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| | 155811 | A. BUILDING 00<br>B. WING | 02/02/2024 |

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| WELLBROOKE OF AVON | 10307 E COUNTY RD 100 N,<br>INDIANAPOLIS, IN 46234 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00414005, IN00416689 and IN00426548. This visit included a State Residential Licensure Survey.<br><br>Complaint IN00414005 - Federal/State deficiencies related to the allegations are cited at F684.<br><br>Complaint IN00416689 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00426548 - No deficiencies related to the allegations are cited.<br><br>Survey dates: January 29, 30, 31, and February 1 and 2, 2024.<br><br>Facility number: 013085<br>Provider number: 155811<br>AIM number: 201279600<br><br>Census Bed Type:<br>SNF/NF: 9<br>SNF: 23<br>NF: 15<br>Residential: 37<br>Total: 84<br><br>Census Payor Type:<br>Medicare: 23<br>Medicaid: 15<br>Other: 9<br>Total: 47<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | POC due: March 4, 2024<br>Date of Compliance: ___March 1, 2024_____<br><br>The submission of this plan of correction does not indicate an admission by Wellbrooke of Avon 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 Avon. 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. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Rachelle Morgan | | 03/01/2024 |

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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| | Quality review completed on February 13, 2024. | | | |
| F 0550 SS=D Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§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.<br><br>§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.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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. | | | |

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| | §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.<br>Based on observation, interview, and record review, the facility failed to ensure a resident was wearing weather appropriate clothing when leaving the facility for 1 of 2 residents reviewed for dignity (Resident 104).<br><br>Findings include:<br><br>On 1/30/24 at 3:10 p.m., Resident 104's record was reviewed. He was admitted on 1/24/24.<br><br>An Inventory of Resident Personal Items showed Resident 104 had 3 shirts, 3 pants, and no jacket. No items were added or removed after admission.<br><br>His diagnoses included, but were not limited to, weakness, chronic obstructive pulmonary disease (COPD), and hepatocellular carcinoma (liver cancer).<br><br>His care plan, dated 1/25/23, indicated he had potential for complications, functional, and cognitive status decline related to respiratory disease: COPD.<br><br>A physician order, dated 1/26/24, indicated Resident 104 had an oncology (cancer care) consultation appointment on 1/29/24 at 2:30 p.m.<br><br>A Transportation Request form indicated Resident 104 was transported on 1/29/24 at 2:30 p.m. and returned at 2:50 p.m. He was transported by the facility bus for a physician appointment. It was completed by the facility Bus Driver (BD) 87. | F 0550 | F550<br>1. Resident 104 was affected. Resident is without adverse effect. Education was immediately provided to the transportation driver regarding appropriate outerwear for taking residents out of the facility.<br>2. All residents have the potential to be affected. Education provided to all nursing staff regarding appropriate outerwear for taking residents out of the facility.<br>3. As a measure of ongoing compliance, DHS or designee will audit 5 residents to ensure proper outerwear for the weather for residents leaving facility, weekly x4 weeks, then every other week x2 months, then monthly x3 months.<br>4. 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 plans will be revised as warranted. | 03/01/2024 |

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| | On 1/29/24 at 4:12 p.m., Resident 104 was observed to be assisted to exit the facility's bus by BD 87. He was in his wheelchair on the wheelchair lift. He did not have a winter coat on, but a tee shirt. Resident 104 indicated he was cold and he did not have a winter coat. The outside temperature was 34 degrees Fahrenheit (F), with a wind chill of 29 degrees F.<br><br>A nursing progress note, dated 1/29/24 at 4:20 p.m.. indicated Resident 104 returned from an oncology appointment with a new order for oxycodone (narcotic analgesic) 5 mg, by mouth, every 6 hours, as needed (PRN) and a hospice (end-of-life care) referral.<br><br>On 1/30/24 at 9:05 a.m., Resident 104 indicated yesterday he was returning from a doctor's appointment at a local hospital. He indicated the facility could have given him a blanket or something since he did not have a coat. His family was bringing his winter coat on 1/30/24. He indicated he was miserable without a coat. It was so cold on the bus, during the transport to the doctor's appointment, and the ride back.<br><br>On 2/1/24 at 10:46 a.m., the Director of Nursing (DON) indicated she needed to educate the bus driver about transporting residents during winter weather because the resident should have had a blanket or something to be warm.<br><br>On 2/1/24 at 12:18 p.m., the Assistant Director of Nursing (ADON) indicated the staff should have provided a blanket for Resident 104.<br><br>A current policy, titled, "Resident Rights," with no date, was provided with a resident admission packet after entrance conference. It indicated, | | | |

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| | "The resident has a right to be treated with respect and dignity, including ...The right to reside and receive services in the facility with reasonable accommodated of resident needs and preferences ...."<br><br>3.1-3(a)<br>3.1-3(t) | | | |
| F 0657 SS=E Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | | | |

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| | Based on record review and interview, the facility failed to implement complete, person centered care plans for 4 of 4 residents reviewed for advance directive care plans (Residents 19, 26, 33 and 146).<br><br>Findings include:<br><br>1. On 1/31/24 at 1:51 p.m., a record review was completed for Resident 19. She had the following diagnoses which included but were not limited to encephalopathy, urinary tract infection, heart disease, obesity, dementia, and low back pain.<br><br>Resident 19 had an order for DNR (do not resuscitate).<br><br>Resident 19's care plan indicated " ...Resident/resident representative have chosen the following advanced directives, residents 2 daughters are her health care representatives, code status reviewed." The care plan lacked resident specific choices and person centered information.<br><br>2. On 1/30/23 at 10:45 a.m., a record review was completed for Resident 26. He had the following diagnoses which included but were not limited to chronic pulmonary obstructive disease (COPD), respiratory failure, pneumonia, atrial fibrillation, and type 2 diabetes mellitus.<br><br>Resident 26 had an order for DNR.<br><br>Resident 26's care plan indicated, "Resident/resident representative have chosen the following advanced directives." The care plan lacked resident specific choices and person centered information.<br><br>3. On 1/31/23 at 2:17 p.m., a record review was | F 0657 | F657: Care Plan Timing and Revision<br>1 1. Residents 19, 26, 33, and 146 were affected. Residents are without adverse effects. Care plans for all in-house residents were revised to add complete, person-centered advanced directive care plans.<br>2 2.All residents have the potential to be affected. MDS Coordinator and Social Services Director educated on complete, person-centered care plan revision per the “Comprehensive Care Plan Guideline” policy.<br>3 3.As a measure of ongoing compliance, the MDS Coordinator or designee will conduct an audit of five residents (as available) for complete, person-centered advanced care plans weekly x4 weeks, then twice per month x2 months, then monthly x3 months.<br>4.As a quality measure, the MDS Coordinator or designee will review any findings and corrective action monthly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted | 03/01/2024 |

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| | completed for Resident 33. She had the following diagnoses which included but were not limited to chronic obstructive pulmonary disease (COPD), respiratory failure, atrial fibrillation, Parkinson's disease, hypothyroidism and hyperlipidemia.<br><br>She had an order for DNR.<br><br>Resident 33's care plan indicated, "Resident's/resident's representative decision regarding his/her advance directive will be honored." The care plan lacked resident specific choices and person centered information.<br><br>4. On 1/30/24 at 11:33 a.m., a record review was completed for Resident 146. She had the following diagnoses which included but were not limited to hemiplegia related to cerebral infarction, atrial fibrillation, obesity, type 2 diabetes mellitus, heart failure, and anxiety.<br><br>She had an order for full code.<br><br>Resident 146's care plan indicated, "Resident/resident representative have chosen the following advanced directives including code status, daughter is POA." The care plan lacked resident specific choices and person centered information.<br><br>During an interview on 1/30/24 at 3:35 p.m., the Minimum Data Set (MDS) Support indicated the company did not create care plan residents' code status in case it changed. They did not want conflicting information in the system until the next clinical care plan meeting. The nurses found residents' code status information under their banner, order or residents' documents.<br><br>A policy titled, "Comprehensive Care Plan | | | |

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| | Guideline," was provided by the Director of Nursing (DON) on 1/31/24 at 1:42 p.m. It indicated, "Pertinent care plan approaches are communicated to the nursing staff per the Care Assist profile dependent on campus preference ....Comprehensive care plans need to remain current and accurate...."<br><br>3.1-35(c)<br>3.1-35(l) | | | |
| F 0684 SS=D Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br>Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident E) received appropriate and timely treatment after a fall with fracture for 1 of 4 residents reviewed for quality of care.<br><br>Findings include:<br><br>On 1/29/24 at 1:55 p.m., Resident E was initially observed. She was seated in a wheelchair in her room. During a general conversation, Resident E indicated she had been fine until she fell over Christmas and broke her wrist. She held up her arm and her wrist was observed in comparison to her left wrist. It was misshaped and swollen, and Resident E indicated she couldn't not move it as well as her other hand. Resident E indicated she | F 0684 | F684<br>1.Resident E was affected without adverse occurrences noted. Resident was sent to hospital and treated for fracture and returned to campus.<br>2.All residents with falls with injury have the potential to be affected. All Nurses and were educated on timeliness of stat orders and notify MD and responsible party if stat unavailable.<br>3.As a measure of ongoing compliance, DHS or designee to complete audits of up to 5 stat radiology orders as available to ensure timeliness weekly x4 | 03/01/2024 |

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| | had been standing at the end of her bed and her legs gave out. She knew immediately when she fell that it was broken, but no one believed her. She was not taken to the hospital until the following day. She indicated, it "hurt very bad."<br><br>During a follow up interview on 2/1/24 at 10:43 a.m., Resident E was asked about her accident. She gave consistent details and indicated, she had been standing at the end of her bed and her legs gave out. She fell down and knew immediately that her wrist was broken because, "it hurt really bad, it was swollen and didn't look right." When asked how bad it hurt she indicated, "pretty bad, I was able to fall asleep that night but woke up with it hurting a bunch of times."<br><br>During a confidential interview it was indicated, family members had just been in for a visit on Christmas Eve and were concerned about Resident E's weakness. They shared their concern on the way out with the nurse (who no longer worked at the facility). Shortly after they left, around 5:00 p.m., family received a call from the nurse who told them Resident E had fallen but was fine. Resident E complained that her wrist hurt, but she was able to move it fine and family was led to believe it was no big deal. Family indicated it was a very traumatic experience for the resident and worst of all, the resident felt that no one believed her. Resident E still talked about the incident, and her wrist remained deformed.<br><br>During a confidential interview it was indicated, on Christmas day family came back to visit Resident E. Family arrived in the afternoon around 3:30 p.m., and "was horrified." Family had already been informed that Resident E had fallen the night before but had been led to believe everything was fine, so family had not rushed back in to see her or | | weeks, then bi-weekly x8 weeks then monthly x3 months<br>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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| | even thought an x-ray was warranted. However, upon family's arrival and observation of her arm, it was "clearly broken." She was weak and could barely talk through the pain. She guarded her arm which was swollen, deformed, and bruised black and blue. Family ran out of the room to find a nurse but could not find anyone except an x-ray technician who was coming down the hall. The x-ray technician, who confirmed they were there for Resident E, was led to the room. The x-ray technician told the family they were not qualified to read the results and wait for the radiologist's results. But since Resident E still needed to get dressed, the technician advised the family to be very careful when moving her arm since it looked "like a very bad break." Finally a nurse came in and told family it would be faster if they took her straight to the Emergency Room (ER) instead of waiting for an ambulance. At the hospital, Resident E was determined to be in acute hypoxic respiratory failure due to pneumonia. The fractured wrist was cast but did not require surgery. She was in such poor condition, hospital staff kept recommending hospice and family were very concerned it may have been the end. The family indicated Resident E had not received an x-ray sooner or been sent to the ER because they were told the x-ray was supposed to come on the 24th, but couldn't make it until the 25th. The family was told she was not in any pain so they did not think she needed to be seen, until they saw her the next day. Family was very upset they had not been given a full picture of Resident E's rapidly declining condition. Family indicated it was one of the most awful experiences Resident E had ever had. She was more or less back to her old self, but remained anxious about the accident. She often talked about it that she thought she might have died. | | | |

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| | During a confidential interview, it was indicated that a Certified Nursing Aide (CNA) who worked the evening of Resident E's fall had indicated they were surprised Resident E was not sent to the ER since the wrist was deformed and the resident complained of pain.<br><br>During a confidential interview, it was indicated that the x-ray technician remembered Resident E's accident. The family had been there, and both family and Resident E were tearful. Resident E was in pain. Although they were not qualified to read the results of the x-ray, it was "clearly broken and painful," so the technician advised the family not to move the arm if at all possible to avoid any further displacement.<br><br>During an interview on 2/1/24 at 2:24 p.m., the DON indicated the nurse should have contacted the physician to let them know that x-ray would not be available until the following day to determine if Resident E should be sent out or get orders for care and monitoring in the meantime. The nurse on duty the evening of the fall and Resident E "had personality clashes," and they were not fond of each other.<br><br>During an interview on 2/2/24 at 11:18 a.m., the Medical Director (MD) indicated he vaguely remembered the accident when Resident E fall and broke her wrist. He could not say for sure if the facility called to notify him that the STAT (immediate) x-ray could not be obtained within the required timeframe. He indicated if the wrist was noticeably deformed, he would have given an order to splint the arm and closely monitor to ensure pulse was palpable until x-ray could be performed.<br><br>During a confidential interview, it was indicated | | | |

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| | that Resident E's family had expressed their concern and grievances related to Resident E's treatment the night of the fall and the following day. The nurse who was on duty was not "particularly fond" of Resident E and Resident E did not like her. When the nurse called family to tell them about the fall she said, "well, she had a fall but she's just being dramatic." Resident E told family the next day that the nurse did not even help her off the floor and just said, "oh stop that, and get yourself up." Family indicated they came in on 1/9/23 to discuss their care concerns and spoke with the Social Service Director (SSD) particularly in order to make sure that nurse would not care for Resident E any longer.<br><br>Family provided a copy of handwritten notes from a care plan meeting, dated 1/9/23, which indicated the following topics had been discussed (but were not limited to) " ...RUDE experience with the aide and [Name of the nurse on 12/24/22], lack of communication ...." Family indicated no follow up was provided.<br><br>During an interview on 2/1/24 at 1:47 p.m., the SSD indicated she did not recall Resident E's family members complaining about anything related to her fall or customer care concerns related to nursing staff.<br><br>On 1/31/24 at 10:59 a.m., Resident E's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, unspecified dementia, anxiety, post-traumatic stress disorder, repeated falls, and panic disorder.<br><br>A nursing progress note, dated 12/24/22 at 6:00 p.m., indicated Resident E was found lying on the floor next to her bed and stated she had called 911 | | | |

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| | to come get her. She stated, "that her right wrist was broken," but she was able to move it without problems. She did have an area that looked like a hematoma on her right wrist. The Nurse Practitioner (NP) was notified and a new order for a STAT x-ray was placed.<br><br>A fall event, dated 12/24/22 at 5:11 p.m., indicated Resident E fell after transferring herself. She complained of right wrist pain on a scale of 3 of 10. The Event lacked documentation of 1st aide given, if any.<br><br>A nursing progress note, dated 12/24/22 at 7:13 p.m., indicated the x-ray company called and even though they had received the STAT order, would not be able to perform the x-ray until the following day.<br><br>The record lacked documentation that the MD had been notified that x-ray would not be available until the following day.<br><br>A nursing progress note, dated 12/15/22 at 6:11 p.m., indicated x-ray arrived and stated the results were a fracture of the right wrist. Family was present and took Resident to the ER.<br><br>The x-ray results, dated 12/25/22 at 5:21 p.m., indicated, "an acute, approximately 4.1 mm impacted, distal radial metaphyseal (Colles') fracture, with sagittal oriented fracture line extending to the radiocarpal surface (with approximately 2 mm diastases at the radiolunate articular surface).<br><br>A corresponding hospital record, dated 1/4/23, indicated, " ...[family at bedside] very emotional and stated the patient has gone downhill badly this past week ..." She was assessed and | | | |

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| | diagnosed with acute hypoxemic respiratory failure from aspiration pneumonia, dysphagia which required a diet downgrade to nectar thick and puree, a right wrist fracture resulting from a fall, and rhinovirus infection.<br><br>Family submitted a picture that was taken on 12/25/22 at 3:52 p.m. of Resident E's right wrist. The wrist and hand were observed to be swollen and bruised. There was a visible angled deformity that caused her wrist to appear abnormally crooked. A corresponding message with the picture indicated, " ...it's really hurt and she said that they haven't done an x-ray. It's black and blue ..."<br><br>On 2/2/24 at 10:39 a.m., the Clinical Consultant provided a copy of a post-fall investigation.<br><br>An undated Timeline/Chronology of Event and Communication. The fall occurred on 12/24/22 at 5:11 p.m. and order for a STAT x-ray was placed. Just two hours later, on 12/24/22 at 7:13 p.m., the x-ray company called to inform the facility they could not obtain x-ray until the next day related to the holiday, and that the MD was "updated," however lacked documentation of MD recommendations. Throughout the evening/night, Resident E received routine pain medication. On 12/25/22 at 5:21 p.m., x-ray was completed, and results concluded fracture of the right wrist. Resident E was sent to the ER. Immediate steps taken after the fall were, neurological checks and "first aide" although the record lacked documentation of what first aid was given. The timeline was signed by the Director of Nursing (DON) but remained undated.<br><br>A care plan meeting observation, dated 1/10/23, was completed by the SSD but lacked | | | |

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| | documentation of family concerns.<br><br>An SSD progress note, dated 1/10/23 at 8:43 a.m., indicated the SSD met with Resident E's family members and a hospice representative on 1/9/23. " ...family is concerned about resident's decline and would like to hold off on hospice so resident could participate in therapy at this time." The note lacked documentation of care concerns related to nursing staff.<br><br>The grievance log was requested and provided by the DON on 2/1/25 at 2:50 p.m. and lacked documentation of care concerns related to nursing staff for Resident E surrounding her fall with fracture.<br><br>Resident E's comprehensive care plans were reviewed. She had a care plan initiated on 11/3/22 and last reviewed/revised on 11/28/23. The care plan indicated, " ...Resident has a history of a traumatic experience or event. History of spousal abuse, per resident. Diagnosis of PTSD. Currently on a medication regime to alleviate depression, and dementia with delusions. Voices frequent, unspecific concerns with staff, states they don't seem to know that her back and wrist are broken despite evidence to the contrary ..." which lacked revision to include interventions or goals to reflect the fact her wrist had indeed been broken.<br><br>On 1/31/24 at 2:45 p.m., the DON provided a copy of current, but undated, facility policy titled, "Ordering Lab Testing." The policy indicated, " ...STAT lab testing is prioritized over routine testing and will be done in an expedited and timely manner ... results for STAT testing are reported within 4 hours ...."<br><br>On 2/1/24 at 2:50 p.m., the DON provided a copy | | | |

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| | of current facility policy titled, "Fall Management Program Guidelines," reviewed 12/31/23. The policy indicated, " ...even the most vigilant efforts may not prevent all falls ad injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury ... any orders received from the physician should be noted and carried out ...."<br><br>On 2/1/24 at 2:50 p.m., the DON provided a copy of current facility policy titled, "Resident Concern Process," reviewed 12/31/23. The policy indicated, " ...to provide a process for handling, tracking, and resolving customer concerns to provide excellence in customer service ... enter the concern using the desktop icon labeled "Resident Concern Form" all concerns should be entered electronically ... we never ask a family member to complete the form. Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution ... Residents and/or their representatives have the right to voice grievances/concerns or recommendations without discrimination of reprisal. The campus will investigate reported concerns to resolve those concerns ...."<br><br>This citation relates to Complaint IN00414005.<br><br>3.1-37(a) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§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. | | | |

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| | §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(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;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(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.<br><br>§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, interview, and record review, the facility failed to ensure a Foley catheter bag (part of a urinary drainage system) was kept off the floor for a resident with a history of urinary tract infections (UTI) for 1 of 3 residents observed for closed urinary drainage system (Resident 39).<br><br>Findings include:<br><br>On 1/30/24 at 1:41 p.m., Resident 39's record was reviewed. Her diagnoses included, but were not | F 0690 | F690<br>1 Resident 39 was affected without adverse occurrences noted. Foley drainage bag replaced immediately upon discovery of contamination.<br>2 All residents with indwelling catheters have the potential to be affected. An audit was conducted to ensure all drainage bags were appropriately | 03/01/2024 |

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| | limited to UTI, neuromuscular dysfunction of the bladder, and diabetes mellitus (blood sugar disorder).<br><br>Her Foley care plan, dated 1/24/24, indicated the problem started on 9/1/23. The care plan goal was to keep the resident free from adverse effects from catheter use. The approaches included observation for signs of complication such as UTI and assist with catheter care and change Foley catheter per physician orders.<br><br>Her other care plan goals indicated she would have her activities of daily living (ADL) needs met by staff and be free from burning and pain that interfered with comfort level.<br><br>Her physician orders indicated Macrobid (antibiotic)100 milligrams (mg) capsule, twice a day, on 1/22/24 and 1/23/24. The indication for use was UTI.<br><br>On 1/29/24 at 10:43 a.m., Resident 39 was observed in bed with her eyes closed. Her Foley bag was on the floor.<br><br>On 1/31/24 at 2:15 p.m., Resident 39 was observed in bed with her eyes closed. Her Foley bag was on the floor.<br><br>On 1/31/24 at 2:29 p.m., Registered Nurse (RN) 78 observed Resident 39's Foley bag on the floor. She indicated it should not be on the floor because it can lead to contamination and UTI. Resident 39 had a history of UTIs, and she would replace the Foley bag.<br><br>On 1/31/24 at 2:38 p.m., RN 78 with the assistance of the Associate Director of Nursing (ADON) replaced the Foley bag with a clean one. | | placed and free of contamination.<br>3 As a measure of ongoing compliance, the DHS or designee will audit up to 5 residents as available to ensure urinary drainage bags are not touching the floor at various times of day. Audit to be completed weekly x4 weeks, then bi-weekly x 8 weeks, then monthly x3 months.<br>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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| | Resident 39's hospital records were provided by Director of Nursing (DON), on 2/1/24 at 10:17 a.m.<br><br>The emergency department (ED) hospital notes, dated 9/11/23, indicated she was brought in with a Foley with altered mental status (AMS). Her urinalysis (UA) indicated abnormal results and she was given gentamicin 320 mg (antibiotic), IVPB (intravenous piggyback) for a UTI.<br><br>The ED hospital notes, dated 9/29/23, indicated the plan was for her to be treated for a bacterial UTI. She was given ceftriaxone 1 gram (antibiotic), IVPB, and would wait for urine bacterial cultures. The medication was changed to gentamicin 320 mg, IVPB.<br><br>The ED hospital notes, dated 1/7/24, indicated she had an altered mental status likely due to UTI and dehydration. Her UA came back with abnormal results. Orders to give gentamicin 320 mg, IVPB. Bolus (rapid influx of fluids) 1000 mL (milliliters) LR (lactated ringers) and NS (normal saline), with NS running 100 mL/hour.<br><br>A current policy, titled, " Urinary Catheter Care," dated 12/31/22, was provided by the DON, on 2/1/24 at 10:17 a.m. A review of the policy indicated, " ...Overview To prevent infection of the resident's urinary tract ...Be sure the catheter tubing and drainage bag are kept off the floor ...."<br><br>3.1-41(a)(2) | | | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently | | | |

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| | accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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 permit only authorized personnel to have access to the keys.<br><br>§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.<br>Based on record review, observation and interview, the facility failed to dispose of a controlled medication after it had expired for a resident (Resident 17) for 1 of 2 medication storage rooms observed.<br><br>Findings include:<br><br>On 1/31/24 at 10:14 a.m. an observation was made of the refrigerated controlled lock box on the 100 hall. Inside the box contained lorazepam (anti-anxiety medication) belonging to Resident 17.<br><br>Resident 17 had an order, dated 12/28/23, for lorazepam intensol schedule IV concentrate 2 | F 0761 | F761<br>1 Resident 17's was affected without adverse occurrences noted. Medication was destroyed immediately per policy.<br>2 All residents have the potential to be affected. An audit was conducted to ensure all remaining Ativan Intensol was within timeframe for use. Education provided to Nurses and QMAs regarding expiration dates on Ativan Intensol.<br>3 As a measure of ongoing compliance, the DHS or | 03/01/2024 |

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| | milligrams per milliliter (mg/ml). Administer 0.25 ml orally, 30 minutes prior to a.m. care for agitation/anxiety.<br><br>The lorazepam lacked a date that it was opened. The bottle should have been discontinued after being opened after 60 days. The label indicated the medication expired on 12/10/23.<br><br>At the time of observation, the director of nursing (DON) indicated she would destroy the lorazepam and order a new bottle for the resident.<br><br>A policy titled, "Medication Storage in the Facility," was provided by the DON on 1/31/24 at 1:42 p.m. It indicated, " ...Expiration date of dispensed medications shall be determined by the pharmacist at the time of dispensing ....".<br><br>3.1-25(j)<br>3.1-25(m)<br>3.1-25(n) | | designee will audit admission records to ensure admission weights obtained per policy.<br>Audits to occur on 5 residents weekly x4 weeks, then bi-weekly x 8 weeks, then 5 residents monthly x3 months.<br>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 0812<br>SS=D<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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 | | | |

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| | practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>Based on observation, interview, and record review, the facility failed to appropriately assist a resident with eating for 1 or 2 residents observed for assistance with eating (Resident 6) and failed to complete correct hand hygiene during dining services for 2 of 2 dining observations (Resident 6 and 16).<br><br>Findings include:<br><br>1. On 1/29/24 at 11:51 a.m., CRCA (Certified Resident Care Assistance) 25 was observed to touch the arms of the dining room chair with both hands and sat down. She gave Resident 6 a drink, put a napkin on her lap, and gave her another drink. She was observed to touch the chair with both hands again, pulled on the back of her shirt, and started to assist Resident 6 with eating. She provided several bites of food and gave her drinks. She put her right hand in her lap, then used her right hand to give the resident a drink. With her left hand she pulled the back of her shirt down again, scratched her left knee, and gave the resident another drink. She wiped the resident's mouth with a napkin. She adjusted the resident's clothes and necklace with her left hand. She touched the napkin with both hands. She held the chocolate pudding cup in her left hand and served with right hand. She adjusted Resident 6's necklace again, then continued assisting her with eating. She scratched her left thigh with her left hand, then used both hands to wipe chocolate | F 0812 | F812<br>1 CRCA 25 was immediately educated on hand hygiene and feeding assistance. DA 55 was immediately educated on handwashing policy including utilizing paper towel to turn faucet off. RN 85 was educated on hand hygiene.<br><br>2 All residents have the potential to be affected. Education provided to all staff on hand hygiene policy and procedure.<br>3 As a measure of ongoing compliance, the DFS or designee will observe hand hygiene during meal service for 5 employees weekly x4 weeks, then 5 bi-weekly x 8 weeks, then monthly x3 months.<br><br>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 | 03/01/2024 |

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| | pudding off of resident's sweater. Then, CRCA 25 pulled down the back of her shirt again, held the pudding with her left hand and continued assisting her with eating.<br><br>2 On 1/29/24 at 11:46 a.m., Dietary Aide (DA) 55 was observed to bring clean, adaptive plates from the kitchen. She washed her hands, turned the faucet off with her bare hands, then dried with paper towels.<br><br>On 1/31/24 at 11:36 a.m., RN 85 was observed to put her bare hands on the wheelchair handles to move Resident 6, then she provided wrapped silverware to Resident 16. She did not do hand hygiene between residents.<br><br>On 1/31/24 at 11:56 a.m., Division Dining Services Support indicated to complete hand hygiene, the staff should be let the water run, dry hands on paper towels, and turn the water faucet off paper towels.<br><br>A current policy, titled, "Guideline for Handwashing/Hand Hygiene," dated 12/31/23, was provided by the Director of Nursing (DON), on 2/1/24 at 10:31 a.m. A review of the policy indicated, "...Handwashing is the single most important factor in preventing transmission of infection ....All health care worker shall utilize hand hygiene frequently and appropriately ...Before/after preparing/serving meals, drinks ...Wash well for at least 20 seconds ...Rinse hands well under running water ...Dry hands with paper towel(s) ...Turn off faucet with paper towel to avoid recontamination hands from the faucet ...."<br><br>3.1-21(i)(3) | | warranted | |

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| | 155811 | A. BUILDING 00<br>B. WING | 02/02/2024 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00414005, IN00416689 and IN00426548.<br><br>Complaint IN00414005 - Federal/State deficiencies related to the allegations are cited at F684.<br><br>Complaint IN00416689 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00426548 - No deficiencies related to the allegations are cited.<br><br>Survey dates: January 29, 30, 31, and February 1 and 2, 2024.<br><br>Facility number: 013085<br><br>Residential Census: 37<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on February 13, 2024. | R 0000 | POC due: March 4, 2024<br>Date of Compliance: ___March 1, 2024_____<br><br>The submission of this plan of correction does not indicate an admission by Wellbrooke of Avon 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 Avon. 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. | |
| R 0026<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(a)<br>Residents' Rights - Noncompliance<br>(a) Residents have the right to have their | | | |

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| | rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.<br><br>Based on record review and interview, the facility failed to ensure that residents or family representative signed a copy of their resident rights for 4 of 4 residents reviewed (Residents 38, 45, 22, and 39).<br><br>Findings include:<br><br>1. On 2/2/24 at 10:32 a.m., a record review was completed for Resident 38. She had the following diagnoses which included but not limited to encephalopathy (a brain disease that alters brain function or structure), urinary tract infection, pneumonia, schizophrenia, and gastroesophageal reflux disease (GERD). Resident 38 admitted on 7/19/22. She did not have a copy of resident rights signed by her or her family representative upon admission. | R 0026 | R 026<br>1 Residents 38, 45, 22 and 39 were affected. All residents that are still active residents have received their admission packets which include resident rights. Education was immediately provided to the CSR on timely completion of admission documents.<br>2 All residents have the potential to be affected. An audit was conducted to ensure al other AL residents have had documented resident rights received.<br>3 As a measure of ongoing compliance, the ED or designee will audit 5 Assisted | 03/01/2024 |

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| | 2. On 2/2/24 at 10:39 a.m., a record review was completed for Resident 45. She had the following diagnoses which included but not limited to hypertension, hyperlipidemia, depression, dementia, and pain. Resident 45 admitted to the facility on 1/22/24 and discharged from the facility on 1/28/24. She did not have a copy of resident rights signed by her or her family representative upon admission.<br><br>3. On 2/2/24 at 10:01 a.m., a record review was completed for Resident 22. She had the following diagnoses which included but were not limited to seizures. He was admitted to the facility on 10/13/23. He did not have a copy of resident rights signed by him or his family representative upon admission.<br><br>4. On 2/2/24 at 10:27 a.m., a record review was completed for Resident 39. She had the following diagnoses which included but were not limited to iron deficiency anemia, chronic kidney disease, osteoarthritis, fractured ribs, and spondylosis (degeneration of the bones and disks in the neck). Resident 39 was admitted to the facility on 7/10/23. She did not have a copy of resident rights signed by her or her family representative upon admission.<br><br>During the survey, the DON indicated she was unable to find signed resident rights from admission for Residents 38, 45, 22, and 39. A copy titled, "Assisted Living Resident Rights Guideline," was provided by the Director of Nursing (DON) on 2/2/24 at 12:45 p.m. It did not include information regarding having the resident or the resident's representative sign a copy of Resident Rights upon admission to the facility. | | living admission documentation to ensure completion (including resident rights). Audit to be conducted weekly x4 weeks, then 5 bi-weekly x 8 weeks, then monthly x3 months.<br>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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| R 0301<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(5)<br>Pharmaceutical Services - Deficiency<br>(5) Labeling of prescription drugs shall include the following:<br>(A) Resident ' s full name.<br>(B) Physician ' s name.<br>(C) Prescription number.<br>(D) Name and strength of the drug.<br>(E) Directions for use.<br>(F) Date of issue and expiration date (when applicable).<br>(G) Name and address of the pharmacy that filled the prescription.<br>If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.<br>Based on observation, interview, and record review, the facility failed to ensure medications were labeled with expiration dates, failed to ensure medications were labeled with resident name, and failed to ensure prescription details were included on medications on 1 of 1 medication storage room and 1 of 1 medication carts in the Assisted Living unit.<br><br>Findings include:<br><br>1. On 2/4/24 at 10:00 a.m., during a medication storage observation on the Assisted Living (AL) medication cart, the following was observed: an opened/undated Lantus SoloStar pen and NovoLog FlexPen (used to treat diabetes); an opened and unlabeled bottle of Guaifenesin tablets (used to thin and loosen mucus); an opened bottle with no administration specific information of 81 milligram (mg) Aspirin tablets (used to prevent stroke or heart attack); and an opened bottle with no administration specific information of Acetaminophen tablets (used to | R 0301 | R301<br>1 All medications without labels and open dates were labeled and dates appropriately. An audit was completed to ensure all other medications were labeled and dated per policy.<br>2 Education was provided to all Nurses and QMAs on labeling and dating policy and procedure.<br>3 As a measure of ongoing compliance, the Director of Assisted Living or designee will audit medication carts and other medication storage for proper labeling and dating of medications. Audit to be conducted 3x weekly x4 weeks, then 1x/week every other week, then monthly x 3 months<br>4. As a quality measure, | 03/01/2024 |

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| | treat pain).<br><br>During an interview on 2/2/24 at 10:00 a.m., the Director of AL (DAL) and the Assistant Director of Nursing (ADON) indicated all opened medications should have the following: the name of the resident, the date the medication was opened, the date the medication expired, and prescribed administration instructions.<br><br>2. On 10:15 a.m., during the AL medication room observation, the following was observed: an opened and expired Humalog KwikPen (used to treat diabetes).<br><br>During an interview on 2/2/24 at 10:15 a.m., the DAL and the ADON indicated all opened medications should be labeled with the date the medication was opened and the date the medication expires.<br><br>On 2/2/24 at 11:38 a.m. the Clinical Consultant provided the policy titled, "Medication Storage in the Facility," dated 11/2018. The policy indicated, "...C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label ... Expiration Dating (Beyond-use dating) B. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date ... C. Certain medications or package types, such as multiple dose injectable vials ... once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency ... F. No expired medication will be administered to a resident ... G. All expired medications will be removed from the active supply ...."<br><br>On 2/2/24 at 11:38 a.m. the Clinical Consultant provided the policy titled, "Medication Ordering | | 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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| | and Receiving from Pharmacy", dated 11/2018. The policy indicated, "...A. Labels are permanently affixed to the outside of the prescription container ... B. Each prescription medication label includes: 1) Resident's name, 2) Specific directions for use ..., 8) Beyond use (or expiration) date ...." | | | |