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	11/08/2023

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 Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: November 1, 2, 3, 6, and 8, 2023. Facility number: 012993 Provider number: 155806 AIM number: 201208210 Census Bed Type: SNF/NF: 26 SNF: 28 Residential: 42 Total: 96 Census Payor Type: Medicare: 9 Medicaid: 26 Other: 19 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 14, 2023.	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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

P. Aaron Vogel | Executive Director | 11/28/2023

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	adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident was assisted with transfers in accordance with the plan of care for 1 of 5 residents reviewed for accidents. (Resident 36) Finding includes: Resident 36's clinical record was reviewed on 11/2/23 at 2:26 p.m. Diagnoses included hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage affecting left non-dominant side (7/15/22), unspecified fracture of the lower end of left radius (7/24/23), age-related osteoporosis without current pathological fracture (7/10/23), morbid (severe) obesity due to excess calories (7/15/22), unsteadiness on feet (7/12/23), history of falling (7/12/23), muscle weakness (generalized) 7/12/23, and repeated falls (7/12/23). A quarterly Minimum Data Set (MDS) assessment, dated 5/3/23, indicated the resident was cognitively intact and required substantial/maximal assistance with the ability to safely come to a standing position from sitting in a chair or on the side of the bed, the ability to safely get on and off a toilet or commode, and walk 10 feet. A Nursing Progress Note, dated 3/15/23 at 4:30 a.m., indicated the resident was assisted to the bathroom and turned around before she was aligned with the toilet. She sat down onto the floor. No apparent injuries were identified. A fall care plan, initiated on 7/19/22, indicated the	F 0689	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident #36 was affected. Resident #36 fall interventions were reviewed and ensured in place. Therapy evaluation completed to ensure transfer status appropriate. Direct care staff educated on following plan of care regarding transfers for Resident #36. **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. IDT audited all in-house residents with fall events in the previous six months to ensure fall interventions were implemented and appropriate. Audit was completed on 11/9/23 with corrections/revisions completed at the time of discovery. IDT audited all residents care planned for two-person transfers to ensure implementation and appropriateness. Direct care staff re-educated on importance of following resident care plan and ensuring fall preventions are implemented. **What measures will be put into**	11/29/2023

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	resident was at risk for falling related to required assistance. An intervention, dated 3/15/23, indicated the resident was to be verbally cued to sit on the toilet. A Nursing Progress Note, dated 4/6/23 at 8:15 p.m., indicated the resident was holding onto the bar in the bathroom with assistance of a nurse aide when her legs weakened. She was lowered to the floor by the nurse aide. No apparent injuries were identified. An intervention, added to the fall care plan on 4/7/23, indicated the resident required assistance of two staff members for transfers to the toilet. A Nursing Progress Note, dated 4/7/23 at 11:08 a.m., indicated the resident was assisted to the floor. The resident indicated her legs gave out when being transferred from bed to wheelchair. She complained of pain to her left knee and right toes. No apparent injuries were identified. An intervention, added to the fall care plan on 4/10/23, indicated the resident required assistance of two staff members for all transfers. A Point of Care Response, dated 5/17/23 at 8:13 a.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 5/17/23 at 3:32 p.m., indicated the resident was transferred with limited assistance of one person. A Point of Care Response, dated 5/18/23 at 12:34 a.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 5/18/23 at 10:28		**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 rounding audits to ensure fall interventions are implemented. DHS/designee will audit 5 residents bi-weekly for 2 months, weekly for 2 months and every other week for 2 months. As a measure of ongoing compliance, the MDS/designee will audit transfer ADL charting on 5 residents with two-person transfer specific care plans 4x week for 1 month, bi-weekly for 3 months, and weekly 2 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 achieved. This will be monitored by ED/Designee	

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	a.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 5/19/23 at 12:18 a.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 5/19/23 at 11:07 a.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 5/19/23 at 3:19 p.m., indicated the resident was transferred with extensive assistance of one person. A Nursing Progress Note, dated 5/19/23 at 7:10 p.m., indicated when a nurse aide attempted to assist the resident to bed, the bed rolled due to being unlocked. The resident acquired a light purple bruise to her left buttock of 3 centimeters (cm) by 2 cm and a skin tear to her the front of her middle finger of 0.4 cm by 0.2 cm. A Point of Care Response, dated 5/19/23 at 11:20 p.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 5/20/23 at 10:07 a.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 5/20/23 at 2:53 p.m., indicated the resident was transferred with extensive assistance of one person. An intervention, added on 5/22/23 to the fall care plan, indicated the staff should ensure the bed was locked before transferring the resident. A Physical Therapy Discharge Summary for a			

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	discharge date of 6/20/23, provided by the Administrator on 11/8/23 at 9:50 a.m., indicated the resident required partial/moderate assistance with ambulation on level surfaces with hemi-walker and with transfers A Point of Care Response, dated 7/9/23 at 2:40 a.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 7/9/23 at 2:50 p.m., indicated the resident was transferred with extensive assistance of one person. A Point of Care Response, dated 7/10/23 at 12:23 a.m., indicated the resident was transferred with total dependence on the assistance of one person. A Point of Care Response, dated 7/10/23 at 12:25 p.m., indicated the resident was transferred with extensive assistance of one person. A Nursing Progress Note, dated 7/10/23 at 5:00 p.m., indicated the resident was assisted by a nurse aide to the restroom via quad cane. As the resident turned, she fell forward onto the floor and landed on her affected side. Resident complained of left shoulder and wrist pain. A Point of Care Response, dated 7/11/23 at 2:47 a.m., indicated the resident was transferred with total dependence on the assistance of one person. A Nursing Progress Note, dated 7/11/23 at 10:01 a.m., indicated the Interdisciplinary Team reviewed the fall. Intervention was for the resident to use wheelchair for locomotion in room. A Progress Note, dated 7/12/23 at 10:31 a.m., indicated the NP saw the resident to follow up on			

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	pain after a fall. X-rays obtained on 7/10/23 indicated the left ankle had an avulsed (when a small chunk of bone attached to a tendon or ligament gets pulled away from the main part of the bone) fracture tip of lateral fibula, age indeterminate. The fracture was likely an old fracture as the resident no longer experienced left ankle pain. The resident continued to complain of left wrist pain of 10 of 10 on a 1 to 10 scale. The NP ordered ibuprofen (pain med) 400 mg by mouth every 8 hours for 7 days for left wrist pain and consider repeat imaging if needed. A Nursing Progress Note, dated 7/13/23 at 2:11 p.m., indicated the resident went to the orthopedic walk-in clinic in the morning regarding the left wrist and knee pain. The orthopedic clinic sent the resident back with a wrist splint for stabilization. The resident was given an injection to the left knee for the pain and swelling. The resident rated her pain a 10 out of 10 on a 1 to 10 scale and received ibuprofen. An annual Minimum Data Set (MDS) assessment, dated 7/22/23, indicated the resident was cognitively intact and required substantial/maximal assistance with the ability to safely come to a standing position from sitting in a chair or on the side of the bed, the ability to safely get on and off a toilet or commode, and walk 10 feet. A Physician's Note, from the orthopedic office, dated 7/24/23, indicated the resident had no acute ankle problems. The wrist was positive for fracture and would do well with continued treatment. The resident was to follow up with the orthopedic clinic as needed. An orthopedic office visit summary, dated 7/24/23,			

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	indicated the reason for the resident's visit was pain, swelling, an injury, and a fracture to the left ankle which had been present for two weeks. X-rays were taken of the left ankle and of the left wrist. The wrist x-rays indicated a non-displaced distal radius fracture. The ankle x-rays showed nothing acute. The brace to the left wrist was to be continued. During an interview, on 11/6/23 at 2:24 p.m., CNA 7 indicated the resident's profile on the computer told what kind of assistance was needed for the resident. Resident 36 required assistance of two for all transfers. During an interview, on 11/8/23 at 9:25 a.m., QMA 8 indicated the resident's profile in her electronic chart provided information on the assistance a resident required including specific orders and care plan interventions. Resident 26 required assistance of two for all transfers. During an interview, on 11/8/23 at 9:50 a.m., the Administrator indicated the resident required assistance of two with transfers, and not ambulation. She did not have assistance of two people with the fall on 5/19/23 during the transfer to bed. When the resident fell on 7/10/23, she was ambulating to the bathroom with her quad cane and one assist. The DON indicated the resident had received therapy between her falls in April and July with the intent to return home and once the resident was ambulating, she was fine. The current resident's profile from the resident's chart, provided on 11/8/23 at 3:50 p.m. by the Administrator, indicated the resident required assistance for transfers and two staff for all transfers. The Administrator indicated, when providing the profile, that the start dates for each			

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	intervention were not on the profile. All the dates on the profile were the original start date of the care plan. A current policy with a review date of 3/16/22, provided by the Administrator on 11/8/23 at 3:50 p.m., indicated " ...Trilogy health Services (THS) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures ...." 3.1-45(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure medications were available and provided as ordered for 1 of 1 residents reviewed for medication availability. (Resident 28) Findings include: During an interview with Resident 28's representative, on 11/2/23 at 11:50 a.m., they expressed concern regarding a three day period in which the resident was not administered her carbamazepine, a drug used to treat trigeminal neuralgia (TN). (TN is a chronic pain disorder which causes sudden, severe pain on one side of the face.) The daughter indicated her mother began to experience extreme discomfort and jaw pain by the third day. She thought the resident was having a seizure. The DON told her the reason the medication had not been administered was because it was not available. Resident 28's clinical record was reviewed on 11/2/23 at 3:30 p.m. Diagnoses included, but were not limited to, unspecified dementia and trigeminal neuralgia. A physician's order, dated 7/5/23, indicated carbamazepine tablet, extended release 12 hour, 200 mg, 1 tablet twice a day for trigeminal neuralgia.	F 0755	**What corrective actions will be accomplished for residents found to have been affected by the deficient practice:** Resident #28 was affected. Resident's medication orders have been reviewed and up to date with all medications available for administration. **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. EMAR compliance reviewed to ensure all medications are available at this time. Nurses/QMA's educated on appropriate steps to re-order medications with contingency measures in the event the medication is delayed or unavailable. **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, DHS/designee will	11/29/2023

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	A physician's order, dated 8/16/23, indicated carbamazepine tablet, extended release 12 hour, 200 mg, 2 tablets every morning for trigeminal neuralgia. A progress note, dated 10/12/23 at 4:53 p.m., indicated a STAT request for carbamazepine from the pharmacy. The medication was to be delivered that evening. A progress note, dated 10/12/23 at 6:55 p.m., indicated the resident was complaining of jaw pain. The NP was notified and provided a new order for Ibuprofen 400 mg every eight hours. A progress note, dated 10/12/23 at 1:46 p.m., indicated the carbamazepine was received from the pharmacy and administered as ordered at 8:16 p.m. A progress note, dated 10/13/23 at 1:57 p.m., indicated the resident had ongoing, occasional jaw pain. She was encouraged to not drink cold liquids. Review of the 10/2023 medication administration report (MAR), on 11/2/23 at 3:32 p.m., indicated carbamazepine was not administered on 10/10/23, 10/11/23, and 10/12/23, and each entry indicated the "Medication (was) Not Available". During an interview with LPN 2, on 11/3/23 at 10:53, she indicated she did witness the resident's pain on 10/12/23. Carbamazepine was a difficult medication to get because Resident 28 was the only resident who received that medication and it was not kept in the emergency drug kit. She did recognize the resident was in extreme pain and had received Tylenol for the pain. The resident was "back to her normal self" once the		audit EMAR compliance report on 5 residents bi-weekly for 4 weeks, weekly for 3 months, and every other week for 2 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 achieved. This will be monitored by ED/Designee	

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	carbamazepine had been reintroduced. She could understand why the resident's family thought their mother might be having a seizure, because the resident was in extreme pain. During an interview with two of the resident's representatives, on 11/3/23 at 11:15 a.m., they indicated they felt the need to routinely check to make sure the facility had the carbamazepine in stock because they were concerned she might miss her medication again. They were fearful of a repeat of the events on 10/12/23. During an interview with the DON on 11/08/23 at 11:01 a.m., she indicated she found out on 10/12/23 that the medication was not available. A request was made to the pharmacy to resupply the medication. had spoken with the family and explained to them what she was doing to remedy the situation. There should be a way to re-order from the pharmacy. The current process for reordering medications did not provide a way to know when and if an order had gone through to the pharmacy. There was a system in place where the facility could get medications from a "back-up" pharmacy. She was aware of the potential adverse effects that could be triggered when the medication was missed. A document titled "Miscellaneous Special Situations...Unavailable Medications", with a revised date of 11/2018, was provided by the DON on 11/8/23 at 3:52 p.m. and indicated the following: "...Medications used by residents in the facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being			

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	made. The facility must make every effort to ensure that medications are available to meet the needs of each resident....B) Facility personnel shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and option therapies that are available. a) If the facility personnel is unable to obtain a response from the attending physician, the personnel should notify the supervisor and contact the Facility Medical Director for orders and/or directions...." 3.1-25(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: November 1, 2, 3, 6, and 8, 2023. Facility number: 012993 Residential Census: 42 Wellbrooke of Wabash was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed November 14, 2023.	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 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.	

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