STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00402602 and Residential Complaint IN00406672. Complaint IN00402602 - No deficiencies related to the allegations are cited. Complaint IN00406672 - No deficiencies related to the allegations are cited. Survey dates: November 13, 14, 15, 16, 17 and 20, 2023 Facility number: 013444 Provider number: 155833 AIM number: 201294880 Census Bed Type: SNF/NF: 30 SNF: 21 Residential: 27 Total: 78 Census Payor Type: Medicare: 15 Medicaid: 21 Other: 15 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 29, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Carmel 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 Carmel. 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
Kylie Carmack	Executive Director	12/05/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the discharge MDS (Minimum Data Set) assessment was coded correctly for 1 of 1 resident reviewed for hospital discharge. (Resident 54) Findings include: The record for Resident 54 was reviewed on 11/16/23 at 12:41 p.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, pleural effusion (fluid in the lining of the lungs), morbid obesity, cardiomegaly (enlarged heart), paroxysmal atrial-fibrillation (irregular heart beat), pulmonary hypertension (condition which affects the vessels in the lungs), fibromyalgia, COPD (Chronic Obstructive Pulmonary Disease), chronic diastolic heart failure, and CKD (Chronic Kidney Disease) stage 3. A progress note, dated 10/26/2023 at 1:42 p.m., indicated the resident was discharged to another skilled nursing facility. An MDS assessment, dated 10/26/23, indicated the MDS was coded to reflect a discharge to a short-term general hospital. During an interview, on 11/20/23 at 10:28 a.m., the MDS Coordinator indicated the discharge MDS assessment was incorrectly coded, and the facility followed the RAI (Resident Assessment Instrument) manual. A current, RAI Manual, Version 1.17.1, October	F 0641	F641 1. Resident 54 was affected. Resident is without adverse effect A2105 on 10/26/2030 ARD (assessment reference date) has been modified to reflect discharge to another skilled nursing facility. All like residents MDS with ARD within the last 90 days have been review and modified, as needed. 2. All discharged residents have the potential to be affected. MDS coordinator educated on accurately coding A2105 resident discharge status. 3. As a measure of ongoing compliance, the Assessment Support Nurse or designee will audit 5 MDSs for accurate coding of A2105 discharge status as available, weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the MDS coordinator or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	2019, indicated "...entry and discharge reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they leave a nursing home or when a resident's Medicare Part A stay ends, but the resident remains in the facility...entry/discharge reporting includes entry tracking record, OBRA (omnibus reconciliation act) discharge assessments, Part A PPS (prospective payment system) discharge assessment, and death in facility tracking record...." 3.1-31(b)			
F 0644 SS=D Bldg. 00	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: §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. §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. Based on record review and interview, the facility failed to ensure a PASARR (Preadmission	F 0644	F644 1	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	Screening and Resident Review) Level I had accurate information and a Level I was completed when residents had an added mental health diagnosis and psychotropic medications prescribed for 2 of 2 residents reviewed for PASARR. (Resident 38 and 20) Finding includes: 1. The record for Resident 38 was reviewed on 11/14/23 at 4:09 p.m. Diagnoses included, but were not limited to, bipolar disorder, dementia, and anxiety disorder. The transfer paperwork from a previous long term care facility indicated the resident had been prescribed Risperdal (an antipsychotic medication) 1 mg (milligram) once a day starting on 11/10/22. A care plan, dated 12/6/22, indicated the resident presented with diagnoses of bipolar, anxiety, and depression which was treated with an antipsychotic medication. A PASARR Level I, dated 12/21/22, indicated the resident had no known or suspected mental health diagnoses, no diagnosis of dementia or neurocognitive disorder, no mental health symptoms, and no mental health medications were prescribed. The resident had been prescribed the Risperdal since 11/10/22 and this was not added to the PASARR Level I. A pharmacy recommendation, dated 1/22/3, indicated the resident had been receiving Risperdal since admission and needed an assessment for abnormal involuntary movement.		Resi1. Residents 38 and 20 were affected without adverse effects noted. A new level 1 had been completed on Resident 20 on November 16th and her level 2 was completed on November 21, 2023. Resident 38 had a newly completed level 2 on November 21, 2023. 2 2. All residents have the potential to be affected. Education was provided to the SSD and the MDS Coordinator on the state guidelines for PASARR. An audit was completed to ensure that all residents with appropriate diagnoses have completed levels of care. 3 3. As a measure of ongoing compliance, the SSD or MDS coordinator will audit all new admissions and re-admissions for indicating diagnoses or medications requiring levels of care. In addition, the SSD will audit 5 resident records to ensure that all indicating diagnoses and medications will result in new levels of care. Audits will be conducted as follows: weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months 4 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	A psychiatry note, dated 1/20/23, indicated the resident had a mood disorder and anxiety. The resident's bipolar disorder was improving but the anxiety and depression remained a problem. The medications included, but were not limited to, Risperdal 1 mg at bedtime. A physician's order, dated 9/24/23, indicated to give Risperdal at bedtime for bipolar disorder. During an interview, on 11/16/23 at 12:13 p.m., the Social Services Director (SSD) indicated it was a group effort with social services, admissions, and the Minimum Data Set (MDS) staff to make sure the PASARR process was completed for the residents. 2. The record for Resident 20 was reviewed on 11/14/23 at 4:14 p.m. Diagnoses included, but were not limited to, dementia, schizoaffective disorder (a mental health disorder) bipolar type, and psychotic disorder (a mental health disorder) with delusions due to known physiological condition. A PASRR level 1, dated 11/20/2020, indicated no level II was required due to no significant mental illness, intellectual disability, or related condition. The listed diagnoses were dementia with psychotic disorder with delusions due to known physiological condition and major depressive disorder. The behaviors or symptoms listed were delusions or hallucinations. The outcome rationale indicated the level 1 screen did not identify a PASRR disability, because there was no evidence of a PASRR condition of intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. Although the diagnosis of major depression was reported		campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	further screening was not indicated at that time. A care plan, dated 10/16/22, indicated the resident presents with a diagnosis of schizoaffective disorder, bipolar type which was treated with anti-psychotic medication. The diagnosis list indicated schizoaffective disorder bipolar type, dated 6/1/23. A physician's order, dated 9/24/23, indicated Risperdal (an antipsychotic medication) 0.5 mg twice daily for schizoaffective disorder, bipolar type. During an interview, on 11/15/23 at 4:31 p.m., the Clinical Support Nurse indicated a new screen was not submitted for the changes of schizoaffective diagnosis and the antipsychotic medication. During an interview, on 11/17/23 at 11:35 a.m., the Clinical Support Nurse indicated the facility did not have a PASARR policy and utilized the state guidelines for PASARR. 3.1-16(d)(1)(B)			
F 0684 SS=D Bldg. 00	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. Based on interview and record review, the facility	F 0684	F684	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	failed to ensure a resident received the correct dosage of a narcotic for 1 of 1 resident reviewed for quality of care. (Resident C) Finding includes: During an interview, on 11/13/23 at 1:42 p.m., Resident C's family member indicated the resident was receiving poor care. The Certified Resident Medication Aides (CRMA) passed the medications and made many errors. The CRMA gave the wrong amount of hydromorphone to the resident. The record for Resident C was reviewed on 11/15/23 at 9:17 a.m. Diagnoses included, but were not limited to, traumatic hemorrhage of cerebrum, dementia without behavioral disturbance, malignant neoplasm of esophagus, pacemaker, need for assistance with personal care, and cognitive communication deficit. A care plan, dated 9/12/23, indicated the resident was at risk for potential complications related to diagnoses of esophageal cancer. Interventions included, but were not limited to, manage pain and other uncomfortable symptoms, and provide the resident with medication. A care plan, revised 9/12/23, indicated the resident was at risk for pain. Interventions included, but were not limited to, administer medications as ordered, notify the physician of any side effects observed or lack of effectiveness, and notify physician of increased pain. A physician's order, dated 10/21/23 and discontinued on 10/25/23, indicated hydromorphone (a pain medication) 1mg/ml liquid, to give 3 ml every 4 hours for pain.		1 1. Resident C was affected without adverse occurrences noted. A medication error event was completed and MD, hospice and responsible party made aware. 2 2. All residents have the potential to be affected. All Nurses and Certified Medication Aides were educated on medication administration and an audit was completed to ensure that no other resident had received the incorrect dosing of narcotic medication. 3 3. As a measure of ongoing compliance, DHS or designee to complete random audits of narcotic count sheets of 5 residents weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months 4 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	A physician's order, dated 10/25/23, indicated hydromorphone 1mg/ml liquid, to give 1 ml every 4 hours for pain. A Controlled Drug Use Record indicated the resident received the following: a. On 10/25/23 at 8:00 p.m., the resident received 3 ml of the hydromorphone. b. On 10/26/23 at 12:00 a.m., and 4:00 a.m., the resident received 3 ml of the hydromorphone. c. On 10/27/23 at 12:00 a.m., and 4:00 a.m., the resident received 3 ml of the hydromorphone. During an interview, on 11/20/23 at 10:45 a.m., the Director of Nursing (DON) indicated she was unaware of the incorrect dosages given for the hydromorphone. The medication was given incorrectly five times after the physician's order was changed. The resident should have been given 1 ml every 4 hours and not 3 ml. A current policy, titled "Guidelines for Medication Error Reporting," dated as revised 12/31/22 and received from the DON on 11/20/23 at 11:59 a.m., indicated "...In the event of a medication error, nursing personnel should first take whatever immediate action is necessary to protect the resident's safety and welfare...Notify the attending physician promptly of the error...Implement physician's orders...Notify the resident or responsible party...Initiate the appropriate Event form. Monitor the resident closely for 72 hours or as directed...Document the following in the resident's clinical record...A description of the error (brief)...Name of physician and time notified...Physician's subsequent orders...Medication errors will be reviewed by the Quality Assurance Committee to identify trends and/or actions for implementations...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to implement timely interventions after a fall with a stand-up lift which resulted in another fall with a stand-up lift for 1 of 4 residents reviewed for falls. (Resident 33) Finding includes: The record for Resident 33 was reviewed on 11/15/23 at 3:47 p.m. Diagnoses included, but were not limited to, dementia with agitation, diabetic neuropathy, cognitive communication deficit, altered mental status, repeated falls, and pain in the right hip. A care plan, dated 8/30/21 and last reviewed on 8/25/23, indicated the resident would remain free of falls with major injury. The approaches included, but were not limited to, therapy to screen 8/4/23 and staff education on stand-up lift on 8/4/23. A fall event, dated 8/3/23, indicated the resident was lowered to the floor while being transferred with a stand-up lift. The resident's arm was	F 0689	F689 1 Resident 33 was affected without adverse occurrences noted. 2 All residents whom have had falls have the potential to be affected. An audit was conducted to ensure all residents had documented fall interventions in place. 3 As a measure of ongoing compliance, the DHS or designee will audit to ensure fall interventions are in place. Audit will consist of 5 residents weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	coming out of the pad for the lift. The intervention was for therapy to screen the resident. A therapy screen, dated 8/9/23, indicated the resident had a fall and physical therapy was recommended for the use of an assistive device. A therapy referral, dated 8/11/23 at 7:36 a.m., indicated a therapy screen due to falls/transfer. The resident needed increased assistance on transfers from the bed, the toilet, the wheelchair, and increased assistance with adaptive transfer equipment. Physical therapy was recommended. There was no physical therapy provided by the facility between 8/11/23 and 8/20/23. A fall event, dated 8/20/23, indicated the evening shift Certified Nursing Assistant (CNA) reported having to lower the resident to the floor while she was being transferred with the stand-up lift. The CNA was using the stand-up lift and the resident slid through the safety strap and on to the floor. The resident received a small abrasion to the back of her right thigh. A PT/OT referral was placed by nursing for transfer training due to increasing difficulty and decreasing safety with staff transfers because of functional declines, behaviors, and impaired cognition and memory. A physician's order, dated 8/21/23, indicated for physical therapy (PT) and occupation therapy (OT) to evaluate and treat for the appropriate lift to be used for transfers and increased weakness. A physical therapy (PT) evaluation, dated 9/7/23 through 10/6/23, indicated the resident was referred by nursing for transfer training due to increased difficulty and decreased safety with staff transfers because of functional declines,		campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	behaviors, and impaired cognition/memory. The fall intervention of PT treatment did not occur until 37 days after the initial fall and 29 days after the PT screen on 8/11/23. The facility did not include any other new fall interventions during the lapse in PT treatment being started. During an interview, on 11/16/23 at 3:39 p.m., Physical Therapy Assistant (PTA) 10 indicated a payer verification for physical therapy services had to be submitted. The resident could have been waiting for insurance approval before the physical therapy was started. During an interview, on 11/17/23 at 10:59 a.m., the Clinical Support Nurse indicated if there was one intervention in place such as a physical therapy referral and the resident had not obtained the service and the resident had another fall then the facility should have implemented other interventions. Resident 33's documentation did not include any new interventions for the fall on 8/3/23 and 8/20/23 since the physical therapy could not be started right away. During an interview, on 11/17/23 at 11:22 a.m., the Physical Therapy Department Director indicated the facility had to run a payer verification for long term care residents prior to the start of PT. The resident and families would have to be notified of the insurance copays and give permission for the physical therapy to start. During an interview, on 11/17/23 at 1:37 p.m., the Director of Nursing (DON) indicated the only staff education after the fall, on 8/3/23, were the two staff who were involved in the stand-up lift incident. No other staff were educated on the use of the stand-up lift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	A current policy, titled "Falls Management Program Guidelines," dated as reviewed on 3/16/22 and received from the Clinical Support Nurse on 11/17/23 at 1:46 p.m., indicated "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...A fall is considered to be...'any intentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force...An episode where a resident lost his/her balance and would have fallen, if not for staff interventions, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggested otherwise, when a resident is found on the floor, a fall is considered to have occurred '...Should the resident experience a fall the attending nurse shall complete the 'Fall Event'...This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT [interdisciplinary team] to evaluate thoroughness of the investigation and appropriateness of the interventions...Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...Discuss risks and interventions with resident and/or responsible party and communicate interventions during shift report...." 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to obtain an admission weight upon admission and to obtain a timely reweight after the weight was determined to be invalid for 1 of 3 residents reviewed for nutrition. (Resident 13) Finding includes: The record for Resident 13 was reviewed on 11/15/23 at 11:47 a.m. Diagnoses included, but were not limited to type 2 diabetes, acute on chronic combined systolic (pressure of the arteries when the heart beats) and diastolic (pressure of the arteries between the heart beats) congestive heart failure, and anemia. A progress note, dated 10/17/23 at 6:14 p.m., indicated the resident was admitted on 10/17/23. The resident had the following weights: On 10/22/23, the weight was 130 pounds. The	F 0692	F692 1 1. Resident 13's was affected without adverse occurrences noted. Her weight was obtained. 2 2. All residents have the potential to be affected. Education provided to clinical staff regarding admission weights per policy. An audit was conducted to ensure all residents had completed weights per order and policy. 3 3. As a measure of ongoing compliance, the DHS or designee will audit admission records to ensure admission weights obtained per policy. Audits to occur on 5 residents weekly x4	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	weight was struck out and marked as an invalid weight. This weight was obtained 5 days after the resident admitted to the facility. On 10/30/23, the weight was 113.8 pounds. This weight was taken 8 days after the admission weight was taken and struck out as an invalid weight. A progress note, dated 10/24/23 at 2:21 p.m., indicated the RD (Registered Dietician) reviewed the resident's weight and it was 130 pounds. During an interview, on 11/16/23 at 10:06 a.m., the Clinical Support Nurse indicated the note from the RD on 10/24/23 which indicated the resident weighed 130 pounds was a weight from admission the facility had struck out. During an interview, on 11/16/23 at 2:49 p.m., the Clinical Support Nurse indicated the admission weight was deemed a false weight due to other supporting documents from the resident's dialysis treatments. During an interview, on 11/16/23 at 3:23 p.m., the Clinical Support Nurse indicated the facility had used the weight from dialysis on 10/18 as the resident's admission weight. The facility policy could be interpreted as the facility was supposed to weight the resident instead of using a weight from an outside source such as dialysis. A current policy, titled "Guidelines for Weight Tracking," dated as last revised on 1/16/2021 and received from the Clinical Support Nurse on 11/16/23 at 11:00 a.m., indicated "...Residents will have their weight taken and recorded upon admission to establish a baseline...Scales shall be properly maintained and calibrated to ensure accuracy of weight...Residents who have a weight		weeks, then bi-weekly x 8 weeks, then 5 residents monthly x3 months. 4 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	that seem out of normal range shall be re-weighed to determine the accuracy of the original weight...." 3.1-46 (a)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	controlled drugs is maintained and periodically reconciled. Based on observation and interview, the facility failed to dispose of loose pills and have opened dates on medications in 2 of 3 medication carts and 1 of 1 medication room reviewed for medication storage. (Keystone front cart, Keystone medication room and Brickshire medication cart) Findings include: 1. During an observation, on 11/16/23 beginning at 3:02 p.m., the Keystone front medication cart had the following: a. There were three unidentified pills in the bottom of the second drawer. b. The Ozempic (used for diabetes) 1 milligram (mg) injectable pen did not have an opened date. 2. During an observation, on 11/16/23 at 3:09 p.m., the Keystone medication room had a bottle of lorazepam 2mg/ml in the refrigerator for a resident no longer in the facility. 3. During an observation, on 11/16/23 beginning at 3:15 p.m., the Brickshire medication cart had the following: a. There were four unidentified pills in the bottom of the second drawer. b. A Trelegy Ellipta (for chronic obstructive pulmonary disease) 100-62.5-25 mcg (microgram) inhaler had no opened date. c. A Breo Ellipta (to treat asthma) 200-25 mcg inhaler had no opened date. During an interview, on 11/16/23 at 3:02 p.m., Certified Resident Medication Assistant (CRMA) 11 could not identify the loose pills in the medication cart and indicated all medication	F 0755	F755 1 Loose pills were removed from medication carts. Ozempic and the Lorazepam was disposed of per policy. The inhalers identified at the time of the survey were dated per policy. 2 All residents have the potential to be affected. Education provided to nurses and certified medication aides regarding medication storage and disposition. An audit was conducted by our pharmacy services on November 22, 2023 to ensure that all medications were stored and dated per policy. 3 As a measure of ongoing compliance, the DHS or designee will audit medication carts and medication refrigerators to ensure proper storage, medication labeling and disposition weekly x4 weeks, then 5 bi-weekly x 8 weeks, then monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	should have an opened date on the bottle. During an interview, on 11/16/23 at 3:30 p.m., Licensed Practical Nurse (LPN) 5 indicated there should not be any loose pills in the cart and when a medication was opened, a date needed to be added. During an interview, on 11/16/23 at 3:40 p.m., LPN 4 indicated the medication should have an opened date and when medication was discontinued you need to destroy the medication. 3.1-25(j) 3.1-25(o)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to identify the time frame for the consideration of a gradual dose reduction (GDR) with the use of psychotropic medications and to identify resident specific reasons for the declining of gradual dose reductions for 3 of 5 residents reviewed for unnecessary medications. (Resident 38, 33 and 34) Findings include: 1. The record for Resident 38 was reviewed on 11/14/23 at 4:09 p.m. Diagnoses included, but were not limited to, bipolar disorder, dementia, and	F 0758	F758 1 1. Residents 38, 33 and 34 were affected without adverse occurrences noted. Pharmacist and psych provider made aware and residents reviewed/assessed by psych provider on 12/4/23 for appropriateness of GDR. 2 2. All residents on psychotropic medications have the potential to be affected. An audit was conducted to ensure all like residents are reviewed for GDR per	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	anxiety disorder. A physician's order, dated 11/28/22 and opened ended, indicated to give Xanax (an antianxiety medication) 0.25 milligram (mg) at bedtime for anxiety. An order set for target behaviors, dated 11/28/22, indicated to monitor for anxiety behaviors which included agitation, tearfulness, attention seeking, repetitive concerns, and yelling out. A care plan, dated 12/6/22, indicated the resident had the diagnoses of bipolar, anxiety and depression and was treated with antipsychotic medications. The approaches included, but were not limited to, titrate the medication to the lowest effective dose. A psychiatric progress note, dated 1/30/23, indicated the resident was prescribed Xanax 0.25 mg at bedtime for anxiety and the Xanax was not subject to the GDR protocol. A psychiatric progress note, dated 2/27/23, indicated the resident was prescribed Xanax 0.25 mg for anxiety related to the diagnosis of dementia. A dose reduction was contraindicated due to a high risk of symptom escalation. A psychiatric note, dated 11/6/23, indicated the assessment was for anxiety and depression. The generalized anxiety disorder was chronic and stable. A dose reduction was contraindicated due to a high risk of symptom escalation. The psychiatric notes did not include the length of time the resident had been on the Xanax, if it was time to consider a GDR and the resident specific clinical rationale for not completing a GDR		policy. DHS and SSD educated on GDR policy. 3 3. As a measure of ongoing compliance, the DSS or designee will audit to ensure GDR documentation is resident specific. Audits to occur on 5 residents weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 months. 4 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	including what symptoms the resident had or what symptoms would escalate. 2. The record for Resident 33 was reviewed on 11/15/23 at 3:47 p.m. Diagnoses included, but were not limited to, dementia with agitation, a mood disorder due to a known physiological cause, major depressive disorder severe with psychotic symptoms, and generalized anxiety disorder. A care plan, dated 8/30/21, indicated the resident was at risk for developing adverse effects from the use of antidepressant medications. The approaches included, but were not limited to, attempt a GDR in two separate quarters with at least one month between the attempts during the first year the resident received the medication and then yearly unless clinically contraindicated. A target set of behaviors, dated 10/24/21, indicated to monitor for depression, mood swings, negative statements, and sad facial expression. A physician's order, dated 3/31/2022 and open ended, indicated to give venlafaxine (an antidepressant) once a day. A care plan, dated 11/17/22, indicated the resident was at a risk for developing adverse effects from the use of an anticonvulsant medication prescribed for a mood disorder due to a known physiological condition. The approaches included, but were not limited to, attempt a GDR in two separate quarters with at least one month between the attempts during the first year the resident receives the medication and then yearly unless clinically contraindicated. A target set of behaviors, dated 10/24/23, indicated to monitor for anxiety, agitation,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	tearfulness, and attention seeking. A physician's order, dated 6/2022 and open ended, indicated to give Depakote extended release (an anticonvulsant prescribed as a mood stabilizer) 250 mg daily. A psychiatric progress note, dated 9/18/23, indicated a GDR for Depakote was contraindicated due to a high risk of symptom escalation. A GDR for venlafaxine was contraindicated due to a high risk of symptom escalation. The Depakote was for mood and depression. The psychiatric progress note did not include the length of time the resident had been on the same doses of the Depakote and the venlafaxine. The progress note did not include the resident specific symptoms which would escalate of if a GDR had been attempted in the past year. The progress notes did not include the rationale for a mood stabilizer and an antidepressant to be prescribed together. 3. The record for Resident 34 was reviewed on 11/16/23 at 10:42 a.m. Diagnosis included, but were not limited to, generalized anxiety disorder, panic disorder, chronic respiratory failure, and depression. A care plan, dated 11/17/22, indicated the resident was at a risk for developing adverse effects from the use of an antidepressant medication. The approaches included, but were not limited to, attempt a GDR in two separate quarters with at least one month between the attempts during the first year the resident receives the medication and then yearly unless clinically contraindicated. A target set of behaviors, dated 8/15/22, indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	to monitor for depression, verbalization of distress, refusals to get out of bed, refusals of care, tearfulness, and refusing to attend favorite activities. A physician's order, dated 10/19/22 and open ended, indicated to give sertraline (an antidepressant) 125 mg once a day. During an interview, on 11/17/23 at 1:37 p.m., the Clinical Support Nurse indicated Resident 38 and 33 did not have a GDR recommendation which listed the length of time the residents had been on the medications or a resident specific reason the GDR would not be considered. The psychiatric nurse practitioner did write for each resident the general statement the GDR was contraindicated due to a high risk of symptom escalation and did not give resident specific information. Resident 34 did not have a GDR the past year for the antidepressant. A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reduction," dated as reviewed on 12/31/22 and received from the Clinical Support Nurse on 11/17/23 at 1:46 p.m., indicated "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate...A gradual does reduction [GDR] will			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	be attempted for two [2] separate quarters [with at least one month between attempts] per the physician's recommendation. Gradual dose reductions must be attempted annually thereafter, unless medically contraindicated...Reviews of medication use will be conducted by the consultant pharmacist monthly and will...Notify the physician and the nursing staff whenever a psychotropic medication is due for review...." 3.1-48(b)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Residential Complaint IN00406672 and Nursing Home Complaint IN00402602. Complaint IN00406672 - No deficiencies related to the allegations are cited. Complaint IN00402602 - No deficiencies related to the allegations are cited. Survey dates: November 13, 14, 15, 16, 17 and 20, 2023 Facility number: 013444 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 29, 2023.	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Carmel 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 Carmel. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
			respectfully requests from the department a desk review for substantial compliance.	
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance (f) Residents may use the pharmacy of their choice for medications administered by the facility, as long as the pharmacy: (1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws; (2) provides prescribed service on a prompt and timely basis; and (3) refills prescription drugs when needed, in order to prevent interruption of drug regimens. Based on observation, interview and record review, the facility failed to ensure a narcotic medication card was fully intact in 1 of 1 medication cart and the refrigerator in the medication room had recorded temperatures for 1 of 1 medication room reviewed for medication storage. Findings include: 1. During a medication storage observation, on 11/17/23 at 11:45 p.m., the following was observed: a. A medication card for tramadol (a pain medication) 50 mg (milligram) had the foil torn on the back of the card over the dose 1 with tape covering the back to hold the medication in the card. During an interview, on 11/15/23 at 11:28 a.m., CRMA 3 indicated the dose of tramadol should have been destroyed since the back of the card was taped.	R 0305	R305 1. The medication Tramadol was disposed of per medication disposition policy. The Refrigerator log was initiated for the medication Refrigerator. 2. All residents have the potential to be affected. An initial audit was conducted to ensure all medications were in un-tampered and in secure packaging per policy. All refrigerators were audited to ensure temp logs were in place. 3 As a measure of ongoing compliance, the DHS or designee will audit to ensure refrigerator temp logs are updated and completed and medication carts will be audited to ensure medications are in secured packaging. Audits to occur on	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	During an interview, on 11/17/23 at 2:38 p.m., the Director of Nursing (DON) indicated the taped tramadol needed to be destroyed and recorded. 2. The refrigerator in the medication room did not have completed refrigerator temperature. The Refrigerator/Freezer temperature logs were as follows: a. The February log was missing 2 days. b. The March log was missing 12 days. c. The April log was missing 16 days. d. The May log was missing 13 days. e. The June log was missing 21 days. f. The July log was missing 27 days. g. The August log was missing 22 days. h. The September log was missing 29 days. i. There was no October log. j. There was no November log. During an interview, on 11/17/23 at 2:00 p.m., CRMA 3 indicated the refrigerator temperatures need to be written on the temperature log sheet. During an interview, on 11/17/23 at 10:10 a.m., the Director of Nursing indicated the refrigerator temperatures should be recorded on the temperature log posted on the refrigerators in the medication rooms. A current policy, titled "Refrigerator," dated as revised 5/16/17 and received by the Clinical Support Nurse on 11/20/23 at 4:00 p.m., indicated "...To assure that appropriate temperatures are maintained in the campus refrigerators for the health and safety of our residents...Will have a functioning thermometer present in a visible location inside the unit. Will be monitored daily. Temperature checks will be documented on the		weekly x4 weeks, then 5 bi-weekly x 8 weeks, then 5 monthly x3 months. 4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	11/20/2023

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

(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
	refrigerator monitoring log daily...."			