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	01/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on December 6, 2024. Survey dates: January 28 and 30, 2025 Facility number: 012993 Provider number: 155806 AIM number: 201208210 Census Bed Type: SNF/NF: 25 SNF: 29 Residential: 39 Total: 93 Census Payor Type: Medicare: 14 Medicaid: 25 Other: 15 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 5, 2025.	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 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on interview and record review, the facility failed to implement a plan of correction to ensure residents did not receive anti-psychotic medications without indication for 1 of 3 residents reviewed for unnecessary medications. (Resident 5)	F 0744	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident # 5 was affected with no noted adverse events. IDT educated POA on clinical	02/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
P.Aaron Vogel	Executive Director	02/21/2025

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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	Findings include: Resident 5's clinical record was reviewed on 1/28/25 at 12:10 p.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 including olanzapine (antipsychotic) 5 milligram (mg) daily. A quarterly MDS assessment, dated 11/1/24, indicated she had no hallucinations or delusions during the assessment period. A current care plan, dated 3/28/22, indicated the resident demonstrated altered behaviors including delusions, such as (I have to go home to my 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 current 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		necessity of continued use of psychotropic medications along with adverse side effects. POA agreeable to GDR plan. On 2/7/25 IDT & Psych Provider reviewed resident. Provider agreeable to GDR plan for Zyprexa. New order received to reduce Zyprexa to 2.5 P.O. QHS. Campus continuing to monitor resident for changes in mood or behaviors. **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 reviewed for appropriate continued use. 1 other resident identified in review. Care plan and education completed with POA. IDT and Psych Provider review on 2/7/25 with agreeable plan of GDR attempt of Abilify with new order obtained for dose reduction. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** Directed In-Service education scheduled for nursing staff and IDT on 2/21/25. As a measure of ongoing compliance, the SSD or designee will audit 5 residents with	

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	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 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", 0 out of 30 days. 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", 0 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 are not distressing		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. As a measure of ongoing compliance, the DHS, or designee, will complete audits of new/readmissions for the use of antipsychotic medications. The audit will also include a review to ensure that appropriate indication for use in place 3 times per week, as available, for 4 weeks, then 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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	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", 0 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. 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", 0 out of 30 days.			

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	Review of a December 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", 0 out of 30 days. Review of a 12/6/24 Behavior Analysis Report indicated the resident had no behaviors noted in the last 120 days. Review of a January 2025 MAR indicated she displayed delusions, such as wanting to go home or saying, "I have to take care of my children", 3 out of 28 days. Review of a 1/16/25 psychiatric Nurse Practitioner progress note indicated staff reported that she did have intermittent delusional thoughts, however symptoms were not currently distressing. Olanzapine was reported to be effective and she had a history of failed gradual dose reductions (GDR) of olanzapine. During an interview, on 1/28/25 at 12:38 p.m., the Social Services Designee indicated Resident 5 exhibited symptoms of tearfulness and being extremely upset about delusions. She was unable to be redirected. Some of the delusions Resident 5 had included needing to get to her husband or that her parents and children were looking for her. The facility was tracking those behaviors on the MAR. The MAR was the only place those behaviors were being tracked. The MAR showed what days Resident 5 was displaying behaviors and he felt those delusions justified the use for the anti-psychotic medication. During an interview, on 1/28/25 at 12:42 p.m., the Administrator indicated Resident 5 had a history			

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	of delusions and psychotic disorders. The MAR was the only location staff were documenting Resident 5's behaviors. During an interview, on 1/28/25 at 2:50 p.m., LPN 3 indicated Resident 5's symptoms included full blown tears and crying. Resident 5 talked about seeing a man in her room that wanted to kill her. Behaviors were documented on the MAR. Staff could document under event charting for a behavior note or in the progress note. The facility tried to discontinue the olanzapine in the past, but Resident 5's representative did not want the medication discontinued. During an interview, on 1/28/25 at 2:57 p.m., LPN 4 indicated Resident 5 had symptoms of seeing people sitting on her bed. Resident 5 had also tried to grab things floating in the air that were not there. When Resident 5 displayed any type of delusion, that would be documented in the progress note. Resident 5 was usually tearful but easily redirected. 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 accessed on 12/10/24 at 2:20 p.m., indicated Olanzapine has a black box warning for elderly patients with dementia- related psychosis treated			

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	with antipsychotic drugs are at an increased risk of death. Zyprexa (olanzapine) is not approved for the treatment of patients with dementia- related psychosis. This deficiency was cited on 12/6/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-37(a)			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities Based on record review and interview, the facility failed to ensure issues were identified in which quality assessment and assurance activities were necessary as evidenced by deficiencies cited and to ensure quality assurance procedures were followed and plans of action implemented to prevent deficiencies from re-occurring. This affected 1 of 3 residents reviewed for unnecessary medications. (Resident 5) Finding includes: Review of the Summary Statement of Deficiencies for the facility's last annual recertification and licensure survey completed on 12/7/24, indicated the facility had deficiencies related to failure to ensure a resident with dementia did not receive anti-psychotic medications without indication. During an interview, on 1/30/25 at 11:18 a.m., the Administrator indicated the Quality Assessment and Assurance (QAA) committee met monthly. Since the Plan of Correction, staff had been educated on properly documenting Resident 5's behaviors.	F 0867	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident # 5 was affected with no noted adverse events. All antipsychotics have been reviewed for appropriate diagnosis and use with provider communication as appropriate. Campus developed ongoing systematic tracking for antipsychotic class medications. **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. Education provided to ED and DHS related to QA program and ongoing monitoring of compliance with plans of correction. Antipsychotic tracking system established with ongoing monitoring in place. IDT educated on Psychotropic Medication	02/21/2025

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	A facility policy, revised on 11/14/19, titled, "Quality Assessment and Assurance Committee/ Quality Assurance and Performance Improvement (QAPI) Program", provided by the Administrator on 1/30/25 at 11:18 a.m., indicated the following: "... Performance Improvement plans (PIP) will include facility development, monitoring, and evaluation of performance indicators, and include the methodology and frequency for such development, monitoring an evaluation... Reporting to the Quality Assessment and Assurance Committee will include improvement/lack of improvement, with changes to the action plan as deemed necessary to meet compliance...The facility shall set priorities for its performance improvement activities, track adverse resident events, and perform an improvement project as indicated. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the campus' services and available resources, as reflected by the campus assessment...." Cross reference F744. 3.1-52(b)(2)		Usage and GDR policy. **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 campus ED or designee will review audits weekly x8 weeks, then monthly x 4 months to ensure accurate completion. Antipsychotic tracking system to be maintained per DHS or designee and reviewed during QAPI meeting **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 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on December 6, 2024. Survey dates: January 28 and 30, 2025.	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	

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	Facility number: 012993 Residential Census: 39 Wellbrooke of Wabash was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey. Quality review completed February 5, 2025.		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.	