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	01/02/2024

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 the Investigation of Complaint IN00423497. Complaint IN00423497 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey date: January 2, 2024 Facility number: 013444 Provider number: 155833 AIM number: 201294880 Census Bed Type: SNF/NF: 16 SNF: 26 Total: 42 Census Payor Type: Medicare: 14 Medicaid: 16 Other: 12 Total: 42 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed January 8, 2024.	F 0000	POC Due: 1/20/2024 Date of Compliance: 1/19/2024 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 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kylie Carmack		01/16/2024

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.

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	property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse when a staff member was heard speaking to a resident loudly and using profanity for 1 of 3 residents reviewed for abuse. (Resident 2) This deficient practice was corrected on 12/26/23, prior to the start of the survey, and was therefore past noncompliance. Finding includes: An incident report to the Indiana Department of Health, dated 12/25/23, indicated a nurse heard a verbal altercation between an employee and a resident. The record for Resident 2 was reviewed on 1/2/24 at 11:51 a.m. Diagnoses included, but were not limited to, dementia, anxiety, and weakness. Resident 2 admitted to the facility on 12/12/23 and discharged to another facility on 12/29/23. Resident 2 had a Brief Interview for Mental Status completed on 12/19/23 and scored a 12 indicating he was moderately impaired mentally. A facility document, titled "...Statement of	F 0600	2567 reads that this tag is Past noncompliance.	01/19/2024

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	Witness Form" for Resident 2, dated 12/25/23, indicated the male aid was pushy. He was not very nice, and he was harsh with him (Resident 2) while in the shower. A facility document, titled "...Statement of Witness Form" for Dietary Aide 2, dated 12/25/23, indicated Dietary Aide 2 heard CNA 2 using profanity while talking to a resident. Another staff member tried to calm the CNA down. Dietary Aide 5 heard CNA 2 say "...I'm tired of this s**t...." He also heard the CNA say to Resident 2 "...F**k that. I already got him together in the shower...." As CNA 2 was walking away Dietary Aide 5 told him to calm down, he should not talk to residents that way and he could lose his license/certification. The CNA responded he did not "...give a f**k...." A facility document, titled "...Statement of Witness Form" for CNA 8, dated 12/25/23, indicated CNA 8 was sitting at the desk charting and heard the nurse asked CNA 2 to get residents' weights. CNA 2 stated "...Y'll are getting on my d**n nerves with this...." Resident 2 wheeled around the corner and CNA 2 said "...Hell, I guess I'll get him...." CNA 2 grabbed Resident 2's wheelchair, Resident 2 yelled out "...Hey, what's going on?" CNA 2 responded "...you don't ask what I am doing...." The nurse told CNA 2 not to talk to residents like that and the facility was the home of the residents. The CNA responded "...Yeah, he learned his lesson in the shower today, didn't you?" The nurse removed Resident 2 from the CNA for resident's safety and another nurse sent CNA 2 home. A facility document, titled "...Statement of Witness Form" for LPN 9, dated 12/25/23, indicated LPN 9 heard CNA 2 speaking loudly. He			

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	was getting residents' weights and was transferring Resident 2 from the wheelchair to the weight chair but was not telling the resident what he was doing. CNA 2 raised his voice and said to the resident "...just get your a*s over here in this chair. You tried your luck with me this morning in the shower. Didn't you learn from that?" LPN 9 and another nurse told CNA 2 to stop, then removed Resident 2 from the CNA. CNA 2 was told to clock out and leave the facility. CNA 2 went to the nurse's desk to chart. LPN 9 then called the Director of Nursing. There were no other residents near CNA 2 while he was at the desk. A facility document, titled "...Statement of Witness Form" for LPN 10, dated 12/25/23, indicated LPN 10 observed CNA 2 getting residents' weights. She heard CNA 2 tell Resident 2 to get his a*s in the chair. She told the CNA not to curse at the resident, she would take over care of the resident and told the CNA to clock out and go home. The CNA went to the desk and began to chart, Nurse 10 told him it would be best for him to clock out and go home. CNA 2 apologized for his behavior and then left the facility. She notified the Director of Nursing. A facility document, titled "...Statement of Witness Form" for CNA 2, dated 12/26/23, indicated he was giving Resident 2 a shower and the resident grabbed the shower head and sprayed him. Resident 2 continued to make the shower difficult. He told the resident to "...stand here and be still and take this shower...." The resident began yelling and screaming at the CNA and he was getting bowel movement/feces everywhere. A document, titled "Timeline of Events," dated			

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	12/25/23, indicated at 11:30 a.m., the nurse asked CNA 2 to get residents' weights. Without telling Resident 2 what he was doing, CNA 2 told the resident to get his a*s in the chair and then stated, "you tried your luck with me this morning in the shower, didn't you learn anything from that?" Safety was provided to Resident 2 and CNA 2 was asked to leave. The CNA went to the nursing station. At 11:45 a.m., the Director of Nursing was notified and informed CNA 2 would not leave. All residents were accounted for and safe. At 11:50 a.m., the Director of Nursing contacted CNA 2 and asked him to leave the facility, he exited the campus at 11:55 a.m. At 12:05 p.m., staff statements were initiated. A head-to-toe assessment was completed on Resident 2 at 12:10 p.m. The resident was interviewed at 2:30 p.m., and another head-to-toe assessment was completed. Other residents were interviewed and assessed at that time. The responsible party and physician were notified at 5:00 p.m. At 6:00 p.m., all staff in-service on abuse and resident rights was initiated. On 12/26/23 all statements and assessments had been completed. Social Services had completed mental anguish assessments, CNA 2 was terminated from employment at 3:00 p.m., the police had been notified at 3:15 p.m., and the facility received a case number. CNA 2 was terminated from employment, on 12/26/23, for verbal abuse and gross misconduct. During an interview, on 1/2/24 at 1:38 p.m., LPN 3 indicated abuse could be verbal, physical, sexual, emotional, and financial. All abuse needed to be reported immediately. She indicated she was recently re-educated on abuse and abuse reporting. During an interview, on 1/2/24 at 1:43 p.m., QMA 6			

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	indicated staff was re-educated on abuse about a week ago. Abuse could be verbal, physical, sexual, emotional, or as misappropriation of the residents' belongings. During an interview, on 1/2/24 at 1:48 p.m., Physical Therapist (PT) 7 indicated he was contracted staff and he needed to follow the facility policies. He was educated on abuse and indicated abuse was physical, verbal, misappropriation of resident belongings or financials or emotional. Abuse needed to be reported immediately. During an interview, on 1/2/24 at 2:09 p.m., Dietary Aide 5 indicated he was on the Keystone Unit stocking snacks by the refrigerator. He heard CNA 2 say, to Resident 2, he was tired of this s**t and he did not give a F**k. He attempted to talk to CNA 2 and told him to calm down; he could lose his license/certification. CNA 2 told him he did not care. Dietary Aide 5 then returned to the kitchen and reported the incident to his immediate supervisor. A facility policy, titled "Abuse and Neglect Procedural Guidelines," dated as last updated 6/2023 and received from the Corporate Support Nurse on 1/2/24 at 10:16 a.m., indicated "...Verbal Abuse...includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability...." A facility policy, titled "Resident Rights Guidelines," dated as last reviewed on 12/31/22 and received from the Corporate Support Nurse on 1/2/24 at 3:37 p.m., indicated "...Our residents have the right to be...treated with respect and dignity...Be free of...verbal...abuse...."			

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	This deficient practice was corrected on 12/26/23, after the facility implemented a systemic plan which included the following actions: they completed interviews of staff who were witness to the incident, conducted assessments and interviews of residents residing on the unit, provided abuse and resident right training to employees, Social Services conducted mental anguish assessments, CNA 2 was terminated, and a police report was filed. 3.1-27(b)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,			

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	grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, interview and record review, the facility failed to provide toileting assistance when a resident had asked for assistance to use the toilet for 1 of 1 resident reviewed for Activities of Daily Living (ADL) care. (Resident 3) Finding includes: During an observation, on 1/2/24 at 2:39 p.m., Resident 3 was in an activity, painting a wooden Christmas tree. She was sitting in a wheelchair, clean and dry. She had an apron over her clothing and was actively engaged in the activity. During an observation, on 1/2/24 at 3:39 p.m., Resident 4 was in an activity, painting a wooden Christmas tree. She was sitting in a wheelchair, next to Resident 3. She was clean and dry and was actively engaged in the activity. During an interview, on 1/2/24 at 2:13 p.m., CNA 4 indicated on 12/24/23, Resident 3 reported to her she had requested assistance to use the toilet and CNA 2 told her to use her brief. CNA 4 indicated she reported the conversation to the Director of	F 0676	POC Due: 1/20/2024 Date of Compliance: 1/19/2024 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	01/19/2024

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	Nursing, also wrote a statement, and put it under the Director of Nursing's door. During an interview, on 1/2/24 at 2:42 p.m., Resident 4 indicated she was blind. She heard her roommate, Resident 3, ask CNA 2 if she could get up and go to the restroom. CNA 2 responded for her to go in her pants, and he would change her later. She then indicated it sounded as if he walked quickly, the pace was quick, then she heard the door shut and she did not hear his voice in the room anymore. During an interview, on 1/2/24 at 2:50 p.m., Resident 3 indicated CNA 2 told her "No" when she asked to use the toilet and told her to use her brief. She indicated it made her feel like "dirt". The record for Resident 3 was reviewed on 1/2/24 at 340 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, aphasia (difficulty speaking), and traumatic brain dysfunction. A Brief Interview for Mental Status (BIMS) was completed, on 12/12/23, and the resident scored a 15 (resident was alert and oriented). The OBRA assessment, completed on 12/12/23, indicated the resident required moderate assistance to use the toilet with a helper/assistant and did most of the work. The record for Resident 4 was reviewed on 1/2/24 at 3:37 p.m. Diagnoses included, but were not limited to, anxiety, depression, and end stage renal disease. The resident had a BIMS score of 15 on 12/5/23.		facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. F676 1. Resident 3 was affected. Resident is without adverse effect. Care was provided to resident. 2. All residents whom require assistance with toileting and incontinent care have the potential to be affected. All nursing staff have been educated regarding Resident Rights, assisting with ADL care, and incontinence care and an initial audit was completed to ensure that no other resident was affected. 3. As a measure of ongoing compliance, DHS or designee to complete random audits of ADL care and incontinence care to ensure provision of care and services. In addition, the SSD will interview residents to ensure ADL needs are met by staff. Audits to be completed on 5 residents weekly x4 weeks; then 5 residents biweekly x8 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 campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	

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	A handwritten document, dated 12/24/23, indicated the staff member was called to Resident 3's room as a witness to the resident's statement. The resident told two (2) staff members she had activated her call light to go to the bathroom and CNA 2 came in. CNA 2 told the resident to go in her brief. The resident's roommate, Resident 4, told CNA 4 she did hear the conversation between Resident 3 and CNA 2. The document was signed by CNA 4. During an interview, on 1/2/24 at 2:59 p.m., the Director of Nursing indicated she was notified of the incident where CNA 2 had told Resident 3 to use her brief to relieve herself. She did receive a statement from a staff member. A facility document, titled "Certified Resident Care Associate (CNA/STNA/SRNA/CENA) Expectations of Excellence," dated 4/29/10 and received from the Corporate Support Nurse on 1/2/24 at 10:51 a.m., indicated "...If a resident...needs assistance, help then get the assistance they need...." A facility policy, titled "Resident Rights Guidelines," dated as reviewed on 12/31/23 and received from the Corporate Support Nurse on 1/2/24 indicated "...Residents shall not leave their...basic human rights behind when they move to a health campus...Our residents have a right to...Be treated with dignity and respect...Be treated fairly, courteously and with respect by staff...." A facility policy, titled "Abuse and Neglect Procedural Guidelines," dated as reviewed on 8/29/19 and received from the Corporate Support Nurse on 1/2/24 at 10:51 a.m., indicated "...Neglect...the failure of the facility, its		warranted.	

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	employees or service providers to provide goods and services to a resident that are necessary to avoid...mental anguish or emotional distress...." 3.1-38(a)(2)(C)			