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	01/17/2025

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 13, 14, 15, 16, and 17, 2025 Facility number: 013444 Provider number: 155833 AIM number: 201294880 Census Bed Type: SNF: 33 SNF/NF: 22 Residential: 32 Total: 87 Census Payor Type: Medicare: 23 Medicaid: 17 Other: 15 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 23, 2025.	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 an 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.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to ensure a resident's code status was changed when an out of hospital do not resuscitate declaration and order was received for 1 of 3 residents reviewed for advanced directives.	F 0578	F578 1 Resident 9 was affected. Upon discovery, the code status order was immediately changed as well as the status on the	02/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandie Briggs	RN, Clinical Support	02/17/2025

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	(Resident 9) Finding includes: The clinical record for Resident 9 was reviewed on 1/15/25 at 2:35 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, hypertension, attention-deficit hyperactivity disorder, anxiety disorder, depressive disorders, bipolar II disorder, and chronic kidney disease. A physician's order, dated 12/14/24, indicated the resident's code status was a full code. An out of hospital do not resuscitate declaration and order form, dated 12/19/24, was signed by the resident on 12/19/24. The physician signed the form on 12/26/24. It was scanned into the electronic medical record on 12/26/24. The physician did not sign the form until 6 days after the resident signed the form. A social service note, dated 12/19/24 at 9:57 a.m., indicated the resident's code status was reviewed and updated to do not resuscitate during her care plan meeting. A physician's progress note, dated 12/23/24 at 1:03 p.m., indicated the resident was a full code. A physician's progress note, dated 1/13/25 at 12:15 p.m., indicated the resident was a full code. On 1/13/25 at 11:35 a.m., the resident was listed as a full code at the top of her electronic medical record and on her face sheet. On 1/14/25 at 3:54 p.m., Resident 9 was listed as a full code in the information banner of the		resident banner in the electronic medical record to reflect accurate code status. 2 All residents have the potential to be affected. A house wide audit was conducted to ensure that all residents had matching code status orders to the most updated signed code status. Education was provided on Advance Directives. 3 As a measure of ongoing compliance, all new admissions, re-admissions and residents with scheduled quarterly care plan meetings will be audited to ensure no discrepancies in advanced directives. Audits will be conducted weekly x 4 weeks, then every other week x 8 weeks then monthly x 3 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.	

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	electronic medical record. During an interview, on 1/15/25 at 2:53 p.m., the Director of Nursing (DON) indicated the signed form was scanned into the resident's medical record, but the facility was just now updating their charting system with the correct order and changing it in the electronic medical record. It had been missed and was listed incorrectly until now. During an interview, on 1/15/25 at 3:11 p.m., LPN 2 indicated in an emergency, staff would check the computer and look at the resident's top banner information to find out if they should start CPR or if resident wished to be a DNR. A current facility policy, titled "Guidelines for Advanced Directives," dated as revised on 9/26/24 and provided by the Clinical Support Nurse 3 on 1/17/25 at 10:25 a.m., indicated "...To ensure facility staff obtains and follows resident's advanced directives regarding end-of-life care...The nursing staff will confirm the desired code status and obtain an order from the physician...Designation of code status and obtainment of physician order will be part of the medical record. 3.1-4(f)(5)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure a care plan meeting was offered or held for 3 of 3 residents reviewed for care plan meetings. (Resident 23, 29 and 30) Findings include:	F 0657	F657 1 Residents 23, 29 and 30 were affected. Care plan (Resident first) meetings were not held with all 3 residents on a quarterly basis. 2 All residents have the	02/07/2025

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	1. The clinical record for Resident 23 was reviewed on 1/15/25 at 2:20 p.m. The diagnoses included, but were not limited to, depression, anxiety disorder, and Alzheimer's disease. The record for Resident 23 did not have a quarterly care plan meeting documented between 4/17/24 and 12/4/24. During an interview, on 1/17/25 at 10:03 a.m., the Clinical Support Nurse 3 indicated the resident had a care plan meeting on 4/17/24 and 12/4/24, but nothing in between.2. The clinical record for Resident 29 was reviewed on 1/14/25 at 3:29 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, insomnia, and visual hallucinations. A review of the "Resident First Meeting Minutes" indicated the facility had not conducted a care plan meeting for Resident 29 since 5/30/24. The resident had not had a quarterly care plan meeting held since that time. A nursing progress note, dated 10/11/24, indicated Resident 29 had been experiencing intermittent hallucinations. A psychiatry note, dated 10/16/24, indicated Resident 29 had been experiencing visual hallucinations since her husband's death in April 2024. The hallucinations had started to occur more frequently, and Resident 29 was started on Risperidone (an antipsychotic medication) for the visual hallucinations. During an interview, on 1/16/25 at 3:01 p.m., the Clinical Support Nurse 3 indicated the facility had not held a care plan meeting for Resident 29 since 5/30/24 and the last quarterly meeting had been		potential to be affected. A house wide audit was conducted to identify all residents who are out of compliance with care plan meetings. A schedule was created to ensure completion of late Care plan meetings. Education was completed with the Social Services Director on Care Plan timing. 3 As a measure of ongoing compliance, the ED or designee will review 5 residents for updated Care plan/RFM meetings quarterly. Audits will occur weekly x 4 weeks, then every other week x 8 weeks 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 warranted.	

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	missed. 3. During an interview, on 1/13/25 at 11:37 a.m., Resident 30 indicated she had not been invited to attend a care plan meeting in a long time. The clinical record for Resident 30 was reviewed on 1/14/25 at 3:37 p.m. The diagnoses included, but were not limited to, malignant neoplasm of upper lobe, left bronchus or lung, severe protein-calorie malnutrition, and muscle weakness. A review of the "Resident First Meeting Minutes" indicated the facility had not conducted a care plan meeting for Resident 30 since 7/15/24. During an interview, on 1/16/25 at 3:01 p.m., the Clinical Support Nurse 3 indicated the facility conducted a care plan meeting in January 2025, but it was after the last quarterly care plan meeting was due. She indicated the facility had significant employee turnover and had focused on conducting care plan meetings for the rehab residents. A current facility policy, titled "Resident's First Meeting Guidelines," dated as last reviewed on 12/17/24 and received from the Clinical Support Nurse 3 on 1/16/25 at 2:59 p.m., indicated "...To facilitate communication and participation regarding the residents plan of care, medical condition and care needs between the resident, family, resident representative and care givers...Subsequent meetings for non-Medicare residents should be conducted at a minimum of quarterly and with significant change...Subsequent meetings for Medicare residents should be conducted minimally quarterly...Director of Social Services or designee should send invitations to the resident and/or			

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	representative notifying them of the date and time of the conference as far in advance as possible...Prior to the meeting the interdisciplinary team members should: Review the resident's condition since the last assessment...Review recent changes in medications and physician's orders...Make sure issues related to Falls, Restraints, Skin breakdown, Psychotropic medications, and Weight loss/gain are discussed and that reasonable, measurable goals and effective interventions are implemented and documented...The Resident First Meeting is a time to communicate information related to care needs and medical condition and seek input from the resident or representative...Review the residents condition since the last meeting. Recent changes in medications and physician's orders, problems, and any areas of concern should be discussed with the team, family, and resident...Discuss additions or changes that may be needed to goal areas or care routine allowing input from the resident and/or representative...." 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(2)(B) 3.1-35(e)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a blood pressure medication was held according to the physician's ordered hold parameter and to ensure the physician was notified for an elevated blood sugar level according to the call parameter for 3 of 3 residents reviewed for quality of care. (Resident 194, 4 and 2)	F 0684	F684 1 Residents 194, 4, 2 were affected. All residents' providers were made aware of the hold and call orders as well as vital results. None of the residents (194, 4 and 2) had adverse effects from medication received or lack of provider notification.	02/07/2025

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	Findings include: 1. The clinical record for Resident 194 was reviewed on 1/15/25 at 11:29 a.m. The diagnoses included, but were not limited to, metabolic encephalopathy, hypotension, anemia, dementia, and type 2 diabetes mellitus. A physician's order, dated 1/9/25, indicated to give midodrine (a medication used to treat orthostatic hypotension) 5 milligrams (mg) twice a day with special instructions to hold the medication for a systolic blood pressure greater than 120. A review of the January 2025 Medication Administration Record, dated January 8 through 17, 2025, indicated the medication was administered to Resident 194 when the systolic blood pressure was greater than 120 on the following days: On 1/9/25, the resident's systolic blood pressure was 122 in the morning and 126 in the evening, and the medication was administered. On 1/10/25, the resident's systolic blood pressure was 132 in the morning and 129 in the evening, and the medication was administered. On 1/11/25, the resident's systolic blood pressure was 128 in the evening, and the medication was administered. On 1/12/25, the resident's systolic blood pressure was 126 in the morning, and the medication was administered. On 1/13/25, the resident's systolic blood pressure was 130 in the morning and 129 in the evening, and the medication was administered. On 1/14/25, the resident's systolic blood pressure was 130 in the morning and 135 in the evening, and the medication was administered. On 1/15/25, the resident's systolic blood pressure		2 All residents with hold or call parameters have the potential to be affected. A house wide audit was conducted to ensure no other residents had vital signs outside of hold parameters or call parameters without proper action from licensed nurses. The provider reviewed all residents with hold parameters for medications and made changes as warranted. Education was provided to Qualified medication aides as well as licensed nurses on call parameters, hold parameters and following physician orders. 3 As a measure of ongoing compliance, DHS or designee will review 5 residents with vital parameters with orders to ensure that all out of range readings are communicated to medical provider and medications are held/given per parameter orders. Audits will occur weekly x 4 weeks, then every other week 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.	

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	was 136 in the morning and 132 in the evening, and the medication was administered. On 1/16/25, the resident's systolic blood pressure was 137 in the morning and 136 in the evening, and the medication was administered. On 1/17/25, the resident's systolic blood pressure was 134 in the morning, and the medication was administered. The electronic medical record did not include documentation of notification to the physician of the medication being administered outside the ordered hold parameters. During an interview, on 1/15/25 at 3:11 p.m., LPN 2 indicated the staff member's initials were in parenthesis when a medication was held. When there was no parenthesis, the medication was administered. During an interview, on 1/16/25 at 12:06 p.m., the Clinical Support Nurse 3 indicated the nurse should follow the ordered hold parameters and not administer the medication. 2. The clinical record for Resident 4 was reviewed on 1/14/25 at 3:42 p.m. The diagnoses included, but were not limited to, hypertension, hyperlipidemia (high cholesterol), and type 2 diabetes. A physician's order, dated 5/29/24, indicated to give carvedilol (an antihypertensive medication) 12.5 milligrams twice a day. The order had special instructions to hold the medication if the systolic blood pressure was less than 100 or if the heart rate (pulse) was less than 65 beats per minute. A review of the November 2024 Medication Administration Record indicated the medication			

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	was administered to Resident 4 when her heart rate was less than 65 beats per minute on the following days: On 11/05/24, the resident's heart rate was 64 in the morning, the medication was administered. On 11/11/24, the resident's heart rate was 64 in the morning, the medication was administered. On 11/20/24, the resident's heart rate was 64 in the evening, the medication was administered. A review of the December 2024 Medication Administration Record indicated the medication was administered to Resident 4 when her heart rate was less than 65 beats per minute on the following days: On 12/09/24, the resident's heart rate was 60 in the morning, the medication was administered. On 12/13/24, the resident's heart rate was 64 in the morning, the medication was administered. On 12/14/24, the resident's heart rate was 62 in the morning, the medication was administered. On 12/15/24, the resident's heart rate was 63 in the morning, the medication was administered. On 12/16/24, the resident's heart rate was 63 in the morning, the medication was administered. On 12/20/24, the resident's heart rate was 63 in the morning, the medication was administered. On 12/23/24, the resident's heart rate was 61 in the morning, the medication was administered. On 12/24/24, the resident's heart rate was 60 in the morning, the medication was administered. On 12/24/24, the resident's heart rate was 63 in the evening, the medication was administered. On 12/30/24, the resident's heart rate was 64 in the evening, the medication was administered. A current care plan, dated as last revised on 12/17/24, indicated the resident had a potential for cardiovascular distress due to a diagnosis of hypertension and to administer medications as			

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	ordered. During an interview, on 1/16/25 at 10:12 a.m., LPN 1 indicated she followed the physician's order and would not give the carvedilol medication if the heart rate was less than 65.3. The clinical record for Resident 2 was reviewed on 1/15/23 at 10:29 a.m. The diagnoses included, but were not limited to, diabetes mellitus, hypertensive, anxiety disorder, major depressive disorder, and acute kidney failure. A care plan indicated the resident was at risk for hypoglycemia and hyperglycemia related to diabetes mellitus. Interventions included, but were not limited to, give medication per the physician's order and monitor blood sugars per the physician's order. A physician's order, dated 6/13/24, indicated to give Humalog U-100 Insulin solution subcutaneously before meals per the sliding scale. If the blood sugar was less than 70, call the physician. If the blood sugar was 151 to 200, give 0 units. If the blood sugar was 201 to 250, give 4 units. If the blood sugar was 251 to 300, give 6 units. If the blood sugar was 301 to 400, give 10 units. If the blood sugar was greater than 400, call the physician. The Medication Administration Record indicated the resident's blood sugar was 576 on 7/11/24. There was no documentation the physician was notified of the blood sugar greater than 400. During an interview, on 1/16/25 at 8:58 a.m., the Director of Nursing (DON) indicated there was no notification to the physician on 7/11/24 for the			

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	576-blood sugar reading. The nurse did not notify the physician of the blood sugar and should have. During an interview, on 1/16/25 at 11:12 a.m., Licensed Practical Nurse (LPN) 5 indicated if the resident's blood sugar was out of range, she would give the highest amount on the sliding scale and call the doctor to ask if any additional insulin was needed. The facility did not have a policy for blood glucose monitoring. A current facility policy, titled "Medication Administration-General Guidelines," dated as revised 1/2017 and received from the Clinical Support Nurse 3 on 1/17/25 at 10:25 a.m., indicated "...Medications are administered in accordance with written orders of the prescriber...." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to ensure the suprapubic catheter urine output was accurately recorded for 2 of 3 residents reviewed for urinary catheters. (Resident 20 and 1) Finding includes: 1. The clinical record for Resident 20 was reviewed on 1/15/25 at 2:40 p.m. The diagnoses included, but were not limited to, obstructive and reflux uropathy (hindrance of normal urine flow), feeling of incomplete bladder emptying, retention of urine, and the presence of urogenital implants (helps provide normal urine flow).	F 0690	F690 1 Residents 20 and 1 were affected but without adverse effect. 2 All residents with orders for urinary output monitoring have the potential to be affected. Clinical staff were educated on entering urinary output in mL in the electronic medical record. 3 As a measure of ongoing compliance, the DHS or designee will audit the urinary output documentation for 5 residents with catheters weekly x 4 weeks then every other week x 8 weeks	02/07/2025

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	A care plan, dated 2/9/23, indicated the resident had a suprapubic catheter (a tube which drains urine from the bladder through a small incision in the lower abdomen). Interventions included, but were not limited to, record the resident's urinary output and assist with catheter care. A physician's order, dated 2/24/23, indicated to monitor catheter output every shift. A Treatment Administration Record (TAR), dated 12/28/24 through 1/15/25, indicated to empty the catheter every shift and document the output. The following was documented: On 12/29/24 at 8:46 p.m., large was recorded. On 12/30/24 at 2:40 a.m., medium was recorded. On 12/30/24 at 12:00 p.m., medium was recorded. On 12/31/24 at 6:53 a.m., medium was recorded. On 1/1/25 at 9:20 a.m., large was recorded. On 1/2/25 at 8:57 p.m., large was recorded. On 1/3/25 at 1:37 p.m., large was recorded. On 1/4/25 at 8:52 p.m., large was recorded. On 1/5/25 at 9:18 p.m., large was recorded. On 1/5/25 at 11:01 p.m., medium was recorded. On 1/6/25 at 2:16 p.m., medium was recorded. On 1/8/25 at 1:31 p.m., medium was recorded. On 1/9/25 at 12:51 p.m., large was recorded. On 1/9/25 at 1:30 p.m. large was recorded. On 1/12/25 at 1:58 p.m., medium was recorded. On 1/14/25 at 1:39 p.m., medium was recorded. On 1/15/25 at 5:31 a.m., large was recorded. On 1/15/25 at 11:53 a.m., large was recorded. On 1/15/25 at 3:22 p.m., large was recorded. During an interview, on 1/16/25 at 10:38 a.m., Licensed Practical Nurse (LPN) 5 indicated the Certified Nursing Assistant (CNA) normally charted the urine output. If they did not have time, she would add them into the electronic medical		then monthly x 3 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.	

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	155833	A. BUILDING 00 B. WING	01/17/2025

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	record. The urine output should have been documented as milliliters. During an interview, on 1/16/25 at 10:51 a.m., CNA 6 indicated she did not know why the exact urine amount was not documented when the CNA emptied the catheter into the graduated cylinder. When she charted the amount of urine, she would add the amount in milliliters. When the bag was full to the top, she would consider the amount large, halfway would be medium and small would be hardly anything in the bag. During an interview, on 1/16/25 at 11:02 a.m., CNA 7 indicated staff should not chart the catheter outputs by using small, medium, and large for the amounts.2. The clinical record for Resident 1 was reviewed on 1/14/25 at 3:32 p.m. The diagnoses included, but were not limited to, sepsis (a life-threatening complication of an infection), urinary tract infection (UTI), urethral stricture (a condition which blocks the flow of urine), and urinary retention. A physician's order indicated Resident 1 had a suprapubic catheter (a tube which drains urine directly from the bladder through a small incision in the lower abdomen) due to urethral stricture. A physician's order, dated 5/16/24, indicated to monitor Resident 1's urinary output three times a day, every shift. A Treatment Administration Record (TAR), dated 12/1/24 through 1/15/25, indicated the following documented urinary outputs: On 12/1/24 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 12/1/24 between 2:00 p.m. to 10:00 p.m., medium was recorded.			

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	On 12/3/24 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 12/3/24 between 2:00 p.m. to 10:00 p.m., medium was recorded. On 12/17/24 between 6:00 a.m. to 2:00 p.m., large was recorded. On 12/17/24 between 2:00 p.m. to 10:00 p.m., large was recorded. On 12/18/24 between 6:00 a.m. to 2:00 p.m., large was recorded. On 12/19/24 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 12/20/24 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 12/20/24 between 10:00 p.m. to 7:00 a.m., large was recorded. On 12/21/24 between 6:00 a.m. to 2:00 p.m., large was recorded. On 12/23/24 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 12/30/24 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 1/4/25 between 2:00 p.m. to 10:00 p.m., large was recorded. On 1/4/25 between 2:00 p.m. to 10:00 p.m., large was recorded. On 1/5/25 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 1/5/25 between 2:00 p.m. to 10:00 p.m., medium was recorded. On 1/6/25 between 6:00 a.m. to 2:00 p.m., large was recorded. On 1/6/25 between 2:00 p.m. to 10:00 p.m., large was recorded. On 1/8/25 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 1/10/25 between 6:00 a.m. to 2:00 p.m., medium was recorded. On 1/10/25 between 2:00 p.m. to 10:00 p.m., large was recorded.			

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	On 1/11/25 between 6:00 a.m. to 2:00 p.m., large was recorded. On 1/13/25 between 6:00 a.m. to 2:00 p.m., medium was recorded. During an interview, on 1/16/25 at 11:03 a.m., Certified Nursing Assistant (CNA) 4 indicated to measure urinary output from a catheter, the catheter bag would be emptied into a urinal and the amount would be documented in mL (milliliters). CNAs document the output in the Matrix (a facility charting platform). The catheter bag would be emptied at least once a shift, or when the catheter bag looked like it needed emptied. During an interview, on 1/16/25 at 11:16 a.m., LPN 5 indicated the nurse would obtain the urinary outputs from the CNAs and document the output in the Treatment Administration Record (TAR). The urinary output amount should be documented in milliliters. During an interview, on 1/16/25 at 12:16 p.m., Clinical Support Nurse 3 indicated the facility did not have a policy regarding documentation of intake and outputs. The Indiana State Department of Health Nurse Aide Curriculum, revised 11/19/15, indicated "...Resident Care Procedure (RCP) 50...Empty Urinary Drainage Bag...Detach spout (if bag has one) and point the drainage tube into center of graduated cylinder without letting tube touch sides...Unclamp spout and drain urine...Check urine for color, odor, amount and characteristics and report unusual findings to nurse...Changes may be first signs of medical problem. By alerting the nurse you ensure that the resident receives prompt attention...Measure and accurately record			

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	amount of urine...Accuracy is necessary because decisions regarding resident ' s care may be based on your report...." 3.1-41(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure medication administration or reason medication was not given was documented in the Medication Administration Record for 1 of 7 residents reviewed for documentation. (Resident 30) Finding includes: The clinical record for Resident 30 was reviewed on 1/14/25 at 3:43 p.m. The diagnoses included, but were not limited to, adjustment disorder with mixed anxiety and depressed mood, constipation, and bilateral pulmonary embolism (a clot in the lungs). The Medication Administration Record (MAR) was missing documentation of medication administration or lack of administration on the following days: A physician's order for buspirone (an anxiety medication) 5 milligrams (mg) was to be given twice a day for an adjustment disorder. There was no documentation, on 12/12/24, to indicate the evening dose was administered. A physician's order for cholecalciferol (a supplement) 50 micrograms (mcg) was to be given once a day. There was no documentation, on 12/12/24, to indicate the dose was administered.	F 0842	F842 1 Resident 30 was identified with no adverse effects. 2 A campus wide audit was completed to ensure that the eMARs were without omissions for the month and corrective action followed if warranted. Education was provided to all Qualified Medication aides and Licensed nurses 3 DHS or Designee to conduct audits to ensure that eMARS are without omissions weekly x 4 weeks then every other week x 8 weeks then monthly x 3 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.	02/07/2025

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R 0000	A physician's order for Cymbalta (an antidepressant) 20 mg was to be given once a day for an adjustment disorder. There was no documentation, on 12/12/24, to indicate the dose was administered. A physician's order for docusate sodium (a stool softener) 100 mg was to be given twice a day for constipation. There was no documentation, on 12/12/24, to indicate the morning dose was administered. A physician's order for gabapentin (a medication used to treat nerve pain) 300 mg was to be given three times a day for neuropathy. There was no documentation, on 12/12/24, to indicate the morning or afternoon dose was administered. There were seven (7) additional missed medication administration documentation opportunities found in the December MAR. During an interview, on 1/17/25 at 9:24 a.m., the Corporate Support Nurse 3 indicated medications were to be documented after they were given. A current facility policy, titled "PREPARATION AND GENERAL GUIDELINES," dated as revised January 2017 and received from the Corporate Support Nurse 3 on 1/17/25, indicated "...If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time...it is documented on MAR or in the EHR (electronic health record)...." 3.1-50(a)(2)			

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Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 13, 14, 15, 16, and 17, 2025 Facility number: 013444 Residential Census: 32 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 23, 2025.	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 an 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.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure a two-step Mantoux (tuberculosis screening) test was completed for 1 of 7 residents reviewed for tuberculosis testing upon admission to the facility. (Resident 2) Finding includes:	R 0410	R0410 1. Resident 2 was affected. Upon discovery, the TB series was immediately started with the first step of the series. The resident had no adverse affects. 2. All residents have the potential	02/07/2025

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	The clinical record for Resident 2 was reviewed on 1/3/25 at 12:12 p.m. The diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), restless leg syndrome, and osteoarthritis. The documentation for the Mantoux 2-step test for Resident 2 was received from the Director of Nursing on 1/14/25 at 9:25 a.m. The documentation indicated the resident had two Mantoux tests completed on the same day, 9/18/24, one in each forearm. During an interview, on 1/14/25 at 9:25 a.m., the Director of Nursing indicated Resident 2 had two Mantoux tests administered on the same day. Newly admitted residents were supposed to have a 2-step test per facility policy. A current facility policy, titled "AL-Tuberculin Testing Guideline," dated as revised 4/17/24 and received from the Director of Nursing on 1/14/25 at 10:03 a.m., indicated "...Residents should have a Mantoux PPD test...First step shall be read between 48-72 hrs... Second step shall be administered between 1-3 weeks after the first test and read within 48-72 hr. after administration...."		to be affected. A house wide audit was conducted to ensure that all residents had completed TB series. Education was provided on TB testing and documentation. 3. As a measure of ongoing compliance, all new admissions will have completed TB series and all residents will have an annual TB test as well. Audits will be conducted weekly x4 weeks, then every other week x 8 weeks, then monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least once quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance and Performance Improvement meetings. The plan will be reviewed and updated as warranted.	