STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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 the Investigation of Nursing Home Complaint IN00434357. This visit included the Investigation of Residential Complaint IN00428807. Complaint IN00434357 - Federal/state deficiencies related to the allegations are cited at F677 and F726, Complaint IN00428807 - State deficiencies related to the allegations are cited at R0064. Survey dates: May 23 and 24, 2024 Facility number: 013085 Provider number: 155811 AIM number: 201279600 Census Bed Type: SNF/NF: 7 SNF: 20 NF: 15 Total: 42 Census Payor Type: Medicare: 20 Medicaid: 15 Other: 7 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 6, 2024.	F 0000	Date of Compliance: __June 14, 2024_____ The submission of this plan of correction does not indicate an admission by Wellbrooke of Avon that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Avon. 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of 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 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
Bldg. 00	Based on record review, and interview, the facility failed to ensure showers were provided for 1 of 1 residents reviewed for bathing preference (Resident B). Findings include: On 5/23/24 at 12:14 p.m., the medical record for Resident B was reviewed. The resident was admitted to the facility on 10/5/21. Diagnosis included but were not limited to. Hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength) following cerebral infarction (stroke) affecting right dominant side. The point of care ADL (Activities of Daily Living) Report record, which was the documentation recorded by the Certified Resident Care Assistant (CRCA) indicated when the resident was provided a shower, a bed bath, or a partial bath: From 9/20/23 to 10/30/23 the resident was administered 2 showers. From 10/4/23 to 10/30/23 the resident was administered 5 showers. From 11/27/23 to 12/19/23 the resident was administered 6 showers. From 1/8/24 to 1/16/24 the resident was administered 3 showers. The documentation indicated in four months the resident received a total of 16 showers. The residents care profile, dated 4/13/22, indicated	F 0677	F 677 1. Resident B was affected without adverse consequences. 2. All residents have the potential to be affected. Education provided to all nursing staff regarding resident preference for bathing/showers 3. As a measure of ongoing compliance, DHS or designee will audit 5 residents to ensure proper shower/bathing per preference, weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.	06/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	the resident's bathing preference was to be administered 2 showers per week. Showers were to be administered on the day shift on Monday and Wednesday. A care plan, dated 10/21/22, indicated the resident required staff assistance to complete ADL task completely and safely. An annual Minimum Data Set (MDS) assessment, dated 9/25/23, indicated the resident was dependent upon staff for all personal care. On 5/23/24 at 2:15 p.m., during an interview the Director of Nursing (DON) indicated the resident probably did not receive many showers because she was not safe. She did not recall if she required two persons to assist with showering. On 5/24/2024 at 11:13 a.m., the DON provided a document titled, "Guidelines for Bathing Preference," dated 21/31/23, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose ...to establish a personal preference bathing routine ...Procedures ...2. The resident shall determine their preference for bathing upon admission ...a. Day of the week b. Time of day - morning or evening c. Type of bathing - tube, bed bath or shower ...4. Bathing shall occur at least twice a week unless resident preference states otherwise ...." This citation relates to complaint IN00434357. 3.1-38(a)(3)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff	F 0726	F 726	06/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	Based on record review, interview, and observation, the facility failed to ensure a nurse aide was competent to safely transfer a resident while using a mechanical lift for 2 of 4 residents reviewed for mechanical lifts (Resident B). Findings include: 1. On 5/23/24 at 12:14 p.m., the medical record for Resident B was reviewed. The resident was admitted to the facility on 10/5/21. Diagnosis included but were not limited to hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength) following cerebral infarction (stroke) affecting right dominant side. The medical record lacked a Physician order for use of mechanical lift for transfers. The resident was admitted to the hospital on 1/21/24 with diagnosis of sepsis, urinary tract infection (UTI), scalp hematoma, and laceration. A CT scan (a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) indicated no evidence of acute intracranial hemorrhage (bleeding in the brain). A care plan, dated 10/21/22, indicated the resident required staff assistance to complete ADL (activities of daily living) tasks, completely, and safely. A Profile Care Guide, dated 4/13/22, indicated Resident B transferred by Hoyer (mechanical lift) with 2 staff. An annual Minimum Data Set (MDS) assessment, dated 9/25/23, indicated the resident was dependent upon staff for mobility and transfers.		1 Resident B and Resident D were affected without adverse occurrences noted. 2 All residents utilizing a lift for transfer have the potential to be affected. All nursing staff educated on proper lift and sling use. 3 As a measure of ongoing compliance, DHS or designee to complete audits of up to 5 lift transfers to ensure safety weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	The facility investigation report, dated 1/21/24, at 6:50 p.m., indicated Certified Resident Care Assistant (CRCA) 3 was assisting Resident B into a lift pad. When the CRCA attempted to attach the mechanical lift pad to the lift device the resident slid out of the wheelchair and onto the floor and struck her head on the leg of the lift device. On 5/23/24 at 2:15 p.m., during an interview the Director of Nurses (DON) acknowledged Resident B did slide out of a wheelchair while the CRCA was assisting her. She indicated the resident was in the wheelchair and the aide had attached the top hooks of the lift pad but had not yet placed the hooks in the bottom of the pad. The resident had slid down in the chair to the edge of the seat. Before the CRCA could attach the pad the resident slid out onto the floor. She indicated the mechanical lift was a one person assist per guidelines. She indicated there was three residents currently utilizing a mechanical lift for transfers. On 5/23/24 at 2:51 p.m., during an interview CRCA 3 indicated he attached the lift sling of Resident (B) into the top part of the lift. He indicated the resident was slouched down in the wheelchair. The wheelchair moved backwards, and the resident slid out and fell onto the floor. The residents head landed on the bottom of the lift leg. The CRCA indicated he moved the wheelchair, placed a pillow under the residents head and left to find the nurse. The resident had a large bump on the back of her head and a skin tear on her arm. He would normally lock the wheelchair prior to beginning to assist the resident but had not locked the chair at that time. He indicated at the time they were very busy, so he was going to place the resident in the lift pad, attach it to the lift			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	and go get someone for assistance. He normally used assistance of two persons when using the mechanical lift. He indicated after the incident he received training. Training included discussion of steps to use the lift and position the resident by staff with transfers. He indicated during training after the incident he did not return demonstration of the use of a mechanical lift device. On 5/23/24 at 3:45 p.m., during an interview, Registered Nurse (RN) 4 indicated she always used two persons to use the mechanical lift to position and transfer a resident On 5/23/24 at 3:46 p.m., during an interview, CRCA 5 indicated she always used two persons to use the mechanical lift to position and transfer a resident for safety reasons. On 5/23/24 at 3:48 p.m., during an interview, CRCA 6 indicated she always used two persons to use the mechanical lift to position and transfer a resident. On 5/24/24 at 10:42 a.m., Resident E was in bed sleeping. The bed was in low position, he was resting well no signs of pain. The staff indicated they were not going to get him up till later due to a decline in condition. The resident's profile care guide indicated the resident was to have 2 persons to assist with mechanical lift transfers. On 5/24/24 at 10:45 a.m., observed Resident C was resting in bed. She indicated the times she gets up varied and was determined by the CRCA assigned to care for her. She indicated the staff utilized the mechanical lift with two people to transfer her. The resident's profile care guide indicated the resident was to have 2 persons to assist with mechanical lift transfers			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	On 5/24/24 at 10:52 a.m., observed Resident D was sitting up in wheelchair sitting on a grey lift pad with green edging. The pad was over the top of his head and covered his forehead and to the top of his eyes. He indicated only one staff person assisted with placing him in the lift pad and moving him with the mechanical lift. The residents profile care guide indicated; the resident was to have 2 persons to assist with mechanical lift transfers. 2. On 5/24/24 at 9:30 a.m., the medical record for Resident D was reviewed. The resident was admitted to the facility on 8/13/23. Diagnosis included but were not limited to, Hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength) following cerebral infarction (stroke) affecting right dominant side. The medical record lacked a Physician order for use of mechanical lift for transfers. The profile care guide, dated 8/18/23, indicated Resident D transferred with a Hoyer (mechanical Lift) with 2 staff. A care plan, dated 11/22/23, indicated Resident D had impairment in functional status related to CVA with hemiparesis. Interventions included but were not limited to. Approach Start Date: 11/22/2023, Provide assistance as needed with self-care and mobility functional tasks. A quarterly Minimum Data Set (MDS) assessment, dated 2/15/24, indicated the resident was dependent on staff for all mobility including transfers. On 5/24/24 11:52 a.m., during an interview CRCA			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	9, indicated she grabbed a lift pad when she was getting Resident D prepared to transfer from bed to chair. She did not know what size pad to use and went by the size of the resident. She acknowledged the lift pad being used by Resident D was very large and was over the top of the resident's head and forehead. She indicated the lift pad did not have a size on it. The Assistant Director of Nursing (ADON) observed CRCA 9 standing next to the resident and indicated to CRCA 9 the size was determined by the color on the trim. The ADON acknowledged the green trimmed lift pad was too large for the resident and obtained a yellow trimmed lift pad to apply to enable staff to reposition the resident. He indicated the yellow trimmed lift pad was the medium sized lift pad and indicated the size chart was on the back of the lift pad. On 5/24/24 12:10 p.m., observed Resident D being re-positioned to be lifted and re-positioned in the wheelchair. Observed CRCA 8 and CRCA 9 and the ADON prepare the resident to be repositioned. The resident was slouched down in the wheelchair and leaning to the side. The ADON instructed and assisted the CRCA's during preparation. Step by step instructions were verbally given by the ADON to the CRCA's assisting the resident. The green trimmed lift pad was removed, and the yellow trimmed lift pad was positioned under the resident. CRCA 9 positioned the mechanical lift legs to each side of the wheelchair. The ADON instructed CRCA 8 to lock the wheelchair. The CRCAs lifted and repositioned the resident in the wheelchair. The resident tolerated the procedure well. Both CRCA's indicated they used two staff to complete all mechanical lift transfers. , On 5/24/25 at 1:00 p.m., the medical records for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	Resident's C and E were reviewed. The profile care guide for each resident indicated both residents transferred by Hoyer (mechanical Lift) with 2 staff. On 5/23/2024 at 3:00 p.m., the DON indicated she did not have the manufacture guidelines for the mechanical lift currently used at the facility. She indicated she looked up the guidance. The DON provided an undated document titled, "Section 1 -General guidelines," and indicated it was the guidelines provided by the manufacturer of Invacare mechanical lift. The document indicated, "...Operating the lift ...Although Invacare recommends that two assistants be used for all lifting preparation, transferring from, and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case ...Using the sling ...If the patient is in a wheelchair, secure the wheel locks in place to prevent the chair from moving forwards or backwards ...Lifting the patient ...When the sling is elevated a few inches off the surface of the bed and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar. If any attachments are not properly in place, lower the patient back onto the stationary surface and correct this problem-otherwise, injury or damage may occur ...." On 5/23/2024 at 3:07 p.m., the DON provided a document titled, "Guidelines for residents utilizing a lift," dated 12/31/23, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures ...2. If the resident requires the use of a lift device, this will need to be added to the resident plan of care that will be communicated to the caregiver ...3. All devices are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	safe to be used by one staff member per manufacture guidelines. Staff should seek the assistance of a second person for those residents care planned for assistance of two with the lifting device or as needed for safe handling ...." This citation relates to complaint IN00434357. 3.1-14(i)			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00428807. This visit included the Investigation of Nursing Home Complaint IN00434357. Complaint IN00434357 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00428807 - State deficiencies related to the allegations are cited at R0064. Survey date: May 23 and 24, 2024 Facility number: 013085 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 6, 2024.	R 0000	Date of Compliance: __June 14, 2024_____ The submission of this plan of correction does not indicate an admission by Wellbrooke of Avon that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Avon. 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
			facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance Based on observation and interview, the facility failed to ensure a resident's credit card was protected from diversion, resulting in fraudulent charges by an employee without the resident's knowledge, for 1 of 3 residents reviewed for misappropriation of property (Resident L). Findings include: An Indiana State Department of Health Survey System Report, dated 2/19/24, indicated the family of Resident L indicated there were fraudulent charges on a credit card belonging to the resident. The facility Executive Director immediately commenced an investigation. On 5/23/24 at 2:30 p.m., during an interview with the Executive Director (ED) regarding facility reportable of misappropriation of funds. The ED indicated on 2/19/24 she was notified of fraudulent charges on a resident's credit card for a resident who resided in the assisted living side of the facility. She began an investigation and determined an employee, who was a life enrichment assistant, took a credit card from Resident L and purchased items with it. The family noticed suspicious charges on the card and notified the police. The employee was suspended and terminated after an investigation was completed. She indicated she interviewed all other	R 0064	**R064** **1 1. Resident L was affected. Resident is without adverse effect. Door lock added per Resident's preference for added comfort and security.** **2 2. All residents have the potential to be affected. Education provided to all staff on misappropriation. An audit was conducted to ensure all residents personal funds were protected.** **3 3. As a measure of ongoing compliance, ED or designee will audit 5 residents to ensure all residents personal funds were protected, weekly x4 weeks, then every other week x2 months, then monthly x3 months.** **As 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be**	06/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING 00 B. WING	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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
	residents to ensure no other incidents had occurred and offered individual lock boxes for each resident to use. On 5/24/24 at 11:37 a.m., during an interview, Resident L indicated he had a credit card, and it was taken by an employee. A family member noticed there were charges on the card and cancelled the card. He indicated the ED gave him a key to lock his room when he leaves but they did not give him a lock box. He indicated he was fine with utilizing a key to lock his room and indicated he had not had any other items missing. He indicated the staff takes good care of him he likes it at the facility and had no other concerns. The facility took immediate steps to ensure all residents personal funds were protected. The employee was terminated and during resident interviews it was determined this was an isolated incident. Social Services followed up with the resident and determined no psychosocial issues were identified. This citation relates to complaint IN00428807.		**reviewed and updated as warranted.**	