STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155833	A. BUILDING -- B. WING	01/28/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/28/25 Facility Number: 013444 Provider Number: 155833 AIM Number: 201294880 At this Emergency Preparedness survey, Wellbrooke of Carmel was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 74 certified beds. At the time of the survey, the census was 61. Quality Review conducted on 01/29/25	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the survey visit with exit on January 28th, 2025.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/28/25 Facility Number: 013444 Provider Number: 155833 AIM Number: 201294880 At this Life Safety Code survey, Wellbrooke of Carmel was found not in compliance with	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the survey visit with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kylie Carmack	Executive Director	02/07/2025

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 01 B. WING	01/28/2025

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
	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 firewall 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 61 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review conducted on 01/29/25		exit on January 28th, 2025.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 door to the "open space" outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged	K 0293	**K293** **Exit Signage** **Immediate Intervention** The Director of Plant Operations removed signage of a 15 second delayed egress and a sign	02/13/2025

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	01/28/2025

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
	so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect as many as 12 residents, 6 staff and 2 visitors in the facility. Findings include: Based on observations with the Director of Plant Operations (DPO), Assistant DPO, and Facilities Maintenance Support Manager during a tour of the facility at 11:32 a.m. on 01/28/25, the door to the "open space" or courtyard from the main lobby was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observations, the DPO stated the door to the "open space" or courtyard from the lobby is not an exit to the public way and acknowledged that the door to the "open space" or courtyard did not have a NO EXIT sign posted. This item was discussed with the facility Executive Director, DPO, Assistant DPO, and Facilities Maintenance Support Manager at the exit conference on 01/28/25. 3.1-19(b)		indicating a “NO EXIT” was installed as it was not indicated as such. This deficient practice could affect as many as 12 residents, 6 staff and 2 visitors. The Director of Plant Operations was educated by the regional Facilities Support on NFPA 101 Exit Signage – 2012 Existing. Exit and directional signs are displayed in accordance with 7.10.8.3.1 with continuous illumination also served by the emergency lighting system 19.2.10.1 The Director of Plant Operations will visually inspect the facility 1 x per month x 3 months for proper exit signage. The results of these visual inspections will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 35 sets of resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect approximately 40 residents, as well as	K 0363	**K363** **Corridor – Doors** **Immediate Intervention**: Director of plant operations	02/13/2025

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	01/28/2025

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
	staff and visitors. Findings include: Based on observations with the Director of Plant Operations (DPO), Assistant DPO, and Facilities Maintenance Support Manager during a tour of the facility at 11:58 a.m. on 01/28/25, the corridor door to resident room 1105 failed to latch into the doorframe. Based on interview at the time of observations, the DPO acknowledged the aforementioned condition and sent his Assistant to get tools to troubleshoot and fix the door. This item was discussed with the facility Executive Director, DPO, Assistant DPO, and Facilities Maintenance Support Manager at the exit conference on 01/28/25. 3.1-19(b)		adjusted the door and corrected the positive latching on the resident room door to meet compliance of K363. This deficient practice could affect approximately 40 residents, as well staff and visitors. Director of Plant Operations was educated by regional support on K363 NFPA 101 corridor and doors. Corridor doors and doors to rooms that would resist the passage of smoke must have latching hardware. In accordance with 19.3.6.3, CFR Parts 403,418,460,480,482,483and 485. Director of plant operations will verify positive latching hardware to doors protecting corridor openings. Once per weekly X 3months Followed by Once per Month X3 The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	