

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00392899, IN00390209 and IN00384363. This visit included a State Residential Licensure Survey.</p> <p>Complaint IN00392899 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684.</p> <p>Complaint IN00390209 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677.</p> <p>Complaint IN00384363 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 17, 18, 19, 20, 21, 24 and 25, 2022.</p> <p>Facility number: 013085 Provider number: 155811 AIM number: 201279600</p> <p>Census Bed Type: SNF/NF: 9 SNF: 25 NF: 18 Residential: 37 Total: 89</p> <p>Census Payor Type: Medicare: 25 Medicaid: 18 Other: 9 Total: 52</p>	F 0000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Moore	Clinical Operations	11/23/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0554 SS=D Bldg. 00	<p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 8, 2022.</p> <p>483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observations, interviews and record reviews, the facility failed to ensure residents were appropriately assessed, monitored, and care planned for their ability to self-administer medications for 2 of 5 residents reviewed for medications (Resident 33 and 102).</p> <p>Findings include:</p> <p>1. On 10/17/22 at 11:13 a.m., Resident 33 was initially observed in her room. Her room was cluttered with personal items but neatly decorated. There were miscellaneous papers on nearly every surface including her bed. She was sitting in a chair beside her bed. Her clothes were stained, and her hair was unkempt as if she had not had a shower in some time and there were two sheets of Kleenex tissues on the floor which she rested her feet on. Resident 33 indicated she kept her feet on the tissues to protect them from the carpet which was dirty and caused her feet to become, "infected with fungus." She spoke about several things and changed topics quickly.</p> <p>On 10/18/22 at 9:00 a.m., Resident 33 was observed as she paced barefooted throughout her room. She was quite anxious and complained that she was having a hard time using the bathroom because she was very constipated, she felt</p>	F 0554	<p>1. Residents 33 and 102 were affected. Resident 33 was re-evaluated and is no longer appropriate for self-administration of medications. Medications were removed from both rooms and family was educated on bringing in medications from the outside. No adverse effects noted.</p> <p>2. All residents that self-administer medication have the potential to be affected. All residents who currently self-administer medication were reviewed to ensure that assessment was completed, and self-administration ability remains. Education will be provided to licensed nursing staff on self-administration and not leaving medications at the bedside.</p> <p>3. As a measure of ongoing compliance, the Director of Health Services (DHS) or designee will complete the following audits: Room rounding to ensure no medications are left at bedside daily for 5 days per week x4 weeks, then twice weekly every</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(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
	<p>bloated and gassy but she could not pass any stool. There was an odor of bowel near and around her and some brown residue, which appeared to be stool, was observed on one of her fingers, and stool smeared on the handle of her door latch. She came in and out of the bathroom several times. She went to the door and called for the nurse to give her an enema. At that time, as she anxiously paced around the room, in and out of the bathroom, a medication cup with two circular white tablets was observed on her dresser countertop. When asked what the medication was, Resident 33 indicated, "those are my chewable, for my stomach. I forgot to take them." She began to reach into the cup with her soiled fingers but was stopped and reminded that she may need to wash her hands. Resident 33 looked at her fingers and nodded her head in agreement as she walked into the bathroom. While she washed her hands, 5 additional empty pill cups and two pill cups with the same two white tablets in them were observed in a bowel on her dresser countertop. Additionally, there was a smaller white circular pill on the floor under her vanity. This totaled 7 pills.</p> <p>On 10/18/22 at 9:20 a.m., the Director of Nursing (DON) was notified and came to Resident 33's room where she observed and removed the medications. The DON indicated she believed Resident 33 had an order to self-administer her medications, but there should not be any leftover medications as observed or pills on the floor.</p> <p>On 10/18/22 at 9:23 a.m., a Regional Nurse Consultant looked in the medication cart to identify the medication and indicated the 6 larger tablets were simethicone, (an anti-foaming agent used to reduce bloating, discomfort or pain caused by excessive gas) and the smaller white</p>		<p>other week x2 months, then once monthly for 3 months. DHS or designee will review 5 residents for appropriate self-administration assessments, as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months. Minimum Data Set Coordinator (MDSC) or designee will review 5 residents care plans for self-administration, as available, weekly x4 weeks, then every other week x2 months, then once monthly x3 months.</p> <p>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 reviewed and updated as warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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
	<p>pill was a D3 (a vitamin supplement used to help the body absorb calcium).</p> <p>On 10/18/22 at 10:10 a.m., Resident 33's medical record was comprehensively reviewed.</p> <p>She was a long-term care resident who admitted to the facility in 2019. She had active diagnoses which included, but were not limited to delusional disorder, post-traumatic stress disorder (PTSD), an unspecified mental disorder due to a known psychological condition, panic disorder, and unspecified dementia with behavioral disturbances.</p> <p>She had an active physician's orderx, dated 2/3/22, which indicated she may self-administer her medications after set-up, but did not specify which medication nor gave parameters for monitoring her ongoing ability.</p> <p>The record lacked documentation of an initial assessment for Resident 33's ability to self-administer her medications.</p> <p>There was a Self-Administration Assessment completed on 10/18/22 at 9:27 a.m., which was backdated to 4/5/22.</p> <p>There was a second Self-Administration Assessment completed on 10/18/22 at 9:45 a.m., which indicated Resident 33 was no longer able to self-administer her medications due to, "...unable to recount medications times or dose frequency and will hide meds in room"</p> <p>Resident 33's comprehensive care plans were reviewed and lacked documentation of a plan of care to provide ongoing interventions and approaches to ensure she remained safe in her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>ability to self-administer her medications.</p> <p>The record lacked documentation of periodic verification of Resident 33's self-medication administration.</p> <p>Further, the record lacked documentation that the physician had been notified of the medication found in Resident 33's room. 2. On 10/21/22 at 12:19 a.m., during a medication administration observation, Licensed Practical Nurse (LPN) 14 entered Resident 102's room to provide a scheduled medication, methocarbamol 500 milligrams (mg) for muscle spasms.</p> <p>On 10/21/22 at 12:24 a.m., three medications were observed in the Resident 102's room.</p> <p>a. A container of Chlorohexidine 0.12% Rinse (antiseptic/disinfectant), with a pharmacy label, was on his dresser.</p> <p>b. A container of Thera-tears (hydrating eye drops) were on the dresser.</p> <p>c. A medium size tub of Desitin (soothes and relieves minor skin irritations) was on the windowsill.</p> <p>On 10/25/22 at 10:26 a.m., the Director of Nursing Services (DNS) indicated Resident 102 did not have a medication self-administration assessment.</p> <p>On 10/25/22 at 11:44 a.m., Resident 102's Minimum Data Set (MDS) was reviewed for his cognitive (understanding through thought) status. His Brief Interview of Mental Status (BIMS) indicated his cognition was moderately impaired.</p> <p>On 10/25/22 at 11:55 a.m., the DNS provided a copy of Resident 102's medications. Chlorohexidine 0.12%, Thera-tears, Desitin, or Ocusoft Lid Scrub were not on the list of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>physician ordered medications.</p> <p>On 10/25/22 at 11:59 a.m., Resident 102's record was reviewed. He was admitted on 7/29/2022.</p> <p>His diagnoses included, but were not limited to, unspecified depression, heart failure, and respiratory failure.</p> <p>On 10/25/22 at 12:12 p.m., the DNS indicated she found Desitin and Ocusoft Lid Scrub (relieves scratchy, irritated eyes) in the resident's room. She believed the family needed to be educated not to bring medications to the resident. She indicated she would remove the items and place them in the medication cart. She indicated the chlorohexidine 0.12% was no longer in his room.</p> <p>On 10/21/22 at 1:45 p.m., the Administrator (ADM) provided a copies of current facility policies. The first policy was titled, "Guidelines for Self-Administration of Medications," dated 12/1/2021. The policy indicated, " ...to ensure the safe administration of medications for residents who request to self-medicate or when self-medication is a part of their plan of care ... residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation Trilogy-Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. The order should include the type of medication(s) the resident is able to self-medicate. i.e. all oral meds, oral meds with the exception of ..., nebulizer treatment only, all medication including injection, oral, inhalers drops etc ... periodic verification of administration compliance will be observed by nursing staff. A self-medication plan of care will</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/25/2022
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON			STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234		
(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 0609 SS=D	<p>be initiated and updated as indicated. The assessment will be reviewed quarterly, and PRN [as needed] with change of condition"</p> <p>The second policy was undated, but titled, "Medication Storage in the Facility: Bedside Medication Storage." The policy indicated, "...Bedside storage of medication is indicated on the resident medication administration record (MAR). The resident is instructed in the proper use of bedside medication including what the medication is for, how it is to be used, how often it may be used ... at least once during each shift, the nursing staff checks for usage of the medications by the resident"</p> <p>The third policy was titled, "Physician- Provider Notification Guidelines," reviewed 12/1/21. The policy indicated, "...to ensure the resident's physician or practitioner (may include NP PA or clinical nurse specialist) is aware of all diagnostic testing results or changes in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care"</p> <p>A current policy, titled, "Medication Storage in the Facility," dated Jan 2018, was provided by the DNS, on 10/25/22 at 9:19 a.m. A review of the policy indicated, "...Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access"</p> <p>3.1-11(a)</p> <p>483.12(c)(1)(4) Reporting of Alleged Violations</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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	<p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a new fracture and/or injury of unknown origin was reported to the state as required for 1 of 3 residents reviewed for pain (Resident 23).</p> <p>Findings include:</p> <p>On 10/18/22 at 9:32 a.m., Resident 23 was</p>	F 0609	<p>1. Resident 23 was affected. Incident report was submitted to the Indiana State Department of Health on November 18, 2022.</p> <p>2. All residents have the potential to be affected. Skin sweeps were conducted to ensure there are no unidentified areas. Staff education to occur related to</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>observed as she laid in her bed. She indicated she was ok for the most part except for general pain all over, mostly in her left arm. She was unable to recall what caused the pain in her arm, but she appeared to rest comfortably at this time.</p> <p>On 10/20/22 at 1:13 p.m., Resident 23's medical record was reviewed. She was a long-term care resident who admitted in 2020 with chronic diagnoses which included but were not limited to COPD (chronic obstructive pulmonary disease) and type II diabetes (a blood sugar disorder). On 5/4/22 a new diagnosis was added as a displaced fracture of head of left radius, and fracture of the shaft of the humerus of her left arm.</p> <p>A nursing progress note, dated 5/3/22 at 2:13 p.m., indicated Resident 23's left arm was red and slightly warm to the touch and she complained of mild discomfort. The Nurse Practitioner (NP) was notified, and a new order was received for Keflex (an antibiotic medication) to be taken for 10 days.</p> <p>A corresponding Event note was dated 5/4/22 and indicated the Keflex had been ordered to treat suspected Cellulitis of the left arm.</p> <p>A nursing progress note, dated 5/4/22 at 5:00 a.m., (which was recorded as a late entry upon her subsequent transfer to the emergency room) indicated Resident 23 was noted to have a bruise on her left outer aspect of her left arm. When she was questioned, Resident 23 was unable to determine what had happened. She was asked if something or someone did anything to her and she said no.</p> <p>A nursing progress note, dated 5/4/22 at 7:17 p.m., indicated Resident 23's left forearm hematoma was spreading with unknown cause so she was sent to</p>		<p>reporting of skin changes. Education to occur with the Executive Director (ED) and DHS on reportable guidelines.</p> <p>3. As a measure of ongoing compliance, the ED or designee will audit fracture and/or injuries of unknown origin weekly x4 weeks, then every other week x2 months, then monthly x3 months to ensure any findings have been reported according reporting guidelines. The DHS or designee will conduct a skin audit on 5 residents weekly to determine origin of injury and potential reporting needs weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>the emergency room (ER).</p> <p>A nursing progress note, dated 5/5/22 at 12:35 p.m., indicated Resident 23 returned from the hospital with a report from the ER nurse and a diagnoses of Humerus fracture, radial head fracture, and ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising). Resident 23 returned with a soft splint wrap to be worn at all times and had an orthopedic follow up appointment in 5 to 7 days later.</p> <p>A corresponding Emergency Room Physician Progress note, dated 5/4/22 at 7:38 p.m., indicated Resident 23 presented from Wellbrooke of Avon with complaints of left arm bruising. She was diagnosed with a humerus fracture, radial head fracture, and ecchymosis. She was provided patient information for an elbow fracture.</p> <p>A nursing progress note, dated 5/7/22 at 8:08 a.m., indicated Resident 23 was confused and agitated, she stated the nursing team didn't care about her and she wanted to leave the facility. She complained of pain in her left arm but refused pain medication, pushed it away, and stated she would rather die. She also refused to eat breakfast.</p> <p>A Social Service follow up progress note, dated 5/7/22 at 9:45 a.m., indicated Resident 23 was seen due to staff concern that she was tearful. Resident 23 appeared confused and stated everyone was trying to kill her by doping her up until she died. When Resident 23 was questioned further about who everyone was, she stated, "where do I start? From head to toe. I threw the medicine at them today because they don't care." Social Services was unable to ascertain why Resident 23 was making these statements and when discussed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>with nursing they agreed she had been acting like that all morning with no known trigger. She had no plans to harm herself, however, she continued to voice statements that she would be better off dead.</p> <p>During an interview on 10/20/22 at 2:51 p.m., the Administrator (ADM) indicated there were several different reasons to file state reportable incidents including allegations of resident abuse, misappropriation of property, major injury, major disasters, etc. ... He indicated there was only one state reportable for the month of May, and none related to Resident 23. He double checked the reporting system at this time and confirmed there was no reportable for Resident 23's elbow fracture and/or injury of unknown origin.</p> <p>During an interview on 10/20/22 at 3:00 p.m., the Director of Health Services (DHS) indicated she had been advised not to report the injury based on the x-ray results which indicated, "suspected fracture," even though they had not been able to determine the cause of the injury and there was no corresponding investigation into the cause/source of the injury of unknown origin.</p> <p>On 10/21/22 at 1:46 p.m., the ADM provided a copy of current facility policy titled, "Reportable Event Guidelines," revised 12/1/21. The policy indicated, " ...Purpose: to provide guidelines to ensure reportable occurrences are recorded and monitored in accordance with state and federal guidelines ... Occurrences to be reported include ... fractures ... Indiana- NOTE: the areas below are listed in the IN guidelines, but some area may be cause for suspicion of abuse/neglect therefore may be reportable in other states as well.. significant injuries ... fractures ... unusual or life-threatening injury"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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 0641 SS=D Bldg. 00	<p>3.1-28(c)</p> <p>483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>Based on observation, interviews and record reviews, the facility failed to ensure that Minimum Data Set (MDS) assessments accurately reflected the resident's status for 2 of 3 residents reviewed for MDS assessments (Residents 21 and 37).</p> <p>Findings include</p> <p>1. On 10/24/22 at 9:59 a.m., Resident 21 was observed sitting up in her wheelchair and leaning to her right side, resting on the arm of the chair. Resident 21 was not wearing a wander guard. Registered Nurse (RN) 12 assessed Resident 21 for a wander guard and could not find one on her person or wheelchair. RN 12 indicated that she would get one and place it on Resident 21. Resident 21 had a sensor alarm in her bathroom to notify staff of resident going into her bathroom. The alarm was not engaged.</p> <p>On 10/24/22 at 10:12 a.m., a comprehensive record review was completed for Resident 21. Resident 21 had the following diagnoses but not limited to chronic obstructive pulmonary disease, hypertension, hypertensive heart disease with heart failure, hypothyroidism, vitamin B deficiency, other specified depressive disorders, major depressive disorder, restless leg syndrome, peripheral autonomic neuropathy, vascular dementia, insomnia, altered mental status, difficulty in walking, repeated falls, lack of coordination, abnormal weight loss, age-related</p>	F 0641	<p>1. Residents 21 and 27 were affected. MDS has been corrected for both residents and no adverse effects have been noted.</p> <p>2. All residents have the potential to be affected. Education to occur with MDSC on accurate coding of weight changes and wanderguard use. All residents with weight changes and/or wanderguard in place to have audit of most recent MDS to ensure accurate coding.</p> <p>3. As a measure of ongoing compliance, the MDSC or designee will audit 5 residents for new wanderguard and 5 residents for weight changes, as available, to ensure appropriate coding on the MDS weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted.</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>physical debility, and chronic pain.</p> <p>Resident 21 had orders to have a wander guard and a sensor alarm for safety. She had a care plan, dated 4/14/22, addressing risk for elopement. An intervention, dated 4/12/22, indicated for Resident 21 to have a wander guard and to check placement and function as ordered. Resident 21 had a care plan to address falls. The care plan had an intervention, dated 4/27/22, to have a motion sensor alarm in her bathroom.</p> <p>A review of the MDS, dated 9/3/22, did not indicate that Resident 21 had wander guard or a motion sensor alarm in her bathroom.</p> <p>2. On 10/19/22 at 10:35 a.m., Resident 37 was observed lying in bed. She was moaning that she was having pain in her left leg. She had an infusion of normal saline at 60 milliliters an hour into a subcutaneous button inserted into her abdomen.</p> <p>On 10/19/22 at 1:32 pm., a comprehensive record review was completed for resident 37. She had the following diagnoses but not limited to chronic obstructive pulmonary disease, history of falls, essential hypertension, insomnia, muscle weakness, hypothyroidism, major depressive disorder, cellulitis of right lower limb, heart disease, atrial fibrillation, and other symptoms and signs concerning food and fluid intake.</p> <p>Resident 37 had the following weights. On 4/13/22, her weight was 140.6 pounds. On 8/1/22, her weight was 131.0 pounds. On 9/12/22 her weight was 121.2 pounds. The family and physician were aware of her weight loss.</p> <p>Resident 37's MDS was completed on 9/23/22.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0644 SS=D Bldg. 00	<p>Her weight was recorded on the assessment as 121.0 pounds. Resident 37 lost 5% of her weight in and 10% of her weight in a period from 30 to 180 days. The MDS did not reflect that she had lost weight.</p> <p>Resident 37 has a care plan, dated 2/24/20t, addressing her palliative care status and that her wishes will be honored.</p> <p>On 10/21/22 an interview was conducted with the MDS Coordinator and an RN from the home office. They indicated that Resident 37 should have been coded on the MDS for weight loss.</p> <p>On 10/24/22 during an interview with the MDS Coordinator and a RN from the home office. Discussed resident 37's MDS lacking documentation of a wander guard and motion sensor alarm on the MDS. The MDS coordinator indicated that resident 37's MDS was corrected.</p> <p>A policy on accurately coding assessments was not provided at the end of the survey.</p> <p>483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:</p> <p>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident, (Resident 33) received a new PASRR (pre-admission screen and resident review) Level II assessment after she was diagnosed with new serious mental health disorders for 1 of 1 resident reviewed for PASRR.</p> <p>Findings include:</p> <p>On 10/17/22 at 11:13 a.m., Resident 33 was initially observed in her room. Her room was cluttered with personal items but neatly decorated. There were miscellaneous papers on nearly every surface including her bed. She was sitting in a chair beside her bed. Her clothes were stained, and her hair was unkempt as if she had not had a shower in some time and there were two sheets of Kleenex tissues on the floor which she rested her feet on. Resident 33 indicated she kept her feet on the tissues to protect them from the carpet which was dirty and caused her feet to become, "infected with fungus." She spoke about several things and changed topics quickly.</p> <p>On 10/18/22 at 10:10 a.m., Resident 33's medical record was comprehensively reviewed.</p> <p>She was a long-term care resident who admitted to the facility in 2019. She had active diagnoses which included, but were not limited to delusional disorder acquired 3/8/19, post-traumatic stress disorder (PTSD) acquired 5/28/19, an unspecified</p>	F 0644	<ol style="list-style-type: none"> Residents 33 was affected. PASARR Level II has been completed. No adverse effects noted. All residents with diagnoses of mental disorders have the potential to be affected. All have been reviewed for completion of level II assessment. Education to occur with the Social Service Director (SSD) on the level II completion process. All new admission in the past 30 days have been reviewed to ensure Level II was completed, if indicated. As a measure of ongoing compliance, the SSD or designee will audit 5 new admissions and/or new mental health diagnoses, as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months. 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 reviewed and updated as warranted. 	11/23/2022
--	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>mental disorder due to a known psychological condition acquired 10/25/20, and panic disorder acquired 11/6/20.</p> <p>Resident 33 had an original PASRR screen scanned into her electronic health record, but it was dated March of 2016 which she received upon her admission to another long-term care facility.</p> <p>The record lacked documentation that a new Level of Care or PASRR screen had been submitted upon her admission to Wellbrooke.</p> <p>Further, the record lacked documentation that a new Level II screen was submitted when Resident 33 received the new as listed above.</p> <p>During an interview on 10/21/22 at 2:22 p.m., the Social Service Director (SSD) indicated Resident 33 had admitted to the facility before she was hired. She had however attempted to put in a submission for a new Level II but had received a notice that the request had been cancelled. The SSD indicated she had failed to follow up on what that meant or attempt to re-submit a Level II request after Resident 33 received additional mental health diagnoses and a new request should be submitted.</p> <p>On 10/21/22 at 2:45 p.m., the Administrator (ADM) provided a copy of current, but undated facility policy titled, "Indiana PASRR." The policy indicated, "...Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are appropriately placed in nursing facilities for long-term care. PASRR required 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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 0657 SS=D Bldg. 00	<p>disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting; and 3) receive the services they need in those settings ... To comply with the pre-admission procedures within your state requires team approach. While it takes a team, here is a crosswalk to help you understand who best positioned to ensure each step of the process based upon their primary role and functions ... Change in status and Level II follow up: Social Services ensures paperwork is submitted. They will print the outcome letter and upload to Matrix file ... for a change in status a new level I should be submitted to determine if a Level II will also be required"</p> <p>483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/25/2022
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON			STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234		
(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	
	<p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>Based on observations, interviews, and record review, the facility failed to revise care plans for 2 of 3 residents (Resident 14 and Resident D).</p> <p>Findings include:</p> <p>1. On 10/17/22 at 2:18 p.m., Resident 14 was observed lying in bed. He was able to answer yes and no questions only. His hands were tremoring during the observation. His bedside table was not within reach. He did not have an indwelling catheter as ordered.</p> <p>On 10/18/22 at 9:26 a.m., Resident was observed lying in bed. His bedside table was not within reach. Resident 14 able to answer yes and no questions. His hands were observed to be tremoring.</p> <p>On 10/18/22 at 2:52 p.m., a record review was completed. Resident 14 had the following diagnoses but not limited to schizophrenia, Parkinson's disease, UTI (Urinary Tract Infection), PE (Pulmonary Embolism), dementia, mood disorder, psychotic disorder, anxiety, hypothyroidism, vitamin deficiency, hyperlipidemia, bladder neck obstruction and reflux uropathy, benign prostatic hypertrophy, unspecified fall, and age-related cognitive decline.</p> <p>Resident 14 admitted to the facility on 8/29/22. He admitted with an indwelling catheter. His catheter was removed on 10/13/22. He had orders for an</p>	F 0657	<p>1. Residents 14 and D were affected. Both residents have discharged however careplans were updated prior to discharge. No adverse effects noted.</p> <p>2. All residents with urinary related diagnoses and interventions have the potential to be affected. All have been audited to ensure that care plans accurately reflect diagnosis and interventions. House-wide audit has occurred to ensure careplans have been revised. MDSC to be educated on updating care plan interventions with resident changes.</p> <p>3. As a measure of ongoing compliance, the MDSC or designee, will audit 5 residents for urinary changes, new urinary diagnosis, or new urinary interventions to ensure care plan is updated weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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</p>	11/23/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>indwelling catheter and care plan for an indwelling catheter until 10/17/22. Resident 14 was sent to the emergency room on 9/20/22 due to pulling his catheter out with bleeding. The bulb of the catheter was intact.</p> <p>When resident returned from the hospital, a care plan was initiated on 9/22/22 to address pulling his catheter out. The care plan indicated, "...Resident demonstrates non-compliance with physician orders and/or plan of care as evidenced by pulling catheter out ..." Interventions included to assess need for guardian or other legal oversight as needed, educate resident regarding physician orders and risk and benefits of compliance, encourage resident to actively participate in care plan and decision making, encourage resident to participate in decision making by offering choices and discussion of advance directives, and monitor resident's ability to give informed consent and fluctuations in decision making.</p> <p>Resident 14's MDS (minimum data set) with an ARD (assessment reference date) of 9/5/22 indicated that a BIMS (brief interview of mental status) was not able to be completed.</p> <p>Resident 14 had an order dated 10/13/22 to complete bladder scans every 8 hours and as needed if unable to void. I/O (in and out) cath (catheterize) if greater than 250 milliliters residual on bladder scan.</p> <p>Resident 14's care plan was not updated to reflect his diagnoses of urinary neck obstruction, benign prostatic hypertrophy and retention of urine and the order to have bladder scans every 8 hours and as needed.</p>		Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>The record lacked documentation of the results of the bladder scan or indication of need to catheterize.</p> <p>2. On 10/18/22 at 10:31 a.m., Resident D was observed sitting up in her wheelchair with her bedside table over her.</p> <p>On 10/18/22 at 2:42 p.m., a comprehensive record review was completed for Resident D. Resident D had the following diagnoses but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, vitamin D deficiency, hyperlipidemia, restless leg syndrome, essential hypertension, constipation, retention of urine, urinary tract infection, and weakness.</p> <p>Resident D admitted with an indwelling catheter on 10/5/22. An order was received on 10/12/22 to discontinue the indwelling catheter and an order was received on 10/12/22 to complete a bladder scan every 8 hours and as needed if unable to void. In and Out (I/O) catheterize if residual was greater than 250 milliliters.</p> <p>The record lacked a care plan addressing resident 201 urinary retention and the need for bladder scans as ordered.</p> <p>The ED (Executive Director) provided a policy titled "Comprehensive Care Plans" on 10/24/22 at 12:12 p.m., it indicated, "...Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan" and "...Comprehensive care plans need to remain accurate and current, new interventions will be added and updated during CCM meeting and newly recognized problems will have a care plan developed and added after CCM meeting".</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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 0677 SS=D Bldg. 00	<p>3.1-35(c)(1)</p> <p>483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;</p> <p>Based on interview and record review, the facility failed to ensure a resident, (Resident B) who was dependent on staff assistance for bathing received ADL (activities of daily living) assistance according to her preferences for bathing/showers for 1 of 3 residents reviewed for bath/showers.</p> <p>Findings include:</p> <p>During a confidential interview, it was indicated, Resident B was very upset during her stay because she was unable to get cleaned up in a timely manner. After her admission, she developed diarrhea and wanted to have regular baths or showers to stay clean. Her call light would go on for a very long time, it was understandable to wait 30 minutes to an hour if there was an emergency, but Resident B would often have to wait longer than that.</p> <p>On 8/30/22, Resident B admitted to the facility after an acute hospital stay where she was treated for a several injuries after sustaining a fall at home.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 9/6/22, indicated Resident B was dependent of staff for assistance with bathing/showers.</p>	F 0677	<ol style="list-style-type: none"> Residents B was affected. Resident was discharged at the time of the survey. No adverse effects noted. All residents have the potential to be affected. Audit completed to ensure that all showers/bathing are occurring per resident preference. Staff to be educated on utilization of system to determine and review resident preferences for bathing. Life Enrichment Director (LED) to be educated on communicating bathing preferences. As a measure of ongoing compliance, the DHS or designee will audit 5 residents for bathing needs weekly x4 weeks, then every other week x2 months, then monthly x3 months. 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 reviewed and updated as 	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>An admission Life-Enrichment assessment, dated 9/2/22, indicated it was "very important" to choose between a tub bath, showers, bed bath or sponge bath, and her bathing type preferences were for showers on Wednesdays and Saturdays.</p> <p>A comprehensive care plan was initiated on 8/31/22 which specified Resident B's "profile care guide," which specified her preferences for showers on Wednesday and Saturday evenings.</p> <p>Resident B's bathing/shower record was reviewed and revealed she had only received one full shower during her 13 days stay on 9/7/22. Further, she only received 7 partial bed baths.</p> <p>During an interview on 10/24/22 at 2:54 p.m., the Administrator, (ADM) indicated there were no additional shower sheets for Resident B, all the ADL care was charted on POC.</p> <p>The record lacked documentation of any Resident refusals for baths or showers.</p> <p>During an interview on 10/25/22 at 10:28 a.m., the Director of Nursing (DON) indicated staff should honor resident preferences unless the resident refused services.</p> <p>On 10/25/22 at 10:35 a.m., the DON provided a copy of current facility policy titled, " Guidelines for Bathing Preferences," dated 5/11/16. The policy indicated, " ...the resident shall determine their preference for bathing upon admission ... bathing shall occur at least twice a week unless resident preferences states otherwise"</p> <p>This Federal tag related to Complaint IN00390209.</p> <p>3.1-38(a)(3)</p>		warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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 0684 SS=G Bldg. 00	<p>483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>A. Based on observations, interviews, and record reviews, the facility failed to ensure a resident received appropriate care and services to prevent complications with his biliary drainage catheter (a thin, hollow tube which is inserted into the liver through the skin which collects bile that is drained from the liver), which resulted in actual harm when a full physician order set with care instructions for flushing the tube was not re-initiated after a hospital stay and the tube became obstructed for 1 of 1 resident reviewed for biliary drainage catheter (Resident 13).</p> <p>B. Based on interviews and record reviews, the facility failed to ensure neurochecks were assessed after a resident fell for 1 of 1 resident reviewed for post fall procedure (Resident 98).</p> <p>C. Based on observations, interviews, and record reviews, the facility failed to ensure a resident, (Resident 197) received a comprehensive admission assessment to address a PICC dressing for 1 of 3 residents reviewed for new admissions.</p> <p>D. Based on observations, interviews, and record reviews, the facility failed to prevent the development of MASD (moisture associated skin damage) for a resident who was at risk for skin</p>	F 0684	<p>1. Resident 13 was affected. All orders have been placed and care plan has been updated to include biliary drain tube monitoring. Resident 98 was affected. Resident with no adverse effects noted and has discharged. Resident 197 was affected. Dressing was changed with no adverse effects noted. Resident 47 was affected and has since discharged. Resident was affected and was discharged prior to survey.</p> <p>2. All residents have the potential to be affected. All admission in most recent 30 days have been reviewed to ensure all admissions orders and treatment orders in place. Staff education to occur in the following areas: gait belt use and transfers. Licensed clinical staff to be educated in the following areas: biliary drain competency, entering admission orders and second check process, treatment orders related to lines and tubes, completion of</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>breakdown, which resulted in the development of a new wound that was not assessed in a timely manner for 1 of 4 residents reviewed for general skin conditions (Resident 47) .</p> <p>E. Based on observations, interviews, and record reviews, the facility failed to prevent the potential for complications/harm when a resident did not receive bladder scans and in/out catheterization as ordered for 1 of 4 residents reviewed for catheters (Resident D).</p> <p>Findings include:</p> <p>A. On 10/18/22at 2:55 p.m., Resident 13 was observed as he sat in his wheelchair (WC) beside his bed. At that time, he indicated he had recently returned from the hospital. He indicated, "I wish I could have a new body," and pointed to the right side of his abdomen. "It hurts." He pulled up his shirt and his biliary catheter tube was observed, the drainage bag rested on the WC pad beside him with a dark yellow fluid observed inside. Resident 13 indicated he was having a lot of trouble with the tube.</p> <p>During a continuous observation on 10/19/22 from 1:45 p.m., until 1:56 p.m., the following was observed:</p> <p>At 1:45 p.m., Resident 13 was observed as he sat in his WC beside his bed. His call light was illuminated at this time, and he indicated he wanted to lay down. The biliary drainage bag rested on his lap and contained a dark yellow fluid.</p> <p>At 1:47 p.m., Registered Nurse (RN) 8 answered Resident 13's call light and indicated she needed to get some assistance to transfer him into bed as</p>		<p>neurological assessments post fall, skin assessment and documentation upon admission, and documentation of post void residual (PVR) and subsequent treatment and notifications. All falls in the last 30 days have been audited for completion of neurological checks, if indicated. All existing bladder scan and PVR orders have been reviewed and updated if warranted.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit 5 new admissions per week, as available, for completion of all admission and treatment orders weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will audit 5 falls per week, as available, for completion of neuro assessments weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will audit 5 residents with new skin areas per week, as available, for completion of documentation weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will audit 5 resident transfers to ensure gait belt use and appropriate staff assistance and tube management weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>4. As a quality measure, the ED or designee will review any</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>she believed he was a two-person assist.</p> <p>At 1:49 p.m., RN 8 and Certified Nursing Assistant (CNA) 24 entered the room. RN 8 indicated Resident 13 had a lot of tubes, so they preferred to have him assisted by two people to not pull on the tubes. He has oxygen, a urinary catheter, and a biliary drain. CNA 24 indicated Resident 13 had been incontinent of bowel and she needed supplies to clean him up. RN 8 left the room to get supplies as requested.</p> <p>At 1:52 p.m., with RN 8 out of the room, CNA 24 positioned Resident 13 in his WC beside his bed. She removed his oxygen tubing, unlatched the catheter drainage bag from under the WC and tossed it onto the floor. CNA 24 stood behind Resident 13's WC, put her arms under his arm pits and assisted him to stand. He rocked forward several times, then shakily stood to his feet. As he stood his biliary drainage bag slid off his lap and hung to his knees. CNA 24 had to let go of one of Resident 13's arms to move around the WC which remained between them so that she could position herself in front of him and help him pivot to sit on the bed. As he turned, the biliary drainage bag was on the opposite side of the bed, and CNA 24 reached over and pulled it to the other side of the bed before Resident 13 sat on it.</p> <p>At 1:56 p.m., RN 8 re-entered the room and indicated, "oh you already got him in bed."</p> <p>During an interview on 10/19/22 at 1:57 p.m., RN 8 indicated, usually transfer need to be completed with a gait belt in place in case they become unsteady. Resident 13 had just returned from the hospital and had not been evaluated by therapy yet, so he should have two people assist with a transfer, also because of all his tubes.</p>		<p>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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>During an interview on 10/19/22 at 1:57 p.m., CNA 24 indicated, before Resident 13 went to the hospital he was a 1-person assist so she thought it was ok to go ahead and transfer him. She indicated she didn't need a gait belt because she, "had a good hold of him," even though she had to let go of him to come to the front of the WC, and to reposition his tubing.</p> <p>On 10/20/22 at 9:30 a.m., Resident 13 was observed. He sat in his WC beside the bed. There was a very pungent odor around him and he indicated he wanted to get laid down and cleaned up. He indicated he had a lot of pain and pointed to the area where his biliary drain was. He lifted his shirt. The dressing around the tube was observed at this time. There was a dark yellow/greenish stain at the center of the dressing around the tube, which spread outward in a more pink/reddish color. Resident 13 put his head in his hands and indicated, "it hurts a lot." There was no date or initial on the dressing, and there was a white patch next to the dressing.</p> <p>On 10/20/22 at 10:26 a.m., RN 23 was notified of the drainage noted to Resident 13's dressing. At that time, she indicated, she was not familiar with Resident 13, she did not usually work that floor, she had just been pulled to that floor earlier that morning. RN 23 indicated she had put a lidocaine patch (a topical pain patch) on but that was it. She reviewed Resident 13's orders at this time and indicated there were no additional orders related to his biliary catheter besides monitor the drainage output and an order to cleanse the tubing.</p> <p>On 10/20/22 at 10:28 a.m., RN 23 entered Resident 13's room to assess the site. She observed the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>drainage around the tube, and indicated it was green in color, and more soiled than it should be. It appeared the dressing needed to be changed. Resident 13 indicated he was in pain, and RN 23 indicated she would bring him something for the pain.</p> <p>During an interview on 10/20/22 at 11:10 a.m., RN 23 indicated she had spoken with the ADON (Assistant Director of Nursing), who had called the NP (Nurse Practitioner). Resident 13 had been on several courses of antibiotics recently, so she was told to remove the dressing and observed the site for further signs/symptoms of infection. She prepared a medication cup of Resident 13's PRN (as needed) pain medication.</p> <p>On 10/20/22 at 11:30 a.m., (after allowing time for Resident 13's pain medication to become effective), RN 23 entered the room with supplies for a dressing change. She had a printed current physician order which indicated, "cleanse tube area around tube with antibacterial soap and water or 1/2 water 1/2 hydrogen peroxide mixture daily." She indicated there were not specific orders or instruction for the dressing change, the order she had was the only order related the care/treatment of the biliary catheter beside monitoring for output.</p> <p>RN 23 failed to notify the physician and/or get clarifying orders for the dressing change before proceeding. When asked if she should notify the physician, she indicated, she had already spoken to the ADON.</p> <p>During the dressing change, which lasted approximately 30 minutes, Resident 13 expressed that he was still in a great deal of pain, especially as pressure, tugging, or wiping was completed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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
	<p>around the site and to the tube. He clenched the bedsheets in his fists, he grimaced his face, and at one point, put his hand out to stop RN 23 and asked for a minute to catch his breath. The insertion site was observed have some redness around the tube, and Resident 13 indicated it was very tender.</p> <p>RN 23 finished the treatment, cleaned up her supplies and left the room.</p> <p>During an interview on 10/20/22 at 12:02 p.m., Resident 13 indicated the tube had been having a lot of trouble lately, he was not sure how often it was changed or should be changed.</p> <p>On 10/21/22 at 9:43 a.m., Resident 13 was observed as he sat in his WC beside his bed. He indicated he was feeling, "ok," but still tired and in pain. The dressing from the previous day was observed in place, however there was a yellowish discharge noted to the center of the dressing surrounding the tube.</p> <p>During an interview on 10/21/22 at 11:26 a.m., RN 22 indicated he was not sure about Resident 13's dressing, but he had already been down to flush the catheter earlier that morning. When asked about the orders for flushing, RN 23 reviewed Resident 13's order set and indicated there was no order for flushing, and he had not noticed it before. RN 23 indicated it was important to flush the tube because if it was not, it could cause a build-up and that created pain for the resident. RN 23 indicated it appeared the flush orders had not been re-activated after his hospitalization, but it was something they had been doing before.</p> <p>On 10/21/22 at 11:38 a.m., RN 23 contacted the NP and received a new order to flush the biliary</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>catheter twice a day, as before.</p> <p>During an interview on 10/24/22 at 10:33 a.m., the Medical Director (MD) indicated he was Resident 13's attending physician in the facility. Resident 13 had a chronically placed biliary catheter because he was a poor surgical candidate. With any type of tubes such as the biliary drain or urinary catheter, it was important to understand and adhere to transfer and positioning protocols to ensure the tubes aren't tugged on and become dislodged. Additionally, it was important to flush the tube to ensure it was patent and draining bile properly so that it did not get stopped up which could cause infection and would build up pressure also causing pain.</p> <p>On 10/19/22 at 10:00 a.m., Resident 13's medical record was comprehensively reviewed.</p> <p>He was a long-term care resident, admitted in 2019 with active diagnoses which included, but were not limited to; sepsis, unspecified severe protein-calorie malnutrition, urinary tract infection, other mechanical complication of bile duct prosthesis, displacement of bile duct prosthesis ...</p> <p>He had physician orders which included, but were not limited to;</p> <p>a. "cleanse tube area around tube with antibacterial soap and water or 1/2 water 1/2 hydrogen peroxide mixture daily," daily started 8/3/22.</p> <p>b. "monitor biliary drain output every shift," started 4/11/22</p> <p>The record lacked documentation of physician orders to monitor the dressing/incision site, and/or orders to flush for obstruction prevention.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>A nursing progress note, dated 5/1/22 at 7:40 a.m., indicated Resident 13's biliary tube had large amounts of green colored drainage. Resident was complaining of pain and discomfort. There was drainage at the insertion site of the tube, but no drainage was coming through the tube. 911 was called for transport to hospital.</p> <p>The corresponding hospital admission H&P (history and physical) dated 5/27/22 indicated, "...apparently, the biliary drain had been pulled out approximately 6 to 8 cm [centimeters]. Patient does not know how this happened. Staff was unaware until today. Patient is having abdominal pain. He is unable to tell me how long he had been having abdominal discomfort or unwilling to elaborate on history. Apparently had a recent hospitalization between 5/1 and 5/7 for abdominal pain and biliary drain malfunction, which was replaced by IR [interventional radiology] on 5/3/22. He has chronic biliary drain secondary to common bile duct stricture from chronic pancreatitis. In either case upon my assessment, patient's only complaint is abdominal pain ... I presume he does not want to communicate at present time considering his pain"</p> <p>A nursing progress note, dated 5/24/2022 at 10:45 a.m., indicated, "...received call from [Specialist Medical Doctor] regarding [Resident 13's] Biliary Drain. The physician explained he should have a routine exchange every 3 months with daily maintenance of 10 ml [milliliters] flush ... he did not plan any more invasive procedure and [Resident 13] will have his biliary drain long term"</p> <p>On 8/3/22 Resident 13 was sent back from the hospital after a routine biliary exchange with the following instructions, " ... Patient Education: a biliary catheter is a tube that drains bile. The tube</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>goes through your skin and into your liver. It drains bile out of the body into a bag ...</p> <p>Treatment/Procedure/Equipment (Home Care Orders) Flushing means rinsing your tube. This prevents it from getting blocked. Flush your tube 2 times a day with normal saline 10 ml, vigorously forward, without aspirating. Clean your tube/area around tube with antibacterial soap and water or 1/2 water 1/2 hydrogen peroxide mixture 0-1 times a day"</p> <p>A nursing progress note dated 9/22/22 at 9:04 a.m., indicated Resident 13 had a fever and was sent to the ER and he was re-admitted on 9/28/22 after being treated for sepsis, secondary to a UTI (urinary tract infection).</p> <p>On 10/04/22 at 1:29 p.m., Resident 13 was seen by the NP for follow up after his recent re-admission to address his common bile duct stone and biliary drain, which had been replaced 9/25. The NP gave instructions/orders to use sodium chloride 0.9 % (flush) injection syringe with alcohol swab cap, and to flush biliary drain with 10 cc two times a day" However, the record lacked documentation that the flush orders had been initiated.</p> <p>On 10/16/22 at 7:15 p.m., Resident 13 was sent to the ER for after it was noted to have dislodged.</p> <p>The corresponding hospital discharge summary dated 10/16/22 indicated Resident 13's biliary drainage tube had become obstructed and was replaced.</p> <p>Upon his return, the record continued to lack documentation of physician orders to monitor the dressing/incision site, and/or orders to flush for obstruction prevention.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>A nursing progress note dated 10/22/22 at 2:25 p.m., indicated Resident 13's biliary tube had become dislodged again, and was sent to the ER.</p> <p>The corresponding hospital summary dated 10/22/22 indicated Resident 13 had been treated for an obstructed biliary drainage tube. " ... here for evaluation of drainage around the biliary tube site that began this morning. Patient had this drain repositioned about 5 days ago and this morning noticed that it looked out of place and was draining, area is painful ... attempted to contact Wellbrooke with no answer ... tube replaced. The patient was given return precautions and instructions for follow up ... instructions from care team: his biliary tube was replaced by IR today. Please be sure it doesn't get tugged on, pulled on, etc to avoid displacement again"</p> <p>Resident 13's comprehensive care plans were reviewed and lacked documentation of a care plan for his biliary catheter.</p> <p>The record lacked documentation of orders or instructions for routine exchange.</p> <p>The record lacked documentation the physician had been notified of pain during the dressing change observation.</p> <p>On 10/19/22 at 1:48 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, "Guidelines for Resident Transfers and Assistance," dated 5/10/17. The policy indicated, "...to ensure the safety of residents and staff when performing mobility/transfer tasks ... upon admission the admitting nurse and/or therapy department shall determine the type of transfer device needed as well as the amount of assistance</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>required to assist with mobility based on observation and data collection. The following area will need to be observed: cognition, weight being status, resident's weight, upper and lower body strength, trunk stability, skin condition and mobility status"</p> <p>During an interview on 10/25/22 at 10:28 a.m., the DON indicated there was no specific skills check off for nurses to complete related to biliary catheter care, however, if there was a question or concern with the biliary catheter system or procedure, the nurse should not continue until orders or treatments were confirmed with the MD. At this time she provided a copy of current facility policy titled, "Biliary Drain Site Care and Dressing Change," dated 3/18/22. The policy indicated, "Keep the skin around the drain clean and covered with 4 x 4 gauze dressing. The dressing should be changed per order by physician...DON provided last copies and indicated no skills check of for biliary tube...carefully remove the old dressing to avoid pulling on the drain. Note: soreness, redness, drainage or odor at the site where the drain goes into the skin. If any of these signs are noted, change the dressing more frequently and contact the physician for further orders" B. On 10/20/22 at 9:56 a.m., Resident 98 record was reviewed. She was admitted on 10/4/22.</p> <p>A progress note, on 10/7/22 at 7:00 p.m., Registered Nurse (RN) 12 charted she was notified Resident 98 was on the floor. She was found face-down on the right side of her bed, between the bed and the window. Resident 98 was sitting in bed while eating dinner, when she slid out of bed and onto the floor. RN 12, an LPN (unidentified), and three RCAs (resident care assistants) (unidentified) lifted the resident back</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>into bed using a Hoyer pad. Resident 98 had no apparent injuries. No loss of ROM (range of motion) or deformity noted to any extremity. She was PERRLA (pupils equal, round, reactive to light and accommodation). Her neuro status was at baseline. The Nurse Practitioner (NP), the DNS (Director of Nursing Services), and the family notified. A voicemail was left for family, requesting a return phone call. A fall mat was placed on the right side of bed and the bed was placed in position to facilitate safety. Her call light was within reach.</p> <p>On 10/7/222 at 9:25 p.m., RN 30 charted Resident 98 was encouraged and educated to sit up in a chair for meals to assist with ongoing safety related to prior fall.</p> <p>On 10/12/22 10:50 a.m., the Social Services Director (SSD) charted the initial care plan meeting was with herself, therapy, nursing, and the resident's daughter. The resident declined to attend. Discussion indicated the resident was refusing any out of bed activities due to fears of falling and statements of, "I'm tired." Currently, on a low air-loss mattress and working with PT/OT (physical therapy/occupational therapy). She was refusing to work on any out of bed activities with them. She was total care for bed mobility and all ADLs and used a Hoyer lift.</p> <p>On 10/13/22 at 11:08 a.m., the DNS charted that the Interdisciplinary Team (IDT) met. Resident 98 was found on floor beside her bed. She had been on a low air loss (LAL) mattress, and she rolled off the side of bed. No injury was noted. Interventions were updated to include keeping bed at lowest position to facilitate safety and use of mat beside her bed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>On 10/20/22 at 12:39 p.m., Resident 98's chart was reviewed. She was admitted on 10/4/22.</p> <p>Resident 98's diagnoses included, but were not limited to, pressure ulcer of sacral region, stage 4 (full thickness skin loss with exposed bone, tendon or muscle) (primary diagnosis), protein calorie malnutrition, type 2 diabetes (blood sugar disorder), morbid (severe) obesity due to excess calories, necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin), acute candidiasis (yeast infection) of vulva and vagina and diarrhea (loose or liquid stool).</p> <p>Resident 98's fall care plan goal indicated she would be free from falls with major injury.</p> <p>Neuro checks were provided by the Assistant Director of Nursing Services (ADNS), on 10/19/22 at 1:31 p.m. Upon review the neuro checks were determined to be incomplete.</p> <p>a. The initial neuro check was completed on 10/7/22 at 7:00 p.m.</p> <p>b. The second neuro check after 15 minutes was completed on 10/7/22 at 7:15 p.m.</p> <p>c. The third neuro check after 15 more minutes was completed on 10/7/22 at 7:30 p.m.</p> <p>d. The fourth neuro check after 15 more minutes was completed on 10/7/22 at 7:45 p.m.</p> <p>e. The first neuro check after 30 more minutes was completed on 10/7/22 at 8:15 p.m.</p> <p>f. The second neuro check after 30 more minutes was completed on 10/7/22 at 8:45 p.m.</p> <p>g. The third neuro check after 30 more minutes was completed on 10/7/22 at 9:15 p.m.</p> <p>h. The fourth neuro check after 30 more minutes was completed on 10/7/22 at 9:45 p.m.</p> <p>i. The remaining neuro checks had dates and times but the assessments were blank:</p> <p>1. On 10/7/22 at 10:45 a.m., (meant to be 10:45 p.m.) the assessment was blank.</p> <p>2. On 10/7/22 at 11:45 p.m., the assessment was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>blank.</p> <p>3. On 10/8/22 at 12:45 a.m., the assessment was blank.</p> <p>4. On 10/8/22 at 1:45 a.m., the assessment was blank.</p> <p>5. On 10/8/22 at 5:45 a.m., the assessment was blank.</p> <p>6. On 10/8/22 at 9:45 a.m., the assessment was blank.</p> <p>7. On 10/8/22 at 1:45 p.m., the assessment was blank.</p> <p>8. On 10/8/22 at 5:45 p.m., the assessment was blank.</p> <p>C. On 10/18/22 at 2:55 p.m., Resident 197 was observed sitting up in her wheelchair. She was alert and oriented to person, place, and time. Resident 197 indicated she had a dressing on her right arm from a PICC (peripherally inserted central catheter). Resident 197 indicated the insertion site had become infected, and she was put on antibiotics at the hospital which she continued upon her arrival to the facility on 10/12/22. The dressing was observed at this time. It was a bordered foam dressing, dated 10/12/22. Resident 197 indicated that the dressing had not been changed since she had gotten to the facility.</p> <p>On 10/18/22 at 3:00 p.m., RN (registered nurse) 12 and RN 13 came to resident 197's room to assess the dressing to resident 197's right arm. RN 12 indicated, since it was a PICC dressing site, they usually did not remove the dressing for up to 5 days.</p> <p>The dressing had been in place for 7 days. RN 12 removed the old dressing. The site was crusted over with no signs or symptoms of an infection. RN 12 indicated she would clean it and place a new dressing on resident 197's right arm.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>On 10/19/22 at 9:33 a.m., a comprehensive record review was completed for Resident 197. She had the following diagnoses which included, but were not limited to pulmonary fibrosis, cerebral ischemia, morbid obesity, vitamin B deficiency, vitamin D deficiency, hyperlipidemia, abnormal weight loss, diverticulosis of large intestine, essential hypertension, weakness, edema and adult failure to thrive.</p> <p>A nursing progress note dated 10/13/22 at 5:45 p.m., included an admission assessment of Resident 197 which included a complete head-to-toe assessment that did not make note of the PICC line dressing.</p> <p>An admission nursing Observation assessment was completed on 10/14/22. The dressing was not documented on the skin assessment.</p> <p>The record lacked documentation of physician orders for instructions/care for the dressing to her right arm.</p> <p>Although Resident 197 had an active physician order for Keflex (an antibiotic medication) 500 mg (milligrams) four times daily which ended on 10/16/22, there was no indication or diagnosis for it use.</p> <p>The record lacked documentation that neither a baseline or comprehensive care plan had been initiated to address the care requirements for the dressing on her arm.</p> <p>D. On 10/24/22 at 10:37 a.m., a comprehensive record review was completed for Resident 47. He had the following diagnoses but not limited to muscle weakness, cardiac murmur, nausea with vomiting, difficulty in walking, unsteadiness on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(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
	<p>feet, amnesia, pain, abnormal weight loss, cognitive communication deficit, generalized anxiety disorder, painful urination, and aftercare following joint replacement surgery.</p> <p>On 6/27/22 at 12:30 p.m., an Event document was created secondary to Resident 47 having sustained a laceration that measured 1.5 cm (centimeters) long by 1.5 cm wide to his left buttock. The Event note indicated the laceration was acquired due to moisture.</p> <p>Resident 47 had a physician's order dated 6/27/22 for Calmoseptine (methol-zinc oxide) 0.44-20.6% ointment three times daily, apply to buttocks with each episode of incontinence following perineal care.</p> <p>The record lacked further assessment of the area.</p> <p>On 10/24/22 at 2:55 p.m., the Assistant Director of Nursing (ADON) provided a record of a wound management note created 10/24/22 at 12:29 p.m. However, the documentation was backdated to 6/27/22. The late Event Note indicated on 6/7/22 the wound measured 1.5 cm long by 1.5 cm wide. On 7/5/22, the wound measured 0.5 cm long by 0.5 cm wide.</p> <p>The record lacked further documentation related to the wound on resident 47's left buttock.</p> <p>Resident 47's care plan lacked information related to the left buttock wound.</p> <p>E. On 10/18/22 at 10:31 a.m., Resident D was observed sitting up in her wheelchair.</p> <p>On 10/18/22 at 2:42 p.m., a comprehensive record review was completed for Resident D. She had the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(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
	<p>following diagnoses, which included, but were not to, hemiplegia and hemiparesis (paralysis/weakness) following cerebral infarction (stroke) affecting right dominant side, dysphagia (unable or trouble speaking) following cerebral infarction, vitamin D deficiency, hyperlipidemia, restless leg syndrome, essential hypertension, constipation, retention of urine, urinary tract infection and weakness.</p> <p>Resident D admitted with an indwelling catheter on 10/5/22, but later received and ordered to discontinue the use of the catheter on 10/12/22 with instructions to complete a bladder scans every 8 hours and as needed if unable to void and in/out catheterize if residual in the bladder was greater than 250 milliliters (ml).</p> <p>The record lacked documentation that Resident D received bladder scans as ordered on 10/13/22, 10/14/22, 10/16/22, and 10/17/22.</p> <p>On 10/14/22 between 7:10 p.m. and 10:00 p.m., Resident D was noted to have 270 ml recorded from the bladder scan. The record lacked documentation indicating that an in and out catheterization was completed due to greater than 250 ml of residual.</p> <p>On 10/15/22 between 6:00 a.m. and 7:00 a.m., Resident D was noted to have 278 ml of residual urine recorded from the bladder scan. The record lacked documentation that an in and out catheterization was completed for Resident D.</p> <p>The record lacked that her bowel/bladder comprehensive care plan had been revised to reflect the removal of the catheter and bladder scans.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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 0686 SS=D Bldg. 00	<p>On 10/24/22 at 12:12 p.m., the Administrator (ADM) provided a copy of current facility policy titled, "Comprehensive Care Plans." The policy indicated, " ...Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan" and " ...Comprehensive care plans need to remain accurate and current, new interventions will be added and updated during CCM meeting and newly recognized problems will have a care plan developed and added after CCM meeting"</p> <p>On 10/25/22 at 10:28 a.m., the DON provided a copy of current facility policy titled, "Physician-Provider Notification Guidelines," reviewed 12/1/21. The policy indicated, " ...to ensure the resident's physician or practitioner (may include NP PA or clinical nurse specialist) is aware of all diagnostic testing results or changes in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...."</p> <p>This Federal tag related to Complaint IN00392899.</p> <p>3.1-37</p> <p>483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>Based on observation, interview, and record review, the facility failed to e the undermined areas of the wound were cleaned and dressed, the resident was informed of the procedure as it progressed, and failed to clean scissors appropriately before and after using them on the resident dressing for 1 of 3 residents reviewed for pressure ulcers (Resident 98), and failed to prevent a facility acquired pressure ulcer on a resident's heels for 1 of 3 residents reviewed for pressure (Resident 37).</p> <p>Findings include:</p> <p>On 10/20/22 at 9:56 a.m., Resident 98 record was reviewed. She was admitted on 10/4/22.</p> <p>A progress note, dated 10/6/22, indicated Resident 98 was seen by the Nurse Practitioner (NP) 28 at 10:41 a.m. Her findings included but were not limited to the resident was seen for an initial visit related to an infected sacral wound. The resident was in the hospital due to a fall and developed the sacral wound. Went to the extended care facility (ECF) for rehabilitation, her wound got worse, she went back to the hospital but refused a surgical debridement. She was admitted to this facility with 2 intravenous (IV) antibiotics for ongoing wound care. The resident did not have osteomyelitis. Upon examination, resident indicated minimal pain, no fever, cough, or shortness of breath.</p> <p>On 10/9/22 at 11:47 a.m., Registered Nurse (RN) 23 charted Resident 98 had a yellow running</p>	F 0686	<p>1. Resident 98 was affected. Wound was cleaned and treated per order. No adverse effects noted. Resident 37 was affected. No resident information included in 2567 related to this resident citation.</p> <p>2. All residents with the risk for skin breakdown have the potential to be affected. Braden assessment completed on all resident and appropriate preventative measure initiated, if indicated. Skin sweeps conducted on all residents to ensure appropriate documentation and orders in place for all existing pressure ulcers. Staff to be educated on identification of skin areas. Licensed clinical staff to be educated on wound treatments to include treatment of undermining within the wound and pressure ulcer prevention/offloading. All staff education completed related to communicating with hard of hearing residents.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit 5 residents for preventative measure placement weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will monitor 5 dressing changes to</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>discharge from her vagina while changing her dressing. Resident complained of pain and itching. She notified the Nurse Practitioner (NP) 28 and received orders for Diflucan (antifungal) 100 mg daily for 7 days and Nystatin (antifungal) cream.</p> <p>On 10/12/22 10:50 a.m., the Social Services Director (SSD) charted the initial care plan meeting was with herself, therapy, nursing, and the resident's daughter. The resident declined to attend. Regarding the resident's wound, the prognosis, due to wound care needs, were reviewed along with the intravenous (IV) Vancomycin which will discontinued today. Further discussed indicated the resident was refusing any out of bed activities due to fears of falling and statements of "I'm tired." Currently, on a low air-loss mattress and working with PT/OT (physical therapy/occupational therapy). She was refusing to work on any out of bed activities with them. She was total care for bed mobility and all ADLs and used a Hoyer lift. Medications, diagnoses, dietary, and activity preferences were reviewed.</p> <p>On 10/13/22 at 11:08 a.m., the Director of Nursing Services (DNS) charted that the Interdisciplinary Team (IDT) met. The wound to Resident 98's sacrum was reviewed. Resident was admitted with a Stage 4 ulcer with osteomyelitis (bone infection). She completed all the IV antibiotics per the physician's orders. The wound continued to have moderate amounts purulent drainage. The wound bed was 75% slough (dead tissue that needs to be removed) and 25% necrosis (dead tissue). Her treatments continued with Dakin's solution (strong, topical antiseptic) and ABD pad per her physician's orders. The peri-wound was macerated (tissue broken down at the cellular</p>		<p>ensure proper technique is maintained weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>level) due to very frequent loose jelly like stools. Resident continues on low air loss (LAL) mattress and multivitamins. A new order was received to give Pro-Mod (oral protein supplement) and Ensure (nutritional supplement).</p> <p>On 10/17/22 at 4:11 p.m., Licensed Practical Nurse (LPN) 10 charted Resident 98's dressing was changed per physician's order.</p> <p>On 10/18/22 at 1:05 a.m., Registered Nurse (RN) 27 charted a late entry of Resident 98's dressing change per physician's order on 10/17/22 at 4:00 a.m.</p> <p>On 10/19/22 at 5:00 a.m., RN 27 charted Resident 98's dressing was changed per physician's order.</p> <p>On 10/20/22 at 12:54 p.m., Resident 98's physician's orders were further reviewed.</p> <p>Starting on 10/4/22, a general weekly skin assessment was to be completed once a day on Tuesdays and Fridays from 7:00 a.m. to 3:00 p.m. This order was open ended.</p> <p>Starting on 10/4/22, apply Dakin's Solution 0.25% (strong, topical antiseptic) soaked gauze to the sacrum twice a day from 7:00 a.m. to 11:00 a.m. and 3:00 p.m. to 7:00 p.m. This order was open ended.</p> <p>Starting on 10/04/22, give 1 tablet of hydrocodone-acetaminophen 5-325 mg PRN for pain 4 times a day. This order was open ended.</p> <p>Starting on 10/4/22, the order indicated to encourage the resident to turn and reposition while in bed three times a day from 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 6:00 a.m. This order was open ended.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(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
	<p>Starting on 10/4/22, a daily pain assessment should have been completed between 7:00 a.m. to 3:00 p.m. This order was open ended.</p> <p>Starting on 10/4/22, a pressure reducing mattress and pressure reducing cushion to Resident 98's wheelchair. These orders were open ended.</p> <p>Starting on 10/5/22, cleanse sacral wound with wound cleanser or normal saline (NS), apply skin prep to peri-wound, apply Dakin's moistened gauze and cover with island dressing as needed (PRN). Change when dressing becomes dislodged or soiled.</p> <p>Starting on 10/5/22, observe (sacrum) dressing to open area(s) every shift for draining on dressing and dislodgement, three times a day. From 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. This order was open ended.</p> <p>Resident 98's diagnoses included, but were not limited to, pressure ulcer of sacral region, stage 4 (full thickness skin loss with exposed bone, tendon or muscle) (primary diagnosis), protein calorie malnutrition, type 2 diabetes (blood sugar disorder), morbid (severe) obesity due to excess calories, necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin), acute candidiasis (yeast infection) of vulva and vagina and diarrhea (loose or liquid stool).</p> <p>On 10/4/22 at 11:23 a.m., the Observational Detail List Report indicated Resident 98 was incontinent of bowel and bladder due to being bedfast.</p> <p>On 10/20/22 at 12:39 p.m., Resident 98's care plans were reviewed. The care plans were dated 10/12/22.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>Resident had a sacral pressure ulcer, stage IV. The staffing approaches included, but were not limited to, administer analgesics (pain relief) per MD (medical doctors) order, assess and record the condition of the skin and surrounding skin of the pressure ulcer, observe for and report signs of pain related to pressure, encourage fluids unless contraindicated, and observe and report signs of infection (like localized pain, redness, swelling, tenderness, drainage, odor, and fever).</p> <p>Resident was at risk for skin breakdown related to decreased mobility, weakness, incontinence, chronic venous insufficiency (decreased blood flow), necrotizing fasciitis, and history of vaginitis. The staffing approaches included, but were not limited to, avoid shearing skin during positioning, turning, and transferring, pressure reducing mattress to the bed, pressure reducing cushion to the wheelchair, encourage and assist to turn and reposition for comfort and as needed, use moisture barrier product to perineal area as needed, float heels as needed, conduct weekly skin assessment and pay particular attention to bony prominences, keep linens clean and dry, keep resident as clean and dry as possible, minimize skin exposure to moisture, and use a lifting device as needed for bed mobility.</p> <p>Resident demonstrated hearing loss. The staffing approaches included, but were not limited to, hearing aids as indicated, refer to Speech Therapy for evaluation of need for communication device as appropriate, refer to physician to assess for wax buildup, and monitor for changes in hearing, refer to audiologist for a hearing evaluation as needed, ensure resident is near the activity leader/speaker during activities of interest and care-giving, use written communication as</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>needed, and communicate with resident in a clear, concise manner. Increase volume to ensure resident receives the message.</p> <p>On 10/20/22 at 4:48 p.m., LPN 14 indicated Resident 98's dressing would be changed during the night due to her soiling it after a bowel movement (BM). He would be checking her around midnight.</p> <p>On 10/21/22 at 12:02 a.m., LPN 14 provided hydrocodone-acetaminophen 5-325 mg for Resident 98. At first, she refused. After a sip of cold water, she accepted the pain medication. He was talking loudly directly in her ear because she was hard of hearing (HOH). The resident was able to hear and understand him. He asked her to drink all the water so the medication would work faster. Resident 98's response was, please don't hurt me. She had a worried look on her face.</p> <p>On 10/21/22 at 12:34 a.m., LPN 14 indicated he did not do wound measurements. The wound team does the wound assessments and measurements.</p> <p>On 10/21/22 at 12:35 a.m., Resident Care Assistant (RCA) 29 was observed in in Resident 98's room putting on gloves.</p> <p>On 10/21/22 at 12:36 a.m., LPN 14 indicated he would be discarding the soiled dressings and lightly salt the wound with 4 by (x) 4 Dakin's, then lightly pack the wound with 4 x 4 Dakin's-soaked gauze and use abdominal (ABD) pads and tape.</p> <p>On 10/21/22 at 12:39 a.m., RCA 29 tried to tell Resident 98 we were going to change your dressing. Resident 98 indicated she could not hear her. RCA 29 did not clarify or speak directly into her ear. She stopped talking to her.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>On 10/21/22 at 12:52 a.m., LPN 14 indicated the soiled dressing was dated 10/20/22 with no time or initials. He indicated the area below her dressing was an open area of skin where her BM was, "acid was eating her skin." The area was observed to be a large, raw, open skin area with several spots of blood. LPN 14 used A and D ointment for that area.</p> <p>On 10/21/22 at 12:56 a.m., LPN 14 removed the soiled dressing and washed his hands.</p> <p>On 10/21/22 at 12:57 a.m., after putting on clean gloves, LPN 14 used his gloved, dry gauze covered finger to wipe inside the deep area of the wound but not in the undermined areas. He did not use normal saline (NS) or wound cleanser. He changed gloves, did not wash his hands, and used skin prep around wound. LPN 14 changed gloves, did not wash his hands and placed a Dakin's-soaked gauze in the wound. He used sterile cotton swabs to push the dressing up to the wound edges, but not in the undermined area. He changed gloves, did not wash his hands, and placed another Dakin's-soaked gauze in wound with sterile cotton swabs. It was pushed against the wound edges but did not enter the undermined area. He changed gloves, did not wash his hands, and placed ABD pads over the wound. He put A and D ointment on the raw, open area of skin under the ABD with a gloved finger. Resident 98 was continuing to cry out for help from Jesus.</p> <p>On 10/21/22 at 1:03 a.m., LPN 14 placed tape over the ABD pads. He was observed dating the dressing. He used scissors, there was no observation of them being cleaned, to cut the tape slightly at the distal mid-portion nearest to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>rectum. He indicated he used alcohol wipes or sanitizer wipes to clean the scissors if we have them. He indicated those were his personal scissors and he was observing leaving them in the gauze squares box.</p> <p>On 10/21/22 at 1:11 a.m., LPN 14 was observed to clean his scissors in the resident's bathroom with water only. He placed them in the gauze squares box with the 4 x 4s. Then washed his hands.</p> <p>The wound assessments were reviewed.</p> <p>On 10/6/22 at 10:59 p.m., the DNS assessed and measured Resident 98's wound. The wound measured 7 cm long by 7 cm wide, with no depth measured. The wound had a moderate amount of purulent exudate (thick discharge), and an odor was present in the wound. The undermining was 5.2 cm at 6:00. This tissue type was 100% slough and the wound edges were not attached to the base of the wound. There was 4 cm of erythema (redness, but blanchable) around the wound edges. The comments indicated the wound was 100% brown slough and devitalized tissue and undermined at 6:00 at 4.5 cm.</p> <p>On 10/13/22 at 2:52 p.m., the DNS assessed and measured Resident 98's wound. The wound measured 7 cm long by 7 cm wide, with a depth of 3.5 cm. The wound had a moderate amount of purulent exudate (opaque, milky; sometimes green).</p> <p>On 10/20/22 at 4:52 p.m., the DNS assessed and measured Resident 98's wound. The wound measured 7 cm long by 9 cm wide, with a depth of 2 cm. The wound had a moderate amount of purulent exudate. The undermining was 4.3 cm from 11:00 to 3:00, and 1 cm at 6:00. An increase in</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2022
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>granulation tissue noted with some dark and tan slough. This tissue type was 50% slough and 50% granulation, the wound edges were irregular. There was 4 cm of erythema (redness, but blanchable) around the wound edges. The comments indicated the wound was 100% brown slough and devitalized tissue and undermined at 6:00 at 4.5 cm.</p> <p>On 10/21/22 at 10:35 a.m., the Director of Nursing Services (DNS) indicated Resident 98's wound was assessed and measured weekly. She indicated there was no specific order for this wound to be assess more often than the general skin assessment that she did weekly. During a dressing change the undermined area of the wound should have been cleaned and a Dakin's-soaked dressing should have been in contact with the undermined area of the wound as well.</p> <p>On 10/25/22 at 4:50 p.m., NP 28 indicated Resident 98 refused surgical debridement when she was at the hospital, prior to coming to the facility. Her current orders were to cleanse the wound with NS or wound cleanser. For the undermined area, the nurse could have used a cotton swab or just sprayed it, Perhaps the nurses could have possibly squeezed in some NS. For the dressing of the undermined area it should be lightly packed. The nurse should have lightly cleansed the wound with NS or Dakin's solution. NP indicated she talked with the resident frequently, the raw area under wound should have protective cream. It was hard to put a dressing on in a difficult area. This wound was not getting better, it was getting worse.</p> <p>On 10/25/22 at 7:25 p.m., the Medical Director indicated while Resident 98 was in the hospital,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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 0689 SS=G Bldg. 00	<p>the surgical team wanted to debride her wound, but the resident refused. She had a complicated wound and may not survive it. They relied on wound care experts because she had necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin).</p> <p>A current policy titled, "Guidelines of General Wound and Skin Care, with no dated, was provided by the Executive Director (ED), on 10/20/22 at 10:54 a.m. A review of the policy indicated, " ...Dress chronic wounds using clean technique, since all chronic wounds are contaminated...Reevaluate dressing and skin integrity every shift ...Date, time and initial all dressing at time of application...."</p> <p>A current policy, titled, "Dressing Changes, dated 5/11/22, was provided by the ED, on 10/24/22 at 12:02 p.m. A review of the policy indicated, " ...To ensure measure that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination ...Dispose of gloves in plastic bag or trash can. Wash hands with soap and water ...If using scissors make sure, it is clean with antiseptic after contact with soiled dressings. Remove gloves and discard. Wash hands with soap and water"</p> <p>3.1-40(a)(2)</p> <p>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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was not outside smoking at a smoke-free facility and did not sign out for a leave of absence when leaving the building for 1 of 1 resident reviewed for smoking (Resident 32) and failed to ensure that residents received adequate supervision and assistance devices to prevent accidents for 3 of 3 residents reviewed for accidents (Resident 14, 21, and 32).</p> <p>Findings include:</p> <p>1. On 10/18/22 at 4:06 p.m., Resident 32 was observed outside the facility building smoking a cigarette. She was at the edge of the parking lot almost behind a car. No staff were with her. Resident 32 indicated she was a nurse and was alert and oriented x 4 (person, place, time, and event). She was not wearing a coat and indicated she needed to have her daughter bring her one. The temperature outside was 42 degrees. She was observed going directly back into the facility. Her smoking materials were not safely stored by the facility because the facility was smoking-free according to the Director of Nursing Services (DNS) during entrance conference.</p> <p>On 10/19/22 at 1:31 p.m., the receptionist indicated the Leave of Absence (LOA) books were at the nurse's station.</p> <p>On 10/19/22 at 1:37 p.m., Licensed Practical Nurse (LPN) 10 provided the Ren 1 LOA book where Resident 32 resided. A review of the LOA book, including every page and the front and back flaps revealed Resident 32 did not sign out LOA. She</p>	F 0689	<p>1. Resident 32 was affected. Resident was reeducated on the campus smoking policy. Items were removed, secured, and sent home with family. No adverse effects noted. Resident 14 was affected. Resident was discharged to a secured unit without any adverse effects from injury. Resident 21 was affected. New elopement risk assessment completed and resident no longer at risk for elopement. Wanderguard has been removed and orders updated. No adverse effects noted.</p> <p>2. All residents have the potential to be affected. All staff to be educated on resident's signing out for Leave of Absence (LOA) when leaving the campus. LOA book has been reviewed to ensure all residents have LOA forms in place. Education with marketing team to occur related to educating new admission on campus non-smoking policy. Licensed clinical staff educated on documentation of skin impairments. Staff education on identifying a resident who is smoking and notifying if the smoking is witnessed or suspected. Audit completed of all residents at risk for elopement to ensure that wanderguard is in place, if need indicated, and care</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>did not have a sign-out sheet in the LOA book.</p> <p>On 10/19/22 at 1:51 p.m., RN 23 indicated there was only one LOA book for the Ren 1 halls.</p> <p>On 10/19/22 at 1:59 p.m., Resident 32 indicated she had not signed out LOA when leaving the building. She indicated she was in the parking lot, smoking after lunch today. She usually takes a couple of puffs and discards the cigarette.</p> <p>On 10/19/22 at 2:07 p.m., LPN 10 indicated she was aware Resident 32 left the unit and she only found out a week ago that she was smoking. Resident 32 did not tell the staff each time she went out to smoke. She was non-compliant with it. She didn't sign out. LPN 10 thought that if Resident 32 signed out in the LOA book and left the property it was ok if she smoked.</p> <p>On 10/20/22 at 3:03 p.m., Resident 32's chart was reviewed.</p> <p>A progress note, dated 10/19/22 at 2:51 p.m., the Director of Social Services (DSS) indicated that Resident 32 was seen outside on facility property smoking on 10/19/22. The DSS and ADNS went to the resident's room to ask if she had cigarettes. She initially said, "no." When she was told she was seen smoking, she indicated she did have smoking materials. The DSS asked the resident if she would provide her cigarettes and lighter for her family to pick up. She agreed and allowed the DSS to search her belongings for additional smoking supplies. None were found. The DSS asked how she was procuring her cigarettes, Resident 32 stated she ordered them off of Amazon. She was offered a nicotine patch, she refused stating she was allergic to the adhesive. The Nurse Practitioner (NP) will order nicotine</p>		<p>plans in place. Elopement binder has been updated to ensure only in house residents are in the binder and that resident pictures are identifiable.</p> <p>3. As a measure of ongoing compliance, the ED or designee will round to ensure no smoking or smoking materials are noted 5 times weekly x4 weeks, then 5x every other week x2 months, then 5x monthly x3 months. The DHS or designee will monitor 5 resident skin impairments to ensure documentation is in place weekly x4 weeks, then every other week x2 months, then monthly x3 months. The DHS or designee will monitor 5 residents to ensure that wanderguard is in place weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>gum to assist with cravings. Her family was notified that Resident 32 had smoking supplies in building and they will need them picked up.</p> <p>A new care plan was created on 10/20/22 at 3:30 p.m. The problem indicated Resident 32 demonstrated non-compliance with physician orders and/or plan of care as evidenced by smoking on facility property. The goal was stated as Resident 32's preferences would be honored to the extent that non-compliance with physician orders will not result in injury to self or others.</p> <p>On 10/19/22 at 3:43 p.m., Resident 32's record was reviewed. She was admitted 9/15/22.</p> <p>Her smoking status indicated she was a former smoker.</p> <p>Her diagnoses included, but were not limited to, osteomyelitis (bone infection) of vertebra (spine), sacral and sacrococcygeal (sacrum and coccyx), not facility acquired stage 4 pressures ulcers of the sacral region and left hip, and other chronic pain.</p> <p>Her medications included, but were not limited to, baclofen (muscle spasms), Dakin's solution 0.125% (treatment for stage 4 pressure ulcers), jantoven (warfarin) 4 mg (anticoagulant), and oxycodone-acetaminophen 5-325 mg (for pain relief).</p> <p>On 10/19/22 at 2:13 p.m., the Assistant Director of Nursing Services (ADON) indicated he was not aware Resident 32 was a smoker. The facility had no smoking assessment or smoking care plan because they are a smoke-free facility. They will probably request the family to pick up the smoking materials. Until then, we could keep them</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>in the med cart. Smoking could have been an issue for her because of her pressure wounds she arrived with.</p> <p>On 10/19/22 at 2:47 p.m., the DNS indicated Resident 32 stated she had no cigarettes or matches or lighter. Resident 32 should not have put herself and others at risk with smoking. The DNS indicated the resident should have signed-out before leaving the building.</p> <p>On 10/19/22 at 3:05 p.m., the DNS indicated a note was put in Resident 32's chart. The DNS indicated the resident told her, she was ordering cigarettes on Amazon. The Director of Social Services Director (DSS) searched the resident's room. The resident was offered a nicotine patch and she refused it. The facility will be ordering nicotine gum for her. It should arrive tomorrow. Her daughter was coming to take all her money and bill fold. Resident 32 indicated to the DSS that she was caught smoking. 2. On 10/17/22 at 2:18 p.m., Resident 14 was observed lying in bed. He was able to answer yes and no questions only. His hands were tremoring during the observation. His bedside table was not within reach. He did not have an indwelling catheter as ordered.</p> <p>On 10/18/22 at 9:26 a.m., Resident was observed lying in bed. His bedside table was not within reach. Resident 14 able to answer yes and no questions. His hands were observed to be tremoring.</p> <p>On 10/18/22 at 2:52 p.m., a comprehensive record review was completed. Resident 14 had the following diagnoses but not limited to schizophrenia, parkinson's disease, UTI (Urinary Tract Infection), PE (Pulmonary Embolism), dementia, mood disorder, psychotic disorder,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>anxiety, hypothyroidism, vitamin deficiency, hyperlipidemia, bladder neck obstruction and reflux uropathy, benign prostatic hypertrophy, unspecified fall, and age-related cognitive decline.</p> <p>Resident 14 admitted to the facility on 8/29/22. He admitted with an indwelling catheter. Prior to discharging to the facility, the resident's healthcare representative expressed concerns about resident having an indwelling catheter, indicating that he would pull the catheter out.</p> <p>On 10/18/22 at 1:35 p.m., during an interview with the DNS, she indicated that prior to resident admitting, he had hand restraints at the hospital due to attempting to pull his catheter out at the hospital. The DNS informed the hospital that resident would have to be restraint free for at least 24 hours before he could be admitted to the facility.</p> <p>A progress note dated 9/20/22 at 7:30 p.m., indicated that resident 14 was observed lying in bed with his indwelling catheter on the floor. Inside the bathroom, the nurse noticed blood in the bathroom along with blood-soaked clothing. Resident 14 was bleeding from his urethra. The nurse documented that resident 14 was observed to have an abrasion to the top of his head measuring 3.0cm by 2.0 cm. Resident 14 was sent to the hospital for evaluation. Resident 14's discharge paperwork indicated that the emergency room staff questioned a fall due to the abrasion on his head, therefore, completed a CT scan of his head. The emergency room phoned the nurse at the facility, and she was unsure if resident 14 fell or not. He was found in bed and bleeding was observed in the bathroom. The emergency room replaced the indwelling catheter and sent resident 14 back to the facility.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>On 10/20/22 at 11:05 a.m., during an interview with the ADNS, he indicated that resident did not have a fall. He indicated that resident did have an abrasion to his head. The record lacked an event or investigation in the origin of the abrasion on his head. The ADNS indicated that the abrasion should have had an event and investigation to find out what caused the abrasion on his head.</p> <p>On 10/20/22 at 11:20 a.m., the ADNS provided a copy of an event with the creation date of 9/20/22 at 7:30 p.m. The event was recorded on 10/20/22 at 10:57 a.m.</p> <p>On 10/21/22 at 11:13 a.m., during an interview with the ED and DNS regarding resident 14's abrasion. The ADNS providing a copy of an event that was completed on 10/20/22 and a lack of documentation into the origin of the abrasion. No further information was provided.</p> <p>3. On 10/24/22 at 9:59 a.m., Resident 21 was observed sitting up in her wheelchair and leaning to her right side, resting on the arm of the chair. Resident was not wearing a wander guard. RN 12 assessed resident 21 for a wander guard and could not find one on her person or wheelchair. RN 12 indicated that she would get one and place it on resident 21.</p> <p>On 10/24/22 at 10:12 a.m., a comprehensive record review was completed for resident 21. Resident 21 had the following diagnoses but not limited to chronic obstructive pulmonary disease, hypertension, hypertensive heart disease with heart failure, hypothyroidism, vitamin B deficiency, other specified depressive disorders, major depressive disorder, restless leg syndrome, peripheral autonomic neuropathy, vascular dementia, insomnia, altered mental status,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>difficulty in walking, repeated falls, lack of coordination, abnormal weight loss, age-related physical debility, and chronic pain.</p> <p>A quarterly nursing observation dated 9/28/22 indicated that resident was at risk for elopement due to a history of elopement seeking, attempts to leave the campus, exhibits periods of pacing, agitation or wandering toward an exit, and resident wanders.</p> <p>Resident 21 had orders to have a wander guard and to check placement and function of the device.</p> <p>Resident 21 had a care plan dated 4/14/22, addressing risk for elopement. An intervention dated 4/12/22 indicated for resident 21 to have a wander guard and to check placement and function as ordered.</p> <p>Observed an elopement binder at the front desk. It included a profile of resident 21. The picture was pixilated and resident 21's face was unrecognizable. Included in the binder were other residents who were no longer residing in the facility.</p> <p>A policy titled "Guidelines: Elopement Risk Assessment and Prevention" date 9/28/16 was provided by the DNS on 10/25/22 at 2:06 p.m., it indicated " ...each resident will be assessed for elopement risk upon admission, quarterly and with change in condition. An elopement risk binder with be kept at a secure location known to staff that contains a resident elopement risk profile about each resident who may be at risk for elopement. Facilities with wander alert detection systems should place a "wander alert bracelet" on the resident".</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0690 SS=D Bldg. 00	<p>3.1-45(a)</p> <p>483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>Based on observation, interview and record review, the facility failed to ensure a resident (Resident 13) with a history of urinary tract infections (UTIs) and a recent hospital admission for sepsis due to a UTI received appropriate assistance and supervision to keep his catheter tubing and drainage bag off the floor to prevent the potential for complications including infection for 1 of 4 residents reviewed for urinary catheters.</p> <p>Findings include:</p> <p>On 10/18/22 at 9:45 a.m., Resident 13 was observed in the main dining room at a table as he finished his breakfast. A catheter tube was observed looped under his wheelchair (WC) and a long portion of the tube rested on the floor. The urinary drainage bag, which was in a dignity cover, also touched the floor.</p> <p>On 10/18/22 at 11:23 a.m., Resident 13 was observed being assisted up the hall in his wheelchair by QMA (qualified medication aid) 31. As Resident 13's WC rolled, the catheter tubing and the drainage bag drug across the floor, so that it made a scrapping sound against the carpet.</p> <p>On 10/18/22 at 11:26 a.m., Resident 13 remained at the nurse's station, and RN (registered nurse) 17 indicated she needed to check his blood sugar before he went down for lunch. She rolled him in his WC back to his room. The catheter tube and drainage bag remained hanging lose and drug across the floor making a scrapping sound against the carpet.</p> <p>On 10/18/22 at 12:23 p.m., Resident 13 was observed as he was assisted by QMA 31 from the main dining room back to his room. Resident 13's catheter tubing and drainage bag were observed</p>	F 0690	<ol style="list-style-type: none"> Resident 13 was affected. Catheter tubing and bag were placed appropriately so they did not touch or drag on the floor. No adverse effects noted. All residents with catheters have the potential to be affected. Audit of all catheters has been completed for appropriate placement. Staff to be educated on placement of catheter tubing and bag. As a measure of ongoing compliance, the DHS or designee will round to ensure catheter tubing and bag is placed appropriately and not on the floor 5 times weekly x4 weeks, then every other week x2 months, then monthly x3 months. 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 reviewed and updated as warranted 	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(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
	<p>to hang very low, and dragged the ground, which made a scraping sound against the carpet.</p> <p>During an interview on 10/18/22 at 12:25 p.m., QMA 31 indicated he was unaware that Resident 13's catheter tube and drainage bag were touching the ground, but it should not hang so low or drag the ground like that.</p> <p>On 10/19/22 at 1:45 p.m., Resident 13 was observed as he was transferred into bed. He sat in his WC at that time and his catheter tubing was observed as it hung low and rested on the floor. CNA (certified nursing assistant) 24 moved his WC by backing him up and turning him around beside the bed. As she moved his WC the tubing was dragged across the floor, and at one point the front wheel of his WC got stuck on the tube. When CNA 244 notice the tubing was stuck on the wheel, she unhooked the catheter drainage bag, and laid it on the floor as she straightened out the tubing. As she continued to adjust the WC and position Resident 13 closer to the bed, she moved the drainage bag from the floor and raised it above the level of his bladder to set in on top of the bed. When she got his WC into position, she picked up the drainage bag and hooked it onto the frame of the bed.</p> <p>On 10/20/22 at 10:34 a.m., Resident 13 requested to lay down. CNA 24 entered the room with RN 23. CNA 23 indicated Resident 13 had moved his bowels and needed to be cleaned up. As she assisted Resident 13 to stand up, his pants slid fell down his legs. His brief was exposed and observed to be heavily soiled with loose stool which also smeared down his thighs and some was noted to be on his catheter tubing. There was not leg strap observed in place for the catheter tubing. CNA 24 asked RN 23 for a trash can and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>RN 23 retrieved the can from the bathroom. The bottom of the trash can was observed to have a brown substance smeared on the bottom of its rim, and RN 8 set the can down on the carpet next to Resident 13's bed.</p> <p>During an interview on 10/20/22 at 10:50 a.m., as RN 23 washed her hand to prepare for a dressing change, she indicated it appeared to be fecal matter smeared on the bottom of the trash can and it needed to be cleaned especially since the resident usually sat in his WC beside the bed in that area, and he had a catheter. It was important to minimize the potential for infections by keeping the tube and bag off the floor. Also, it should not go above the level of the bladder to prevent back flow.</p> <p>On 10/19/22 at 10:00 a.m., Resident 13's medical record was comprehensively reviewed.</p> <p>He was a long-term care resident, admitted in 2019 with active diagnoses which included, but were not limited to, sepsis, and urinary tract infection.</p> <p>He had a current physician order for a suprapubic catheter (a type of urinary catheter that is left in place, inserted through a hole in the abdomen, directly into the bladder), with instructions to change as needed based on clinical indications such as infection, obstruction, or when the closed system was compromised.</p> <p>A nursing progress note dated 9/22/22 at 9:04 p.m., indicated, Resident 13 had a fever of 101.8 after 20 minutes of administration of Tylenol. He was warm to the touch and sweating profusely. Resident stated that he felt bad and requested to go to the hospital. 911 was called and he was transferred to the Emergency Department (ED).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>A corresponding ED H&P (history and physical) summary dated 9/23/22 at 5:25 a.m., indicated, Resident 13 presented with shortness of breath, fever, and chills. His temperature at the outside facility was noted to be 102.3 and his O2 (oxygen) saturation was 89% on 3 L (liters) via nasal cannula ... Assessment and Plan: 1. Sepsis. Blood cultures and urine cultures are pending. 2 L of IV fluid boluses were given in the emergency room ... the cause of the sepsis is extended-spectrum beta-lactamase E. Coli urinary tract infection, which is a recurrent issue"</p> <p>Resident 13 had a comprehensive care plan dated 7/26/22 which indicated his use of a suprapubic catheter for a diagnosis of obstructive uropathy and urinary retention. Interventions for this plan of care included, but were not limited to, leg strap in place to prevent resident's catheter from being pulled out, maintain a closed system with urinary bag below the resident's bladder and cover, and observe tubing and avoid obstructions.</p> <p>On 10/24/22 at 2:52 a.m., the Assistant Director of Nursing (ADNS) provided a copy of current facility policy titled, "Urinary Catheter Care," dated 12/1/21. The policy indicated, " ...the urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder ... be sure the catheter tubing and drainage bag are kept off the floor ... ensure the catheter remains secured. A leg strap may be used to reduce friction and movement at the insertion site"</p> <p>3.1-41(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/25/2022
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON			STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0697 SS=G Bldg. 00	<p>483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure enough medication was administered to manage pain resulting in harm when the resident was in acute pain and yelling out during a wound treatment for 1 of 2 residents reviewed for pain management (Resident 98).</p> <p>Findings include:</p> <p>On 10/20/22 at 9:56 a.m., Resident 98 record was reviewed. She was admitted on 10/4/22.</p> <p>A progress note, dated 10/6/22, indicated Resident 98 was seen by the Nurse Practitioner (NP) 28 at 10:41 a.m. Her findings included, but were not limited to, the resident was seen for an initial visit related to an infected sacral wound. The resident was in the hospital due to a fall and developed the sacral wound. Went to the extended care facility (ECF) for rehabilitation, her wound got worse, she went back to the hospital but refused a surgical debridement. She was admitted to this facility with 2 intravenous (IV) antibiotics for ongoing wound care. The resident did not have osteomyelitis. Upon examination, resident indicated minimal pain, no fever, cough, or shortness of breath.</p> <p>On 10/9/22 at 11:47 a.m., Registered Nurse (RN) 23 charted Resident 98 had a yellow running</p>	F 0697	<ol style="list-style-type: none"> 1. Resident 98 was affected. Physician was notified and resident pain was treated per orders. 2. All residents have the potential to be affected. All residents have been audited for signs, symptoms of increased pain. Daily pain assessments have been implemented as indicated. Pain monitoring initiated with all dressing changes. Licensed clinical staff educated on pain management prior to and during treatment. 3. As a measure of ongoing compliance, the DHS or designee will monitor 5 residents during treatment to ensure pain is managed weekly x4 weeks, then every other week x2 months, then monthly x3 months. 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 reviewed and updated as 	11/23/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>discharge from her vagina while changing her dressing. Resident complained of pain and itching. She notified the Nurse Practitioner (NP) 28 and received orders for Diflucan (antifungal) 100 mg daily for 7 days and Nystatin (antifungal) cream.</p> <p>On 10/13/22 at 11:08 a.m., the DNS charted that the Interdisciplinary Team (IDT) met. The wound to Resident 98's sacrum was reviewed. Resident was admitted with a Stage 4 ulcer with osteomyelitis (bone infection). She completed all the IV antibiotics per the physician's orders. The wound continued to have moderate amounts purulent drainage. The wound bed was 75% slough (dead tissue that needs to be removed) and 25% necrosis (dead tissue). Her treatments continued with Dakin's solution (strong, topical antiseptic) and ABD pad per her physician's orders. The peri-wound was macerated (tissue broken down at the cellular level) due to very frequent loose jelly like stools. Resident continues on low air loss (LAL) mattress and multivitamins. A new order was received to give Pro-Mod (oral protein supplement) and Ensure (nutritional supplement).</p> <p>On 10/20/22 at 12:54 p.m., Resident 98's physician's orders were further reviewed.</p> <p>Starting on 10/04/22, give 1 tablet of hydrocodone-acetaminophen 5-325 mg PRN for pain 4 times a day. This order was open ended.</p> <p>Starting on 10/4/22, the order indicated to encourage the resident to turn and reposition while in bed three times a day from 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 6:00 a.m. This order was open ended.</p> <p>Starting on 10/4/22, a daily pain assessment</p>		warranted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>should have been completed between 7:00 a.m. to 3:00 p.m. This order was open ended.</p> <p>Starting on 10/4/22, a pressure reducing mattress and pressure reducing cushion to Resident 98's wheelchair. These orders were open ended.</p> <p>Starting on 10/5/22, cleanse sacral wound with wound cleanser or normal saline (NS), apply skin prep to peri-wound, apply Dakin's moistened gauze and cover with island dressing as needed (PRN). Change when dressing becomes dislodged or soiled.</p> <p>Resident 98's diagnoses included, but were not limited to, pressure ulcer of sacral region, stage 4 (full thickness skin loss with exposed bone, tendon or muscle) (primary diagnosis), protein calorie malnutrition, type 2 diabetes (blood sugar disorder), morbid (severe) obesity due to excess calories, necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin), acute candidiasis (yeast infection) of vulva and vagina and diarrhea (loose or liquid stool).</p> <p>On 10/20/22 at 12:39 p.m., Resident 98's care plans were reviewed. The care plans were dated 10/12/22.</p> <p>Resident had a sacral pressure ulcer, stage IV. The staffing approaches included, but were not limited to, administer analgesics (pain relief) per MD (medical doctors) order, assess and record the condition of the skin and surrounding skin of the pressure ulcer, observe for and report signs of pain related to pressure, encourage fluids unless contraindicated, and observe and report signs of infection (like localized pain, redness, swelling, tenderness, drainage, odor, and fever).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(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
	<p>Resident was at risk for skin breakdown related to decreased mobility, weakness, incontinence, chronic venous insufficiency (decreased blood flow), necrotizing fasciitis, and history of vaginitis. The staffing approaches included, but were not limited to, avoid shearing skin during positioning, turning, and transferring, pressure reducing mattress to the bed, pressure reducing cushion to the wheelchair, encourage and assist to turn and reposition for comfort and as needed, use moisture barrier product to perineal area as needed, float heels as needed, conduct weekly skin assessment and pay particular attention to bony prominences, keep linens clean and dry, keep resident as clean and dry as possible, minimize skin exposure to moisture, and use a lifting device as needed for bed mobility.</p> <p>Resident demonstrated hearing loss. The staffing approaches included, but were not limited to, hearing aids as indicated, refer to Speech Therapy for evaluation of need for communication device as appropriate, refer to physician to assess for wax buildup, and monitor for changes in hearing, refer to audiologist for a hearing evaluation as needed, ensure resident is near the activity leader/speaker during activities of interest and care-giving, use written communication as needed, and communicate with resident in a clear, concise manner. Increase volume to ensure resident receives the message.</p> <p>On 10/20/22 at 4:48 p.m., LPN 14 indicated Resident 98's dressing would be changed during the night due to her soiling it after a bowel movement (BM). He would be checking her around midnight.</p> <p>On 10/21/22 at 12:02 a.m., LPN 14 provided hydrocodone-acetaminophen 5-325 mg for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>Resident 98. At first, she refused. After a sip of cold water, she accepted the pain medication. He was talking loudly directly in her ear because she was hard of hearing (HOH). The resident was able to hear and understand him. He asked her to drink all the water so the medication would work faster. Resident 98's response was, please don't hurt me. She had a worried look on her face.</p> <p>On 10/21/22 at 12:34 a.m., LPN 14 indicated he did not do wound measurements. The wound team did the wound assessments and measurements.</p> <p>On 10/21/22 at 12:35 a.m., Resident Care Assistant (RCA) 29 was observed in in Resident 98's room putting on gloves.</p> <p>On 10/21/22 at 12:36 a.m., LPN 14 indicated he would be discarding the soiled dressings and lightly salt the wound with 4 x 4 Dakin's, then lightly pack the wound with 4 x 4 Dakin's-soaked gauze and use abdominal (ABD) pads and tape.</p> <p>On 10/21/22 at 12:39 a.m., RCA 29 tried to tell Resident 98 we were going to change your dressing. Resident 98 indicated she could not hear her. RCA 29 did not clarify or speak directly into her ear. She stopped talking to her.</p> <p>On 10/21/22 at 12:40 a.m., 12:42 a.m., 12:43 a.m., and 12:44 a.m., Resident 98 used a loud, pleading voice, "Why me?" LPN 14 and RCA 29 were in the room. They did not speak with her.</p> <p>On 10/21/22 at 12:47 a.m., Resident 98 indicated loudly, in a pleading voice, she should not have to go through this. LPN 14 was talking to her, but not in her ear. She indicated loudly, "I cannot hear you."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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
	<p>On 10/21/22 at 12:48 p.m., Resident 98 had a teary, worried expression and loudly pleaded, "Lord Jesus, help me!"</p> <p>On 10/21/22 at 12:47 a.m., LPN 14 washed his hands with no concerns and put on gloves. He told Resident 98 he was going to put the head-of-the-bed (HOB) down and turn her on her side.</p> <p>On 10/21/22 at 12:49 a.m., Resident 98 indicated she did not know what he was saying. As she was turned, she made loud groaning sounds.</p> <p>On 10/21/22 at 12:51 a.m., LPN 14 indicated to the resident, she had had a BM and he needed to clean her up. He indicated he was sorry. Resident 98 responded in a loud voice, "you are not sorry."</p> <p>On 10/21/22 at 12:52 a.m., LPN 14 indicated the soiled dressing was, dated 10/20/22, with no time or initials. He indicated the area below her dressing was an open area of skin where her BM was, "acid was eating her skin." The area was observed to be a large, raw, open skin area with several spots of blood. LPN 14 used A and D ointment for that area. Resident was openly crying now.</p> <p>On 10/21/22 at 12:56 a.m., LPN 14 removed the soiled dressing and washed his hands.</p> <p>On 10/21/22 at 12:57 a.m., after putting on clean gloves, LPN 14 used his gloved, dry gauze covered finger to wipe inside the deep area of the wound but not in the undermined areas. He did not use normal saline (NS) or wound cleanser. Resident 98 was calling out in pain. He changed gloves, did not wash his hands, and used skin prep around wound. Resident 98 was continuing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>to call out in pain. LPN 14 changed gloves, did not wash his hands and placed a Dakin's-soaked gauze in the wound. He used sterile cotton swabs to push the dressing up to the wound edges, but not in the undermined area. He changed gloves, did not wash his hands, and placed another Dakin's-soaked gauze in wound with sterile cotton swabs. It was pushed against the wound edges but did not enter the undermined area. He changed gloves, did not wash his hands, and placed ABD pads over the wound. He put A and D ointment on the raw, open area of skin under the ABD with a gloved finger. Resident 98 was continuing to cry out for help from Jesus.</p> <p>On 10/21/22 at 1:03 a.m., LPN 14 placed tape over the ABD pads. He indicated in a normal (not loud) voice to Resident 98, "we are almost done and thank you for your patience." He did not talk in her ear. She did not respond. He was observed dating the dressing. He used scissors, there was no observation of them being cleaned, to cut the tape slightly at the distal mid-portion nearest to the rectum. He indicated he used alcohol wipes or sanitizer wipes to clean the scissors if we have them. He indicated those were his personal scissors and he was observing leaving them in the gauze squares box.</p> <p>On 10/21/22 at 1:05 a.m., LPN 14 and RCA 29 placed a clean disposable brief on Resident 98. When she was turned from side and side, she continued to call out in pain. The staff continued to reposition and re-centered her on the bed.</p> <p>On 10/21/22 at 1:09 a.m., LPN 14 indicated to the resident, "we are going to pull you up in bed now." Resident 98 indicated loudly, "what are you saying?" He did not speak into her ear. After she was pulled up in bed, she called out loudly, "how</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>long Lord?"</p> <p>On 10/21/22 at 1:11 a.m., LPN 14 was observed to clean his scissors in the resident's bathroom with water only. He placed them in the gauze squares box with the 4 x 4s. Then washed his hands.</p> <p>On 10/21/22 at 10:51 a.m., Resident Care Assistant (RCA) 15 indicated she was finishing a bed bath for Resident 98. She indicated when she turned Resident 98 to clean her back, she was screaming.</p> <p>On 10/21/22 at 10:38 a.m., the Assistant Director of Nursing Services (ADNS) indicated Licensed Practical Nurse 14 was probably trying to hurry with the sacral wound dressing change because the Resident 98 was in pain and did not take the time to clean or dress the undermined portions of the wound.</p> <p>On 10/25/22 at 4:50 p.m., NP 28 indicated Resident 98 refused surgical debridement when she was at the hospital, prior to coming to the facility. She had no report from the staff that the resident had been uncomfortable or in pain with dressing changes. She discontinued the order for scheduled Tylenol. She talked to Resident 98's daughters frequently. They had not reported she was in pain; we can increase her Norco to 2 pills prior to a dressing change. The staff could have reviewed the planned procedure into the resident's ear for her understanding before doing the dressing change. NP indicated she talked with the resident frequently.</p> <p>On 10/25/22 at 7:25 p.m., the Medical Director indicated while Resident 98 was in the hospital, the surgical team wanted to debride her wound, but the resident refused. She had a complicated wound and may not survive it. We relied on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>wound care experts because she had necrotizing fasciitis (serious bacterial infection that destroys tissue under the skin). He believed her to have hyper-responses to pain, but the pain medications had room to be increased for possible pain relief. For this wound, she would almost need conscious sedation (combination of medicine to help her to relax, a sedative, and to block pain, an anesthetic) to change the dressing without pain. Long term acute care might a better option than long term care.</p> <p>On 10/26/22 at 1:13 p.m., NP 28 indicated she discontinued the scheduled Tylenol per Resident 98's family request and had now increased the dose of scheduled Norco from, 5/325 mg to 7.5/325 mg four times a day. The family had wanted the Norco to be PRN (as needed) because when she took it in the hospital, she was loopy. The resident indicated she had pain with the dressing change.</p> <p>Scheduled Tylenol twice a day with Norco 30 min prior to twice a day dressing changes. If it is a PRN dressing change, then give Tylenol 30 minutes prior to the dressing change. The daughter indicated her mom complained of pain, but not severe. She believed the Resident's pain was mostly when she was moved or turned. She indicated she had not been in the resident's room during a dressing change.</p> <p>A current policy, titled, "Dressing Changes, dated 5/11/22, was provided by the ED, on 10/24/22 at 12:02 p.m. A review of the policy indicated, " ...To ensure measure that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination ...Dispose of gloves in plastic bag or trash can. Wash hands with soap and water ...If using</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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 0755 SS=D Bldg. 00	<p>scissors make sure, it is clean with antiseptic after contact with soiled dressings. Remove gloves and discard. Wash hands with soap and water"</p> <p>3.1-37(a)</p> <p>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.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>controlled drugs is maintained and periodically reconciled.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all medications were disposed of when expired (Resident 10 and 39).</p> <p>Findings include:</p> <p>On 10/24/22 at 11:31 a.m., Licensed Practical Nurse (LPN) 10 provided a tour of the medication storage room.</p> <p>a. Resident 39 had 2 containers of Mary's Magic Mouthwash, one expired on 10/4/22, the other one expired on 10/20/22. She indicated she would dispose of them.</p> <p>On 10/24/22 at 11:45 a.m., Registered Nurse (RN) 17 was on the Ren 1 medication cart.</p> <p>a. Resident 10 had antacid reliever, opened 2/16/21 and the pharmacy label indicated it expired on 1/22/22. RN 17 indicated she did not decide expiration dates from the pharmacy labels, she used the manufacturer's expiration date of 10/22. She indicated it expired at the end of this month.</p> <p>A current policy, titled, "Medication Storage in the Facility," dated 10/19, was provided by the Director of Nursing Services (DNS), on 10/25/22 at 9:19 a.m. A review of the policy indicated, " ...The medication administration personnel will check the expiration date of each medication before administering it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner"</p> <p>3.1-25(o)</p>	F 0755	<ol style="list-style-type: none"> Residents 10 and 39 were affected. All medications were disposed of with no adverse effects noted. All residents have the potential to be affected. Licensed clinical staff educated on medication expiration dates and returning or wasting expired medications. All medications have been audited to ensure no expired medications are available. As a measure of ongoing compliance, the DHS or designee will conduct medication cart and med room audits weekly x4 weeks, then every other week x2 weeks, then monthly x3 months. 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 reviewed and updated as warranted. 	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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 0757 SS=E Bldg. 00	<p>483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs</p> <p>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>Based on interview and record review, the facility failed to ensure that residents' medication regimen had adequate indication for use for 8 of 8 residents reviewed for medication (Residents 14, 21, 104, 7, 5, 32, 1, and 98)</p> <p>Findings include</p> <p>1. On 10/19/22 at 10:35 a.m., a comprehensive record review was completed for Resident 14. He was prescribed the following medications. These medications lacked rationale for it use.</p> <p>Acetaminophen 325 milligrams (mg) by mouth</p>	F 0757	<p>1. Residents 4, 21, 104, 7, 5, 32, 1, and 98 were affected. All orders have been updated with indication for use. No adverse effects noted.</p> <p>2. All residents have the potential to be affected. All resident orders have been reviewed and indication for use placed. Licensed clinical staff, MD, and NP educated on placing indication when entering medication orders.</p> <p>3. As a measure of ongoing</p>	11/23/2022
----------------------------	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>three times per day (used to treat pain) Atorvastatin 10 mg by mouth at bedtime (used to treat high cholesterol) Cephalexin 500 mg by mouth four times daily (used to treat infections) Combigan (brimonidine-timolol) 0.2-0.5% 1 drop to both eye one time per day (used to treat glaucoma) Daily Multi-vitamin by mouth daily (a supplement) Eliquis 5 mg by mouth two times daily (a blood thinner used to treat blood clots) Fludrocortisone 0.1mg by mouth daily (used to treat the amount of sodium and fluids in the body) Fluticasone Propionate 50 mcg/actuation spray suspension 1 spray to both nostrils, nasal one time per day (used to treat nasal symptoms) Gabapentin 100 mg by mouth two times daily Latanoprost 0.05% drops 1 drop to both eyes at bedtime Levothyroxine 50 mcg by mouth daily (used to treat hypothyroidism) Loratadine 10 mg by mouth daily (used to treat allergies) Pantoprazole 40 mg by mouth daily (used to treat gastric reflux) Sennosides-Docusate Sodium 8.6-50 mg by mouth two times daily (used to treat constipation) Tamsulosin 0.4 mg by mouth at bedtime (used to treat prostate diseases) Thiamine HCL (vitamin B1) by mouth daily (a supplement)</p> <p>2. On 10/24/22 at 3:30 p.m., a comprehensive record review was completed for Resident 21. She was prescribed the following medications. The medication regimen lacked a rational for use of the medications listed below:</p> <p>Acetaminophen 325 mg give 650 mg by mouth three times daily (used to treat pain)</p>		<p>compliance, the DHS or designee will monitor 5 residents charts to ensure indications were added to medication orders, to include new admissions, weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>Amlodipine 10 mg give by mouth daily (used to treat hypertension)</p> <p>Calcium with Vitamin D (calcium carbonate-vitamin D3) 600 mg (1500mg) 400-unit tablet by mouth daily (supplement)</p> <p>Cranberry extract 425 mg by mouth at bedtime (supplement used to help prevent urinary tract infections)</p> <p>Cyanocobalamin (Vitamin B12) 1000 mcg/ml give IM (intramuscular) one time per daily on the 12th in January, March, May, July, September, and November (supplement)</p> <p>Docusate Sodium 100 mg by mouth at bedtime (used to treat constipation)</p> <p>Levothyroxine 100 mcg by mouth daily (used to treat hypothyroidism)</p> <p>Lisinopril 10 mg by mouth at bedtime (used to treat hypertension)</p> <p>Pantoprazole 20 mg by mouth daily (used to treat gastric reflux)</p> <p>Polyethylene Glycol 3350 17 gram/dose powder give 8.5 gram at bedtime with 4-6 ounces of water or juice (used to treat constipation)</p> <p>Refresh Optive Advance (Carboxymethylcellulose-glycerin-poly 80) 0.5-1-0.5% 1 drop both eyes four times per day (used to treat dry eyes)</p> <p>Requip (ropinole) 0.25 mg by mouth at bed (used to treat restless leg syndrome)</p> <p>Warfarin 4mg by mouth daily (a blood thinner used to treat blood clots)3. Resident 104 was prescribed the following medications. These medications lacked rationale for it use.</p> <p>a. Alogliptin 25 mg table, (antidiabetic) once a day.</p> <p>b. Ascorbic acid (vitamin C) (supplement) 500 mg tablet, one a day</p> <p>c. Atorvastatin 40 mg tablet, (treats high cholesterol) at bedtime.</p> <p>d. Cholecalciferol (vitamin D3) (supplement) 25</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>mcg (1,000 unit) capsule, once a day.</p> <p>e. Cyanocobalamin (vitamin B-12) (supplement) 1,000 mcg tablet, once a day.</p> <p>f. Eliquis (apixaban) (anticoagulant) 5 mg tablet, twice a day.</p> <p>g. FeroSul (ferrous sulfate) (supplement) 325 mg (65 mg iron) tablet, once every other day.</p> <p>h. Furosemide (diuretic) 20 mg tablet, once a day.</p> <p>i. Insulin aspart U-100 100 unit/mL (3 mL) insulin pen (antidiabetic), 5 units twice a day.</p> <p>j. Jardiance (empagliflozin) 10 mg tablet (antidiabetic), once a day.</p> <p>k. Lantus Solostar U-100 Insulin (insulin glargine) 100 unit/mL (3 mL) insulin pen (antidiabetic), 19 units twice a day.</p> <p>l. Melatonin 3 mg tablet, (sleep aid) 3 tablets once a day.</p> <p>m. Metformin 1,000 mg tablet, (antidiabetic) twice a day with meals.</p> <p>n. Metoprolol succinate 25 mg tablet extended release 24 hours (antihypertensive), once a day.</p> <p>o. Multivitamin tablet (supplement), once a day.</p> <p>p. Pantoprazole 40 mg tablet, delayed release (DR/EC), (treats acid reflux) twice a day.</p> <p>r. Terazosin 2 mg capsule, (antihypertensive) at bedtime.</p> <p>4. Resident 7 was prescribed the following medications. These medications lacked rationale for it use.</p> <p>a. Atorvastatin 10 mg tablet, (treats high cholesterol) at bedtime.</p> <p>b. Carvedilol 6.25 mg tablet, (antihypertensive) twice a day.</p> <p>c. Eliquis (apixaban) (anticoagulant) 5 mg tablet, twice a day.</p> <p>d. Levetiracetam 250 mg tablet,(anticonvulsant) twice a day.</p> <p>e. Levothyroxine 75 mcg tablet, (hormone supplement) once a day.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>f. Lisinopril 5 mg tablet (antihypertensive), once a morning.</p> <p>g. Multivitamin 7.5 mg iron-400 mcg tablet (supplement), once a day.</p> <p>h. Vitamin D3 (cholecalciferol (vitamin d3)) 50 mcg (2,000 unit) tablet (supplement), once a day</p> <p>5. Resident 5 was prescribed the following medications. These medications lacked rationale for it use.</p> <p>a. Calcium citrate-vitamin D3 315 mg-6.25 mcg (250 unit) tablet (supplement), once a day.</p> <p>b. Cyanocobalamin (vitamin B-12) 1,000 mcg tablet extended release (supplement), once a day.</p> <p>c. Fluoxetine 20 mg capsule, (antidepressant) once a day.</p> <p>d. Hydroxyzine HCl 25 mg tablet, (antihistamine) at bedtime.</p> <p>e. Levothyroxine 75 mcg tablet (hormone supplement), once a day.</p> <p>f. Metoprolol succinate 25 mg tablet extended release 24 hours (antihypertensive), once a day.</p> <p>g. PreserVision tablet, chewable (supplement), once a day.</p> <p>h. Tylenol (acetaminophen) 325 mg tablets x 2, (pain relief), three times a day.</p> <p>6. Resident 32 was prescribed the following medications. These medications lacked rationale for it use.</p> <p>a. Dakin's Solution 0.125 % solution, (strong, topical antiseptic) twice a day.</p> <p>b. Diazepam 10 mg tablet, (antianxiety) at bedtime.</p> <p>c. Diltiazem HCl 240 mg capsule, extended release 24 hours, (antihypertensive) once a day.</p> <p>d. Fluconazole 150 mg tablet, (antifungal) twice a day on Tue and Fri.</p> <p>e. Hydralazine 25 mg tablet, (antihypertensive) twice a day.</p> <p>f. Jantoven (warfarin) 4 mg tablet (anticoagulant),</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>once a day.</p> <p>g. Methylphenidate HCl 10 mg tablet extended release, (treats attention deficit-hyperactivity disorder) once a day.</p> <p>h. Metoprolol succinate 50 mg tablet extended release 24 hours, (antihypertensive), once a day.</p> <p>i. Multivitamin 7.5 mg iron-400 mcg tablet, (supplement), once a day.</p> <p>j. Ondansetron 8 mg tablet, disintegrating (antiemetic), every 8 hours as needed.</p> <p>k. Oxybutynin chloride 5 mg tablet, (bladder relaxant) 3 times a day.</p> <p>l. Pantoprazole 40 mg tablet, delayed release (DR/EC), (treats gastric reflux) once a day.</p> <p>m. Trimethoprim 100 mg tablet, once a day.</p> <p>n. Jantoven (warfarin) 4 mg tablet (anticoagulant), once a day on Sun, Tue, Thu, Fri, and Sat.</p> <p>p. Multivitamin with min-folic acid 0.4 mg tablet (supplement), once a day.</p> <p>q. Omeprazole 40 mg capsule, delayed release (DR/EC), once a day.</p> <p>7. Resident 1 was prescribed the following medications. These medications lacked rationale for it use.</p> <p>a. Amlodipine 10 mg tablet, (antihypertensive) once a day.</p> <p>b. Aspirin 81 mg tablet, chewable (pain relief), once a day.</p> <p>c. Atorvastatin 40 mg tablet, (treats high cholesterol) at bedtime.</p> <p>d. Bisacodyl 10 mg suppository, (laxative) once a day as needed.</p> <p>e. Cyanocobalamin (Vitamin B-12) 1,000 mcg/mL solution (supplement), once a day on the 1st of the month.</p> <p>f. Dantrolene 25 mg capsule, (muscle relaxant) at bedtime.</p> <p>g. Florastor 250 mg capsule, (probiotic) once a day.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>h. Glipizide 5 mg tablet, (anti diabetic) twice a day.</p> <p>i. Magnesium oxide 400 mg (241.3 mg magnesium) tablet (supplement), once a day.</p> <p>j. Melatonin 3 mg tablet, (supplement) at bedtime.</p> <p>k. Pantoprazole 40 mg tablet, delayed release, (treats acid reflux) once a day on Sun, Tue, Thu, and Sat.</p> <p>l. Polysaccharide iron complex 150 mg iron capsule (supplement), twice a day.</p> <p>m. Senna with Docusate Sodium 8.6-50 mg tablet, (treats constipation) twice a day.</p> <p>8. Resident 98 was prescribed the following medications. These medications lacked rationale for it use.</p> <p>a. Acetaminophen 500 mg tablet x 2 (pain relief), three times a day.</p> <p>b. Amlodipine 10 mg tablet, (antihypertensive) once a day.</p> <p>c. Ascorbic acid (vitamin C) 500 mg tablet (supplement), once a day.</p> <p>d. Aspirin 81 mg tablet, chewable, (pain relief), once a day.</p> <p>e. Carvedilol 12.5 mg tablet, (antihypertensive) twice a day.</p> <p>f. Cholecalciferol (vitamin D3) 25 mcg (1,000 unit) capsule (supplement), once a day.</p> <p>g. Ergocalciferol (vitamin D2) 200 mcg/mL (8,000 unit/mL) drops, (supplement), once a day.</p> <p>h. Florastor 250 mg capsule, (probiotic) twice a day.</p> <p>i. Insulin glargine 100 unit/mL (3 mL) insulin pen, 5 unit subcutaneous (antidiabetic), at bedtime.</p> <p>j. Lisinopril 40 mg tablet (antihypertensive), once a day for 30 days.</p> <p>k. Melatonin 3 mg tablet, (sleep aid), at bedtime.</p> <p>l. Multivitamin tablet (supplement), once a day.</p> <p>m. Nystatin 100,000 unit/gram topical cream , (antifungal) three times a day.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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 0812 SS=E Bldg. 00	<p>n. Daily Vites/Iron (multivitamin with iron) tablet (supplement), once a day.</p> <p>o. Piperacillin-tazobactam 3.375-gram reconstituted solution, (antibiotic), four times a day.</p> <p>p. Thiamine HCl (vitamin B1) 100 mg tablet (supplement), twice a day.</p> <p>q. Vancomycin 1,000 mg reconstituted solution, 1 gram intravenous (antibiotic), once a day.</p> <p>r. Zinc sulfate 50 mg zinc (220 mg) tablet (supplement), once a day.</p> <p>On 10/21/22 at 10:26 a.m., the Director of Nursing Services (DNS) indicated the facility did not add reason for physician ordered medications unless they were PRN (as needed) medications only.</p> <p>A policy titled "Guidelines for Medication Orders" was provided by the ED on 10/20/22 at 10:36 a.m., it indicated, " ...When recording orders specify: the type, route, dosage, frequency, strength of the medication and reason for order. (i.e., "dilantin 100mg po, TID for seizure disorder)".</p> <p>3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)</p> <p>483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
--------------------------	--	---------------------	--	----------------------------

	<p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all foods were adequately dated and the snack carts on units "Ren" 1 and 2 did not have expired single serving juices inside for 51 of 52 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>On 10/17/22 at 9:49 a.m., the Dietary Manager (DM) as she provided a kitchen tour, she indicated the kitchen was short staffed.</p> <p>The walk-in refrigerator had food without labels and dates.</p> <ol style="list-style-type: none"> Four opened, but over-wrapped bags of prepared salad. A small container of chicken salad. A small container of peaches. About 30 pounds (lbs.) of butter, One cut pineapple. About 2 lbs. of sliced bacon. A plastic bag of mozzarella shredded cheese. A five lb. plastic wrapped ground beef. It was 	F 0812	<ol style="list-style-type: none"> No residents were affected by the alleged deficient practice. All items were labeled or disposed of if expired. All residents have the potential to be affected. All items audited to ensure label in place and are discarded if expired. Education with culinary team to occur related to labeling items and discarding expired items. As a measure of ongoing compliance, the Direct of Food Services (DFS) will round for completion of labeling, dating, and disposal of expired items, weekly x4 weeks, then every other week x2 months, then monthly x3 months. 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 	11/23/2022
--	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>leaking blood on a solid leak proof tray.</p> <p>i. Four large beef briskets.</p> <p>j. One container of shredded ham in a stainless-steel container.</p> <p>k. A 2 lb. package of ham luncheon meat with no open or expiration date.</p> <p>l. Five lb. package of hot dogs with no open or expiration date. The package was open to the air.</p> <p>m. A whole deli-style ham in 2 wrapped packages.</p> <p>n. A package of pastrami luncheon meat about 32 oz with no open or expiration date.</p> <p>o. Two large, prepared beef pasta containers.</p> <p>p. Six prepared pizzas covered with parchment paper.</p> <p>The walk-in freezer had 2 open boxes with open plastic bags. The DM indicated the first open bag was bread and the second open box was raw chicken.</p> <p>On 10/17/22 at 12:13 p.m., an unlocked snack cart on Ren 1 was observed to have 3 expired, single service cups of prune juice They expired on 7/5/22.</p> <p>On 10/17/22 at 1:58 p.m., an unlocked snack cart on Ren 1 was observed to have 3 expired, single service cups of prune juice They expired on 7/5/22. The housekeeping/laundry supervisor indicated she would let the kitchen know.</p> <p>On 10/19/22 at 9:45 a.m., a locked snack cart on Ren 1 was unlocked by staff personnel. She indicated a resident would have come by and locked it. It was observed to have 9 expired, single service cups of prune juice They expired on 7/5/22. She left it unlocked.</p> <p>On 10/19/22 at 9:50 p.m., LPN 9 indicated we keep the snack cart locked because some diabetic</p>		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: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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 0888 SS=A Bldg. 00	<p>residents will get food from it. Fruit was observed on top.</p> <p>A current policy, titled, "Food Labeling and Dating," dated 4/26/22, was provided by the Executive Director (ED), on 10/24/22 at 12:02 p.m. A review of the policy indicated, " ...Any food item must have a received-on label/received-on date, and or a label that indicates the production date and the use by date for the product ...Foods in production need BOTH a production date AND a use by date ...All food items must be properly covered (not exposed to air) prior to being labeled and dated"</p> <p>483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.</p> <p>§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.</p> <p>§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:</p> <p>(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and</p> <p>(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.</p> <p>§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:</p> <p>(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;</p> <p>(iii) A process for ensuring the implementation of additional precautions,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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
	<p>intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;</p> <p>(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;</p> <p>(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;</p> <p>(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;</p> <p>(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;</p> <p>(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:</p> <p>(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and</p> <p>(B) A statement by the authenticating practitioner recommending that the staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH 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
	<p>member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;</p> <p>(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and</p> <p>(x) Contingency plans for staff who are not fully vaccinated for COVID-19.</p> <p>Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on record review and interview the facility failed to ensure 100% of staff were fully vaccinated for COVID-19, when Dietary Aid (DA) 6 failed to receive the second dose of his initial Pfizer series within the required timeframe for 1 of 1 staff that did not finish the vaccination or exemption process. This deficient practice had the potential to effect 52 of 52 residents who were served from the kitchen after he continued to work past his vaccination due date.</p> <p>Findings include:</p>	F 0888	no POC required due to A level scope and severity.	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(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
	<p>On 10/19/22 at 8:54 a.m., the Infection Preventionist (IP) provided staff vaccination documentation which was reviewed at this time.</p> <p>DA 6 received the first dose of the Pfizer Covid-19 vaccination on 8/8/22. His record indicated the second dose of the series had not been completed and was considered past due on 10/3/22.</p> <p>During an interview on 10/19/22 at 10:45 a.m., the IP indicated he double checked the record and it appeared that DA 6 had not received the second shot, and was therefore not considered fully vaccinated.</p> <p>On 10/19/22 at 11:00 a.m., the IP provided the working schedule for DA 6 and it was reviewed at this time. DA 6 had worked the following days after he was past due for his second shot, in the kitchen as an aid and a server: October 3, 6, 7, 8, 10, 13, 14, 15, 16, 17, 20, 21, and 22, 2022.</p> <p>Upon the survey entrance conference on 10/18/22 at 9:30 a.m., the administrator provided copies of current COVID-19 staff vaccination policies. A current facility policy titled, "COVID-19 Health Care Staff Vaccination," revised 9/28/22 indicated, "...this policy is intended to comply with applicable federal, state, and local laws and regulations, as well and guidance from the Centers for Disease Control and Prevention (CDC) and other public health safety and welfare organizations and agencies ... as a condition of employment, each current employee shall receive the vaccination required under this policy or obtain an approved accommodation ... the facility must develop an maintain a tracking system for facility staff regarding COVID-19 vaccination. Tracking system to include facility staff member</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
R 0000 Bldg. 00	and specific vaccine received including manufacturer and date of each dose or date of next scheduled dose" This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaints IN00392899, IN00390209 and IN00384363 Complaint IN00392899 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00390209 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00384363 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 17, 18, 19, 20, 21, 24 and 25, 2022. Facility number: 013085 Residential Census: 38 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 8, 2022.	R 0000	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.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:</p> <p>(1) meet the needs or preferences, or both, of cognitively impaired residents; and</p> <p>(2) gain understanding of the current standards of care for residents with dementia. Based on interview and record review, the facility failed to complete and submit a Dementia Care Disclosure form, State Form 48896, to the Indiana Department of Health. This deficient practice had the potential to effect 15 of 15 residents who resided in the Memory Care Unit.</p> <p>Findings include:</p> <p>On 10/21/22 at 10:00 a.m., during the entrance conference, with the Executive Director (ED) and Wellness Director (WD), a copy of the Dementia Care Disclosure form was requested.</p>	R 0095	<ol style="list-style-type: none"> 1. No residents were affected by the alleged deficient practice. Form has been completed and ED has submitted the form to the IDOH. 2. No residents have the potential to be affected. Dementia Disclosure Form will be submitted when invitation from IDOH is received. 3. ED has been educated on annual completion of form. 4. As a quality measure, the ED or designee will review findings 	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
R 0215 Bldg. 00	<p>On 10/25/22 at 11:41 a.m., the ED provided a copy of the Dementia Care Disclose Form, State Form 48896. The date completed indicated 10/24/22.</p> <p>On 10/25/22 at 11:41 a.m., during an interview, the ED indicated it was due annually, by December, so it was submitted on time for this year. He was not familiar with the form and the system showed the last submission was 2019. The facility followed the State rules for submission of all required documentation.</p> <p>410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility.</p> <p>Based on record review and interview, the facility failed to complete a preadmission assessment or admission assessment and evaluation for admission to the Assisted Living Facility for 1 of 1 residents reviewed for new admission (Resident 42).</p> <p>Findings include:</p> <p>On 10/25/22 at 9:15 a.m., the medical record was reviewed for Resident 42. The diagnoses included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, heart failure and chronic kidney disease.</p> <p>Resident 42 was admitted to the facility on 9/30/22. The record did not contain a</p>	R 0215	<p>in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted</p> <ol style="list-style-type: none"> 1. Resident 42 was affected. Admission assessment has been completed and no adverse effects noted. 2. All residents on the Assisted Living have the potential to be affected. All new admission in the last 30 days have been reviewed to ensure admission assessment has been completed. Assisted Living licensed staff have been educated on completion of admission assessments for new residents. 3. As a measure of ongoing compliance, the DHS or designee with audit 5 new admissions, as 	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
R 0216 Bldg. 00	<p>preadmission or admission assessment/evaluation and/or admission screenings.</p> <p>Copies of the preadmission and admission assessments and screenings were requested but not provided.</p> <p>On 10/25/22 at 10:39 a.m., during an interview, the Wellness Director (WD) indicated the nurses in the Assisted Living (AL) were responsible to complete assessments for all of the residents. Resident 42 had been over in the Health Center and was transferred to the AL as an Almost Home Stay, short term, when his insurance ran out. If she had them (requested assessments) she would have provided them. They did not have a policy for Almost Home Stay and she had contacted corporate for further guidance.</p> <p>On 10/25/22 at 9:25 a.m., the WD provided a current policy, dated 12/11/22, titled, "Assisted Living Evaluation and Service Plan Guidelines." This policy indicated "Purpose: To provide documentation of nursing and ancillary care needs to develop a service plan. To determine acuity level based on the amount of assistance provide [sic] with both activities of daily living (ADL) and nursing care. Procedures: 1. Upon admission, semi-annually and with significant change in health status or functioning and care needs ...2. A service plan shall be identified and implemented in response to the resident's evaluation and in collaboration with the resident and/or responsible party...."</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs</p>		<p>available, for completion of preadmission/admission assessment weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
--------------------	--	---------------	---	----------------------

	<p>assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who had over the counter medications in his apartment had been assessed and evaluated to self administer medications for 1 of 5 residents observed for medication administration (Resident 42).</p> <p>Findings include:</p> <p>On 10/25/22 at 8:05 a.m., during a medication pass observation, with Licensed Practical Nurse (LPN) 4, Resident 42 was observed seated in his wheel chair, in his apartment.</p> <p>LPN 4 informed Resident 42 she was unable to locate two (2) of his ordered medications. She needed to contact the pharmacy. Medication containers were observed on Resident 42's dresser and bedside table.</p> <p>Upon examination, LPN 4 identified the medications as diphenhydramine 50 mg gel capsules, Systane eye drops and pepto bismol chew tablets. They were not the medications she was looking for.</p> <p>LPN 4 asked Resident 42 about the three (3)</p>	R 0216	<p>1. Resident 42 was affected. New self-administration assessment was completed and resident is no longer able to self-administer. Medications have been removed from resident apartment.</p> <p>2. All residents on the Assisted Living have the potential to be affected. All residents with medications in their room, including over the counter medications, have been reviewed for ability to self-administer medications. Licensed clinical staff have been educated related to medications being brought in from the outside.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will round for medications in rooms and ensure that self-administration is appropriate weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>4. As a quality measure, the ED or designee will review any findings and corrective action at</p>	11/23/2022
--	--	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>medications. He indicated his doctor told him to take sleeping pills whenever he needed them. He needed them to help him sleep because he had pain in his legs. He could not identify the name of the medication or the strength. Those were his medicines and he needed them where he could get to them.</p> <p>On 10/25/22 at 8:20 a.m., during an interview, LPN 4 indicated she would have to call the Nurse Practitioner (NP) for an order, Resident 42 did not have orders for diphenhydramine, pepto bismol or Systane eye drops. He would also need an evaluation to self administer and keep them at bedside. He did not have a self administer order or evaluation.</p> <p>On 10/25/22 at 9:15 a.m., the medical record was reviewed for Resident 42. The diagnoses included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, heart failure and chronic kidney disease.</p> <p>Resident 42 was admitted to the facility on 9/30/22. The record did not contain a medication self administer assessment.</p> <p>On 10/25/22 at 9:25 a.m., the Wellness Director (WD) provided a current policy, dated 8/11/16, titled "Assisted Living Self Administration of Medications Guidelines." This policy indicated "Purpose: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is part of the plan of care. Procedures: Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed for safety by a licensed nurse. Results of the assessment will be presented to the physician for evaluation and an order for self-medication...The medication will be</p>		<p>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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
R 0217 Bldg. 00	<p>kept in a locked drawer in the resident's room. The resident will maintain the key and a second key will be maintained by the licensed nurse and or QMA [Qualified Medication Aid]...Thee assessment will be reviewed bi-annually and PRN [as needed] with change of condition. The assessment will be recorded in the medical record."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>the services to be provided.</p> <p>Based on record review and interview, the facility failed to create a service plan for a newly admitted resident (Resident 42) and failed to complete a semi-annual (180 day) service plan, in a timely manner, for another resident (Resident 47) for 2 of 6 residents reviewed for service plans.</p> <p>Findings include:</p> <p>1. On 10/24/22 at 10:30 a.m., the medical record was reviewed for Resident 47. The diagnoses included, but were not limited to, sinusitis and polyosteoarthritis. He was admitted to the facility on 3/3/22. The medical record contained an initial admission evaluation and service plan, dated 3/3/22.</p> <p>An incomplete semi-annual (180 day) service plan in the electronic record, dated 9/26/22, showed status: incomplete and had no signatures.</p> <p>2. On 10/25/22 at 9:15 a.m., the medical record was reviewed for resident 42. The diagnoses included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, heart failure and chronic kidney disease.</p> <p>Resident 42 was admitted to the facility on 9/30/22. The record did not contain a service plan. A copy of the service plan was requested, but not provided.</p> <p>On 10/25/22 at 10:39 a.m., during an interview, the Wellness Director (WD) indicated the nurses in the Assisted Living (AL) are responsible to complete service plans for all of the residents. Resident 42 had been over in the Health Center and was transferred to AL as a Almost Home Stay, short term, when his insurance ran out. That</p>	R 0217	<p>1. Residents 42 and 47 were affected. Service plans have been completed on both residents with no adverse effects noted.</p> <p>2. All residents on the Assisted Living have the potential to be affected. All residents have been reviewed to ensure that service plans have been completed on admission and semi-annually. Assisted living licensed staff to be educated on completion of admission and semi-annual service plans.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit 5 residents for completion of admission or semi-annual services plans, as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
R 0295 Bldg. 00	<p>was why his paperwork and assessments were not done. If she had them, she would have provided them. They did not have a policy for Almost Home Stay and she had contacted corporate for further guidance.</p> <p>On 10/25/22 at 9:25 a.m., the WD provided a current policy, dated 12/11/22, titled, "Assisted Living Evaluation and Service Plan Guidelines." This policy indicated, "Purpose: To provide documentation of nursing and ancillary care needs to develop a service plan. To determine acuity level based on the amount of assistance provide [sic] with both activities of daily living (ADL) and nursing care. Procedures: 1. Upon admission, semi-annually and with significant change in health status or functioning and care needs"</p> <p>410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review the facility failed to ensure a resident who had over the counter medications in his apartment had them kept secured and had a physician's order for the medications for 1 of 5 residents observed during medication administration (Resident 42)</p> <p>Findings include:</p> <p>On 10/25/22 at 8:05 a.m., during a medication pass observation, with Licensed Practical Nurse (LPN) 4, Resident 42 was observed seated in his wheel chair.</p>	R 0295	<p>1. Residents 42 was affected. Orders for medications have been obtained and medications have been moved to the medication cart to be administered by campus staff. No adverse effects noted.</p> <p>2. All residents on the Assisted Living have the potential to be affected. All residents with medications kept in their apartment have been reviewed to ensure that orders are in place. Staff to be educated on medication brought in from outside and the need for orders to be</p>	11/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>LPN 4 informed Resident 42 she was unable to locate two (2) of his ordered medications. She needed to contact the pharmacy. Medication containers were observed on Resident 42's dresser and bedside table.</p> <p>Upon examination, LPN 4 identified the medications as diphenhydramine 50 mg gel capsules, Systane eye drops and pepto bismol chew tablets. They were not the medications she was looking for.</p> <p>LPN 4 asked Resident 42 about the three (3) medications. He indicated his doctor told him to take sleeping pills whenever he needed them. He needed them to help him sleep because he had pain in his legs. He could not identify the name of the medication or the strength. Those were his medicines and he needed them where he could get to them.</p> <p>On 10/25/22 at 8:20 a.m., LPN 4 indicated she would have to call the Nurse Practitioner (NP) for an order, Resident 42 did not have orders for diphenhydramine, pepto bismol or Systane eye drops. He would also need an evaluation to self administer and keep them at bedside.</p> <p>On 10/25/22 at 9:15 a.m., the medical record was reviewed for resident 42. The diagnoses included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, heart failure and chronic kidney disease.</p> <p>Resident 42 was admitted to the facility on 9/30/22. The record did not contain orders for diphenhydramine, pepto bismol or Systane eye drops. Resident 42 did have orders for trazadone at melatonin at bedtime (for sleep), they were documented as having been administered by the</p>		<p>placed.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit 5 residents for completion of orders for all medications, include self-administered, as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months.</p> <p>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 reviewed and updated as warranted</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2022

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP COD 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
--	--

(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
	<p>nursing staff.</p> <p>On 10/25/22 at 9:25 a.m., the Wellness Director (WD) provided a current policy, dated 8/11/16, titled "Assisted Living Self Administration of Medications Guidelines." This policy indicated "Purpose: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is part of the plan of care. Procedures: Residents requesting to self-medicate or has self-medication as part of their plan of care shall be assessed for safety by a licensed nurse. Results of the assessment will be presented to the physician for evaluation and an order for self-medication...The medication will be kept in a locked drawer in the resident's room. The resident will maintain the key and a second key will be maintained by the licensed nurse and or QMA [Qualified Medication Aid]...Thee assessment will be reviewed bi-annually and PRN [as needed] with change of condition. The assessment will be recorded in the medical record."</p>			