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	08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 31, and August 1, 2, 5, 6, and August 7, 2024 Facility number: 013107 Provider number: 155812 AIM number: 201279670 Census Bed Type: SNF/NF: 16 SNF: 37 Residential: 42 Total: 95 Census Payor Type: Medicare: 19 Medicaid: 16 Other: 18 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 12, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Crawfordsville that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of Crawfordsville. 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 all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Bulan	RN, DHS	08/28/2024

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	of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to ensure resolutions to the concerns voiced by the Resident Council were communicated back to the Resident Council for 1 of 3 months of Resident Council minutes reviewed (Resident 35).	F 0565	**F565-Resident/Family Group and Response** **1 What corrective action was taken for the resident affected by the alleged deficient practice?**	08/28/2024

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	Findings include: During an interview with the Resident Council, on 8/5/24 at 1:20 p.m., Resident 35 indicated she could not recall ever having any of the department managers or anyone else coming in to meet with the Resident Council to discuss the resident council's grievances. Review of the Resident Council Meeting Minutes, dated 5/13/24, indicated the following: a. A form related to nursing concerns of call light wait times and staffing number concerns, lacked documentation of any response from the nursing department. b. A form related to a maintenance concern of a missing bathroom door, lacked documentation of any response from the maintenance department. c. A form related to a request for more variety in menu options, lacked documentation of any response from the dietary department. During an interview, on 8/5/24 at 1:30 p.m., the Activity Director indicated she would document the Resident Councils concerns on the Resident Council response forms. She then would put the form in the mailbox of the appropriate department directors. The department directors were responsible to address the concern. She rarely received any response from the directors. During an interview, on 8/5/24 at 2:19 p.m., the Executive Director (ED) indicated no staff would ever attend one of the Resident Council meetings unless they had been invited. Any grievance from the Resident Council would be documented on		All resident concerns voiced in May 2024 and August 2024 were addressed with the appropriate department leader and followed up on as appropriate. Concerns were communicated back to the Resident Council. **2 What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?** All residents had the potential to be affected by the alleged deficient practice. **3 What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur?** Department leaders will be re-in serviced on the policy titled "Resident Council: by Home Office, Clinical Support or designee. As a measure of ongoing compliance, the ED or designee will monitor resident council meetings to ensure resolutions to the concerns voiced by the Resident Council are communicated back to Resident Council monthly for 6 months. **4 How will corrective actions be monitored to ensure the alleged deficient practice does not recur?** The Executive Director or designee will audit resident council minutes monthly to ensure concerns are being addressed by the appropriate department leader.	

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	the facility grievance forms and given to the appropriate department director for a resolution. The resolution would then be communicated to the Resident Council by the staff who was invited to attend the meeting. The information would be documented under old business on the Resident Council meeting minutes. On 8/5/24 at 3:18 p.m., the ED provided a document, dated January 1, 2017, titled, "Resident Council," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures: ...8. The group's grievances and recommendations will be brought to the attention of the Executive Director who will forward the concerns to the appropriate department leader for attention and response. 8.1 Responses regarding resolutions will be documented, reviewed by the Executive Director, and kept with the Resident Council minutes...9. Actions taken and/or considerations given to issues will be reported back to the Resident Council at the next meeting...." 3.1-3(l)		The Executive Director or designee will report finding to QAPI for 6 months or until 100% compliance is obtained.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.			

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	(D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plan meetings were conducted at least quarterly for 3 of 24 resident's reviewed for care plan meetings (Residents 34, 23, and 1). Findings include: 1. During a family interview, on 8/1/24 at 11:14 a.m., Resident 34's daughter-in-law indicated she could not recall having a care plan meetings quarterly over the past year. Resident 34's record was reviewed on 8/5/24 at 9:56 a.m. The census indicated the resident had been admitted to the facility on 10/6/21. A quarterly Minimum Data Set (MDS) assessment, dated 5/3/24, indicated the resident had severe cognitive deficit. A Resident First Meeting (care plan meeting) notes, dated 7/1/23 to 8/5/24, indicated the	F 0657	F657-Care Plan Timing and Revision 1. What corrective action was taken for the resident affected by the alleged deficient practice. Resident 1 and 23 suffered no ill effects from the alleged deficient practice. Residents will have resident care conferences completed in a timely manner per policy. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice? Active residents have the potential to be affected by the alleged deficient practice. Active residents have been audited to ensure care conferences are completed in a timely manner. 3. What systemic measures or changes are put in place to ensure	08/28/2024

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	following: a. A Resident First Meeting was held on 5/2/24. The resident's representative had attended the meeting via telephone. The resident declined to attend. b. A Resident First Meeting was held on 8/1/24. The resident's representative had attended the meeting via telephone. The resident declined to attend. The record lacked documentation of a Resident First Meeting being conducted between the dates of 7/1/23 and 5/3 2/24. 2. During an interview, on 7/31/24 at 12:21 p.m., Resident 23 indicated she did not remember being invited to or attending a care plan meeting recently. She could not recall when the last one was. Resident 23's record was reviewed on 8/2/24 at 10:59 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/3/23, indicated the resident was cognitively intact. Census information indicated the resident was admitted to the facility on 8/2/23. A Resident First Metting note, dated 5/3/24 at 2:51 p.m., indicated a care plan meeting was conducted on this day for Resident 23. A Resident First Meeting note, dated 8/3/23 at 10:08 a.m., indicated a care plan meeting was conducted on this day for Resident 23. Resident 23's record lacked documentation of a quarterly care plan meeting being conducted between the months of August 3, 2023 - May 3, 2024.		the alleged deficient practice does not recur. The IDT-SSD, DHS, ADHS, ED, MDS were educated on completing care conferences timely and documenting the care conference. As a measure of ongoing compliance, ED or designee will audit to ensure residents resident care conferences are held timely and appropriate documentation is included in medical record, audits will consist of 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months 4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until 100% compliance is met.	

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	3. During an interview, on 8/1/24 at 1:42 p.m., Resident 1 indicated he did not remember being invited to or attending a care plan meeting recently. He could not recall when the last one was. Resident 1's record was reviewed on 8/2/24 at 10:22 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/16/24, indicated the resident was cognitively intact. Census information indicated the resident was admitted to the facility on 1/22/21. A Resident First Meeting note, dated 5/7/24 at 9:47 a.m., indicated a care plan meeting was conducted on this day for Resident 1. Resident 1's record lacked documentation of a quarterly care plan meeting being conducted between the months of July 4, 2023 through May 7, 2024. During an interview, on 8/5/24 at 1:42 p.m., the Social Service Director (SSD) indicated she was aware that they were behind on the quarterly care plan meetings. She indicated the care plan meetings should be conducted quarterly. She indicated Resident 23 and 1 did not have the quarterly care plan meetings conducted. She was hired at the facility in November of 2023, and she had been trying to get caught up on them since then. During an interview, on 8/5/24 at 2:51 p.m., the Regional MDS Support indicated she was aware that some of the residents had missed their quarterly care plan meetings. She indicated the facility identified they were behind in January of			

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	2024 and began an audit action plan. She indicated the audit was ongoing and they were getting close to being caught up. On 8/5/24 at 2:05 p.m., the Director of Nursing provided a document, dated 12/31/23, titled, "Resident's First Meeting Guidelines," and indicated it was the current policy being used by the facility. The policy indicated, "...2. Subsequent meeting for non-Medicare residents should be conducted at a minimum of quarterly and with a significant change ...." 3.1-35(e)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 0692	**F692-Nutrition/Hydrations**	08/28/2024

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	Based on record review and interview, the facility failed to ensure a resident with a weight loss of greater than 5% in a 30-day period, had been addressed at the time the weight loss occurred for 1 of 1 residents reviewed for nutrition (Resident 34). Findings include: Resident 34's record was reviewed on 8/5/24 at 9:56 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified 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 dysphasia oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). A quarterly Minimum Data Set (MDS) assessment, dated 5/3/24, indicated the resident had severe cognitive deficit, required supervision with eating, had no documented weight loss, and had no swallowing or nutritional concerns. A care plan, dated 4/6/23, indicated the resident was malnourished and was at risk for malnutrition. Interventions included, but were not limited to, dietician to re-evaluate as indicated and weight as ordered. A care plan, dated 2/6/24, indicated the resident had impaired swallowing related to dysphasia. Interventions included, but were not limited to, monitored record weight. Notify physician and family of significant weight loss. A care plan, dated 7/31/24, indicated the resident had experienced a significant weight loss. Interventions included, but were not limited to,		**Status Maintenance** **1 What corrective action was taken for the resident affected by the alleged deficient practice?** Resident 34 was affected by the alleged deficient practice. Resident has been placed on fortified foods and nutritional supplement. **2 What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?** All residents have the potential to be affected. All residents have been reviewed for weight loss. **3 What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur?** As a measure of ongoing compliance, the DHS or designee will review weight variance during CAR weekly to ensure weight loss is identified and interventions are put into place in a timely manner. DHS or designee to review five residents weekly x 4 weeks, then every other week x 2 months, then monthly x 3 months. **4 How will corrective actions be monitored to ensure the alleged deficient practice**	

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	weight as ordered. Review of the resident's weight from 2/1/24 to 8/5/24, indicated on 5/5/24 the resident weighed 129.8 pounds (lbs). Her weight on 6/5/24 was 121 lbs. The weight review indicated the resident had lost 8.8 lbs or 9.3% in 30 days. The record lacked documentation of the weight loss being identified and acted upon. A quarterly nutrition note, dated 5/17/24 at 9:17 a.m., indicated the resident's average intake was 13.63%. The note lacked documentation of any weight loss for the resident. A nutrition note, dated 6/20/24 at 3:09 p.m., indicated the resident was being followed by the interdisciplinary team (IDT-brings together knowledge from different health care disciplines to help people receive the care they need) for weight loss. The IDT recorded the resident average intake at 13.63%. The note lacked documentation of any weight loss by the resident. A dietician's note, dated 7/31/24 at 4:02 p.m., indicated the resident had a significant weight loss for the period of 3 and 6 months from the weight recorded on 7/28/24. A physician's order, dated 8/1/24, indicated to administer 120 milliliters (ml) of MedPass 2.0 (a dietary supplement to help people to gain weight and/or recover from illness) between meals two times a day. A physician's order, dated 8/1/24, indicated to provide a diet to include fortified foods (foods that have extra nutrients added to it or has nutrients added that are not normally there), under a mechanical soft consistency (soft-textured		**does not recur?** As a quality measure, the DHS or designee will review any finding and corrective action monthly in the campus Quality Assurance Performance Improvement meetings until 100% compliance is achieved. The plan will be reviewed and updated as warranted.	

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	foods that could be pureed, mashed, or blended), and thin liquids, at each meal. During an interview, on 8/5/24 at 2:54 p.m., the Regional MDS Support indicated she was unsure why the resident's weight loss had not been addressed. She believed the resident was being treated for a UTI (urinary tract infection) during the time of the weight loss. During an interview, on 8/5/24 at 2:58 p.m., the Regional Clinical Support indicated she was unsure why the 30-day weight loss had not been addressed. She had reviewed the resident's actual intakes, and they did not correlate with the documentation found in the dietician assessment, which indicated 13.63% of meals. On 8/5/24 at 3:03 p.m., the Regional MDS Support provided a document, with a revised date of 5/10/24, titled, "Guidelines for Weight Tracking," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures...3. The Registered Dietician (RD) or the Nutrition & Dietetics Technician, Registered (NDTR) will review the resident's nutritional status, usual body weight and current weight...8. The physician, resident representative, and Registered Dietician (RD) or the Nutritional & Dietetics Technician, Registered (NDTR) shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days...9. The facility may open and complete a ...Weight/Nutrition Event for a significant weight variance of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days...." 3.1-46(a)(1)			

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were labeled properly for 1 of 2 medication carts observed for medication storage (Residents 254, 255, and 18). Findings include: During a medication storage observation with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) 20, on 8/5/24 at 1:45 p.m., the 200-hall	F 0761	F761- Label/Store Drugs and Biologicals 1. What corrective action was taken for the resident affected by the alleged deficient practice. Residents 254, 255, and 18 were affected by alleged deficient practice. Residents did not experience any adverse effects related to alleged deficient practice.	08/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication cart contained the following items: a. An undated and opened Humalog (medication used to lower blood sugar) insulin medication, it contained a label that indicated it was for Resident 254. b. An undated and opened Lantus (medication used to lower blood sugar) insulin medication, it contained a label that indicated it was for Resident 255. c. An opened and undated Lantus insulin pen that contained an incomplete sticker label. The label name and room number lines were blank, directions line indicated to see the medication administration record (MAR), and the date line was blank. At the bottom of the label was a residents handwritten first name only. During an interview, on 8/5/24 at 1:47 p.m., LPN 20 indicated all insulins should be dated when opened, and the reason the insulin pen had a different label was because it was pulled from their MedBank tower (automated medication dispensing unit). She did not know when the insulin pen was pulled or opened. At first, she was unable to determine the resident's last name, but after looking she was able to determine the insulin pen belonged to Resident 18. During an interview, on 8/5/24 at 1:48 p.m., the DON indicated she tried to access the system to find out when the medication was pulled from the MedBank tower but was unable to determine when it was retrieved. The only time they pulled medications from the tower was if it was a new medication, change in medication, or a new admission. She was unsure why it had been pulled and was going to contact the pharmacy.		2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice? All nurses educated on medication storage. All medication carts were immediately reviewed with all unlabeled medications removed and destroyed per policy. 3. What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur. As a measure of ongoing compliance, the Director of Health Services or designee to check 2 medication carts for appropriate medication storage 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. 4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue for the past 6 months if warranted until	

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	155812	A. BUILDING 00 B. WING	08/07/2024

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	During an interview on 8/5/24 at 3:20 p.m., Employee 25 indicated he was the Account Manager, he had tried, but was unable to locate any documentation in the MedBank of any insulin pen being pulled for Resident 18, and that sometimes, if not stocked properly, it would not log it when it was removed. On 8/6/24 at 11:06 a.m., Resident 254's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (a chronic condition that affects the way the body processes blood sugar, where the person has high blood sugar levels). A physician's order, dated 7/31/24, indicated to administer Humalog U-100 insulin solution subcutaneously (into the deepest layer of the skin) per sliding scale (a method of calculating insulin dosages based on blood glucose levels and mealtime) before meals. On 8/6/24 at 11:10 a.m., Resident 255's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia A physician's order, dated 8/2/24, indicated to administer Lantus U-100 insulin, 10 units subcutaneously at bedtime. On 8/5/24 at 11:20 a.m., Resident 18's record was reviewed. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia. A physician's order, dated 6/30/24, indicated to administer Lantus SoloStar U-100 insulin; 100		100% compliance is met.	

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	units/milliliter (ml); 14 units subcutaneously once a day. On 8/5/24 at 2:00 p.m., the DON provided and identified a document as a current facility policy, titled, "MEDICATION STORAGE IN THE FACILITY," revised date 11/18. The policy indicated, " ...D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) A "date opened" sticker shall be placed on the medication ...E. The medication administration personnel will check the expiration date of each medication before administering it ...." 3.1-25(j) 3.1-25(k)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure proper handwashing for 2 of 2 dining observations. This had the potential to affect 53 of 53 residents who ate meals from the kitchen. Findings include: During a dining observation on 7/31/24 the following was observed: a. At 11:41 a.m., Cook 5 was observed washing his hands at the sink in the dining room, he turned off the faucet with his bare hands, without using a paper towel to turn off the water. He then proceeded back into the kitchen. b. At 11:43 a.m., Cook 5 was observed washing his hands at the sink in the dining room, he turned off the faucet with his bare hands, without using a paper towel to turn off the water. He then grabbed paper towels to dry off his hands and dropped the paper towel on the floor. Cook 5 picked up the paper towels from the floor and continued to finish drying his hands. The paper towels were then disposed of, and he obtained a plate of food from the steam table and served a resident their lunch plate. c. At 11:45 a.m., Dietary Services Assistant 6 was observed to wash his hands for less than 20 seconds and touched the faucet handle with bare hands, without using a paper towel to turn off the water. He then proceeded back into the kitchen. d. At 11:49 a.m., Dietary Services Assistant 6 was	F 0812	**F812-Food Procurement Store/Prepare/Serve-Sanitary** **1 What corrective action was taken for the resident affected by the alleged deficient practice?** No residents were affected by the alleged deficient practice. Staff members have been educated on proper hand hygiene with written education and return demonstration. **2 What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice?** All residents have the potential to be affected. Meal service will be audited to ensure proper hand washing technique is being followed during meal service. Education with all staff will be done on proper hand hygiene. **3 What systemic measures or changes are put in place to ensure the alleged deficient practice does not recur?** As a measure of ongoing compliance, the Infection Control Nurse will observe hand hygiene during meal service, weekly x 4 weeks, then every other week x 2	08/28/2024

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	observed to have soap on his hands at the sink, he was lathering his hands with the soap and then proceeded to turn on the faucet handle with soapy hands, he touched the touched the faucet handle with bare hands without using a paper towel to turn off the water. He entered the kitchen and returned with a bowl of food that he served to a resident. e. At 11:51 a.m., Cook 5 was observed washing his hands at the sink in the dining room, he turned off the faucet with his bare hands, without using a paper towel to turn off the water. He then proceeded to steam table and obtained a plate a food to serve to a resident. f. At 11:53 a.m., Dietary Services Assistant 3 was observed to wash his hands for less than 20 seconds and touched the faucet handle with bare hands, without using a paper towel to turn off the water. He then proceeded back into the kitchen and returned with a bowl of food and served it to a resident. During a second dining observation on 8/5/24 the following was observed: g. At 11:44 a.m., Activity Associate 17 was observed to wash his hands for less than 20 seconds and touched the faucet with bare hands, without using a paper towel to turn off the water. He then proceeded to steam table and obtained a plate a food to serve to a resident. h. At 11:47 a.m., Dietary Services Assistant 6 was observed to have soap on his hands at the sink, he was lathering his hands with the soap and then proceeded to turn on the faucet handle with soapy hands, he touched the faucet handles with bare hands without using a paper towel to turn off		months, then monthly x 3 months, **4 How will corrective actions be monitored to ensure the alleged deficient practice does not recur?** As a quality measure, the ED or designee will review any finding and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	the water. He went into a cabinet and obtained a glass to prepare a drink for a resident. During an interview, on 8/5/24 at 11:54 a.m., Certified Residential Medication Aide (CRMA) 16 indicated staff were to wash their hands with soap and water and they were to turn off the faucet handle by using a paper towel. Staff were not to touch the faucet handle with their bare hands. During an interview, on 8/5/24 at 11:57 a.m., Registered Nurse (RN) 18 indicated staff were to wash their hands with soap and water, make sure to scrub well, and they were to turn off the faucet handle by using a paper towel. Staff were not to touch the faucet handle with their bare hands. On 8/5/24 at 1:15 p.m., the Director of Nursing (DON) provided a document, with a revised date of 2/9/17, titled, "Guideline for Handwashing/Hand Hygiene," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Hand Washing a) turn water on to a comfortable temperature b) Wet hands with running water. Appy liquid soap and work into a lather c) Wash well for at least 20 seconds ...d) Rinse hands well under running water ...e) Dry hands with paper towels f) Turn off faucet with paper towels to avoid recontamination hands from faucet ...." 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Recertification and State Licensure Survey.	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Crawfordsville that the findings and	

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	Survey dates: July 31, and August 1, 2, 5, 6, and August 7, 2024 Facility number: 013107 Residential Census: 42 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 August 12, 2024.		allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of Crawfordsville. 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 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.	