| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155833 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Wellbrooke of Carmel | 12315 Pennsylvania Street<br>Carmel, IN 46032 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49891<br><br>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. (Resident 9)<br><br>Finding includes:<br><br>The clinical record for Resident 9 was reviewed on [DATE] 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.<br><br>A physician's order, dated [DATE], indicated the resident's code status was a full code.<br><br>An out of hospital do not resuscitate declaration and order form, dated [DATE], was signed by the resident on [DATE]. The physician signed the form on [DATE]. It was scanned into the electronic medical record on [DATE].<br><br>The physician did not sign the form until 6 days after the resident signed the form.<br><br>A social service note, dated [DATE] at 9:57 a.m., indicated the resident's code status was reviewed and updated to do not resuscitate during her care plan meeting.<br><br>A physician's progress note, dated [DATE] at 1:03 p.m., indicated the resident was a full code.<br><br>A physician's progress note, dated [DATE] at 12:15 p.m., indicated the resident was a full code.<br><br>On [DATE] 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.<br><br>On [DATE] at 3:54 p.m., Resident 9 was listed as a full code in the information banner of the electronic medical record.<br><br>(continued on next page) |

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.

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

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on [DATE] 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.<br><br>During an interview, on [DATE] 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.<br><br>A current facility policy, titled Guidelines for Advanced Directives, dated as revised on [DATE] and provided by the Clinical Support Nurse 3 on [DATE] 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.<br><br>3XXX,d+[DATE](f)(5) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>44598<br><br>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)<br><br>Findings include:<br><br>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.<br><br>The record for Resident 23 did not have a quarterly care plan meeting documented between 4/17/24 and 12/4/24.<br><br>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.<br><br>50901<br><br>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.<br><br>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.<br><br>A nursing progress note, dated 10/11/24, indicated Resident 29 had been experiencing intermittent hallucinations.<br><br>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.<br><br>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 missed.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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 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<br><br>3.1-35(a)<br><br>3.1-35(b)(1)<br><br>3.1-35(d)(2)(B)<br><br>3.1-35(e) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>49891<br><br>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)<br><br>Findings include:<br><br>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.<br><br>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.<br><br>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:<br><br>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.<br><br>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.<br><br>On 1/11/25, the resident's systolic blood pressure was 128 in the evening, and the medication was administered.<br><br>On 1/12/25, the resident's systolic blood pressure was 126 in the morning, and the medication was administered.<br><br>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.<br><br>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.<br><br>On 1/15/25, the resident's systolic blood pressure was 136 in the morning and 132 in the evening, and the medication was administered.<br><br>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.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/17/25, the resident's systolic blood pressure was 134 in the morning, and the medication was administered.<br><br>The electronic medical record did not include documentation of notification to the physician of the medication being administered outside the ordered hold parameters.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>A review of the November 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:<br><br>On 11/05/24, the resident's heart rate was 64 in the morning, the medication was administered.<br><br>On 11/11/24, the resident's heart rate was 64 in the morning, the medication was administered.<br><br>On 11/20/24, the resident's heart rate was 64 in the evening, the medication was administered.<br><br>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:<br><br>On 12/09/24, the resident's heart rate was 60 in the morning, the medication was administered.<br><br>On 12/13/24, the resident's heart rate was 64 in the morning, the medication was administered.<br><br>On 12/14/24, the resident's heart rate was 62 in the morning, the medication was administered.<br><br>On 12/15/24, the resident's heart rate was 63 in the morning, the medication was administered.<br><br>On 12/16/24, the resident's heart rate was 63 in the morning, the medication was administered.<br><br>On 12/20/24, the resident's heart rate was 63 in the morning, the medication was administered.<br><br>On 12/23/24, the resident's heart rate was 61 in the morning, the medication was administered.<br><br>On 12/24/24, the resident's heart rate was 60 in the morning, the medication was administered.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/24/24, the resident's heart rate was 63 in the evening, the medication was administered.<br><br>On 12/30/24, the resident's heart rate was 64 in the evening, the medication was administered.<br><br>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 ordered.<br><br>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.<br><br>44598<br><br>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.<br><br>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.<br><br>A physician's order, dated 6/13/24, indicated to give Humalog U-100 Insulin solution subcutaneously before meals per the sliding scale.<br><br>If the blood sugar was less than 70, call the physician.<br><br>If the blood sugar was 151 to 200, give 0 units.<br><br>If the blood sugar was 201 to 250, give 4 units.<br><br>If the blood sugar was 251 to 300, give 6 units.<br><br>If the blood sugar was 301 to 400, give 10 units.<br><br>If the blood sugar was greater than 400, call the physician.<br><br>The Medication Administration Record indicated the resident's blood sugar was 576 on 7/11/24.<br><br>There was no documentation the physician was notified of the blood sugar greater than 400.<br><br>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 576-blood sugar reading. The nurse did not notify the physician of the blood sugar and should have.<br><br>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.<br><br>The facility did not have a policy for blood glucose monitoring.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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<br><br>3.1-37(a) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>44598<br><br>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)<br><br>Finding includes:<br><br>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).<br><br>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.<br><br>A physician's order, dated 2/24/23, indicated to monitor catheter output every shift.<br><br>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:<br><br>On 12/29/24 at 8:46 p.m., large was recorded.<br><br>On 12/30/24 at 2:40 a.m., medium was recorded.<br><br>On 12/30/24 at 12:00 p.m., medium was recorded.<br><br>On 12/31/24 at 6:53 a.m., medium was recorded.<br><br>On 1/1/25 at 9:20 a.m., large was recorded.<br><br>On 1/2/25 at 8:57 p.m., large was recorded.<br><br>On 1/3/25 at 1:37 p.m., large was recorded.<br><br>On 1/4/25 at 8:52 p.m., large was recorded.<br><br>On 1/5/25 at 9:18 p.m., large was recorded.<br><br>On 1/5/25 at 11:01 p.m., medium was recorded.<br><br>On 1/6/25 at 2:16 p.m., medium was recorded.<br><br>On 1/8/25 at 1:31 p.m., medium was recorded.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/9/25 at 12:51 p.m., large was recorded.<br><br>On 1/9/25 at 1:30 p.m. large was recorded.<br><br>On 1/12/25 at 1:58 p.m., medium was recorded.<br><br>On 1/14/25 at 1:39 p.m., medium was recorded.<br><br>On 1/15/25 at 5:31 a.m., large was recorded.<br><br>On 1/15/25 at 11:53 a.m., large was recorded.<br><br>On 1/15/25 at 3:22 p.m., large was recorded.<br><br>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 record. The urine output should have been documented as milliliters.<br><br>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.<br><br>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.<br><br>50901<br><br>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.<br><br>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.<br><br>A physician's order, dated 5/16/24, indicated to monitor Resident 1's urinary output three times a day, every shift.<br><br>A Treatment Administration Record (TAR), dated 12/1/24 through 1/15/25, indicated the following documented urinary outputs:<br><br>On 12/1/24 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 12/1/24 between 2:00 p.m. to 10:00 p.m., medium was recorded.<br><br>(continued on next page) |

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|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/3/24 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 12/3/24 between 2:00 p.m. to 10:00 p.m., medium was recorded.<br><br>On 12/17/24 between 6:00 a.m. to 2:00 p.m., large was recorded.<br><br>On 12/17/24 between 2:00 p.m. to 10:00 p.m., large was recorded.<br><br>On 12/18/24 between 6:00 a.m. to 2:00 p.m., large was recorded.<br><br>On 12/19/24 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 12/20/24 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 12/20/24 between 10:00 p.m. to 7:00 a.m., large was recorded.<br><br>On 12/21/24 between 6:00 a.m. to 2:00 p.m., large was recorded.<br><br>On 12/23/24 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 12/30/24 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 1/4/25 between 2:00 p.m. to 10:00 p.m., large was recorded.<br><br>On 1/4/25 between 2:00 p.m. to 10:00 p.m., large was recorded.<br><br>On 1/5/25 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 1/5/25 between 2:00 p.m. to 10:00 p.m., medium was recorded.<br><br>On 1/6/25 between 6:00 a.m. to 2:00 p.m., large was recorded.<br><br>On 1/6/25 between 2:00 p.m. to 10:00 p.m., large was recorded.<br><br>On 1/8/25 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 1/10/25 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>On 1/10/25 between 2:00 p.m. to 10:00 p.m., large was recorded.<br><br>On 1/11/25 between 6:00 a.m. to 2:00 p.m., large was recorded.<br><br>On 1/13/25 between 6:00 a.m. to 2:00 p.m., medium was recorded.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155833 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wellbrooke of Carmel | 12315 Pennsylvania Street<br>Carmel, IN 46032 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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.<br><br>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 amount of urine .Accuracy is necessary because decisions regarding resident ' s care may be based on your report<br><br>3.1-41(a)(2) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155833 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Wellbrooke of Carmel | 12315 Pennsylvania Street<br>Carmel, IN 46032 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>38872<br><br>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)<br><br>Finding includes:<br><br>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).<br><br>The Medication Administration Record (MAR) was missing documentation of medication administration or lack of administration on the following days:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>There were seven (7) additional missed medication administration documentation opportunities found in the December MAR.<br><br>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.<br><br>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)<br><br>3.1-50(a)(2) |