STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING **01** B. WING _____	R **01/18/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/12/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 1/18/24 Facility Number: 013444 Provider Number: 155833 AIM Number: 201294880 At this PSR Life Safety Code survey, Wellbrooke of Carmel was found in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility located on the first floor of a two-story building was determined to be of Type V (111) construction and fully sprinklered. A 2-hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first-floor healthcare occupancy and the second-floor residential occupancy is provided by a 2-hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2-hour rated construction. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 74 and had a census of	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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
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{K 000}	Continued From page 1 48 at the time of this PSR visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 01/19/24	{K 000}		