STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155806	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WABASH	20 JOHN KISSINGER DRIVE WABASH, IN 46992

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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. Survey dates: December 2, 3, 4, 5, and 6, 2024. Facility number: 012993 Provider number: 155806 AIM number: 201208210 Census Bed Type: SNF/NF: 28 SNF: 24 Residential: 42 Total: 94 Census Payor Type: Medicare: 11 Medicaid: 28 Other: 13 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 19, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Wabash 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 Wabash. 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 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to maintain a resident's dignity and provide privacy during a random observation of personal care. (Resident 46) Findings include:	F 0550	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident #46 was affected with no noted adverse effects. CRCAs providing care were immediately	01/02/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Aaron Vogel	Executive Director	01/02/2025

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	Resident 46's clinical record was reviewed on 12/3/24 at 9:50 a.m. Current diagnoses included morbid (severe) obesity, multiple sclerosis, depression, anxiety, chronic pain syndrome, overactive bladder, constipation, muscle weakness, paresthesia of skin, and need for assistance with personal care. An admission Minimum Data Set (MDS), dated 9/12/24, indicated the resident was frequently incontinent of both bowel and bladder. The resident was cognitively intact and required total assistance for personal hygiene, including pericare. A current care plan, initiated 9/20/24, indicated the resident had impairment in functional status and required assistance with all activities of daily living (ADLs). During a personal care observation on 12/4/24 at 11:45 a.m., CNA 11 and CNA 12 were performing pericare for Resident 46 in her room. Resident 46 was fully undressed, with an adult brief open. CNA 12 assisted the resident to her side and CNA 11 removed the adult brief from underneath the resident. The two CNAs continued to assist the resident. During that time, the resident remained without any clothing or covering. The resident's sheet and blanket were observed on the chair next to her bed. At 11:52 a.m., the resident was left lying flat on top of her brief. CNA 11 indicated to Resident 46 to finish moving her bowels and that they (the CNAs) would return to complete peri care after she was finished. At that time, CNA 12 helped the resident put on her shirt. No other coverings were provided to the resident.		educated on maintaining resident dignity/privacy when providing personal care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. Staff who provide resident care educated on resident rights to maintain dignity and privacy by not exposing parts of body not necessary to perform personal care. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the DHS/ designee will complete random observation audits of personal care to ensure all steps are completed to maintain resident dignity and privacy. DHS/designee will conduct observation audits for 5 residents a week x 4 weeks, then bi-weekly for 2 months, and monthly for 3 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the	

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	During an interview with CNAs 11 and 12, on 12/4/24 at 12:00 p.m., CNA 12 indicated she had forgotten to cover the resident up with a sheet. It was not her practice to leave the resident exposed during peri care, and she should have put the resident's shirt on before continuing. A facility policy, titled "Perineal Care for Incontinence," was provided by the Nurse Consultant on 12/6/24 at 11:40 a.m. The policy did not address ensuring dignity was maintained during the procedure. The Indiana State Department of Health Nurse Aide Curriculum, retrieved from https://www.in.gov/health/files/Indiana_Nurse_Aide_Curriculum.pdf indicated the following instructions for bed baths and perineal care on Page 196 - "...3) Provide resident privacy - Maintains resident's dignity and right to privacy by not exposing body. Keeps resident warm...13) Place towel over chest and abdomen - Maintains resident's right to privacy...14) Exposing only the area of the body necessary to do the procedure maintains resident's dignity and right to privacy...." 3.1-3(a)		Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on record review and interview, the facility failed to ensure a resident with a change in condition was assessed prior to hospitalization for 1 of 1 residents reviewed for hospitalization (Resident 51). Findings include:	F 0658	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident #51 was affected. Resident assessed by NP with no new orders. Resident has successfully discharged home	01/02/2025

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	During an interview, on 12/2/24 at 10:04 a.m., Resident 51 sat in her recliner with her feet elevated. The resident indicated she had been hospitalized shortly after she had been admitted because she had become incoherent. Her blood sugar had been very low. Resident 51's clinical record was reviewed on 12/3/24 at 11:05 a.m. Diagnoses included displaced intertrochanteric fracture of left femur, subsequent encounter for close fracture with routine healing (9/23/24), type 2 diabetes mellitus with diabetic chronic kidney disease (9/23/24), and anxiety disorder, unspecified (9/23/24). Physician orders included glimepiride (for high blood sugar) 2 milligrams (mg) daily (started 9/23/24 and discontinued 9/30/24), metformin (for high blood sugar) 500 mg twice a day (started 9/23/24 and discontinued 9/30/24), and pioglitazone (for high blood sugar) 15 mg daily (started 9/23/24 and discontinued 9/30/24). An admission Minimum Data Set (MDS) assessment, dated 10/7/24, indicated the resident was cognitively intact. A current care plan for hypoglycemic (lower blood sugar) medications was initiated on 9/24/24 with a long-term goal to be free from adverse effects associated with hypoglycemic medications. The interventions included the following: Monitor blood sugar as ordered or as needed (9/24/24) and observe for and report signs and symptoms of adverse effects of medication such as dizziness, drowsiness, nausea, and hypoglycemia (9/24/24). A current care plan for a risk for hypo/hyperglycemia related to diabetes mellitus was initiated on 9/24/24. The interventions		with no acute concerns and no adverse effects reported. Nursing staff educated on obtaining timely glucose checks with residents with dx of diabetes who have noted change in condition. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. Nursing staff educated on obtaining timely glucose checks with residents with dx of diabetes who have noted change in condition. All residents with dx of diabetes were audited for noted s/s of hyper/hypoglycemia and appropriate assessments/interventions. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the DHS/ designee will review changes in condition for complete assessment with appropriate vitals obtained daily in CCM x5 days, then weekly x 4 weeks, then bi-weekly for 2 months, and monthly for 3 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put**	

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	included observe the resident for hypoglycemia such as sweating, cold, clammy skin, numbness of the fingers, toes, mouth, rapid heartbeat, tremors, and dizziness. A Nurses Note, dated 9/28/24 at 5:32 p.m., indicated the resident was alert and oriented to person, place, time, and event. A Nurses Note, dated 9/28/24 at 9:53 p.m., indicated the resident was lying in her bed and put on her call light. She was unable to tell the certified nurse aide (CNA) what she needed. She did not know why she turned on the call light. The resident turned on her call light again within five minutes. Another CNA entered her room and asked what she needed, and she did not know what she needed. The resident put on her call light after five more minutes. The nurse obtained vital signs. The resident stared into space with pinpoint slow reactive pupils and with involuntary twitching all over her body. The resident was unable to answer any questions or speak any clear words. The resident was sent to the hospital via emergency medical services for evaluation. A Nurses Note, dated 9/29/24 at 5:01 a.m., indicated the resident was admitted to the hospital for hypoglycemia. The resident's clinical record lacked blood sugar tests taken by the facility during the change in condition and prior to hospitalization. A hospital history and physical with the hospital admission paperwork on 10/1/24 indicated the resident presented with aphasia to the hospital on 9/28/24. She was normally alert and oriented but around 9:30 the staff stated the resident was unable to speak, had jerky movements and had		**into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	

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	pinpoint pupils. The medics obtained a blood sugar of 29 mg/dL (milligrams per deciliter). During an interview, on 12/4/24 at 9:46 a.m., LPN 4 indicated Resident 51 had a lot of anxiety when she was first admitted. The change in the resident's condition started as increasing anxiety, and LPN 4 tried to calm the resident. When LPN 4 went to check on the resident she had body shakes, and her blood pressure was low. The resident's family wanted her sent to the hospital. LPN 4 had not realized the resident's diabetes was not stable. LPN 4 indicated it did not register for her to check the resident's blood sugar. During an interview, on 12/4/24 at 12:31 p.m., NP 10 indicated she remembered the resident had several hypoglycemics ordered when she was admitted. She did not recall seeing the resident prior to the rehospitalization as she had been at the facility for only a few days before going back to the hospital. She would not have typically ordered routine blood sugars for a resident on oral hypoglycemics if there was not a history of problems with the blood sugar. During an interview, on 12/4/24 at 2:25 p.m., the Director of Nursing (DON) indicated she would expect a blood sugar to be obtained with a change in condition of a resident with diabetes. A facility policy, dated 12/31/23, provided by the Corporate Nurse Consultant on 12/6/24 at 11:41 a.m., titled "HYPER/HYPOGLYCEMIA," indicated the following: " ...All residents diagnosed with diabetes mellitus, will receive interventions according to their physician orders. If the attending physician (s) have not provided specific orders on what treatment is to be provided to treat hypoglycemic episodes, the following guidelines			

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	will be followed until the attending physician can be contacted ...Symptoms of hypoglycemia (<60) may consist of (not necessarily limited to) the following: 1. tremors ...anxiety ...altered mental capacity such as confusion or abnormal behaviors ...PROCEDURE: 1. Finger stick blood glucose will be done when the resident exhibits signs of hyper/hypoglycemia. 2. Notify the physician of the result of the resident's finger stick glucose level and report the resident's condition ...If the resident does not have specific order for treatment, the following procedure will be followed: ...BLOOD GLUCOSE < 50 MG/DL and ALERT - Give 30-gram carbohydrate oral feeding of one of the following: 2 tubes of glucose gel, 8 ounces of any juice without added sugar, 8 ounces of regular soda pop. Wait 15 minutes and recheck blood sugar. If resident continues to have hypoglycemic symptoms or blood sugar < 70, repeat 15-gram carbohydrate oral feeding. Recheck blood sugar every 15 minutes and repeat 15-gram carbohydrate oral feeding until symptoms are resolved or blood sugar is >70. Notify resident's primary physician of condition and what has been done (including current diabetes medication, blood glucose results at the time of discovery and past treatment, vital signs at the time of discovery and past treatment, signs and symptoms, action taken and response ...BLOOD GLUCOSE < 50 MG/DL AND UNABLE TO SWALLOW - If a resident has a decreased level of consciousness and is unable to safely take oral treatment: Administer 1 mg glucagon IM. Resident should awaken within a couple of minutes. If resident continues to be unresponsive, administer additional 1 mg glucagon IM and call emergency assistance. Notify resident's primary physician of condition and what has been done (including current diabetes medication, blood glucose results at the time of discovery and past treatment, vital			

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	signs at the time of discovery and past treatment, signs and symptoms, action taken and response ...." 3.1-35(g)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review, and interview, the facility failed to ensure physician's orders were followed for 3 of 18 residents reviewed for medications (Resident 29, 37, and 44). Findings include: 1. Resident 29's clinical record was reviewed on 12/4/24 at 9:46 a.m. Diagnoses included, but were not limited to, unspecified dementia with unspecified severity or behavioral disturbances, anxiety, respiratory failure with hypoxia (oxygen deficiency), hypertensive heart disease, and restlessness and agitation. A current physician's order, dated 7/30/21, indicated the resident's head of bed (HOB) should be elevated to alleviate/reduce shortness of breath while lying flat related to a diagnosis of emphysema, and low oxygen saturations. A current care plan, dated 7/30/21 and last reviewed on 10/25/24, indicated the resident had a potential for shortness of breath while lying flat. Shortness of breath was related to chronic obstructive pulmonary disease, emphysema, and a history of pneumonia. An intervention, dated 7/30/21, was to elevate the head of the bed or place in an upright position as needed. During an observation on 12/4/24 at 10:46 a.m.,	F 0684	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Residents #29, 37, and 44 were affected with no noted adverse effects. Staff ensured resident #29's head of bed was elevated, nursing staff educated, and care plan updated. Resident #37 was assessed and new order obtained for bilateral support hose. Resident #44 was assessed with no new or repeat labs orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. All residents with MD orders to elevate head of bed were audited to ensure proper compliance. Audit of residents with support hose completed to ensure that orders are in place. All lab orders were audited to ensure collection and compliance. Nursing staff educated on following physicians orders. **What measures will be put into**	01/02/2025

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	Resident 29 was observed lying flat on her back in bed. The head of the bed was not elevated. During an observation on 12/4/24 at 2:08 p.m., the resident's bed was in a low position and the head of the bed was flat. During an observation on 12/4/24 at 2:36 p.m., Certified Nursing Assistant (CNA) 14 and CNA 15 transferred the resident from chair to bed. The CNAs settled the resident in the bed and the bed remained flat when they left the room. During an interview, after the CNAs left the room, CNA 14 and CNA 15 both indicated they were not sure if the head of the bed was supposed to be elevated. During an observation on 12/5/24 at 10:59 a.m., Resident 29 was lying flat on her back in bed. The head of the bed was not elevated. During an interview with LPN 16 on 12/6/24 at 12:11 p.m., she indicated she was unsure whether the head of Resident 29's bed was supposed to be elevated. During an interview on 12/6/24 at 12:17 p.m., CNA 11 indicated there was nothing in the resident's profile in the clinical record to indicate the head of the bed should be elevated. A current facility document, titled "Guidelines for Medication Orders", was provided by the nurse consultant on 12/6/24 at 3:23 p.m. The policy indicated the following: "...2) A current list of orders will be maintained in the electronic clinical record for each resident...9) Treatment Orders - a. When recording treatment orders specify 1). What is to be done, location and frequency and		**place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the DHS/ designee will review 5 non-pharmaceutical orders to ensure completion daily in CCM x5 days, then weekly x 4 weeks, then bi-weekly for 2 months, and monthly for 3 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	

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	duration of treatment...." The facility did not provide a policy regarding following physician orders not pertaining to medications ...."2. During an observation, on 12/2/24 at 10:10 a.m., Resident 37 was wearing support hose on her bilateral lower legs. Resident 37's clinical record was reviewed on 12/03/24 at 10:30 a.m. Diagnoses included hypertension, heart failure, shortness of breath, chronic obstructive pulmonary disease, and sepsis. Resident 37 had a past physician order for support hose to be applied in the morning and removed at bedtime, initiated 10/4/22 and discontinued on 7/23/24. A nursing progress note, dated 9/18/24 at 10:54 p.m., indicated the resident stated this morning when staff applied the support hose, her right lower leg was scratched, and a small scab was intact without drainage or edema. During an observation, on 12/3/24 at 11:18 a.m., Resident 37 walked out of her room wearing support hose on her bilateral lower legs. Resident 37 indicated the staff put support hose on her legs every morning. During an interview, on 12/3/24 at 11:19 p.m., LPN 6 indicated the resident was wearing her support hose, but she was unsure why she didn't have an order for them. During an interview, on 12/3/24 at 11:26 a.m., CNA 13 indicated Resident 37 normally wore support hose and staff applied them daily. A new physician order, dated 12/3/24 at 12:05			

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p.m., indicated the resident was to wear support hose.

During an interview, on 12/6/24 at 2:22 p.m., the DON indicated the resident wanted staff to put the support hose on so the facility got the order for them.

A current facility policy, dated 5/2016, Titled Guidelines for Medication Orders, provided by the corporate nurse, on 12/6/24 at 3:23 p.m., indicated the following: " ...Treatment orders: When recording treatment orders specify what is to be done, location, frequency and duration of treatment ...."3. Resident 44's clinical record was reviewed on 12/3/24 at 12:25 p.m. Diagnoses included acute posthemorrhagic anemia and anemia.

Current physician orders included apixaban (blood thinner) 5 milligrams (mg) twice a day (2/9/24) and occult blood fecal one time (4/9/24).

A quarterly 11/7/24 Minimum Data Set (MDS) assessment indicated the resident had anemia and received an anticoagulant (blood thinner).

A care plan for risk of excessive bleeding and bruising related to medications was initiated on 2/6/24. Interventions included labs as ordered and notify physician of abnormal labs (2/6/24).

A Progress Note, dated 4/8/24 at 11:19 a.m., indicated the resident was seen by the Nurse Practitioner (NP) for multiple concerns including abdominal distention with an eight-pound weight gain over one month. The family was concerned about ongoing urinary and bowel and reported the resident's abdomen had been bloated and hard. The resident had been having dark, tarry

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	stools. The resident was taking iron and apixaban. The resident had a positive fecal occult blood test on 9/25/23. The NP's assessment/plan included the resident had black, tarry stools with a history of melena (black, tarry stools indicating bleeding in the upper gastrointestinal tract). Hemoccult stools daily x 3 days and complete blood count (CBC) on the next day were ordered. For the abdominal distention with mild lower abdominal tenderness an abdominal X-ray was ordered. Orders were discussed with the family and nursing staff. A Nurses Note, dated 4/8/24 at 11:30 p.m., indicated written orders were received from the NP for hemoccult stools for 3 days, CBC 4/9/24, and abdominal X-ray. A Progress Note, dated 4/10/24 at 8:39 a.m., indicated the resident was seen by the NP. The abdominal X-ray was negative. Hemoccult stools and labs were still pending. A Progress Note, dated 4/25/24 at 7:46 a.m., indicated the resident was seen by the NP. The hemoccult stools were pending. CBC on 4/10/24 was stable. The resident's clinical record lacked indication of completion of hemoccult testing and the results. During an interview, on 12/4/24 at 2:45 p.m., the Nurse Consultant indicated she would look for the results of the resident's hemocult testing. During an interview, on 12/5/24 at 2:05 p.m., the Nurse Consultant indicated she had been unable to locate documentation of the resident having had the hemoccult testing completed.			

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	155806	A. BUILDING 00 B. WING	12/06/2024

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	During an interview, on 12/6/24 at 2:22 p.m., the Director of Nursing (DON) indicated the facility did not have documentation of performing the hemoccult testing. The NP had given a verbal order to discontinue the hemoccult order when her labs came back okay, but no one had removed the order. During an interview, on 12/9/24 at 2:45 PM, the Nurse Consultant indicated she was unable to locate a facility policy for physician orders for labs and diagnostics. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview, and record review, the facility failed to ensure a resident with recurrent urinary tract infections received sufficient fluids for 1 of 2 residents reviewed for hydration. Findings include: During an observation, on 12/4/24 at 9:29 a.m., Resident 29 was not in her room. Her full water jug was on the table next to her bed, did not contain any ice, and was warm to the touch. Resident 29's clinical record was reviewed on 12/4/24 at 9:46 a.m. Diagnoses included anxiety disorder, paranoid personality disorder, hypertensive heart disease without heart failure, cognitive communication deficit, and urinary tract infection. A physician's order, dated 1/21/24 at 1:14 a.m., indicated regardless of urinalysis results, fluids	F 0692	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident 29 was affected. Fresh ice water was provided and encouraged. Resident was assessed with no noted adverse effects. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. All staff educated on Guidelines for hydration management policy **What measures will be put into place or what systemic changes will be made to**	01/02/2025

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	were to be pushed. A current care plan, dated 3/1/22 and last reviewed on 12/4/24, indicated the resident had a history of urinary tract infections. Interventions included to encourage the resident to drink fluids. A current care plan, dated 8/10/21 and last reviewed on 10/25/24, indicated the resident had impairment in functional status in regards to bed mobility, transfers, toileting, and eating. Interventions included to encourage the resident to eat and drink as able. A current care plan, dated 8/10/21 and last reviewed on 12/4/24, indicated the resident experienced episodes of incontinence. Interventions included to encourage fluids, unless contraindicated. On 12/4/24 at 10:32 a.m., the full water jug remained in the same position on the table next to the resident's bed. There was no ice in the water and the jug was warm to the touch. On 12/4/24 at 2:08 p.m., the water jug had not been moved. It was in the same position, at the same (full) level, did not have ice, and was warm to the touch. On 12/5/24 at 10:59 a.m., the resident's water jug was on the table next to her bed. The water jug was full, with no ice, and was warm to the touch. On 12/6/24 at 12:02 p.m., the resident's water jug was on the table next to her bed. The water jug was full, with no ice, and was warm to the touch. The resident was diagnosed with urinary tract infections (UTI's) on the following dates: 12/14/23,		**ensure the deficient practice does not recur:** House wide audit completed to ensure ice is being passed and fluids are being offered to appropriate residents. As a measure of ongoing compliance, the DHS/ designee will complete random audits of hydration compliance weekly x 4 weeks, then bi-weekly for 2 months, and monthly for 3 months. The campus will implement a labeling and dating system on resident ice water containers to ensure fresh ice water is passed per policy. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	

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	1/20/24, 3/23/24, 7/19/24, 8/16/24, and 9/21/24. During an interview with LPN 16 on 12/6/24, at 12:11 p.m., she indicated fresh water with ice was provided to residents at 6:00 a.m., 2:00 p.m., and 11:00 p.m. Resident 29 was able to hold a cup if offered to her. The resident was not able to reach from her bed to the side table to retrieve the water jug. During an interview with LPN 17, on 12/6/24 at 12:18 p.m., she indicated Resident 29 was not able to drink water independently. If handed the jug of water, the resident would drink from a straw. The resident would sometimes refuse the water, depending on her mood. A current facility policy, titled "Guidelines for Hydration Management," provided by the Nurse Consultant on 12/6/24 at 3:56 p.m., indicated the following: "...Purpose - To identify residents at risk for dehydration and implement individualized interventions which promote sufficient fluid intake to maintain proper hydration...." 3.1-46(2)(b)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to ensure a resident with dementia did not receive anti-psychotic medications without indication for 1 of 5 residents reviewed for unnecessary medications (Resident 5) Findings include: On 12/2/24 at 10:30 a.m., Resident 5 was sitting in	F 0744	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Noted resident was affected. Clinical indication and supporting documentation for continued use of Olanzapine to be reviewed with psych np, pharmacist and IDT at next behavior meeting. No adverse	01/02/2025

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	her wheelchair near the main lounge on 200 hall. On 12/3/24 at 10:36 a.m., the resident was propelling herself around in her wheelchair. On 12/5/24 at 11:04 a.m., the resident was propelling herself in her wheelchair, smiling and talking to a resident near her. Resident 5's clinical record was reviewed on 12/3/24 at 10:57 a.m. Diagnoses included, but were not limited to, Parkinson's disease without dyskinesia, psychotic disorder with delusions due to known physiological condition, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, anxiety disorder due to known physiological condition, and insomnia due to other mental disorder. She had current physician orders for sertraline (anti-depressant) 50 mg (milligram) daily, trazodone (anti-depressant) 12.5 mg daily, and olanzapine (antipsychotic) 5 mg daily. An annual Minimum Data Set (MDS) assessment, dated 12/6/23, indicated she had no hallucinations or delusions during the assessment period. A quarterly MDS assessment, dated 7/24/24, indicated she had no hallucinations or delusions during the assessment period. A quarterly MDS assessment, dated 11/1/24, indicated she had no hallucinations or delusions during the assessment period. A care plan, dated 3/28/22, indicated the resident demonstrated altered behaviors including delusions, such as (I have to go home to my		events noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents receiving antipsychotic medications have the potential to be affected. All residents currently taking antipsychotic medications have been reviewed for completion of AIMS assessment and appropriate indication for use. Nursing staff educated on recording resident specific behaviors in documentation. SSD educated on placing resident specific behaviors in the medical record for monitoring and obtaining clinical rationale related to GDRs. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the SSD or designee will audit 5 residents with behaviors for appropriate target behavior monitoring weekly x4 weeks, then every other week x2 months, then monthly x3 months. SSD or designee to audit 5 residents, as available, for documentation of clinical rationale to continue psych med use weekly x4 weeks, then every other week x2 months, then monthly x3 months.	

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	parents and/or I have to go home to take care of my children). Interventions included checking for unmet needs, toiletings, thirst, and/or hunger, inform resident that the resident's parents wanted her to stay the night at the facility and they will get her tomorrow, observe for behavioral triggers and casual relationships to medical changes with all hands on care and contacts, offer diversionary activities, such as watching TV or doing a puzzle, offer to show resident to her room for the night and to orient to room. A care plan, dated 11/6/21, indicated the resident demonstrated exit-seeking behaviors. Interventions included assess need for wander guard and apply as appropriate, encourage regular family contact and/or visits with others, evaluate need for secured unit and transfer if needed, monitor for wandering triggers such as need for toileting, inactivity, time of day, etc, offer diversional activities as needed, provide structured routine to resident's day, re-direct resident away from doors/ exits as needed, and wander guard on right ankle. Review of a 12/6/24 Behavior Analysis Report indicated the resident had no behaviors noted in the last 120 days. Review of a 7/3/24 psychiatric Nurse Practitioner progress note indicated staff denied any new or worsening symptoms of delusions which was an improvement. The resident had intermittent delusional thoughts however symptoms were not distressing in any way. Review of a July 2024 Medication Administration Record (MAR) indicated she displayed delusions, such as wanting to go home or saying, "I have to take care of my children", zero out of 30 days.		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	

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	Review of an 8/29/24 psychiatric Nurse Practitioner progress note indicated staff denied any new or worsening symptoms of delusions. She did have intermittent delusional thoughts, however symptoms were not distressing in any way. Olanzapine was reported effective. No current concerns were voiced by staff or observed during the visit. Review of an August 2024 Medication Administration Record (MAR) indicated she displayed delusions, such as wanting to go home or saying, "I have to take care of my children", zero out of 30 days. Review of a 9/26/24 psychiatric Nurse Practitioner progress note indicated staff reported intermittent delusional thoughts. No reported changes in sleep. She did have intermittent delusional thoughts, however symptoms were not distressing in any way. Olanzapine was reported effective. No current concerns were voiced by staff or observed during the visit. Review of a September 2024 Medication Administration Record (MAR) indicated she displayed delusions, such as wanting to go home or saying, "I have to take care of my children", zero out of 30 days. Review of a 10/14/24 psychiatric Nurse Practitioner progress note indicated staff reported occasional nervousness. Staff reported that she did have delusional thoughts, however symptoms were not currently distressing. Olanzapine was reported effective. History of failed gradual dose reduction (GDR). No current concerns voiced during visit. A GDR for olanzapine was clinically contraindicated on 10/4/24.			

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	Review of an October 2024 Medication Administration Record (MAR) indicated she displayed delusions, such as wanting to go home or saying, "I have to take care of my children", 1 out of 30 days but she was easily redirected. Review of an 11/20/24 psychiatric Nurse Practitioner progress note indicated staff reported that she had delusional thoughts, however symptoms were not currently distressing. Olanzapine was reported effective. History of failed GDR. No current concerns voiced during visit. A GDR for olanzapine was clinically contraindicated on 10/4/24. Review of a November 2024 Medication Administration Record (MAR) indicated she displayed delusions, such as wanting to go home or saying, "I have to take care of my children", zero out of 30 days. During an interview, on 12/5/24 at 10:57 a.m., RN 18 indicated resident states she wants to go home and doesn't understand why she was here. She was easily redirected. During an interview, on 12/5/24 at 11:20 a.m., QMA 19 indicated they were tracking behaviors for tearfulness. She had not displayed any recent hallucinations, and she was easily redirected. During an interview, on 12/6/24 at 2:00 p.m., the psychiatric Nurse Practitioner indicated the resident was admitted to the facility on olanzapine. The resident had failed prior GDR attempts of olanzapine. She had increased confusion, tearfulness, changes in mood, and continued with her intermittent delusional thoughts. The resident's family reported that she			

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	had a history of psychosis. Before prescribing a resident an antipsychotic, without a mental health history, she looked at symptoms lasting longer than 6 months. Then she would question are the symptoms distressing to the resident; has the facility tried any non-pharmacological interventions, etc. She reassesses the need for an antipsychotic at every visit, which is usually weekly. The resident's psychosis caused her frequent delusions, tearfulness, and difficulty calming her down. She contraindicated the GDR of olanzapine if she has supporting documentation and input from the staff to support why she wouldn't GDR a medication. A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reductions", provided by the Nurse Consultant, on 12/6/23 at 3:23 p.m., indicated the following: " ...Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage...." The Olanzapine manufacturer guidelines website at https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/020592s062021086s040021253s048lbl.pdf indicated olanzapine has a black box warning for elderly patients with dementia- related psychosis treated with antipsychotic drugs are at an increased risk of death. Zyprexa (olanzapine) is not approved for the treatment of patients with dementia- related psychosis. 3.1-37(a)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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	Based on observation, interview, and record review, the facility failed to utilize infection prevention and control procedures during blood glucose testing for 2 of 4 residents reviewed for medication administration (Residents 51 and 106) and during perineal care for 1 of 1 residents observed during perineal care (Resident 46). Findings include: 1. During a random medication administration observation on 12/4/24 at 11:30 a.m. LPN 4 removed a bottle of glucometer strips from the top of the medication cart and a plastic bag containing Resident 51's glucometer from the right-side top drawer of the medication cart. When LPN 4 went into Resident 51's room, she placed the plastic bag and the bottle of glucometer strips on Resident 51's bedside table. No barrier was placed on the bedside table prior to placing the plastic bag and bottle of glucometer strips. LPN 4 performed hand hygiene, applied gloves, used an alcohol wipe to cleanse the resident's finger, performed a finger stick with a lancet, wiped off the first drop of blood, and used the next drop of blood for the blood sugar test. Upon completion of the blood sugar test, LPN 4 removed her gloves, washed her hands, and gathered the glucometer bottle and plastic bag with supplies. She placed the bottle of glucometer strips on top of the medication cart. The plastic bag was placed on top of the medication cart until the glucometer was disinfected, then the glucometer was put into the plastic bag and back into the top right drawer of the medication cart with other plastic bags. She did not clean or disinfect the bottle of glucometer strips or the plastic bag prior to placing on or in the medication cart. Resident 51's clinical record was reviewed on	F 0880	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Residents #51,106, and 46 were affected with no noted adverse events noted. Noted staff were immediately educated on proper infection control practices with blood sugar checks and peri care. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. All nursing staff to be educated with return demonstrations on blood sugar testing and peri care. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the DHS/ designee will complete random return demonstrations to ensure proper technique is used with peri care and blood sugar testing on 5 nursing employees weekly x4 weeks, then bi-weekly for 2 months, and monthly for 3 months. **How the corrective action will be monitored to ensure the deficient practice will not**	01/02/2025

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	12/4/24 at 2:30 p.m. Diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease. Physician's orders included blood sugar check before meals and at bedtime (10/1/24). 2. During a random medication administration observation on 12/4/24 at 11:52 a.m. LPN 4 removed a bottle of glucometer strips from the top of the medication cart and a plastic bag containing Resident 106's glucometer from the right-side top drawer of the medication cart. When LPN 4 went into Resident 106's room, she placed the plastic bag and the bottle of glucometer strips on Resident 106's bedside table. No barrier was placed on the bedside table prior to placing the plastic bag and bottle of glucometer strips. LPN 4 performed hand hygiene, applied gloves, used an alcohol wipe to cleanse the resident's finger, performed a finger stick with a lancet, wiped off the first drop of blood, and used the next drop of blood for the blood sugar test. Upon completion of the blood sugar test, she removed her gloves, washed her hands, and gathered the glucometer bottle and plastic bag with supplies. She placed the bottle of glucometer strips on top of the medication cart. The plastic bag was placed on top of the medication cart until the glucometer was disinfected, then the glucometer was put into the plastic bag and back into the top right drawer of the medication cart with other plastic bags. She did not clean or disinfect the bottle of glucometer strips or the plastic bag prior to placing on or in the medication cart. Resident 106's clinical record was reviewed on 12/4/24 at 2:35 p.m. Diagnoses included diabetes mellitus.		**recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	

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	Physician orders included insulin lispro (rapid acting insulin) 100 unit/milliliter (ml) per sliding scale. If blood sugar is 121 to 150, give 2 units. If blood sugar is 151 to 200, give 4 Units. If blood sugar is 201 to 250, give 6 Units. If blood sugar is 251 to 300, give 8 Units. If blood sugar is 301 to 350, give 10 Units. If blood sugar is greater than 350, call MD (physician). Give subcutaneously (12/2/24). During an interview, on 12/4/24 at 12:08 p.m., LPN 4 indicated she had not thought about putting the strips on the table then back onto the cart and should not have moved the supplies from dirty to clean. During an interview, on 12/6/24 at 2:05 p.m., the Director of Nursing (DON) indicated the bottle of glucometer strips and the plastic bags should not have been placed on the residents' tables without a barrier. A facility policy, dated 12/31/23, provided by the Nurse Consultant on 12/6/24 at 2:50 p.m., titled "Glucometer SOP [standard operating procedure]," indicated the following: " ...Appropriate infection control technique shall be followed during testing procedures ...."3. Resident 46's clinical record was reviewed on 12/3/24 at 9:50 a.m. Diagnoses included, but were not limited to, morbid (severe) obesity, multiple sclerosis, depression, anxiety, chronic pain syndrome, overactive bladder, constipation, muscle weakness, parasthesia of skin, and need for assistance with personal care. An admission Minimum Data Set (MDS), dated 9/12/24, indicated the resident was frequently incontinent of both bowel and bladder. The resident was cognitively intact and required total			

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	assistance for personal hygiene, including peri-care. A current care plan, dated 9/20/24, indicated the Resident 46 had impairment in functional status and required assistance with all activities of daily living (ADLs). During an observation of incontinence care on 12/4/24, at 11:45 a.m., CNA 11 and CNA 12 began to perform perineal care for Resident 46. CNA 12 assisted the resident to a side-lying position. CNA 11 performed perineal care by cleansing the peri-area with wet wipes. She was observed to wipe from front to back and from back to front. The resident continued to be incontinent of bowel at that time. Each swipe with the wet wipes produced additional amounts of fecal matter. CNA 11 indicated they would leave the resident to finish the bowel movement before completing peri care. During an interview with CNA 11 on 12/4/24 at 12:00 p.m., she indicated it was not appropriate to wipe the peri-area from back to front. An undated facility policy, titled "Perineal Care for Incontinence", provided by the Nurse Consultant on 12/6/24 at 11:40 a.m. indicated the following: The procedure included the following instruction(s): "...7) Pay particular attention to infection prevention and control techniques when performing peri-care, to prevent introduction of contamination that may lead to a urinary tract infection...." The Indiana State Department of Health Nurse Aide Curriculum, retrieved from https://www.in.gov/health/files/Indiana_Nurse_Aide_Curriculum.pdf indicated the following:			

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	"...Procedure 33 - Bed Bath/Perineal Care - Step 23) Wipe from front to back and from center of perineum to thighs. If washcloth is visibly soiled, change cloths. Rationale 23 - . Prevents spread of infection. Females: Removes secretions in skin folds which may cause infection or odor...Step 28) Clean anal area from front to back. Rinse and pat dry thoroughly. Rationale 28 - Prevents spread of infection...." 3.1-18(l) 3.1-18(a)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to accurately document the administration and results tuberculin (TB) skin tests performed on 4 of 5 new employee files reviewed. (CNA 5, LPN 6, CNA 7, CNA 8)	F 9999	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Employees 5,6,7, 8 were identified in the alleged deficient practice. All noted employees were scheduled for another TB test. No adverse events noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All employees and residents have the potential to be affected. Employee records were audited to ensure TB records were compliant and read within 48-72 hours. Employee TB forms were updated with space and heading to record time given and read. TB certified nursing staff educated on timeline and documentation requirements	01/02/2025

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	Findings include: Employee records were provided by the Administrator on 12/2/24 at 3:47 p.m. and reviewed on 12/3/24 at 8:45 a.m. An Employee Physical form for CNA 5 indicated a first step TB test was performed on 6/26/24 and read on 6/28/24. A second step TB test was performed on 7/10/24 and read on 7/12/24. The tests administered did not include the times administered or read. An Employee Physical form for LPN 6 indicated a first step TB test was performed on 6/26/24 and read on 6/28/24. A second step TB test was performed on 7/8/24 and read on 7/10/24. The tests administered did not include the times administered or read. An Employee Physical form for CNA 7 indicated a second step TB test was performed on 10/16/24 and read on 10/18/24. The test administered did not include the times administered or read. An Employee Physical form for CNA 8 indicated a first step TB test was performed on 7/10/24 and read on 7/12/24. A second step TB test was performed on 7/29/24 and read on 7/31/24. The tests administered did not include the times administered or read. During an interview, on 12/4/24 at 2:32 p.m., LPN 9 indicated dates and times were documented on the TB testing forms. During an interview, on 12/4/24 at 2:38 p.m., the DON indicated she forgot to document the times for administering and reading the TB results.		of TB test. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the Employee Experience Manager (EXM) or designee, will audit 5 newly hired employees, as available, to ensure TB test and documentation meets CDC criteria. Audits occur weekly for 4 weeks, every other week for 2 months, then monthly for 3 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	

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	A current facility policy, dated 4/17/24, provided by the Corporate Nurse on 12/9/24 at 2:31 p.m., indicated the following: " ... Tuberculin Testing Guidelines: Mantoux testing should be a two-step process unless there has been continuous annual testing following the two- step process. A) First step test shall be read between 48-72 hours after administration. B) Second step shall be administered between 1-3 weeks after the first test and read within 48-72 hours after administration ...." The Mantoux Tuberculin Skin Testing Fact Sheet from the Centers for Disease Control and Prevention (CDC) website at https://www.cdc.gov/tb/publications/factsheets/testing/Tuberculin_Skin_Testing_Information_for_Health_Care_Providers.pdf indicated:"...The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 2, 3, 4, 5, and 6, 2024. Facility number: 012993 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Wabash 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 Wabash. The facility recognizes its obligation to provide legally and medically necessary care and	

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	Quality review completed December 19, 2024.		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.	
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on observation, record review, and interview, the facility failed to have the most recent State Survey results readily available to residents and the public. This deficiency had the potential to affect 42 of 42 residents residing in the facility. Findings include: During an observation, on 12/9/24 at 10:51 a.m., a State Survey results binder was resting in a wall pocket in the entrance hallway to the facility's assisted living section. A review of the binder's contents, completed at the time of the observation, indicated the binder lacked survey results with their plans of correction from the last two surveys on 12/8/23 and 1/30/23. During an observation, on 12/9/24 at 11:22 a.m., a State Survey results binder was resting in a wall pocket on the 200 hall of the skilled nursing care portion of the facility. A review of the binder's contents, completed at the time of the observation, indicated the binder lacked survey results with their plans of correction for the	R 0042	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** No residents were affected. Survey Binder on AL updated to include all survey findings and plans of correction from previous 3-year survey cycles. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected. Staff educated on Resident Right's and survey binder compliance. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the ED or designee,	01/02/2025

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	residential portion of the facility. During an interview, on 12/9/24 at 12:56 p.m., the Administrator indicated he was responsible for maintaining the State Survey results binders. He had thought it was not necessary to include the last two residential survey results since there had been no findings. During an interview, on 12/9/24 at 2:45 p.m., the Corporate Nurse indicated the facility did not have a policy on the posting of the State Survey results.		will audit placement and content of AL survey binder to ensure proper compliance. Audits will occur monthly x 6 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work.	R 0410	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident 3, Resident 9, Resident 28, Resident 43, Resident 44 were identified in the alleged deficient practice. All noted residents were scheduled for another TB test. No adverse events noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to	01/02/2025

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	This state rule was not met as evidenced by: Based on record review and interview, the facility failed to accurately document the administration and results of mandatory tuberculin (TB) skin tests performed prior to admission for 5 of 7 residents. (Resident 3, Resident 9, Resident 28, Resident 43, Resident 44) Findings include: Review of Resident 3's clinical record was completed on 12/9/24 at 12:28 p.m. Diagnoses included urinary tract infection, squamous cell carcinoma of skin, anxiety, and low back pain. Review of the clinical record indicated the resident had a first step TB test administered on 9/28/22 and read on 9/30/22. The tests administered did not include the times administered or read. Review of Resident 9's clinical record was completed on 12/9/24 at 1:15 p.m. Diagnoses included Alzheimer's disease, essential hypertension, chronic kidney disease, peripheral vascular disease, hyperlipidemia, and stage 3 mild cognitive impairment. Review of the clinical record indicated the resident had a first step TB test administered on 9/27/24 and read on 9/29/24. The test administered did not include the times administered or read. A second step TB test was administered on 10/31/24 and read on 11/2/24. Review of Resident 28's clinical record was completed on 12/9/24. Diagnoses included essential hypertension, major depressive disorder, muscle weakness, shortness of breath, tremor, and secondary Parkinsonism. Review of the clinical record indicated the resident had an annual TB test administered on 7/16/24. There was no		be affected. Resident records were audited to ensure TB records were compliant and read within 48-72 hours. Residents found with uncompliant TB documentation were scheduled for another TB test. TB certified nursing staff educated on timeline and documentation requirements of TB test. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** As a measure of ongoing compliance, the AL Director or designee, will audit all new AL admissions and 5 other AL residents monthly to ensure TB test and documentation meets CDC criteria. Audits will occur monthly x 6 months. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** As a quality measure, results of the audits and any corrective action will be forwarded to the Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance is achieved. This will be monitored by ED/Designee	

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	documentation that it was read. Review of Resident 43's clinical record was completed on 12/9/24. Diagnoses included sepsis, pneumonia, atrial fibrillation, anemia, chronic kidney disease, dysphagia, and hematuria. Review of the clinical record indicated the resident had an annual TB test administered on 4/1/24 and read on 4/3/24. The test administered did not include the times administered or read. Review of Resident 44's clinical record was completed on 12/9/24. Diagnoses included urinary incontinence, insomnia, major depressive disorder, hypertension, vitamin D deficiency, irritable bowel syndrome and sciatica. Review of the clinical record indicated the resident had a first step TB test administered on 11/12/23 and read on 11/14/23. The tests administered did not include the times administered or read. During an interview, on 12/9/24 at 1:23 p.m., the Administrator indicated the TB testing documentation was incomplete. A current facility policy, dated 4/17/24, provided by the Corporate Nurse on 12/9/24 at 2:31 p.m., indicated the following: " ... Tuberculin Testing Guidelines: Mantoux testing should be a two-step process unless there has been continuous annual testing following the two- step process. A) First step test shall be read between 48-72 hours after administration. B) Second step shall be administered between 1-3 weeks after the first test and read within 48-72 hours after administration ...." The Mantoux Tuberculin Skin Testing Fact Sheet from the Centers for Disease Control and Prevention (CDC) website at			

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	https://www.cdc.gov/tb/publications/factsheets/testing/Tuberculin_Skin_Testing_Information_for_Health_Care_Providers.pdf indicated guidance included: "...The skin test reaction should be read between 48 and 72 hours after administration by a health care worker trained to read TST results. A patient who does not return within 72 hours will need to be rescheduled for another skin test...."			