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	155833	A. BUILDING _____ B. WING _____	C 02/23/2024

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WELLBROOKE OF CARMEL	**12315 PENNSYLVANIA STREET CARMEL, IN 46032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Nursing Home Complaint IN00428611. This visit resulted in a Partially Extended Survey - Immediate Jeopardy. Complaint IN00428611 - Federal/State deficiencies related to the allegations are cited at F602. Unrelated deficiencies are cited. Survey dates: February 21, 22 and 23, 2024. Facility number: 013444 Provider number: 155833 AIM number: 201294880 Census Bed Type: SNF/NF: 22 SNF: 21 Residential: 29 Total: 72 Census Payor Type: Medicare: 13 Medicaid: 16 Other: 14 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 29, 2024.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12	F 602		

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

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F 602	Continued From page 1 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect a resident from misappropriation of property, specifically medications, when the facility discovered the resident was missing 12 oxycodone (a narcotic) from the narcotic box for 1 of 3 residents reviewed for misappropriation of property. (Resident C) The deficient practice was corrected by 2/15/24 prior to the start of survey and was therefore past noncompliance. Finding includes: An Indiana Department of Health (IDOH) incident report, dated 2/10/24, indicated a resident was noted to have 12 missing oxycodone 10/325 milligrams (mg). The resident had an order for the administration of the medication one tablet, twice a day. The clinical record for Resident C was reviewed on 2/21/24 at 12:08 p.m. The diagnoses included, but were not limited to, spinal stenosis cervical region (the neck area of the spine), other cervical disc degeneration, and weakness. A physician's order, initiated on 10/03/23, indicated to give oxycodone/acetaminophen 10/325 mg one tablet twice a day for pain.	F 602	Past noncompliance: no plan of correction required.	

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A facility witness statement, dated 2/10/24, indicated QMA 5 counted the narcotics and received the medication cart from the day shift nurse. The count was correct. She administered the resident's pain medication and signed it out on the narcotic count sheet. She removed one card and documented on the back of the narcotic sheet the card had been removed. She could not recall if she counted the narcotics with the staff member coming on for the next shift. There was a handwritten addendum, dated 2/15/24, which indicated "...On shift-to-shift count sheet, I wrote -1. The -2 written over it was not written by me...." The statement was dated 2/15/24 and signed by QMA 5.

A facility witness statement, dated 2/10/24, indicated RN 11 came in at 10:00 p.m., and took over both medication carts on the unit. She did not count the carts. The QMA told her the count was okay and gave her the keys. She did not administer any medications to the resident during the night. The resident's spouse usually asked for a pain pill about 1:00 a.m. She documented on the narcotic sheet she had removed one card and one sheet because she thought she would be administering the medication from the card which contained one tablet. The resident's spouse did not request the pain medication, and RN 11 forgot to correct the numbers on the narcotic count sheet. She did count the cart with the day shift on-coming nurse and the count was correct based on the number of cards and sheets.

During an interview, on 2/23/24 at 3:19 p.m., the Director of Nursing indicated the facility did not know what happened to the narcotics.

During an interview, on 2/23/24 at 3:19 p.m., the

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Corporate Support Nurse indicated the narcotics and the narcotic sign-off sheet had not turned up.

During an interview, on 2/23/24 at 3:30 p.m., QMA 5 was unable to say why she did not count the narcotics with RN 11 for the shift change to hand off the medication cart.

During a telephone interview, on 2/23/24 at 5:12 p.m., RN 11 indicated there were usually two nurses/QMAs on the unit and the nurse left after counting with the QMA. The nurse gave her keys, to the QMA. RN 11 indicated QMA 5 told her the cart was good and without counting the cart she accepted the keys and the carts. RN 11 indicated it was totally her fault and she had learned to count the cart. It would never happen again.

A facility policy, titled "IIA7: CONTROLLED SUBSTANCES," dated as last revised 11/18 and received from the Executive Director on 2/21/24 at 12:24 p.m., indicated "...Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed staff member administering the medication immediately enters the following information on the accountability record and the medication administration record...Date and time of the administration...Amount administered...Remaining quantity...Initials of the staff member administering the dose, completed after them medication is actually administered...."

A facility policy, titled "Guidelines for Narcotic Count," dated as last reviewed 12/31/23 and received from the Executive Director on 2/21/24 at 12:24 p.m., indicated "...At the time one nurse or other staff qualified to pass medications

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F 602	Continued From page 4 relinquishes the keys to the medication cart to another staff member the narcotic shall be reconciled by comparing the medication in the cart to the count sheets...." This deficient practice was corrected by 2/15/24, prior to the start of the survey and was therefore past non-compliance. The facility investigated the missing narcotics, suspended QMA 5, RN 11 and LPN 12 pending the investigation and drug testing. Staff received in-service on narcotics on 2/12/24 and an audit of all PRN (as needed) pain medications documented in the Medication Administration Record began on 2/10/24. All drug test results were completed on 2/15/24. This citation relates to complaint IN00428611.	F 602		
F 803 SS=J	3.1-28(a) Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 803		

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F 803	Continued From page 5 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff followed the physician's order for a resident on a mechanical soft diet when the wrong texture of the diet was provided and failed to provide assistance with meals which resulted in a resident choking for 1 of 4 residents reviewed for dietary requirements. (Resident B) This deficient practice resulted in Resident B's death. The Immediate Jeopardy began on 1/24/24, when it was identified Resident B was provided a regular diet in place of a mechanical soft diet. Resident B choked on her dinner, was provided the Heimlich Maneuver, lost consciousness, and expired in the facility. The Executive Director (ED), Director of Health Services (DHS), and the Clinical Support Nurse were notified of the immediate jeopardy on 2/23/24 at 11:48 a.m. The Immediate Jeopardy was removed and the deficient practice corrected on 1/25/24 prior to the start of survey and therefore was past non-compliance. Finding includes: An Indiana Department of Health (IDOH) incident	F 803	Past noncompliance: no plan of correction required.	

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report, dated 1/25/24, indicated Resident B experienced a change in condition upon leaving the dining room, on 1/24/24. The report indicated the resident appeared to be blue in color and was alert and able to speak with staff prior to the event. The resident choked on food during the evening meal, the Heimlich Maneuver (a first-aid procedure for dislodging an obstruction from a person's windpipe) was unsuccessfully performed, the resident lost consciousness, and emergency services (EMS) was contacted.

The clinical record for Resident B was reviewed on 2/21/24 at 12:35 p.m. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing), dementia, and mild cognitive impairment of uncertain or unknown etiology.

The resident was admitted to the facility on 1/13/24.

A hospital Speech Therapy (ST) evaluation, dated 1/10/24, indicated the ST recommendations were for a soft and bite sized diet with thin liquids and medications crushed in puree or as tolerated. Per husband, the patient had a history of dysphagia including pocketing and occasional choking of solid foods. During the evaluation, the patient ate at a rapid rate and benefited from verbal and tactile cueing to slow her pace. Recommend soft and bite sized diet with thin liquids and 1:1 assistance for pacing strategies when family was not present. Patient had a history of choking with solids and her husband had completed the Heimlich once due to choking.

A physician's order, dated 1/14/24, indicated the resident was to have a mechanical soft diet with thin liquids.

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A profile care guide, initiated on 1/15/24, indicated the interventions included, but were not limited to, mechanical soft diet with thin liquids, eating supervision/assist of (1) one, and the resident pocketed food in her mouth at times.

A care plan, initiated on 1/16/24, indicated the resident was at risk for aspiration due to having a swallowing problem related to dysphagia and pocketing food in her mouth. The goal was the resident would not choke, aspirate, or have adverse effects while consuming food or liquids. The interventions included, but were not limited to, diet as ordered.

A care plan, initiated on 1/16/24, indicated the resident had impaired cognition with associated short term memory impairment and was at risk for confusion, disorientation, altered mood, and impaired or reduced safety awareness related to dementia. The goal was that the resident would remain safe and not injure herself secondary to impaired decision making. Interventions included, but were not limited to, providing cues and supervision for decision making.

A care plan, initiated on 1/16/24, indicated the resident had a potential for alteration in nutritional status. Interventions included, but were not limited to, assisting with meals as needed and providing the diet as ordered.

A care plan, initiated on 1/16/24, indicated the resident had a potential for mouth pain. Interventions included, but were not limited to, to observe and report difficulties chewing and swallowing, and to observe for the need to change diet consistency to increase the ease of

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eating.

A Minimum Data Set (MDS) scheduled 5-day assessment, dated 1/17/23, indicated the resident was severely impaired cognitively, held food in her mouth/cheeks or had residual food in her mouth after meals. It also indicated the resident had a mechanically altered diet and required supervision or touching assistance for eating.

A nursing progress note, dated 1/24/24 at 6:20 p.m., indicated LPN 6 was alerted by a CNA, the resident was choking. Upon entering the unit, LPN 6 observed another nurse administering the Heimlich Maneuver on the resident. Her face was purple, lips were blue, and her eyes were rolled in her head. Another nurse swept the resident's mouth and there was food removed. LPN 6 attempted the Heimlich Maneuver but was not successful in clearing the airway. The resident was moved to her room, the nurse swept the resident's mouth, and removed food from the oral cavity. A suction machine was retrieved, and suction attempted, however the resident remained purple in color. LPN 6 and another nurse assessed for a pulse, but the resident was found to be without a pulse. Emergency Medical Services arrived and assessed for a pulse, but no pulse was found.

In a facility witness statement, dated 1/24/24, Scribe 4 indicated she was sitting at the nurses' station reviewing paperwork sometime around 5:45 p.m., to 5:55 p.m. She heard LPN 8 say "she's choking, she's choking". They both ran to the area where staff were surrounding the resident. Scribe 4 observed the resident to be off colored with a blue hue. She observed LPN 8 begin to provide the Heimlich Maneuver. She

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overheard Cook 7 call 911. She looked up the resident's code status and informed the nurse the resident was a do not resuscitate. When she returned to the scene, CNA 6 was observed to be holding a piece of silverware and was attempting to clear food from the resident's mouth. LPN 8 had left the scene to obtain the crash cart and suction machine. Upon LPN 8's return she told CNA 6 to stop and move away from the resident. CNA 6 did not stop after being told to stop. Scribe 6 observed food coming from the resident's mouth and described it as chunky but unidentifiable other than bread and something she believed to be fruit.

In a facility witness statement, dated 1/24/24, CNA 6 indicated she observed the resident being taken towards the hallway and heard them ask where the nurse was because someone was choking. CNA 6 approached them, and noted the resident was slightly blue in color. CNA 6 began the Heimlich Maneuver and CNA 3 assisted in getting food out of the resident's mouth. Mostly fruit was coming out, a grape was identified. Other food had been chewed and was not identifiable. LPN 8 came and took over doing the Heimlich and brought a suction machine.

In a facility witness statement, dated 1/24/24, CNA 9 indicated she observed CNA 3 take the resident toward her room. She observed LPN 6 performing the Heimlich Maneuver and CNA 3 performing a sternal rub. The resident was more purple/blue in color than white, and she noticed chunks of food being swept from the resident's mouth. She was not able to identify the food.

In a facility witness statement, dated 1/24/24, Cook 7 indicated she was the cook for the

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evening shift and did not observe the resident when she arrived in the dining area, as she was preparing meals. Cook 7 took a break, around 5:45 p.m., when she returned to the dining room CNA 3 alerted her to the resident's condition. She noticed the resident's mouth was full of food, she was shaking, and had signs of choking. CNA 3 remained with the resident while the cook ran to the hall and yelled for help. The Heimlich Maneuver was started on the resident. A nurse called out to call 911 and Cook 7 did. Cook 7 indicated meal service began at 4:30 p.m., Resident B had a hamburger with cheese and French fries. The cheeseburger had been quartered for smaller bites. A hamburger patty had been used for the meal. Cook 7 indicated a red meal ticket indicated a special/altered diet. She put the food on the resident's plate. The resident's meal did not include green beans and the meal was prepared per the meal ticket. There were no toppings with the cheeseburger because they were not mechanically soft.

In a witness statement, dated 1/24/24, LPN 6 indicated she was on break when a CNA came to her and said, "they need you, one of your resident's is choking." LPN 6 indicated she came back into the facility and found LPN 8 doing the Heimlich on the resident. LPN 8 then went to sweep food out of the resident's mouth and LPN 6 took over the Heimlich. LPN 6 indicated when clearing the airway, a large, chewed chunk of bread and meat, pineapple chunks and other melons were noted. The bread and burger were chewed up and hard to distinguish, but the fruit was unchewed and identifiable.

In a witness statement, dated 1/24/24, CNA 3 indicated she went into the dining room to see

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which residents needed assistance leaving the dining room after the meal service. She noticed Resident B was attempting to get fruit out of her fruit cup, so she stayed in the dining room with the resident. She noticed the resident's C-collar was dirty and assisted to clean the resident up. CNA 3 indicated it seemed food was falling out of the resident' mouth so she cleared the food away. CNA 3 went to the drink station to fill up a cup and when she turned back around, Resident B was attempting to fork fruit and put it in her mouth and CNA 3 felt her motions seemed off. CNA 3 noted cantaloupe fruit in the resident's mouth and attempted to remove it. CNA 3 noticed the resident had a blue-ish hue to her and was shaking. CNA 3 took the resident in her wheelchair quickly towards the hall where she resided. CNA 3 indicated she helped clear fruit from the resident's mouth while the nurse was doing the Heimlich. She was not able to quantify how much food was cleared from the resident's airway, but it seemed like a decent amount and the majority was fruit. She saw the resident's plate in the dining room and the resident had a cheeseburger cut into quarters on her plate. The resident had consumed 2 quarters of the cut-up cheeseburger.

In a witness statement, dated 1/24/24, LPN 8 indicated when she arrived at the resident, she was blue in color. CNA 3 had what looked like a piece of silverware and was sweeping the resident's airway of visible food. LPN 8 told CNA 3 to stop, and LPN 8 began the Heimlich. Food immediately started to come out. LPN 8 pulled what looked like unchewed chunks of bun out of the resident's mouth.

A coroner's report, dated 1/25/24 and received on

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2/22/24 at 2:34 p.m., indicated the cause of death was from choking due to food bolus at the vocal cord level obstructing the airway. The bolus was described "firmly impacted ground red meat and bread material."

During an interview, on 2/22/24 at 3:09 a.m., the Corporate Support Nurse indicated the physician's ordered diet had not been followed for Resident B.

During an interview, on 2/22/24 at 3:29 p.m., CNA 5 indicated at about dinner time, a CNA and a dietary employee came to the unit with a resident. The resident was looking blueish. CNA 5 ran to the resident and began the Heimlich Maneuver. Some of the "stuff" came out of her mouth like fruit, a grape, and some food which was soft and mashed up. During that time, another nurse from the other unit took over and suctioned the resident and CNA 5 left the room.

During an interview, on 2/22/24 at 3:56 p.m., Cook 7 indicated at the time of the incident she had completed meal service, returned from her break, and was delivering employee meals. CNA 3 said "What's wrong with her". Resident B was shaking and had food in her mouth. It looked like she was choking, so Cook 7 went to get a nurse. She returned to the dining room and CNA 3 was taking Resident B to the other nursing station. Cook 7 called 911. She indicated Resident B had been served a hamburger with French fries for the meal. Cook 7 indicated the hamburger was cut into smaller pieces and to her knowledge that was mechanical soft. She indicated she knew now mechanical soft meant to grind up the meat and a mechanical soft diet also required the use of canned fruit, not fresh.

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	155833	A. BUILDING _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBROOKE OF CARMEL	**12315 PENNSYLVANIA STREET CARMEL, IN 46032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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During a telephone interview, on 2/22/24 at 4:23 p.m., CNA 3 indicated she was in the dining room to return residents to their units. There were only two residents left, one of which was Resident B. Cook 7 said she would assist the other resident. When CNA 3 turned around and observed Resident B "jabbing" her fork into a fruit cup. It was grapes, pineapple, and cantaloupe. Cook 7 indicated the resident's mouth was blue. They both ran to the resident. She had a piece of cantaloupe stuck in her mouth. CNA 3 hit her back and the cantaloupe flew out. She then grabbed the resident and took her to a nurse who began the Heimlich Maneuver. CNA 3 indicated she grabbed a spoon to scoop food out the resident's mouth because the finger sweep was not getting the food. The resident had a lot of food in her throat. A whole grape, pineapple, a whole French fry, and hamburger which was chunky came out. It was like she did not even chew the food and just swallowed it.

During an interview, on 2/23/24 at 9:16 a.m., the Director of Food Service indicated the only canned fruit the facility used were pears and peaches. The facility dd not have mixed canned fruit with pineapple, grapes, and melon.

During an interview, on 2/23/24 at 10:02 a.m., the Speech and Language Pathologist (SLP) indicated she had worked with Resident B for swallowing and cognition. She had seen the resident for meals; sometimes breakfast, sometimes lunch, but she was not in the facility for dinner. She described the resident as impulsive. She would take large bites when she should have been taking small ones and was very fast with eating, even with maximum cueing. It

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was difficult for Resident B to follow directions due to her severe dementia. Cueing included telling the resident to take smaller bites, alternate her liquids with food, to slow down, and to make sure no residual food was in her mouth. Typically, she had a lot of residual food in her mouth. The SLP indicated the recommendation from the hospital was a mechanical soft diet. She described a mechanical soft diet as soft texture food which would exclude anything that needed to be really chewed like nuts, hard vegetables, fried bread, toast, and meat. Meat needed to be ground up. They could have fruit, but no grapes due to the skin. Pineapple and melon would have to be small pieces. It was recommended, typically, for residents on a mechanically altered diet to have supervision, preferably sitting with the resident if they were impulsive like Resident B. The recommendation for supervision with dining would be verbally relayed to the Director of Nursing, Assistant Director of Nursing or the CNAs as the facility did not want speech therapy to add the order. The order would be added by the nursing staff.

A facility meal ticket, titled "Wednesday-Dinner Daily Special," received from the Director of Nursing on 2/21/23 at 12:50 p.m., indicated Resident B was to receive a mechanical soft diet consisting of a burger and fries. The meal ticket was red.

A facility document, titled "Inservice Topic: Altered Diets and Resident Meal Service," dated 1/24/24 and received from the Director of Nursing on 2/21/24 at 12:50 p.m., indicated "...Colored meal tickets mean there was an altered diet, liquid, major allergy, etc...."

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A facility document, titled "Trilogy Health Service Mechanical Soft Cheat Sheet," dated as reviewed and approved on 10/2023 and received from the Director of Nursing on 2/21/24 at 12:50 p.m., indicated "...Meats...All meats are ground...All ground meats should have gravy/sauce...No fresh fruit (may have bananas, canned fruit)...No Coated/battered French Fries (May have Soft or Crinkle cut-no hard, burnt or crispy ends)...."

A facility document, titled "Guidelines for Meal Service," dated as last reviewed on 12/31/23 and received from the Executive Director on 2/23/24 at 3:46 p.m., indicated "...Staff will be available to assist with...eating...."

A facility document, titled "Comprehensive Care Plan Guideline," dated as last reviewed on 12/31/23 and received from the Executive Director on 2/23/24 at 3:45 p.m., indicated "...PURPOSE...To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability or disease in accordance with state and federal guidelines...."

A facility document, titled "Meal Service," dated as last revised 01/2023 and received from the Director of Nursing on 2/21/24 at 12:50 p.m., indicated "...Staff will assist the individual as needed...."

A facility document, titled "Abuse and Neglect Procedural Guidelines," last reviewed on 8/29/19 and received from the Executive Director on 2/21/23 at 9:36 a.m., indicated "...DEPRAVATION OF GOODS AND SERVICES BY STAFF: staff has the knowledge and ability to provide care and services, but choose not to do it...which result in

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F 803	Continued From page 16 care deficits to a resident(s)...ADVERSE EVENT-An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof...UNUSUAL DEATH-means the death of a resident that is unusual and/or the result of an accident...NEGLECT-is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm...." The Past Noncompliance Immediate Jeopardy began on 1/24/23 The Immediate Jeopardy was removed and corrected by 1/25/24, after the facility implemented a systemic plan which included the following actions: a full investigation of the incident to include witness statements, staff in-service education on altered diets and meal service, placement of suction machines in the dining room(s), all residents with mechanically altered diets were audited with the tray cards (meal tickets) for accuracy and the residents had assessments both of oral and respiratory systems to include vital signs and oxygen saturation readings, audits to ensure altered diets were being followed appropriately, and education to the Dietary Supervisor related to having the spreadsheets and recipe book accessible at all times on the cook's line. 3.1-20(a) 3.1-20(h) 3.1-20(i)(4)	F 803		