STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155808	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

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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. This visit also included the Investigation of Complaint IN00455772. Complaint IN00455772-No deficiencies related to the allegations are cited. Survey dates: April 21, 22, 23, 24, 25 and 28, 2025 Facility number: 012937 Provider number: 155808 AIM number: 201208220 Census Bed Type: SNF/NF: 48 Residential: 42 Total: 90 Census Payor Type: Medicare: 6 Medicaid: 20 Other: 22 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 1, 2025.	F 0000		
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on interview and record review, the facility failed to ensure the pre-admission screening and resident review (PASARR) was completed	F 0644	1 Resident 18 and 33 were affected. PASSRs were not correct. Levels of care were	05/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maggie Miller	Executive Director	05/08/2025

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.

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	accurately for 2 of 5 residents reviewed for PASARR. (Resident 18 and 33) Findings include: 1. The clinical record for Resident 18 was reviewed on 4/23/25 at 8:33 a.m. The diagnoses included, but were not limited to, visual hallucinations, psychosis, and major depressive disorder. The PASARR for Resident 18, dated 3/28/25, did not include all his mental health diagnoses or mental health medications. A physician's order, dated 3/31/25, indicated Resident 18 was to take aripiprazole (an antipsychotic medication). Aripiprazole was not listed on Resident 18's PASARR and the PASARR did not include a mental health diagnosis to adequately justify the need for antipsychotic medication. A physician's order, dated 3/31/25, indicated Resident 18 was to take clonazepam (an anti-anxiety medication). Clonazepam was not listed on Resident 18's PASARR and the PASARR did not include a mental health diagnosis to adequately justify the need for anti-anxiety medication. During an interview, on 4/24/25 at 10:04 a.m., the Director of Nursing (DON) indicated Resident 18's neurologist followed up on all his psychotropic medications which included, but were not limited to, aripiprazole and clonazepam. During an interview, on 4/23/25 at 2:42 p.m., the Social Service Director (SSD) indicated Resident		reviewed and adjusted per current diagnoses and orders. 2 All residents have the potential to be affected. A house wide audit was conducted to ensure that all residents had appropriate PASSRs in place. Education was provided to SSD on levels of care. 3 As a measure of ongoing compliance, review new admissions, psychotropic order changes as well as level 1s to ensure accuracy, complete new level 1 if indicated, complete on days that CCM occurs x 6 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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	18's PASARR did not contain all Resident 18's mental health diagnoses or mental health medications and the PASARR needed to be updated. 2. The clinical record for Resident 33 was reviewed on 4/23/25 at 8:38 a.m. The diagnoses included, but were not limited to, insomnia and pain. The PASARR for Resident 33, dated 2/7/25, indicated Resident 33 did not have any mental health diagnoses and did not take any mental health medications. A physician's order, dated 3/18/25, indicated Resident 33 was to take zolpidem (a sedative-hypnotic medication). During an interview, on 4/24/25 at 12:58 p.m., the SSD indicated Resident 33's PASARR did not include any mental health diagnoses or mental health medications. During an interview, on 4/23/25 at 3:10 p.m., the SSD indicated the facility followed the CMS guidelines and did not have a policy related to PASARR. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)			
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 there was sufficient documentation to show a behavior care plan was prepared by an interdisciplinary team, which included the participation of the resident and the resident's representative prior to initiation and to	F 0657	1 Residents 2, 23, and 42 were affected. Care plan (Resident first) meetings were held for resident 2, 42 and 23. 2 All residents have the potential to be affected. A house	05/16/2025

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	ensure care plan meetings were conducted and documented for 3 of 8 residents reviewed for care plans. (Resident 2, 23 and 42) Findings include: 1. The clinical record for Resident 2 was reviewed on 4/23/25 at 10:01 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, depression, and dementia. A quarterly Minimum Data Set (MDS) assessment, dated 2/20/25, indicated the resident was cognitively intact and had no mood or behavior concerns. A care plan, dated 4/18/25, indicated Resident 2 had impaired cognition with a short-term memory impairment and was at risk for confusion, disorientation, an altered mood, and an impaired or reduced safety awareness related to Alzheimer's disease and dementia. A care plan, dated 4/22/25, indicated Resident 2 demonstrated inappropriate behaviors which included making false accusations towards staff and family. The clinical record for Resident 2 did not contain documentation to indicate she made false accusations towards staff or family. During an interview, on 4/23/25 at 11:49 a.m., Licensed Practical Nurse (LPN) 6 indicated Resident 2 did not necessarily make false statements but she did embellish things sometimes. During an interview, on 4/24/25 at 10:32 a.m., Clinical Support 3 indicated care plan revisions		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. Added care plans will be reviewed during CCM to ensure accuracy. 3 As a measure of ongoing compliance, the ED or designee will review 5 resident records to ensure supportive documentation is in place for added care plans 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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	were often done during their clinical review or interdisciplinary team (IDT) meetings. During an interview, on 4/25/25 at 10:12 a.m., Clinical Support 3 indicated she would look for documentation for the IDT meeting which was held prior to initiating the care plan. She did not find documentation in the clinical record where the resident made false statements. The facility should document the IDT meetings in the clinical record. During an interview, on 4/25/25 at 11:19 a.m., the Director of Nursing indicated there was no IDT meeting documented.2. During an interview, on 4/21/25 at 11:17 a.m., Resident 23 indicated she was not sure when her last care plan meeting was held. The clinical record for Resident 23 was reviewed on 4/25/25 at 9:10 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance, and hypertensive kidney disease. The last documented care plan meeting was 11/7/24. There was no care plan meeting for 2/25 documented in the record. During an interview, on 4/25/25 at 1:09 p.m., the Social Service Director (SSD) indicated there was no documented care plan meeting in February 2025 for Resident 23. 3. During an interview, on 4/21/25 at 10:59 a.m., a family member of Resident 42 indicated they went to a few care planning meetings when Resident 42 had Medicare, but they pay privately now and			

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	have not had a meeting recently. The clinical record for Resident 42 was reviewed on 4/24/25 at 2:06 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy (a brain dysfunction caused by underlying metabolic disorders or conditions which disrupt the brain's energy supply or chemical balance), sepsis, and dehydration. The last documented care plan meeting was on 11/4/24. During an interview, on 4/23/25 at 9:53 a.m., the SSD indicated there was no documented care plan meeting in February 2025 for Resident 42. A current facility policy, titled "Resident's First Meeting Guidelines," dated as reviewed on 12/17/24 and received from Corporate Support Nurse 3 on 4/25/25 at 2:07 p.m., indicated "...Subsequent meetings for non-Medicare residents should be conducted minimally quarterly...Subsequent meetings for Medicare residents should be conducted minimally quarterly...." A current facility policy, titled "Comprehensive Care Plan Guideline," dated as revised on 5/22/18 and received from the MDS Clinical Support on 4/24/25 at 11:35 a.m., indicated "...Comprehensive care plans need to remain accurate and current. A. New interventions will be added and updated during or directly following the CCM meeting. B. Newly recognized problems will have a care plan developed and added after CCM meeting...." 3.1-35(a) 3.1-35(d)(2)(B)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure a resident's oxygen concentrator was turned on to deliver oxygen therapy according to the physician's order and failed to obtain a physician's order for the use of oxygen for 2 of 4 residents reviewed for respiratory care. (Resident 15 and 201) Findings include: 1. During an observation, on 4/21/25 at 1:40 p.m., a staff member walked out of Resident 15's room. Upon entering the room, Resident 15 was observed to be wearing a nasal cannula, but the oxygen concentrator was not turned on. During an observation and interview, on 4/21/25 at 1:47 p.m., Resident 15's oxygen concentrator was turned off. Licensed Practical Nurse (LPN) 6 indicated the oxygen was turned off and it should be turned on. The clinical record for Resident 15 was reviewed on 4/22/25 at 2:01 p.m. The diagnoses included, but were not limited to, a history of Covid 19, chronic respiratory failure with hypoxia, and asthma. A care plan, dated 11/11/23, indicated the resident had a potential for shortness of breath while lying flat related to asthma. Interventions included, but were not limited to, administer oxygen per the physician's orders. A physician's order, dated 4/10/25, indicated Resident 15 was to receive oxygen at 3 liters per minute.	F 0695	1 Residents 15 and 201 were affected. Resident 15 was immediately assessed, determined not to be in respiratory distress, and oxygen administered per order. Resident 201 order for oxygen was added to the clinical record. 2 All residents who wear oxygen have the potential to be affected. A house wide audit was conducted to ensure residents with oxygen had appropriate orders in Matrix and that oxygen was on per order. Education was provided to clinical staff on oxygen administration and following physician orders. 3 As a measure of ongoing compliance, DHS or designee will review 5 residents with oxygen to ensure that appropriate orders are in place and oxygen is on per order. Audits to 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.	05/16/2025

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	2. During an observation, on 4/21/25 at 10:17 a.m., Resident 201 was sitting in her wheelchair in her room. An oxygen concentrator was in the corner of the room and the oxygen tubing was in a bag. During an observation and interview, on 4/22/25 at 8:49 a.m., Resident 201 was sitting in her wheelchair in her room. Her oxygen tube and cannula were lying on her bed, and the oxygen concentrator was on and running. An imprint from the oxygen tubing and nasal cannula was observed on Resident 201's face. Resident 201 indicated she wore oxygen at night while in bed. The clinical record for Resident 201 was reviewed on 4/22/25 at 12:43 p.m. The diagnoses included, but were not limited to, malignant neoplasm of right main bronchus, chronic obstructive pulmonary disease, and pan lobular emphysema. A care plan, dated 4/9/25, indicated Resident 201 had the potential for complications and a functional and cognitive status decline related to her respiratory disease and to administer oxygen per the physician's orders. A physician's order for oxygen was not found in the electronic health record. The resident's hospice binder indicated the hospice RN visited the resident on 4/8/25 and documented the need for oxygen at 2 liters per minute. A physician's order for oxygen was not found in the hospice binder. During an interview, on 4/22/25 at 12:57 p.m., LPN 5 indicated a physician's order for the use of oxygen was not found in the electronic health record.			

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	During an interview, on 4/22/25 at 1:04 p.m., the Assistant Director of Nursing (ADON) indicated she was not able to find a physician's order in the electronic health record for the use of oxygen. She observed the oxygen concentrator in Resident 201's room and indicated the concentrator was delivered by the hospice company. She reviewed the hospice binder and was unable to find a written order for the use of oxygen. A current facility policy, titled "Guidelines for Medication Orders," dated 12/17/24 and received from the Clinical Support 3 on 4/22/25 at 1:38 p.m., indicated "...The purpose of this policy is to: To establish uniform guidelines in the receiving and recording of medication orders...A current list of orders will be maintained in the electronic clinical record of each resident...Oxygen orders...When recording oxygen orders specify...The rate of flow, route and rationale...." A current facility policy, titled "Administration of Oxygen," dated 12/13/24 and received from the Clinical Support 3 on 4/22/25 at 1:38 p.m., indicated "...Guidelines to properly Administering Oxygen and any Respiratory procedure...Verify physician's order for the procedure...Turn on the oxygen...." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview and record review, the facility failed to ensure a medication was labeled with a resident's name in 1 of 2 medication carts and staff signed the narcotic count log during shift change in 2 of 2 narcotic	F 0755	1 A narcotic count was completed upon discovery of missing signatures and insulin was discarded immediately. 2 All residents have the	05/16/2025

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	books reviewed for medication storage. (boardwalk south and 200 south) Findings include: 1. During an observation and interview, on 4/22/25 at 10:24 a.m., a Lantus (insulin) injectable pen was observed inside the boardwalk south medication cart, and it was not labeled with the name of the resident. LPN 5 indicated there should have been a name on the insulin pen. 2. The boardwalk south medication cart "Narcotic Count Sheet" for April 2025 indicated there were missing signatures for the oncoming shift: On 4/4/25, for the night shift. On 4/6/25, for the evening shift. On 4/12/25, for the day and evening shift. The sheet was missing signatures for the off going shift: On 4/4/25, for the night shift. On 4/6/25, for the evening shift. On 4/12/25, for the evening and night shift. 3. The 200 south medication cart "Narcotic Count Sheet" for April 2025, indicated there were missing signatures for the oncoming shift: On 4/1/25, for the evening shift. On 4/4/25, for the night shift. On 4/6/25, for the evening and night shift. The sheet was missing signatures for the off going shift: On 4/1/25, for the night shift. On 4/4/25, for the night shift. On 4/6/25, for the evening and night shift. During an interview, on 4/23/25 at 9:23 a.m., LPN 6 indicated the narcotic count sheet needed to be		potential to be affected. A house wide audit was conducted to ensure that all medications had appropriate labels and that narcotic logs were complete per policy. Education was provided to all nurses on shift to shift narcotic count as well as medication storage policy. 3 As a measure of ongoing compliance, the DHS or designee will review shift to shift narcotic count sheets to ensure completion for 3 carts weekly x 4 weeks then every other week x 8 weeks then monthly x 3 months. 3 medication carts will be reviewed to ensure that med labels are in place 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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	signed every shift change. A current facility policy, titled "Guidelines for Narcotic Count," dated 12/17/24 and received from the Corporate Support Nurse on 4/22/25 at 11:09 a.m., indicated "...Each controlled drug shall have a corresponding count sheet to track distribution...The narcotic book shall contain a sheet providing space for the off going and oncoming nursing staff to record their signature indicating the narcotics have been reviewed...Both staff members shall signed that the narcotic count is accurately reconciled...." A current facility policy, titled "MEDICATION ORDERING AND RECEIVING FROM PHARMACY," dated November 2018 and received from the Clinical Support Nurse on 4/23/25 at 12:03 p.m., indicated "...Each prescription medication label include...Resident's name...." 3.1-25(e)(3) 3.1-25(k)(1)			
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 a resident's medical record was complete and accurately documented related to meal intakes for 1 of 1 resident reviewed for documentation. (Resident 2) Findings include: During an interview, on 4/22/25 at 10:12 a.m., Resident 2 indicated she did not get her lunch meal delivered to her sometimes.	F 0842	1 Resident 2 was affected. CNAs responsible for omitted consumption were educated on meal service policy. 2 All residents have the potential to be affected. Education was provided to clinical staff on meal service policy. 3 Ensuring documentation of meal intake is completed and as a measure of ongoing compliance, the DHS or designee will review	05/16/2025

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	The clinical record for Resident 2 was reviewed on 4/23/25 at 10:01 a.m. The diagnoses included, but were not limited to, vitamin deficiency, repeated falls, and muscle weakness. The meal intakes for Resident 2 were reviewed and indicated: On 3/27/25, no lunch intake was documented. On 4/3/25, no lunch intake was documented. On 4/9/25, no lunch intake was documented. On 4/20/25, no lunch intake was documented. On 4/23/25, no lunch intake was documented. During an interview, on 4/24/25 at 11:18 a.m., Licensed Practical Nurse (LPN) 5 indicated meal intakes were charted in the care assist and would "pop up" in the vitals tab. Meal intakes should be charted before the end of the staff member's shift. If a resident refused a meal, it would be charted as refused. During an interview, on 4/24/25 at 10:32 a.m., the Clinical Support nurse indicated meals were documented in the record under the meal intake tab. She did not see the lunch intakes documented in the record. A current facility policy, titled "Guidelines for Meal Service," dated 5/22/20 and received from the Clinical Support on 4/24/25 at 11:35 a.m., indicated "...Meal intakes should be recorded in the electronic health record...." 3.1-50(a)(1) 3.1-50(a)(2)		charting completion for 5 residents 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.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

(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
	Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00455772. Complaint IN00455772-No deficiencies related to the allegations are cited. Survey dates: April 21, 22, 23, 24, 25 and 28, 2025 Facility number: 012937 Residential Census: 42 Wellbrooke of Westfield was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on May 1, 2025.			