STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155808	A. BUILDING 00 B. WING	04/04/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00428770 and IN00428393. Complaint IN00428770 - No deficiencies related to the allegations are cited. Complaint IN00428393 - No deficiencies related to the allegations are cited. Survey dates: March 27, 28, 29, April 1, 2, 3 and 4, 2024 Facility number: 012937 Provider number: 155808 AIM number: 201208220 Census Bed Type: SNF/NF: 30 SNF: 24 Residential: 39 Total: 93 Census Payor Type: Medicare: 15 Medicaid: 24 Other: 15 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review wass completed on April 17, 2024.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maggie Miller	Executive Director	04/24/2024

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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F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility,			

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	the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) options were documented as reviewed with the resident in the Electronic Health Record (EHR) and the resident choose correctly for 2 of 3 residents reviewed for beneficiary notices. (Resident 20 and I) Findings include: 1. The SNF ABN notice for Resident 20 indicated, starting on 2/21/24, the resident may have to pay out of pocket for the care listed which may not meet Medicare requirements. The care included skilled nursing, physical therapy, occupational therapy, speech therapy, labs, X-ray, treatments, and extras as needed. The resident was to make an informed decision about their care. The resident chose Option 3 which indicated the resident did not want the care listed and understood she was not responsible for paying for the care. The resident remained in the facility and	F 0582	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a	05/01/2024

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	continued to receive some of the care listed on the SNF ABN notice. 2. The SNF ABN notice for Resident I indicated, starting on 2/3/24, the resident may have to pay out of pocket for the care listed which may not meet Medicare requirements. The care included skilled nursing, physical therapy, occupational therapy, speech therapy, labs, X-ray, treatments, and extras as needed. The resident was to make an informed decision about their care. The resident chose Option 3 which indicated the resident did not want the care listed and understood he was not responsible for paying for the care. The resident remained in the facility and continued to receive some of the care listed on the SNF ABN notice. During an interview, on 4/1/24 at 3:00 p.m., the Social Services Director (SSD) indicated she thought option 3 was if the resident wanted to continue the care although did not want Medicare to be billed. She indicated she "guessed" she was advising the residents wrong about which option to choose. She did not document the conversations with the residents/representatives about the SNF ABN notice and the options which were explained in the electronic health record. A current policy, titled "NOMNC [notice of Medicare non-coverage] Completion SOP [standard operating procedure]," dated as reviewed on 10/24/22 and received from the Clinical Support Nurse on 4/2/24 at 3:00 p.m., indicated "...To streamline communication for completion of the Notice of Medicare Non-Coverage [NOMNC] and Skilled Nursing Facility Advanced Beneficiary Notice [SNF ABN], this SOP outlines the expectations for		matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Plan of Correction: 1. Residents 20 and I were affected. No adverse occurrences noted. The Social Services Director was educated regarding the notice of Medicaid/Medicare coverage/liability notice policy. 2. All residents transitioning out of a skilled service have the potential to be affected. An audit was conducted to ensure all residents' notices of non-coverage were completed accurately for the month of March. 3. As a measure of ongoing compliance, the ED or designee will complete an audit to ensure Notices of Medicaid and Medicare non-coverage are completed accurately. Audits to be completed on 2 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	completion...When is a campus required to issue an ABN...Only issue when the resident intends to continue services and the campus believes the services may not be covered under Medicare...." 3.1-4(f)(3)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility			

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	would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and			

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	(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care Ombudsman when a resident was hospitalized for 1 of 3 residents reviewed for hospitalization. (Resident J) Finding includes: The clinical record for Resident J was reviewed on 4/4/24 at 11:35 a.m. The diagnoses included, but were not limited to, a urinary tract infection, urine retention, and obstruction and reflux uropathy	F 0623	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and	05/01/2024

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	(obstruction of urinary flow). A progress note, dated 7/18/23, indicated the resident was sent to the hospital to be evaluated and treated. A progress note, dated 7/30/23, indicated the resident was sent to the hospital to be evaluated and treated. The Electronic Health Record did not include notification to the Office of the State Long-Term Care Ombudsman for Resident J's hospital discharges on 7/18/23 and 7/30/23. During an interview, on 4/2/24 at 4:40 p.m., the Clinical Support Nurse indicated the Ombudsman was not notified of Resident J going out to the hospital on 7/18/23 and 7/30/23. The staff did not know they were required to report to the Ombudsman. They had no documentation to support the facility contacted the Ombudsman and they should for any transfer and discharges. A current policy, titled "Ombudsman Notification," dated as revised on 1/15/21 and received from the Clinical Support Nurse on 4/2/24 at 4:16 p.m., indicated "...CMS Requirements of Participation, this SOP will detail expectations on communication of facility-initiated transfer or discharges to the State Long-Term Care Ombudsman...Federal regulation requires that the facility sends a copy of the notice of transfer or discharge to a representative of the Office of the State Long-Term Care Ombudsman...." 3.1-12(a)(6)(A)(iv)		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. Plan of Correction: 1 Resident J was affected without adverse occurrences noted. The ombudsman was notified of the discharge upon discovery of the omission of notification. Education was provided to Social Services Director on ombudsman notifications. 2 All residents who discharge have the potential to be affected. An audit was conducted to ensure ombudsman notification occurred for the last 3 months of discharges. 3 As a measure of ongoing compliance, ED or designee to complete audits of ombudsman notification for all discharges by the 6th of every month x 6 months to ensure compliance.	

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			4 As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a physician's order was transcribed correctly to the Medication Administration Record (MAR), to ensure a physician's order was followed, and to notify the physician when a physician's order was not followed for 1 of 1 resident reviewed for dialysis (Resident 25) and failed to monitor and document bowel movements for 2 of 5 residents reviewed for bowel and bladder function. (Resident F and G) Findings include: 1. The clinical record for Resident 25 was reviewed on 4/3/24 at 4:19 p.m. The diagnoses included, but were not limited to, kidney disease with heart	F 0684	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the	05/01/2024

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	failure and with stage 5 chronic kidney disease or end stage renal disease, type 2 diabetes mellitus with diabetic chronic kidney disease, and dependence on renal dialysis. A care plan, dated 1/11/24, indicated the resident received diuretic medication related to congestive heart failure (CHF). The approaches included, but were not limited to, administering the medications as ordered by the physician and reporting adverse drug reactions as needed. A care plan, dated 1/22/24, indicated the resident had a potential for weight fluctuations due to receiving dialysis treatments. The goal included maintaining appropriate weights. The approaches included, but were not limited to, obtaining weight as ordered and periodically reviewing renal specific weights. A physician's order, dated 12/9/23, indicated to give furosemide (a diuretic) 40 milligram (mg) daily as needed (prn) for a weight gain of 5 pounds in one week for a diagnosis of acute on chronic diastolic congestive heart failure. A physician's order, dated 12/14/23, indicated to weigh the resident once a month. The vital records form indicated the resident had the following weights: a. On 12/13/23, the weight was 193.8 pounds. b. On 12/18/23, the weight was 213.2 pounds which was a 19.4-pound weight gain in 5 days. c. On 12/27/23, the weight was 194 pounds. d. On 1/3/24, the weight was 202.4 pounds which was an 8.4-pound weight gain in 7 days. e. On 2/9/24, the weight was 189.8 pounds. f. On 2/12/24, the weight was 197.5 pounds which was a 7.7-pound weight gain in 3 days.		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. Plan of Correction: 1 Resident 25 was affected without adverse occurrences noted. The provider was notified of the PRN furosemide order and order obtained to discontinue medication. Residents G and F were also affected. Both residents were assessed and had stated that bowels had moved within 72 hours. Bowel movements were documented in the health records. 2 All residents have the potential to be affected. All clinical staff educated on the bowel protocol and PRN medication orders. 3 As a measure of ongoing compliance, DHS or designee to complete audits of all residents who have not had a bowel movement recorded in 72 hours 5x/week x 4 weeks then weekly x 8 weeks then every other week x 3 months. PRN medications to be audited on 5 residents weekly x 4 weeks then every other week x 8 weeks then monthly x 3 months to	

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	g. On 3/8/24, the weight was 186.8 pounds. h. On 3/15/24, the weight was 194.2 pounds which was a 7.4-pound weight gain in 7 days. The MAR, dated 12/1/23 through 4/4/24, indicated to give furosemide 40 mg once a day as needed for acute on chronic diastolic congestive heart failure. The MAR did not include "for a weight gain of 5 pounds in one week" and did not include any resident weights. The MAR, dated December 2023 through April 2024, showed no furosemide as needed had been administered at all since the physician's order had been obtained. During an interview, on 4/4/24 at 12:07 p.m., the Clinical Support Nurse indicated the physician's order should have been clarified, and the resident's weights should have been recorded on the MAR to show if there had been the 5-pound weight gain. The Clinical Support Nurse indicated the facility pharmacy had not noted a discrepancy with this order. The physician was not notified the order had not been followed. 2. The clinical record for Resident F was reviewed on 4/1/24 at 9:00 a.m. The diagnoses included, but were not limited to, Parkinsonism, dementia, and hypothyroidism. A quarterly Minimum Data Set assessment, dated 1/29/24, indicated the resident was moderately impaired cognitively and was frequently incontinent of bowel. A care plan, initiated 2/16/24, indicated the resident had a potential for constipation.		ensure nurses are following PRN orders. 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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	Interventions included, but were not limited to, documenting the frequency and character of bowel movements, and to administer medications/enemas/suppository as ordered. A physician's order, initiated on 11/2/23, indicated to give Miralax 17 grams once a day as needed. A physician's order, initiated on 11/19/23, indicated if the resident had no bowel movement within 72 hours the following bowel protocol may be implemented; give 2 tablespoons of Natural Laxative as needed once a day, if no results within 24 hours after the Natural Laxative, then give 30 cc (equal to 30 milliliters) of Milk of Magnesia (MOM) as needed once a day. If no results within approximately 12 hours of the MOM administration, give a Dulcolax suppository as needed once a day. If the results are not satisfactory within 2 hours of the suppository administration give a fleet's enema as needed once a day. The clinical record did not have a recorded bowel movement from 1/1/24 to 1/4/24 (4 days), 1/30/24 to 2/3/24 (5 days), and 2/27/24 to 3/2/24 (5 days). There was no documentation of a bowel assessment in the record or staff had spoken to the resident about his bowel movements. There was no ineffective bowel event or abdominal assessment found in the record. 3. The record for Resident G was reviewed on 4/2/24 at 10:14 a.m. The diagnoses included, but were not limited to, constipation, epigastric pain, and difficulty walking. An annual Minimum Data Set assessment, dated			

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WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

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	2/2/24, indicated the resident was moderately cognitively impaired. A care plan, initiated 9/6/20, indicated the resident had the potential for constipation. Interventions included, but were not limited to, documenting frequency and character of bowel movements and to administer medications/enemas/suppositories as ordered. A physician's order, dated 12/9/23, indicated may use bowel protocol as needed. A physician's order, dated 12/9/23, indicated docusate sodium capsule (a laxative) 100 milligrams. Give two times a day as needed for constipation. A physician's order, dated 12/9/23, indicated to give Miralax powder 17 grams daily as needed for constipation. There was no recorded bowel movement found in the record for 2/20/24 to 2/25/24 (6 days), 2/28/24 to 3/2/24 (4 days) and 3/4/24 to 3/11/24 (8 days). There was no documentation of a bowel assessment in the record or staff had spoken to the resident about his bowel movements. During an interview, on 4/1/24 at 3:44 p.m., the Corporate Support Nurse indicated the facility did not have nursing notes, a bowel assessment, or observations noted, and the staff should ask the resident if they had a bowel movement. A current policy, titled "Guidelines for Medication Orders," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/3/24 at 2:34 p.m., indicated "...To establish uniform			

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	guidelines in the receiving and recording of medication orders...PRN Medication orders...When recording PRN orders specify...The type, route, dosage, frequency, strength and the reason for administration...." A current policy, titled "Physician-Provider Notification Guidelines," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/4/24 at 4:26 p.m., indicated "...To ensure the resident's physician or practitioner...is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...." A current facility policy, titled "Bowel Protocol Guidelines," dated as last reviewed on 12/31/24 and received from the Corporate Support Nurse on 4/1/24 at 3:44 p.m., indicated "...The Ineffective Bowl Pattern Event should be initiated for any resident not have a BM (bowel movement) with 72 hours...A progress note associated to the Ineffective Bowel Event, should be completed until the resident has a BM...The progress note should include abdominal distention, pain and bowel sounds...Nursing staff shall assess for effectiveness, orders may be written as follows...If no bowel movement within 72 hours, 2 tablespoons (30 cc) of 'Natural Laxative'...if no results within 24 hours, after...give 30 cc of Milk of Magnesia...if no results within approximately 12 hours after MOM administer Dulcolax suppository...If results of suppository are not satisfactory within 2 hours give Fleets enema...Nursing staff will enter bowel movements, in the...system each shift...." 3.1-37(a)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen was administered according to an active physician's order, failed to administer oxygen at the specified flow rate once an order was obtained, and failed to label the oxygen tubing for 1 of 2 residents reviewed for respiratory care. (Resident 307) Finding includes: During an observation, on 3/27/24 at 12:36 p.m., Resident 307 was wearing oxygen at a flow rate of 3 liters and the nasal cannula tubing was not labeled with a date. During an observation, on 3/28/24 at 9:45 a.m., Resident 307 was wearing oxygen at 2.5 liters. During an observation, on 3/29/24 at 10:02 a.m., Resident 307 was wearing oxygen at 2.5 liters. The clinical record for Resident 307 was reviewed on 3/28/24 at 3:45 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, pleural effusion, and acute posthemorrhagic anemia.	F 0695	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for	05/01/2024

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	The electronic medical record did not contain orders for oxygen, a flow rate, or nasal cannula and humidity change frequency. A physician's order for 2 liters of oxygen prn (as needed) was started on 3/28/24. A vital signs record, dated 3/25/24 at 6:35 a.m., indicated the oxygen flow rate was at 3 liters. A vital signs record, dated 3/27/24 at 3:16 p.m., indicated the oxygen flow rate was at 3 liters. During an interview, on 3/27/24 at 1:12 p.m., LPN 7 indicated Resident 307 was currently on oxygen. During an interview, on 3/29/24 at 11:23 a.m., the Clinical Support Nurse indicated a physician's order for oxygen administration was required and the tubing was to be labeled with a date. During an interview, on 4/4/24 at 2:09 p.m., RN 3 indicated the nurses were to administer oxygen at the flow rate which was ordered by the physician. A current policy, titled "Administration of Oxygen," dated as approved on 5/2018 and received from the Executive Director on 4/2/24 at 3:35 p.m., indicated "...Verify physician's order for the procedure...Date the tubing for the date it was initiated...Adjust the oxygen delivery device so that...the proper flow of oxygen is administered...." 3.1-47(a)(6)		substantial compliance. Plan of Correction: 1 Resident 307 was affected without adverse occurrences noted. Resident had discharged at time of discovery. 2 All residents on oxygen have the potential to be affected. Education provided to clinical staff regarding oxygen orders, liter flow and labeling of oxygen tubing. An initial audit was completed to ensure oxygen orders obtained and in place for all residents wearing oxygen with correct liter flow in place with tubing labeled. 3 As a measure of ongoing compliance, the DHS or designee will audit orders for oxygen with correct liter flow and tubing labeled for 5 residents. Audits to occur weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			

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	Based on observation, interview and record review, the facility failed to ensure a current nurse staff posting was displayed daily at the beginning of each shift for 1 of 7 days reviewed for nurse staff posting. (3/27/24) Finding includes: During an observation, on 3/27/24 at 11:06 a.m., the daily nurse staff posting displayed at the reception desk was dated for 3/25/24. During an interview, on 3/27/24 at 11:08 a.m., the Executive Director (ED) indicated the scheduler was off and the daily staff posting was not updated. The daily staff posting should be displayed daily. A current policy, titled "Guidelines for Staff Posting," dated as revised on 5/11/16 and received from the Clinical Support Nurse on 3/28/24 at 11:51 a.m., indicated "...To ensure compliance with federal regulations requiring posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care...At the beginning of the day the number and amount of hours of licensed nurses (RN and LPN) and the number and hours of unlicensed nursing personnel, per shift, who provide direct care to residents will be posted...Staffing sheets should be posted in a common area easily visible upon entry to the campus...." 3.1-17(a)	F 0732	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Plan of Corrections: 1 No residents were affected. The updated staffing information was immediately posted after brought to the attention of the Executive Director. 2 All residents have the potential to be affected. The ADHS and ED was educated on the posting of the clinical staffing information.	05/01/2024

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			3 As a measure of ongoing compliance, the ED or designee will audit to ensure staffing hours are posted with accurate dates 5 days/weekly x4 weeks, then 5x bi-weekly x 8 weeks, then 5x monthly x3 months. 4 As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
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			

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	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 interview and record review, the facility failed to ensure a lab was obtained according to the physician's order and prior to giving an antibiotic for 1 of 2 residents reviewed for antibiotics. (Resident I) Findings include: The clinical record for Resident I was reviewed on 4/3/24 at 2:56 p.m. The diagnoses included, but were not limited to, right neck femur (thigh bone) fracture, methicillin-resistant staphylococcus aureus (infection usually associated with invasive procedures or devices, such as surgeries) and anxiety disorder. A care plan, dated as revised on 4/1/24, indicated the resident required Intravenous (IV) medication related to an infection. Interventions included, but were not limited to, assessing for complication from the IV site and administering IV medications as ordered. A physician's order, dated 3/14/24 to 3/25/24, indicated vancomycin (an antibiotic) reconstituted solution infusing 1.5 gram by IV daily. A physician's order, dated 3/18/24, indicated to obtain a vancomycin trough (trough levels should be obtained within 30 minutes before the next scheduled dose) lab draw one time. No results for the lab draw ordered on 3/18/24 were in the resident's medical record.	F 0757	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Plan of Correction: 1 Resident 5 was affected without adverse occurrences	05/01/2024

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	A physician's order, dated 3/24/24, indicated to obtain a vancomycin trough lab draw one time. A physician's order, dated 3/26/24 to 4/3/24, indicated vancomycin 750 milligram (ml) intravenous solution every 12 hours. During an interview, on 4/3/24 at 3:20 p.m., the Assistant Director of Nurse Services (ADNS) indicated the vancomycin lab was ordered on 3/18/24. The pharmacy called on 3/21/24, to ask for the results to adjust the resident's medication. The ADNS had no record of the lab results for 3/18/24. The pharmacy told the ADNS to continue the same dosage until the lab results were available. On 3/24/24, the antibiotic dosage was adjusted. The ADNS indicated the nurse either did not put the blood drawn in the correct tub or the lab lost the specimen. During an interview, on 4/3/24 at 12:23 p.m., the Clinical Support Nurse indicated the facility should have obtained the vancomycin level on the resident and they did not. A current policy, titled "Ordering Lab Test," not dated and received from the Clinical Support Nurse on 4/3/24 at 12:21 a.m., indicated "...Once the specimen has been collected, call [name of lab] Customer Care Team to arrange for transport of your STAT (immediate) specimen(s) to the STAT partner with which we have contracted to you...." A current policy, titled "Antibiotic Stewardship Guideline," dated 11/10/17 and received from the Executive Director at entrance, indicated "...Optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic. Reduce		noted. Resident had Vanc trough drawn with MD and pharmacy notification of results following missed lab. 2 All residents on IV Vancomycin have the potential to be affected. Education provided to nurses regarding lab orders for medication administration. 3 As a measure of ongoing compliance, the DHS or designee will audit vancomycin troughs to ensure collected and resulted per orders on all residents with vancomycin troughs weekly x4 weeks, then bi-weekly x 8 weeks, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use...Obtain and review laboratory reports for campus trends of resistance. Monitor antibiotic resistance patterns (MRSA)...Pharmacy provider will assist in review of all antibiotic usage for appropriateness...." 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;			

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	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure a correct diagnosis was added to an antipsychotic order and to monitor for psychotic symptoms for 1 of 5 residents reviewed for unnecessary medications. (Resident 10) Finding includes: The clinical record for Resident 10 was reviewed on 4/1/24 at 11:48 a.m. The diagnoses included, but were not limited to, mild cognitive impairment, major depressive disorder, anxiety disorder, and mild intellectual disabilities. A physician's order, dated 12/20/22, indicated to give aripiprazole (an antipsychotic) 10 milligram (mg) once a day for the single episode major depressive disorder.	F 0758	1 The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction	05/01/2024

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	A care plan, dated 12/20/22, indicated the resident received an antipsychotic medication for a major depressive disorder. The approaches included, but were not limited to, administer medications as ordered by the physician, attempt a gradual dose reduction (GDR) in two separate quarters during the first year and yearly unless clinically contraindicated and attempt to give the lowest dose possible. A psychiatry progress note, dated 10/11/23, indicated the resident denied any changes to his mood or perceptual disturbance. The diagnoses and plan included continuing the aripiprazole 10 mg daily for the major depressive disorder, recurrent severe with psychotic symptoms. The resident had a history of psychosis with auditory hallucinations. The physician's orders did not include the psychotic symptoms and auditory hallucinations or the severe, recurrent major depressive disorder. The care plans did not include monitoring the resident for psychosis and auditory hallucinations. During an interview, on 4/4/24 at 10:27 a.m., the Clinical Support Nurse indicated the electronic health record (EHR) did not contain any monitoring for auditory hallucinations. During an interview, on 4/4/24 at 11:04 a.m., the Clinical Support Nurse indicated the Social Services Director (SSD) was not aware of the auditory hallucinations and did not have monitoring in place or a care plan for auditory hallucinations. During an interview, on 4/4/24 at 11:21 a.m., the		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 RRResident 10 was affected without adverse occurrences noted. 2 Resident's diagnosis of History of auditory hallucinations was added to his diagnosis list and target behaviors were added to address monitoring for auditory hallucinations. The diagnosis of Major Depressive Disorder was also associated to aripiprazole order. All residents on antipsychotics have the potential to be affected. A facility wide audit was conducted to ensure that all target behavior monitoring and appropriate diagnoses were associated to antipsychotic orders. 3 As a measure of ongoing compliance, the DHS or designee will audit to ensure appropriate dx associated for use of antipsychotics and appropriate target behavior monitoring in place for 2 residents. Audits to occur weekly x 4 weeks, then bi-weekly x 8 weeks, then 5 residents monthly x3 months. 4 As a quality measure, the	

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	Clinical Support Nurse indicated the resident's past hospital records indicated depression and did not include major depression, recurrent and severe with psychosis and auditory hallucinations. The psychiatric provider notes were given to the Social Services Director (SSD) and the clinical leadership should have looked at the notes and seen the diagnosis of psychoses and auditory hallucinations. These diagnoses should have been reviewed and added to the electronic health record. The facility pharmacy did not note a discrepancy for the aripiprazole being given for a single episode of major depression. A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reductions," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/4/24 at 11:35 a.m., indicated "...To ensure every effort is made for residents receiving psychoactive mediations to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and the care planning process...Regular monthly review of antipsychotics in CAR [clinically at risk] for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident..." 3.1-48(a)(3)		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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	155808	A. BUILDING 00 B. WING	04/04/2024

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F 0839 SS=D Bldg. 00	483.70(f)(1)(2) Staff Qualifications §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on interview and record review, the facility failed to ensure a staff member had a valid nursing license for 1 of 21 nurses reviewed for current licenses. (Registered Nurse 9) Finding includes: During the staff nurse license review, on 4/3/24 at 10:32 a.m., Registered Nurse (RN) 9 had a RN license for the state of New Mexico. RN 9 did not have a nurse compact license (a license which included multiple states). The RN license for the State of Indiana was pending. RN 9 had worked the following shifts at the facility: a. Night shift in training on 3/10/24. b. Night shift in training on 3/12/24. c. Night shift on 3/15/24. d. Night shift on 3/16/24. e. Night shift on 3/17/24. f. Night shift on 3/18/24. g. Evening shift on 3/20/24. h. Evening shift from 6:00 p.m. until 6:00 a.m., on 3/22/24. i. Evening shift from 6:00 p.m. until 6:00 a.m., on 3/23/24. j. Evening shift from 6:00 p.m. until 6:00 a.m., on 3/24/24.	F 0839	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	05/01/2024

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	k. Evening shift on 3/26/24. l. Evening shift on 3/27/24. m. Night shift on 3/29/24. n. Night shift on 3/30/24. o. Night shift on 3/31/24. p. Evening shift 4/2/24. During an interview, on 4/3/24 at 10:34 a.m., the Executive Director (ED) indicated she thought RN 9 had a valid Indiana license even though it was not showing on the Indiana Professional Licensing Agency website. During an interview, on 4/3/24 at 3:01 p.m., the Clinical Support Nurse indicated RN 9 had applied for her Indiana RN license in February 2024 and had not received it yet. Someone in the facility's corporate staff had told them RN 9 could work while her Indiana license was pending. A current policy, titled "Background Check Screening Policy," dated as last updated June 2023 and received from the Clinical Support Nurse on 4/3/24 at 3:43 p.m., indicated "...Professional credential, work history and personal and professional reference checks will be verified prior to an offer being extended...." 3.1-14(s)		1. RN 9 was immediately suspended until Indiana RN license was active. 2. All licensed staff potential to be affected. An audit was conducted to ensure all nurses have active Indiana nursing license. 3 As a measure of ongoing compliance, the AP/Payroll will audit all new licensed staff to ensure an active Indiana license is obtained. Audit to be conducted upon hire for 6 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

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	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure medications were handled in a sanitary manner for 1 of 7 residents observed for medication administration (Resident D) and failed to ensure staff transported clean linen/gowns in a manner which prevents contamination for 2 of 3 staff observed transporting linen. (Housekeeper 5 and CNA 4) Findings include: 1. During a medication administration observation, on 4/1/24 at 11:41 a.m., RN 3 was observed to take a clonidine (a blood pressure medication) 0.2 milligrams from the packaging and put it into her hand, then put the medication into the medication cup after she handled it with her bare hand.	F 0880	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To	05/01/2024

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	During an observation and interview, on 4/1/24 at 11:41 a.m., RN 3 indicated she did put the medication in her hand and when informed of the concern with infection control, she indicated "well I guess we won't do that again". RN 3 was then observed to carry the medication to Resident D's room for administration. The resident was not in the room. RN 3 then returned to her medication cart, put the resident information on the outside of the cup, placed a second medication cup on top of the pill in the cup, taped the cups together and placed it in the top drawer of her cart. She was not observed to destroy the medication she handled with her hands or retrieve a new pill for the resident. During an interview, on 4/1/24 at 12:02 p.m., the Executive Director indicated staff were not to put medications into their hands or touch the medications with their hands. 2. During a random observation, on 4/1/24 at 10:15 a.m., Housekeeper 5 was observed to transport clean bed linen pressed against her upper left side of her body with the linen in contact with her clothing. Housekeeper 5 was not able to describe the proper way to transport clean linen. She was not observed to replace the linen with clean linen and proceeded to take the linen to the room. 3. During a random observation, on 4/1/24 at 10:22 a.m., CNA 4 was observed carrying clean linen/gown with the items pressed against her shirt. She was not able to explain the proper way to transport linens. A facility policy, titled "Specific Medication Administration Procedures," dated as revised on 1/17 and received from the Corporate Support Nurse on 4/1/24 at 2:26 p.m., indicated		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. 1. Resident D was affected without adverse occurrences noted. Pill was destroyed and replaced with pill that had not been touched with bare hands. RN 3 was immediately educated on proper medication handling. CNA 4 and housekeeper 5 discarded linen immediately upon observation and replaced with clean linen. Both employees were immediately educated on proper linen handling procedure. 2. All like residents have the potential to be affected. Education was provided to licensed and qualified medication passers on proper medication handling. All staff were educated on clean linen handling. 3. As a measure of ongoing compliance, DHS or designee will audit 5 residents 'medication passes to ensure proper medication handling. Audits to occur weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months. The environmental	

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	"...administer medications in a safe and effective manner...." A facility policy, titled "Guidelines for Handling Linen," dated as last reviewed 12/31/23 and received from the Corporate Support Nurse on 4/2/24 at 11:25 a.m., indicated "...PURPOSE: To provide clean, fresh linen to each resident...To prevent contamination of clean linen...Linens should be carried away from the body to prevent contamination from clothing...." 3.1-18(b) 3.1-19(g)(2)		services director will observe 5 employees for proper linen handling/transport. Audits to occur weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00428770 and IN00428393. Complaint IN00428770 - No deficiencies related to the allegations are cited. Complaint IN00428393 - No deficiencies related to the allegations are cited. Survey dates: March 27, 28, 29, April 1, 2, 3 and 4, 2024 Facility number: 012937 Residential Census: 39	R 0000		

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review wass completed on April 17, 2024.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure a semi-annual evaluation was completed for 1 of 7 residents reviewed for semi-annual evaluations. (Resident 38) Finding includes: The clinical record for Resident 38 was reviewed on 4/1/24 at 2:28 p.m. The diagnoses included, but were not limited to, pain, other muscle spasm, neurocognitive disorder with Lewy Bodies (a type of dementia with abnormal deposits of protein in the brain), and insomnia. The Electronic Health Record included a Semi-Annual Evaluation completed on 7/7/23. There was no semi-annual evaluation for the month of January 2024 in the Electronic Health Record. During an interview, on 4/1/24 at 2:29 p.m., the Clinical Support Nurse indicated there should have been a semi-annual evaluation completed in the month of January 2024 and there was not an	R 0214	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility	05/01/2024

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	evaluation. A current policy, titled "AL-Evaluation and Service Plan Guidelines," dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/2/24 at 2:08 p.m., indicated "...Upon admission, semi-annually and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial functioning and care needs...."		respectfully requests from the department a desk review for substantial compliance. Plan of Correction: 1 Resident 38 was affected. At time of discovery, the resident had discharged. 2 All residents have the potential to be affected. An audit was conducted on Assisted Living to ensure all service plans were completed timely. 3 As a measure of ongoing compliance, the Staff Development Nurse or designee will audit to ensure service plans are completed timely. Audits to occur for 5 residents weekly x 4 weeks then every other week x 8 weeks then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and			

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	procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation and interview, the facility failed to store medications at the proper temperature for 1 of 2 medication refrigerators reviewed for medication storage. (the upstairs assisted living medication refrigerator) Finding includes: During an observation, on 3/27/24 at 2:00 p.m., the medication refrigerator had multiple insulin pens for residents. The temperature in the refrigerator was 50 degrees Fahrenheit. During an observation and interview, on 3/27/24 at 2:13 p.m., the Assisted Living Director indicated the medication refrigerator was at 50 degrees Fahrenheit. The refrigerator temperature log for the month of March indicated the following temperatures: a. 3/19/24 - 50 degrees. b. 3/20/24 - 50 degrees. c. 3/24/24 - 48 degrees. d. 3/26/24 - 48 degrees. During an interview, on 3/27/24 at 2:10 p.m., Maintenance 1 indicated the temperatures in the medication refrigerators should be 36-46 degrees Fahrenheit. A current policy, titled "MEDICATION	R 0298	The submission of this plan of correction does not indicate an admission by Wellbrooke of Westfield that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Westfield. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Plan of Correction: 1 All medications were removed and discarded from	05/01/2024

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	STORAGE IN THE FACILITY," dated as revised in November of 2018 and received from the Clinical Support Nurse on 3/28/24 at 11:50 a.m., indicated " ...Medications requiring refrigeration are kept in a refrigerator at temperatures between 2*C (36*F) and 8*C (46*F) with a thermometer to allow temperature monitoring...."		refrigerator. Temperature was adjusted to appropriate temperature. 2 Education was provided to staff on Refrigerator Temperature Policy. An audit was conducted to ensure all refrigerators on Assisted Living were within appropriate temperature range 3 As a measure of ongoing compliance, the Assisted Living Director or designee will monitor temperature logs to ensure appropriate temperature on medication refrigerators weekly x 4 weeks, then every other week x 8 weeks then monthly x 3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	