STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbrooke of Avon	10307 E County Rd 100 N, Indianapolis, IN 46234

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51296 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan related to recurrent Urinary Tract Infections (UTI) for a resident (Resident 4) who had seven UTI's in a 12-month period for 1 of 16 residents reviewed for care plans. Findings include: On 3/5/25 at 1:43 p.m. Resident 4's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, UTIs, chronic kidney disease, and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage). A physician note, dated 2/2/24, indicated on 1/29/24 the Resident was seen for dysuria (pain while urinating). A urine analysis (UA)(a test to determine if a UTI is present) and a C&S (culture and sensitivity)(a test to determine what antibiotic the infection is sensitive to) was ordered. It was found that the Residents UA was positive for E. Coli (a bacteria of the lower intestines commonly found in feces.). Macrobid (an antibiotic used to treat UTI)) was ordered to treat the UTI. A progress note, dated 2/7/24, indicated Resident 4 had completed her antibiotics and her dysuria had resolved. A physician note, dated 2/28/24, indicated on 2/23/24 a UA and C&S were ordered due to discomfort when urinating. It was found that the Residents UA was positive for E. Coli. Keflex (an antibiotic used to treat UTI) was ordered to treat the UTI. A physicians progress note, dated 3/5/24, indicated Resident 4 had completed her antibiotics and her dysuria had resolved. A progress note, dated 3/19/24, indicated Resident 4 had auditory hallucinations (hearing something that is not there) and confusion causing her to fall out of bed. An Interdisciplinary Team (IDT) note, dated 3/20/24, indicated a UA was ordered to rule out UTI. An infection control event, dated 3/26/24, indicated Resident 4 had a UTI and was ordered an antibiotic to be administered from 3/26/24 to 3/29/24. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician progress note, dated 4/1/24, indicated on 3/25/24 the resident was ordered Ciprofloxacin (an antibiotic used to treat UTI) for a UTI caused by E. Coli in the urine. On 4/1/24 the symptoms had resolved. A progress note, dated 11/13/24, indicated a family member requested Resident 4 be tested for a UTI. Orders for a UA and C&S were placed. A physician progress note, dated 11/18/24, indicated it was found that the UA was positive for E. Coli. Macrobid was ordered to treat the UTI. A Nurse Practitioner (NP) note, dated 11/25/24, indicated Resident 4 had completed her antibiotics and her dysuria had resolved. A NP note, dated 12/20/24, indicated the Resident had burning with urination. Orders for a UA and C&S were placed. A progress note, dated 12/26/24, indicated Keflex was ordered until 12/30/24 to treat the UTI. A progress note, dated 12/31/24, indicated Resident 4 had finished her antibiotics and her dysuria had resolved. A physicians progress note, dated 1/6/25, indicated the UTI being treated on 12/26/24 was treated with four days of Keflex and seven days of extra strength Bactrim (an antibiotic used to treat UTI) with an end date of 1/2/25. on 1/2/25 Resident 4 continued to have UTI symptoms. Orders to extend the Bactrim to a ten-day course with an end date of 1/5/25 were placed. On 1/6/24 antibiotics were complete and dysuria had resolved. Resident 4's care plans were reviewed. The record lacked documention of a care plan for recurrent UTI's or the prevention of UTI's, only a general bowel bladder care plan indicating nurses would monitor signs and symptoms of UTI. On 3/7/25 at 1:30 p.m., a copy of a current facility policy titled, Comprehensive Care Plan Guideline, dated 12/17/24, was provided by the Minimum Data Set (MDS) support staff. The policy indicated, .2. Acute problems that arise with the resident and are expected to be resolved within a short time frame will be addressed on the event form specific for that problem. Address problems that become ongoing or chronic with a new comprehensive care plan . 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observation, interview, and record review, the facility failed to ensure appropriate/effective interventions were in place to prevent the development of new open pressure and failed to ensure accurate documentation was detailed in the medical records for 2 of 2 residents reviewed for pressure ulcers (Residents 16 and 24). Finding include: 1. On 3/4/25 at 12:36 p.m., Resident 16 was observed. She was seated in a wheelchair with a pressure reducing cushion in place. Resident 16 indicated her bottom had been sore a couple weeks ago, but she thought it had cleared up. It still got a little sore and tender if she stayed up for too long. On 3/5/25 at 11:44 a.m., Resident 16's medical record was reviewed. She had diagnoses which included, but were not limited to, urinary tract infection (UTI), type 2 diabetes mellitus, muscle weakness, and pelvic and perineal pain. An admission minimum data set (MDS) assessment, dated 11/21/24, indicated Resident 99 admitted with a stage II (partial-thickness skin loss that presents as a wound with a red or pink wound bed) pressure ulcer on her coccyx. A nursing admission assessment, dated 11/15/24 at 5:16 p.m., indicated Resident 16 did not have any skin impairment upon admission and her Braden score (a series of questions scored to determine pressure ulcer risk) was 15, which indicated, she had a low to moderate risk of developing a pressure ulcer. A nursing admission progress note, dated 11/15/24 at 5:16 p.m., indicated there were no open areas and foam dressing was applied to her bottom for protection. A Dietitian admission progress note, dated 11/19/24 at 10:21 a.m., indicated, .noted pressure related impairment to coccyx on admission--will recommend fortified therapeutic diet, MVI [multivitamin infusion] with minerals and ProStat 30 cc BID to aid in wound healing The record lacked admission documentation of wound details (i.e. length, width, depth, tissue type etc .) until 12 days after admission when a Wound Observation Tool was opened. The first Wound Observation Tool was dated 11/27/24 at 11:38 a.m., and indicated the wound was a stage II pressure ulcer which measured 10 centimeters (cm) wide and 10 cm long with red, but blanchable wound edges. A second Wound Observation Tool, dated 12/9/24 at 8:54 a.m., indicated the wound was improved to 8 cm wide by 8 cm long with red but blanchable wound edges. A third Wound Observation Tool, dated 12/12/24 at 10:17 a.m., indicated the wound was stable and still measured 8 cm long by 8 cm wide, with red but blanchable wound edges. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Observation Tools and/or would tracking lacked documentation the pressure ulcer had been resolved. A Dietitian progress note, dated 1/6/25 at 12:52 p.m., indicated Resident 16 had a coccyx pressure impairment present on admission, but it was resolved on 12/19/24. Resident 16's Treatment Record Administration (TAR) records were reviewed. Throughout December 2024, January 2025, and March 2025, Resident 16's TARs indicated a treatment was still being administered as ordered, Order Set: (Coccyx): cleanse wound with wound cleanser or normal saline, apply skin prep to peri-wound, and cover with foam (gentle or life) dressing change every 5 days, and was completed until 3/5/35. During an interview on 3/6/25 at 12:53 p.m., the Director of Nursing (DON) indicated Resident 16 had a wound upon admission, but it was healed in December 2024. She did not know why the order for wound treatments was still in place, but the Resident did not have an open area. 2. On 3/6/25 at 12:39 p.m., Resident 24 was observed. She was reclined in bed and propped on her right side. She indicated she had a pressure ulcer once, and sometimes her bottom still got sore. She did not believe she had a wound at that time. On 3/6/25 at 1:01 p.m., Resident 24's medical record was reviewed. She was a long-term care resident who was admitted on [DATE]. She had diagnoses which included, but were not limited to, chronic kidney disease, stage 3, morbid (severe) obesity due to excess calories and type 2 diabetes mellitus with diabetic peripheral angiopathy (disease/damage of the blood vessels). A nursing progress note, dated 12/10/24 at 7:30 p.m., indicated the CNA notified the nurse of a new open area to Resident 24's buttock. Upon the nurses' assessment, a small opening to her intergluteal cleft was noted. The DON and Nurse Practitioner (NP) were notified. The record lacked a New Wound/Skin Integrity Event. The record lacked documentation of additional wound details. A Medical Doctor (MD) progress note was entered into the record late, created on 12/15/24 at 11:10 a.m. effective for 12/11/24 at 11:10 a.m. The MD saw Resident 24 for dermatitis associated with moisture and a new wound, open to her buttock.Acute, unstable. [right] gluteal open wound w/ surround MASD. Suspect shearing [secondary to] moisture). The MD placed a new order for triad cream twice a day until the area was healed Resident 24's December TAR was reviewed and revealed the order was placed and discontinued on the date 12/11/24, with a comment: other but lacked details of what the comment was. A MD progress note was entered into the record late, created on 1/23/24 at 9:08 a.m. effective for 1/21/24 at 9:07 a.m. The MD note identically indicated, .Acute, unstable. [right] gluteal open wound w/ surround MASD [moisture associated skin damage]. Suspect shearing [secondary to] moisture). The MD placed a new order for triad cream twice a day until the area was healed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 24's January TAR was reviewed and revealed, an order to observe (buttocks) dressing to open area(s) every shift for draining on dressing and dislodgement, had been completed for every day. The record lacked documentation of the wound details related to the current treatments in place. A third MD progress note was entered into the record late; created on 2/12/24 at 10:24 a.m. effective for 2/7/24 at 10:24 a.m. The MD note identically indicated, .Acute, unstable. [right] gluteal open wound w/ surround MASD. Suspect shearing [secondary to] moisture). The MD placed a new order for triad cream twice a day until the area was healed Resident 24's February TAR was reviewed and revealed, an order to observe (Buttocks) dressing to open area(s) every shift for draining on dressing and dislodgement, had been completed for every day until it was discontinued on 2/7/25. The record lacked documentation of the wound details related to the current treatments in place and/or documentation the area was healed/resolved. During an interview on 3/6/25 at 1:45 p.m., the DON indicated she had just observed Resident 24 and there were no current open areas. At the time she was notified of what the nurse thought was an open area, the DON went to assess and found nothing there. There was no wound documentation at that time because there had been no wound to document. The DON did not know why the MD continued to address the area in the MD notes, and/or why the nurses continued to chart that treatments were completed. On 3/6/25 at 9:10 a.m., the Administrator (ADM) provided a copy of current facility policy titled, Pressure/Statis/Arterial/Diabetic Wound Guidelines, revised 4/16/24. The policy indicated, Purpose Statement: To provide weekly documentation of wound measurements and condition . 1. If skin as noted upon admission, admitting nurse should complete progress note assessment. IDT [Interdisciplinary team] should review this timely and wound nurse or designee complete an assessment and wound management. 2. If skin alteration occurs post admission follow the steps below: a. appropriate wound incident is completed by a RN/LPN in EHR [electronic health record]. b complete incident for each impaired area and assessment of the wound. C. all measurements are recorded in centimeters. d. IDT to review incident. Wound nurse/designee will add wound into wound management tool. e. Wound incident will remain open and EHR until wound management tool is initiated. 3. Document description of wound using: a. Length . b. Width . c. Depth . d. Exudates . e. Color . f. Odor . g. Wound margins . h. Surrounding tissue . i. Tunneling and/or undermining if applicable. 4. Re-assessment/measurement weekly . DHS/ADHS and/or designee to close/complete wound management PUSH tool 3.1-40

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38768 Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 99) who had a history of falls, had an environment free from the potential for accidents when the rubber threshold of the shower was unattached and loose on the floor for 1 of 3 residents reviewed for accidents. Findings include: During an initial observation and interview on 3/4/25 at 11:00 a.m., Resident 99 indicated she was afraid of falling. She was observed as she sat in a wheelchair at the foot of her bed, with an over-bed table pulled in front of her. She had an immobilizer boot on her left foot and indicated she had broken her foot after a fall at home. Resident 99 indicated she often felt rushed, and staff told her not to hold onto the grab bars. She became tearful and indicated she was too afraid to fall because she could not see very well. Even when staff were there to help, she was afraid of falling especially in the bathroom because the rubber strip on the floor was loose. If she were on the toilet, the shower and stopper were on her left side, which was affected by her vision loss. She was afraid she would trip on it when she transferred because it was hard for her to see. On 3/4/25 at 11:05 a.m., Resident 99's bathroom was observed. There was a long white rubber threshold guard which separated the bathroom floor from the shower floor. The threshold had become detached from the floors and was loose to the touch. On 3/5/25 at 1:50 p.m., Resident 99's bathroom was observed. The rubber threshold remained in disrepair, loose on the floor. On 3/6/25 at 10:51 a.m., Resident 99's bathroom was observed, and the rubber threshold remained in disrepair, loose on the floor. During an interview on 3/6/25 at 10:54 a.m., Certified Nursing Aide, (CNA) 14 indicated Resident 99's bathroom shower stopper had been loose for about a week. Her wheelchair wheel had accidently dislodged it during a transfer when her wheel got stuck on it. CNA 14 did not know if it had been repaired yet. On 3/5/25 at 2:03 p.m., Resident 99's medical record was reviewed. She had diagnoses which included, but were not limited to, homonymous bilateral field defects on the left side (a condition where a person experiences vision loss on the left side of their visual field in both eyes), vascular dementia, history of falls, and a displaced fracture of cuboid bone of left foot. A hospital discharge summary, dated 2/17/25, indicated, .she very clearly tells me about the falls. She notes they occurred because of her chronic left homonymous hemianopsia as a sequela of previous stroke and she was attempting to get something off a table but couldn't see to her left side very well, became off balance, and fell (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 99 had a comprehensive care plan dated 3/3/25 which indicated she was at risk for falls. Interventions included, but not limited to, .ensure the floor is free of liquids and foreign objects . On 3/6/25 at 11:00 a.m., Resident 99's bathroom was observed with the Assistant Director of Nursing (ADON). The ADON indicated, the rubber threshold was loose and could be trip hazard. The ADON would have Maintenance come and assess for repairs. On 3/6/25 at 9:10 a.m., the Administrator (ADM) provided a copy of current facility policy titled, Fall Management Program Guidelines, reviewed 12/17/24. The policy indicated, .Trilogy Health Services [THS] strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures 3.1-45(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on interview and record review, the facility failed to ensure Medical Providers entered their visit assessments, summaries, and/or progress notes into the resident's medical records timely for facility staff access. Theis deficient practice had the potential to effect of 6 of 13 residents records reviewed, (Residents 1, 9, 12, 14, 16, and 99). Findings include: On 3/6/25 at 9:17 a.m., Residents 1, 9, 12, 14, 16, and 99's records were reviewed related to Medical Provider documentation into the electronic health record (EHR) for timely submission and access to facility staff as a part of resident's continuity of care. The following pattern of more than 3 business days late were noted: 1. Resident 1 was a long-term care resident who had resided in the facility for more than a year. The previous 6 months of physician documentation was reviewed. From 8/8/24 until 3/6/25, Resident 1 had 12 late entry physician's notes. Half were more than three business days late, the greatest discrepancy was a late note entered on 1/30/25 at 1:29 p.m., for a visit on 1/23/25 at 11:29 a.m. 7 days late. This visit included a new recommendation to start the resident on a topical anti-inflammatory for pain in her knee. 2. Resident 9 was a long-term care resident who had resided in the facility for more than a year. The previous 6 months of physician documentation was reviewed. From 8/1/24 until 3/6/25, Resident 9 had 9 (nine) late entry physician's notes. A late note entered 3/3/25 at 12:03 p.m., from a visit 4 days before on 2/27/25 at 12:02 p.m., included a new order related to moisture associated skin damage and candidiasis of female genitalia for fluconazole (an antifungal medication) weekly for 2 weeks and calmoseptine (a topical ointment to treat skin irritation). 3. Resident 12 was admitted on [DATE]. Since their admission, until 3/6/25, there were 12 late entry notes, 3 of which were more than 3 (three) business days late. 4. Resident 14 was a long-term care resident who had resided in the facility for more than a year. The previous 6 months of physician documentation was reviewed. From 8/1/24 until 3/6/25, Resident 14 had 15 late physician's notes, 6 were more than three business days late. 5. Resident 16 was admitted on [DATE]. Since their admission until 3/6/25, there were 25 late entry physician's notes, 10 were more than 3 business days late with the greatest discrepancy being; a note recorded 13 days late on 12/9/24 at 5:42 a.m., for a visit on 11/26/24 at 11:52 a.m. 6. Resident 99 was admitted on [DATE]. Since their admission, until 3/6/25, there were 5 late entry physician's notes, 1 being later than 3 business days. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/6/25 at 12:53 p.m., a contracted Nurse Practitioner (NP) Provider indicated, it would be impossible to have every document signed the day of the visit with as many patients and documents there were, but as a rule, it was his Provider's Practice to have notes signed and accessible in the EHR within 48 hours of the visit. During an interview on 3/7/25 at 12:41 p.m., the Home Office Clinical Support Nurse indicated, the facility policy did not give specific timelines for signing and uploading or making their documentation available to the nurses within a certain timeframe, but she expected notes to be up within three (3) business days. On 3/6/25 at 11:00 a.m., the Home Office Clinical Support Nurse provided a copy of current facility policy titled, Guidelines for Physician Services, reviewed 12/17/24. The policy indicated, . the resident's attending physician shall participate in the resident's assessment and care planning, monitor changes in the resident's medical status, and provide consultation or treatment as required by resident condition, regulations and or when consulted or called by the campus . position orders and progress notes shall be maintained in accordance with the OBRA regulations and campus policy At the time of the survey exit on 3/7/25 at 1:00 p.m., the Home Office Clinical Support Nurse provided an example of a Stand-Down Physician Visit Summary and indicated the summary was printed off and left at each nurses station at the conclusion of the providers visit. The summary and/or policy lacked documentation of how/if the Stand-Down was accessible to the nurses if the print out was lost/misplaced, if it stood in lieu of the signed physician note until it could be uploaded to the EHR, and/or the physician's signature at the time the Stand-Down was printed/distributed. 3.1-22(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46414 Based on observation and interview, the facility failed to date medications when opened for 1 of 3 medication carts reviewed. Findings include: On 3/6/25 at 10:53 a.m., the Renaissance ([NAME]) 1 B cart was observed. Resident 91 had an insulin pen, lantus 100 unit/milliliter (ml) in the medication cart and it lacked a date to indicate when it was opened. During an interview with the Assistant Director of Nursing Services (ADNS) on 3/6/25 at 11:00 a.m., he indicated that a nurse must have pulled the insulin pen from the refrigerator the night before and did not date it. A policy dated 11/18, titled, Medication Storage in the Facility was provided by the ADNS on 3/7/25 at 1:00 p. m. It indicated, .When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated 3.1-25(j) 3.1-25(m) 3.1-25(n)