STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155808	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbrooke of Westfield	937 E 186th Street Westfield, IN 46074

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed for 1 of 4 residents reviewed for PASARR. (Resident 13)Findings include:The clinical record for Resident 13 was reviewed on 3/12/26 at 11:25 a.m. The diagnoses included, but were not limited to, Parkinsonism, major depressive disorder, and dementia.A physician's order, dated 10/3/25, indicated to administer escitalopram (an antidepressant medication) 5 milligrams (mg) for depression.A physician's order, dated 10/3/25, indicated to administer quetiapine (an antipsychotic medication) 50 mg for depression.There was no PASARR screening located in Resident 13's clinical record.During an interview, on 3/12/26 at 10:35 a.m., Clinical Support Nurse 1 indicated the facility did not have a PASARR for Resident 13 and it was missed.A current facility policy, titled Indiana PASRR, undated and received from the Executive Director on 3/12/26, indicated .admission from Hospital. CSR insures hospital completes required appropriate screenings.admission from Home.CSR/back-up ensures paperwork is submitted to gain approval as part of admission process.410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)(2)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure a medication was held according to the physician's order for 2 of 2 residents reviewed for quality of care. (Resident 3 and 58) The deficient practice was corrected on 3/6/26, prior to the start of the survey, and was therefore past noncompliance.Findings include:1. The clinical record for Resident 3 was reviewed on 3/12/26 at 10:14 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia, and chronic diastolic congestive heart failure. A care plan, dated as last reviewed on 12/19/25, indicated the resident received hypoglycemic medication and to administer the medication as ordered. A physician's order, discontinued on 2/26/26, indicated to administer seven (7) units of Novolog FlexPen U-100 Insulin (insulin aspart u-100) with breakfast and lunch and to hold for a blood sugar less than 150. The Medication Administration Record (MAR), dated January 2026, indicated Resident 3 received seven (7) units of insulin with breakfast and/or lunch with a blood sugar less than 150 on the following dates:On 1/3/26, at breakfast with a blood sugar of 122. On 1/4/26, at breakfast with a blood sugar of 116. On 1/6/26, at breakfast with a blood sugar of 117, and at lunch with a blood sugar of 136. On 1/7/26, at breakfast with a blood sugar of 95, and at lunch with a blood sugar of 129. On 1/13/26, at breakfast with a blood sugar of 118.On 1/15/26, at breakfast with a blood sugar of 102.On 1/17/26, at breakfast with a blood sugar of 105, and at lunch with a blood sugar of 118. On 1/18/26, at breakfast with a blood sugar of 118.On 1/24/26, at breakfast with a blood sugar of 118. On 1/31/26, at breakfast with a blood sugar of 123, and at lunch with a blood sugar of 138. The MAR (Medication Administration Record), dated February 2026, indicated Resident 3 received seven (7) units of insulin with breakfast and/or lunch with a blood sugar less than 150 on the following dates:On 2/6/26, at lunch with a blood sugar of 135. On 2/7/26, at breakfast with a blood sugar of 108.On 2/8/26, at breakfast with a blood sugar of 115. On 2/14/26, at breakfast with a blood sugar of 111, and at lunch with a blood sugar of 149. On 2/16/26, at breakfast with a blood sugar of 113, and at lunch with a blood sugar of 112. On 2/19/26, at breakfast with a blood sugar of 118, and at lunch with a blood sugar of 139. On 2/21/26, at lunch with a blood sugar of 142. On 2/22/26, at breakfast with a blood sugar of 119.On 2/25/26, at breakfast with a blood sugar of 117.On 2/26/26, at breakfast with a blood sugar of 110. A physician's order, discontinued on 2/26/26, indicated to administer five (5) units of Novolog FlexPen U-100 Insulin (insulin aspart u-100) at dinner and to hold for a blood sugar less than 150. The MAR, dated January 2026, indicated Resident 3 received five (5) units of insulin at dinner with a blood sugar less than 150 on the following dates: On 1/1/26, with a blood sugar of 124. On 1/3/26, with a blood sugar of 99. On 1/9/26 with a blood sugar of 133. On 1/18/26, with a blood sugar of 98. On 1/22/26, with a blood sugar of 129. On 1/23/26, with a blood sugar of 108. On 1/24/26, with a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugar of 96. On 1/31/26, with a blood sugar of 109. The MAR, dated February 2026, indicated Resident 3 received five (5) units of insulin at dinner with a blood sugar less than 150 on the following dates: On 2/5/26, with a blood sugar of 136. On 2/7/26, with a blood sugar of 98. On 2/8/26, with a blood sugar of 117. On 2/12/26, with a blood sugar of 100. On 2/14/26, with a blood sugar of 127. On 2/15/26, with a blood sugar of 122. On 2/19/26, with a blood sugar of 93. On 2/22/26, with a blood sugar of 99. On 2/23/26, with a blood sugar of 107. During an interview, on 3/13/26 at 2:54 p.m., the Clinical Support Nurse 2 indicated the DON (Director of Nursing) had noted medication was administered against the physician's order prior to the start of the survey. During an interview, on 3/13/26 at 2:59 p.m., the DON indicated all medication parameters were to be followed, and the medication should not have been administered. She had educated all staff on following the physician's orders, including the hold parameters. 2. The clinical record for Resident 58 was reviewed on 3/13/26 at 10:30 a.m. The diagnoses included, but were not limited to, hypertensive emergency, primary hypertension, and myocardial infarction (heart attack). A care plan, dated 12/5/25, indicated Resident 58 had the potential for cardiovascular distress related to, but not limited to, hypertension and to administer medications as ordered. A physician's order, dated 1/27/26 to 1/29/26, indicated to administer isosorbide mononitrate (a medication to treat heart related chest pain and blood pressure) and to hold the medication for a systolic blood pressure greater than 120. The MAR indicated, on 1/28/26, Resident 58's blood pressure before the medication administration was 140/78 and the isosorbide mononitrate was administered outside of the physician's ordered hold parameters. During an interview, on 3/13/26 at 2:55 p.m., Clinical Support Nurse 2 indicated the facility had conducted an audit on medication administration and had found medications were being administered outside of physician's ordered hold parameters. During an interview, on 3/13/26 at 2:59 p.m., the DON indicated the medication hold parameters were to be followed and the medication should not have been administered. A current facility policy, titled Medication Administration-General Guidelines, dated 11/2018 and provided by the Administrator on 3/16/26 at 9:08 a.m., indicated .Medications are administered in accordance with written orders of the prescriber This deficient practice was corrected by 3/6/26 after the facility implemented a systemic plan that included the following actions: education to all nursing staff on physician ordered medication parameters, medication audits were completed, and ongoing auditing/monitoring tools were in place. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)