1/14/22, indicated digoxin (a drug used to treat irregular heartbeat and some types of heart failure) tablet 0.125 milligrams (mg) once daily. A care plan, dated 1/26/22, indicated the resident had potential for cardiovascular distress related to diagnoses of hypertension and AFIB. Interventions included, but were not limited to, labs per physician's order. A pharmacy recommendation, dated 3/14/23, indicated to consider monitoring digoxin trough level (a lab drawn just before the next dose of digoxin medication to determine the level of the medication in the blood) and BMP (a test that measures eight different substances in the blood) on the next lab day and every 6 months. A handwritten note at the bottom of the recommendation form indicated BMP done 3/8/23 and had someone's initials next to it. The record lacked documentation of the digoxin trough level having been ordered or completed. A pharmacy recommendation, dated 5/24/23, indicated to consider monitoring digoxin trough level and BMP on the next lab day and every 6 months. The form indicated the lab had been ordered. A physician's order document, attached to the pharmacy recommendation, dated 5/17/23, indicated digoxin level, once a day on 2nd Wednesday of May and November. The record lacked documentation of the digoxin trough level having been completed. A pharmacy recommendation, dated 6/14/23, indicated a digoxin level had been ordered, but no		All Residents in house receiving medications were reviewed and pharmacy recommendations were completed in a timely manner by DHS/Designee. **3) Measures put into place/ System changes:** All nursing management staff were educated by DHS/Designee on Pharmacy Recommendation Policy. As a measure of ongoing compliance, the DHS/designee, will complete a Pharmacy Recommendation Review QAPI Audit. **4) How the corrective actions will be monitored:** As a measure of ongoing compliance, the DHS/Designee, will complete pharmacy recommendation audit of 5 residents to ensure that all Pharmacy Recommendations are completed in a timely manner 2x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure	

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	results were in the chart for level ordered 5/17/23. The record indicated the lab had not been drawn until 6/23/23. A lab report document, dated 6/26/23 at 5:26 a.m., indicated the digoxin level had been completed. The document indicated the level was low. During an interview, on 7/12/23 at 3:13 p.m., the Regional Clinical Support indicated she had investigated the recommendation for the resident's digoxin level. The lab had not been drawn in a timely manner. During an interview, on 7/14/23 at 9:34 a.m., the Executive Director (ED) indicated not addressing the digoxin level for 3 months was not good practice and did not conform to the facility policy. On 7/14/23 at 9:24 a.m., the ED provided a document, with a revision dated of 11/18, titled, "Consultant Pharmacist Reports," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedures: ...E. Recommendations are acted upon and commented on by the facility personnel and/or the prescriber. 1) Prescriber accepts and acts upon the upon suggestion or rejects and provides an explanation for disagreeing...." 3.1-48(a)(3)		substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included an Investigation of Complaint IN00409672.	R 0000	NA	

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	Complaint IN00409672 - No deficiencies related to the allegations are cited. Survey dates: July 10, 11, 12, 13, 14, and 17, 2023 Facility number: 013107 Residential Census: 26 Wellbrooke of Crawfordsville was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on July 27, 2023.			