STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155808	A. BUILDING _____ B. WING _____	C 11/09/2023

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

(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	F 000		

This visit was for the Investigation of Nursing Home Complaint IN00419511 and Residential Complaints IN00414987, IN00402052 and IN00401982.

Complaint IN00419511 - No deficiencies related to the allegations are cited.

Complaint IN00414987 - No deficiencies related to the allegations are cited.

Complaint IN00402052 - No deficiencies related to the allegations are cited.

Complaint IN00401982 - No deficiencies related to the allegations are cited.

Unrelated deficiencies are cited.

Survey dates: November 6, 8 and 9, 2023

Facility number: 012937
Provider number: 155808
AIM number: 201208220

Census Bed Type:
SNF/NF: 23
SNF: 24
Residential: 31
Total: 78

Census Payor Type:
Medicare: 9
Medicaid: 16
Other: 22
Total: 47

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

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F 000	Continued From page 1 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 21, 2023.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §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 residents from misappropriation of property, specifically medications, when a Registered Nurse removed discontinued medications from the facility without consent and ordered medications without the authorization of a licensed medical provider and then removed them from the facility for 5 of 5 residents reviewed for misappropriation of property. (Resident 2, 3, 4, 5, and 6) The deficient practice was corrected on 11/02/23, prior to the start of the survey and was therefore past noncompliance. Findings include: During an interview, on 11/06/23 at 10:10 a.m., the Executive Director indicated RN 2 was an employee with the facility. RN 2 would take medications out of the facility and give them to another party not affiliated with the facility. She	F 602	Past noncompliance: no plan of correction required.	

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F 602	Continued From page 2	F 602		

indicated the medications were antibiotics and an antifungal. The medications were discontinued except for the Rifampin (an antibiotic) and the Terbinafine (an antifungal). None of the residents involved received any medications they did not have ordered. The Rifampin and Terbinafine were not ordered by the facility Nurse Practitioner or the Physician. RN 2 wrote the scripts and placed the orders early to ensure they made the delivery and then discontinued the medications after she knew they were on the way to the facility. The other antibiotics were discontinued medications which had not been returned to the pharmacy. There were no narcotics involved.

1. The record for Resident 2 was reviewed on 11/09/23 at 12:57 p.m. Diagnoses included, but were not limited to, surgical wound after care, disruption (reopening) of a surgical wound, and bariatric surgery status.

A physician's order, dated 6/26/23, indicated to give Bactrim DS (an antibiotic) 800-160 mg (milligram) twice a day.

The Medication Administration Record indicated the resident received 18 doses of the medication, refused one dose, and missed two doses because she was in the hospital.

During an interview, on 11/09/23 at 12:57 p.m., the Corporate Support Nurse indicated a dose was pulled from the EDK (Emergency Drug Kit) and the resident refused the medication. The resident was off campus in the emergency department on 7/29 to 7/30/23. The wound clinic wrote the order. The medication was filled by the facility pharmacy and the EDK. She was not sure how many pills were taken, and the facility was

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F 602	Continued From page 3	F 602		

not completing the medication disposition records at that time.

2. The record for Resident 3 was reviewed on 11/09/23 at 1:02 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the bladder (bladder cancer), sepsis (a severe infection), and bacteremia (bacteria in the blood stream).

A physician's order, dated 6/08/23, indicated to give Bactrim DS (an antibiotic) 800-160 milligrams twice a day. The order was discontinued on 6/09/23.

A physician's order, dated 6/09/23, indicated to give Bactrim DS 800-160 milligrams twice a day. The order was discontinued on 6/12/23.

A physician's order, dated 6/12/23, indicated to give Bactrim DS 800-160 milligrams twice a day. The order was discontinued on 6/15/23.

The Medication Administration Record indicated the resident received 13 tablets of the medications. 30 tablets were diverted per the facility's investigation.

During an interview, on 11/09/23 at 1:02 p.m., the Corporate Support Nurse indicated the resident's medication was discontinued on 6/12/23. The medications were not returned to the pharmacy for credit. There were three (3) separate orders filled.

3. The record for Resident 4 was reviewed on 11/09/23 at 1:05 p.m. Diagnoses included, but were not limited to, urinary tract infection, chronic kidney disease, and dementia.

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F 602	Continued From page 4	F 602		

A physician's order, dated 6/08/23, indicated to give sulfamethoxazole-trimethoprim (an antibiotic) 800-160 mg twice a day. The order was discontinued on 6/13/23 due to the resident discharged from the facility.

The Medication Administration Record indicated the resident received 11 doses of the medication. She was prescribed to take it twice a day for five (5) days.

During an interview, on 11/09/23 at 1:05 p.m., the Corporate Support Nurse indicated all doses were charted as given on the Medication Administration Record. The resident was reviewed for diversion because the police had provided the prescription number for the medications. She indicated the first dose may have been taken from the Emergency Drug Kit.

4. The record for Resident 5 was reviewed on 11/09/23 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, pleural effusion, and multiple left sided rib fractures.

A physician's order, dated 8/13/23, indicated to give terbinafine hydrochloride (an antifungal) 500 mg immediately. This medication was ordered by RN 2 and was not authorized by the resident's physician or nurse practitioner.

A physician's order, dated 8/13/23, indicated to give terbinafine hydrochloride 500 mg once a day.

Two tablets of terbinafine 250 mg were sent to the facility.

The Medication Administration Record indicated

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F 602	Continued From page 5	F 602		

no medication was provided to the resident and the medication was discontinued on 8/13/23.

During an interview, on 11/09/23 at 1:20 p.m., the Corporate Support Nurse indicated RN 2 ordered the medication in the morning and discontinued the medication late. There was no physician's order for the terbinafine. The pharmacy did send the medication to the facility and the nurse took it before the order was printed on the Medication Administration Record.

5. The record for Resident 6 was reviewed on 11/09/23 at 1:28 p.m. Diagnoses included, but were not limited to, Parkinson's disease, asthma, and cyst of the kidney.

A physician's order, dated 7/22/23, indicated to give Rifampin (an antibiotic) 300 mg twice a day. The order was discontinued on 07/22/23. This medication was ordered by RN 2 and was not authorized by the resident's physician or nurse practitioner.

A narrative from the Police Department indicated a former staff member, who was terminated from the facility on 6/21/23, was stopped by the police on 8/18/23. He was driving a car registered to RN 2. During the search and seizure of goods from the vehicle, medications identified as belonging to the residents in the facility were found.

A facility document, titled "Trilogy Health Services, LLC Statement of Witness Form," dated 8/23/23 and received by the Executive Director on 11/06/23 indicated, RN 2 contacted the facility via cell phone and was informed of the arrest of another RN while he was in possession of her car. There were several prescription

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F 602	Continued From page 6	F 602		

medications which were traced back to former and current residents in the facility. She was informed as part of the investigation she was suspended from her position. RN 2 initially denied knowledge of how the former employee came into possession of the medications from the facility and indicated she "...must have left them in her bag instead of destroying them...." The order for Rifampin was questioned as the Nurse Practitioner told the facility she did not order the medication. RN 2 then indicated she took the medications, from the campus, with purpose. RN 2 indicated the former staff member needed the medication and had no other way of getting them. He had contacted her in late July and requested she get the medications for him. She indicated she attempted to order the medication online but could not get them due to not having a prescription. Resident 3's Bactrim had been discontinued and not returned to the pharmacy, so she took the medication. Resident 2 also had left over medications, and she took those. Resident 4 had a prescription which had been ordered twice but only delivered to the facility once, she removed them from the facility also. Resident 6 did not have an order for Rifampin, she placed/wrote an order for the medication and then stopped/discontinued the order later in the evening. The medication came in and she removed it from the facility. RN 2 stated she took all the medications, from the facility, over one weeks' time. The facility requested RN 2 provide a statement within an hour, but the facility never received a statement from RN 2.

RN 2 was terminated from employment, on 8/29/23, for gross misconduct.

During an interview, on 11/08/23 at 9:33 a.m., the

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Corporate Support Nurse indicated all the residents affected, in the diversion of the medications, were on the skilled unit. She indicated RN 2 ordered or refilled medications early in the morning and when the medications were processed and sent out, she would discontinue the orders. The medications did not show up on the Medication Administration Record (MAR). The residents did not receive any medications they were not ordered to receive. The medications had either been discontinued or the medication course had been completed. The medications, which were left over, were stored in the medication room and the returns had not been sent back to the pharmacy. RN 2 told the facility everything about how she acquired the medications and admitted to the diversion of the drugs. After the incident medication audits were completed, the medication carts were audited, staff was educated on return/disposition of medications, and RN 2 was terminated from employment.

During a telephone interview, on 11/09/23 at 3:21 p.m., Nurse Practitioner 3 indicated the Rifampin and Terbinafine medications had not been ordered or authorized to be ordered. Nurses were not authorized to order medications without a licensed provider's authorization.

A current facility policy, titled "Guidelines for Medication Orders," dated as last reviewed 12/31/2022 and received from the Executive Director on 11/09/23 at 1:34 p.m., indicated "...Each resident shall be under the care of a licensed physician authorized to practice medication in the state where care is provided...Physician orders...must be signed and dated in accordance with state regulations...."

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F 602	Continued From page 8 A current facility policy, titled "Long-Term Care/Abuse and Incident Reporting Policy," dated as effective 12/08/22 and received by the Executive Director on 11/06/23 at 1:10 p.m., indicated "...Misappropriation of resident property/exploitation...Missing prescription medications...Misappropriation of resident property: Deliberate misplacement...wrongful temporary or permanent use of a resident's property...without the resident's consent. Includes any medication dispensed in the name of the resident...." A current facility policy, titled "Abuse and Neglect Procedural Guidelines," dated as last reviewed 8/29/19 and received from the Executive Director on 11/06/23 at 1:10 p.m., indicated "...Misappropriation of Property-means the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings...without the resident's consent...." The deficient practice was corrected by 11/02/23 after the facility terminated Registered Nurse 2, implemented drug disposition procedures, performed disposition audits, medication cart audits, and educated their staff on abuse and misappropriation of property.	F 602		
F 755 SS=E	3.1-28(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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	F 755		

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F 755	Continued From page 9 §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. §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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a record of disposition/return of unused and discontinued medications to the pharmacy and failed to ensure a licensed physician or nurse practitioner authorized or prescribed medications for 5 of 5 residents reviewed for pharmacy services. (Resident 2, 3, 4, 5, and 6) The deficient practice was corrected on 11/02/23, prior to the start of the survey and was therefore past noncompliance.	F 755	Past noncompliance: no plan of correction required.	

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F 755	Continued From page 10	F 755		

Findings include:

During an interview, on 11/06/23 at 10:10 a.m., the Executive Director indicated RN 2 was an employee with the facility. She had worked with another nurse who was terminated prior. RN 2 and the former employee were working together. RN 2 would take the medications out of the facility and give them to the former employee. The medications were antibiotics and an antifungal which had been discontinued and had not been returned to the pharmacy for credit. The medications were discontinued orders except for the Rifampin (an antibiotic) and the Terbinafine (an antifungal). The Rifampin and Terbinafine were not ordered by the facility Nurse Practitioner or the Physician. RN 2 wrote the scripts and placed the orders early to ensure they made the delivery and then discontinued the medications after she knew they were on the way to the facility. None of the residents involved received any medications they did not have ordered. There were no narcotics involved.

1. The record for Resident 2 was reviewed on 11/09/23 at 12:57 p.m. Diagnoses included, but were not limited to, surgical wound after care, disruption (reopening) of a surgical wound, and bariatric surgery status.

A physician's order, dated 6/26/23, indicated to give Bactrim DS (an antibiotic) 800-160 mg (milligram) twice a day.

The Medication Administration Record indicated the resident received 18 doses of the medication, refused one dose, and missed two doses because she was in the hospital.

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F 755	Continued From page 11	F 755		

During an interview, on 11/09/23 at 12:57 p.m., the Corporate Support Nurse indicated a dose was pulled from the EDK (Emergency Drug Kit) and the resident refused the medication. The resident was off campus in the emergency department on 7/29 to 7/30/23. The wound clinic wrote the order. The medication was filled by the facility pharmacy and the EDK. She was not sure how many pills were taken, and the facility was not completing the medication disposition records at that time.

2. The record for Resident 3 was reviewed on 11/09/23 at 1:02 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the bladder (bladder cancer), sepsis (a severe infection), and bacteremia (bacteria in the blood stream).

A physician's order, dated 6/08/23, indicated to give Bactrim DS (an antibiotic) 800-160 milligrams twice a day. The order was discontinued on 6/09/23.

A physician's order, dated 6/09/23, indicated to give Bactrim DS 800-160 milligrams twice a day. The order was discontinued on 6/12/23.

A physician's order, dated 6/12/23, indicated to give Bactrim DS 800-160 milligrams twice a day. The order was discontinued on 6/15/23.

The Medication Administration Record indicated the resident received 13 tablets of the medications. 30 tablets were diverted per the facility's investigation.

During an interview, on 11/09/23 at 1:02 p.m., the

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F 755	Continued From page 12	F 755		

Corporate Support Nurse indicated the resident's medication was discontinued on 6/12/23. The medications were not returned to the pharmacy for credit. There were three (3) separate orders filled.

3. The record for Resident 4 was reviewed on 11/09/23 at 1:05 p.m. Diagnoses included, but were not limited to, urinary tract infection, chronic kidney disease, and dementia.

A physician's order, dated 6/08/23, indicated to give sulfamethoxazole-trimethoprim (an antibiotic) 800-160 mg twice a day. The order was discontinued on 6/13/23 due to the resident discharged from the facility.

The Medication Administration Record indicated the resident received 11 doses of the medication. She was prescribed to take it twice a day for five (5) days.

During an interview, on 11/09/23 at 1:05 p.m., the Corporate Support Nurse indicated all doses were charted as given on the Medication Administration Record. The resident was reviewed for diversion because the police had provided the prescription number for the medications. She indicated the first dose may have been taken from the Emergency Drug Kit.

4. The record for Resident 5 was reviewed on 11/09/23 at 1:20 p.m. Diagnoses included, but were not limited to, dementia, pleural effusion, and multiple left sided rib fractures.

A physician's order, dated 8/13/23, indicated to give terbinafine hydrochloride (an antifungal) 500 mg immediately. This medication was ordered by

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F 755	Continued From page 13	F 755		

RN 2 and was not authorized by the resident's physician or nurse practitioner.

A physician's order, dated 8/13/23, indicated to give terbinafine hydrochloride 500 mg once a day.

Two tablets of terbinafine 250 mg were sent to the facility.

The Medication Administration Record indicated no medication was provided to the resident and the medication was discontinued on 8/13/23.

During an interview, on 11/09/23 at 1:20 p.m., the Corporate Support Nurse indicated RN 2 ordered the medication in the morning and discontinued the medication late. There was no physician's order for the terbinafine. The pharmacy did send the medication to the facility and the nurse took it before the order was printed on the Medication Administration Record.

5. The record for Resident 6 was reviewed on 11/09/23 at 1:28 p.m. Diagnoses included, but were not limited to, Parkinson's disease, asthma, and cyst of the kidney.

A physician's order, dated 7/22/23, indicated to give Rifampin (an antibiotic) 300 mg twice a day. The order was discontinued on 07/22/23. This medication was ordered by RN 2 and was not authorized by the resident's physician or nurse practitioner.

A narrative from the Police Department indicated a former staff member, who was terminated from the facility on 6/21/23, was stopped by the police on 8/18/23. He was driving a car registered to RN 2. During the search and seizure of goods from

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	155808	A. BUILDING _____ B. WING _____	C 11/09/2023

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

(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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the vehicle, medications identified as belonging to the residents in the facility were found.

A facility document, titled "Trilogy Health Services, LLC Statement of Witness Form," dated 8/23/23 and received by the Executive Director on 11/06/23 indicated, RN 2 contacted the facility via cell phone and was informed of the arrest of another RN while he was in possession of her car. There were several prescription medications which were traced back to former and current residents in the facility. She was informed as part of the investigation she was suspended from her position. RN 2 initially denied knowledge of how the former employee came into possession of the medications from the facility and indicated she "...must have left them in her bag instead of destroying them...." The order for Rifampin was questioned as the Nurse Practitioner told the facility she did not order the medication. RN 2 then indicated she took the medications, from the campus, with purpose. RN 2 indicated the former staff member needed the medication and had no other way of getting them. He had contacted her in late July and requested she get the medications for him. She indicated she attempted to order the medication online but could not get them due to not having a prescription. Resident 3's Bactrim had been discontinued and not returned to the pharmacy, so she took the medication. Resident 2 also had left over medications, and she took those. Resident 4 had a prescription which had been ordered twice but only delivered to the facility once, she removed them from the facility also. Resident 6 did not have an order for Rifampin, she placed/wrote an order for the medication and then stopped/discontinued the order later in the evening. The medication came in and she

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removed it from the facility. RN 2 stated she took all the medications, from the facility, over one weeks' time. The facility requested RN 2 provide a statement within an hour, but the facility never received a statement from RN 2.

RN 2 was terminated from employment on 08/29/23 for gross misconduct.

During an interview on 11/08/23 at 9:33 a.m., the Corporate Support Nurse indicated all the residents effected were on the skilled unit. All the residents except for Resident 4 were covered by Medicare Part A insurance. Resident 4 was private pay. The facility paid for all the medication bills including Resident 4, due to the theft by their staff member. She indicated RN 2 ordered or refilled medications early in the morning and when the medications were processed and sent out, she would discontinue the orders. The medications did not show up on the Medication Administration Record (MAR). The residents did not receive any medications they were not ordered to receive. The medications had either been discontinued or the medication course had been completed. The medications, that were left over, were stored in the medication room and the returns had not been sent back to the pharmacy. RN 2 told the facility everything about how she acquired the medications and admitted to the diversion of the drugs. After the incident medication audits were completed, the medication carts were audited, staff was educated on return/disposition of medications, and RN 2 was terminated from employment.

During a telephone interview on 11/09/23 at 3:21 p.m., Nurse Practitioner 3 indicated the Rifampin and Terbinafine had not been ordered or

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authorized to be ordered and nurses are not authorized to order medications without a licensed provider's authorization.

A facility job description, titled "Registered Nurse (RN)," undated and received by the Corporate Support Nurse on 11/09/23 at 1:41 p.m., indicated "...Administer and document medication...per the physician's order...."

A current facility policy, titled "Guidelines for Medication Orders," dated as last reviewed 12/31/2022 and received from the Executive Director on 11/09/23 at 1:34 p.m., indicated "...Each resident shall be under the care of a licensed physician authorized to practice medication in the state where care is provided...Physician orders...must be signed and dated in accordance with state regulations...."

The deficient practice was corrected by 11/02/23 after the facility terminated Registered Nurse 2, implemented drug disposition procedures, performed disposition audits, medication cart audits and educated their staff on abuse and misappropriation of property.

3.1-25(e)(2)
3.1-25(o)