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	03/13/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to hold ordered blood pressure medication when a resident's blood pressure was outside prescribed parameters for 1 of 6 residents reviewed (Resident 9) and failed to properly assess a Resident (Resident 96) for their ability to properly manage their own eye drops before they were kept at the bedside for 1 of 24 residents reviewed for medications at bedside.Findings include:.1. On 3/10/26 at 10:53 a.m., a record review was completed for Resident 9. She had the following diagnoses which included, but were not limited to, heart failure, and hypertension (high blood pressure). A physician order, dated 8/12/25, for carvedilol (medication for high blood pressure) 12.5 milligram (mg) administer 1 tablet two times daily for hypertensive heart disease with heart failure, hold if heart rate less than 60 or systolic blood pressure (SBP) less than 100. A physician order, current as of 3/10/26, for clonidine 0.1mg administer 1 tablet three times daily for essential hypertension, hold if SBP less than 140. Resident's Medication Administration Record (MAR), dated February 2026, indicated Resident 9 received carvedilol on 2/4/26 between 7 a.m. and 10:00 a.m., for a heart rate of 59, and on 2/17/26 for a heart rate of 59. Resident's MAR, dated February 2026, indicated Resident 9 received clonidine on 2/4/26 between 7:00 a.m. and 8:00 a.m., for a blood pressure of 109/65. Resident's MAR, dated March 2026, indicated Resident 9 received clonidine on 2/3/26 between 7:00 a.m. and 8:00 a.m., for a blood pressure of 138/66 and between 2:00 p.m. and 3:00 p.m. for a blood pressure of 139/78. On 3/5/26 she received clonidine between 7:00 a.m. and 8:00 a.m. for a blood pressure of 101/63 and between 2:00 p.m. and 3:00 p.m. for a blood pressure of 128/78. On 3/10/26 at 1:50 p.m., RN 3 indicated the medications should have been held due to blood pressure readings. On 3/11/26 at 11:12 a.m., the Director of Nursing (DON) indicated there was no policy for parameters. They followed the physician's orders. 2. On 3/10/26 at 10:15 a.m. Resident 96 was observed as she sat in a chair next to her bed. On the nightstand on the opposite side of the bed the resident was sitting on was an open bottle of Systane eye drops (artificial tears designed to provide temporary relief from dry, irritated, burning, or gritty eyes). On her rolling bedside table was an unopened box of the same brand eye drops. Resident 96 indicated that the eye drops were hers and that she used them because her eyes would get dry often. (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

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	03/13/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She indicated she had had them at her bedside since she arrived at the facility. On 3/11/26 at 10:42 a.m. Resident 96's medical record was reviewed.She was a rehab Resident whose diagnoses included but were not limited to chronic respiratory failure. Resident 96 was admitted to the facility on [DATE]. Upon review of Resident 96's assessments it was found that the record lacked a medication self-administration assessment for eye drops. Upon review of Resident 96's orders it was found that the record lacked an order to self-administer Systane eye drops. On 3/11/26 at 2:50 p.m. the Director of Nursing (DON) and the Executive Director (ED) indicated they would look for a medication self-administration assessment for Resident 96. On 3/12/26 at 9:30 a.m. the DON provided a copy of a medication self-administration assessment for Resident 96 dated 3/11/26 at 4:34 p.m. On 3/12/26 at 12:50 p.m. the DON indicated a Certified Nursing Assistant (CNA) had come to her before the assessment was requested, and that was when they started the process of getting the assessment completed. The DON indicated they would have been prompted to do a medication self-administration assessment when the resident asked to self-administer the eye drops, or when a staff member found the medications in a Residents room. 410 Indiana Administrative Code (IAC) 16.2-3.1-37

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	03/13/2026

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 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. Based on observation and interview, the facility failed to refrigerate a medication until opened and failed to date nasal sprays and eye ointment when opened for 1 or 2 medication carts reviewed.Findings include: On 3/11/26 at 11:55 a.m., medication carts were observed with LPN 4. Resident 6 had fluticasone nasal spray (used for seasonal allergies) in the cart without a date to indicate when opened. Resident 40 had deep sea premium saline (used for nasal congestion) in the cart without a date to indicate when it was opened. Resident 61 had retaine PM ointment (used for dry eyes) without a date to indicate when opened. Resident 8 had latanoprost eye drops (used for glaucoma) in the cart. They were unopened with a label indicating to refrigerate until opened. On 3/11/26 at 12:00 p.m., LPN 4 indicated there were no dates indicating medications had been opened. She removed latanoprost from the medication cart. The facility did not provide a policy by the end of exit. 410 Indiana Administrative Code (IAC) 16.2-3.1-25(j)410 Indiana Administrative Code (IAC) 16.2-3.1-25(m)410 Indiana Administrative Code (IAC) 16.2-3.1-25(n)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to ensure proper infection control practices were in place for 2 of 24 residents reviewed for infection control when a resident with a central line (a long, flexible tube inserted into a major vein in the neck, chest, or groin, extending to just above the heart) and a resident with a suprapubic urinary catheter were not in Enhanced Barrier Precautions (EBP) (an infection control strategy designed to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes) (Residents 2 and 85) and the dressing for the central line was not changed per policy for 1 of 1 resident reviewed for central lines (Resident 2). Findings include:1. On 3/10/26 at 11:00 a.m. Resident 2 was observed as he lay in bed resting. Resident 2 had a central line inserted in his right chest, just under his clavicle. The dressing was a 4 by 4 gauze pad that covered the entire insertion site and the surrounding skin, with a clear adhesive dressing covering the gauze and adhering the dressing to his skin. The dressing was dated 3/9. At the time of that observation, there was no signage indicating Resident 2 was in EBP and there was no Personal Protective Equipment (PPE) (specialized clothing or gear, such as helmets, goggles, gloves, and masks) outside or inside of the resident's room. On 3/11/26 at 12:24 p.m. Resident 2 was observed as he lay in bed resting with his eyes closed. Resident 2's central line dressing was visible, and it appeared to be the same dressing as observed on 3/10/26. At the time of that observation an EBP sign was on Resident 2's door and a stacked three drawer caddy with PPE was outside of Resident 2's door. On 3/11/26 at 1:15 p.m. Resident 2's medical record was reviewed. Resident 2's diagnoses included but were not limited to necrotizing fasciitis (a rare, life-threatening flesh-eating bacterial infection that spreads rapidly, destroying muscle, skin, and fat tissue, often requiring emergency surgery and intravenous antibiotics) and gangrene (a life-threatening condition involving tissue death (necrosis) due to lack of blood flow or severe infection, often affecting limbs, fingers, or toes) of the left foot and osteomyelitis (a serious, often bacterial, infection of the bone causing pain, swelling, and fever). Resident 2 had an active order for his central line dressing to be changed every 5 days. Resident 2's medical record lacked an order for EBP. A progress note, dated 3/12/26 at 4:03 p.m., indicated Resident 2's central line dressing had been changed. On 3/12/26 at 2:49 p.m. a copy of a current facility policy titled, Catheter Insertion and Care- Central Venous Catheter Dressing Changes, dated 12/15 was provided. That policy indicated, .6. Change gauze dressings and TSM over gauze dressing every 48 hours. 7. An implanted vascular access port that is in use may be covered with either a transparent semi permeable [TSM] dressing or gauze dressing. 8. If gauze is used to support the wings of the access needle under a TSM dressing and does not obscure the insertion site it can be changed every five to seven days with the TSM dressing. On 3/13/26 at 12:30 p.m. the Infection Preventionist (IP) nurse indicated Resident 2's dressing had been changed in accordance with the facility's policy, and she indicated the order set for central line dressing changes was changed to align with the facilities policy and federal regulation. 2. On 3/10/26 at 10:14 a.m., two unidentified CNAs entered Resident 85's room and closed the door. There was no PPE equipment outside of the door, and no EBP sign posted on the resident's door. (continued on next page)

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	03/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/26 at 10:20 a.m., upon opening Resident 85's door, they indicated they were performing resident care, getting him washed and clothes changed. They were not observed to wear any PPE. Resident 85 was observed with a suprapubic catheter. The CNAs indicated, they weren't sure if Resident 85 was in EBP or not, because they had not seen a sign on his door and there was no PPE inside or outside of his room. On 3/11/26 at 11:40 a.m., Resident 85's record was reviewed. He was a newly admitted resident with diagnoses which included but were not limited to sepsis and acute kidney injury. He had a current physician's order for a suprapubic catheter. He had a comprehensive care plan initiated 3/9/26 which indicated staff should utilize PPE per facility policy during high contact ADL care which included dressing, hygiene and transfers. On 3/12/26 at 2:49 p.m. a copy of a current facility policy titled, Enhanced Barrier Precautions (EBP) Standard Operating Procedure, dated 4/1/24 was provided. That policy indicated, .1. Enhanced barrier precautions (EBP) will be in place during high contact care activities for residents with the following conditions: a. Residents at an increased risk of MDRO [Multi-Drug-Resistant Organism] acquisition which include: ii. All residents with indwelling medical devices 1. Includes but not limited to: catheters, central lines,. 2. Personal protective equipment (PPE) should be used even if blood and bodily fluid exposure is not anticipated. a. At minimum, staff shall wear gloves and gowns during high contact care activities. May include face protection if splashes or sprays are anticipated during care 3. High contact care activities include but are not limited to: morning.ADL [Activities of Daily Living] care. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)

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	03/13/2026

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, interviews and record reviews, the facility failed to ensure essential kitchen equipment and associated systems were maintained in proper working order to prevent the potential contamination for 2 of 2 observations. Findings include:On 3/10/26 at 9:45 a.m., during an initial kitchen tour with the Assistant Director of Food Service, the freezer was observed. Inside the freezer unit, an apparent leak from the freezer compressor system was observed. Frozen droplets and ice cycles were observed on the piping coming in and out of the unit. There were drops and mounds of ice that had developed on top of carboard boxes that contained frozen bread in opened plastic wrap. The presence of frozen condensation above exposed food items indicated the freezer system may have been leaking or producing excess condensation. During an interview with the Assistant Director at that time, he indicated, he had not noticed the ice, and kitchen staff had not notified him of any ice build up either. During a follow up observation on 3/12/26 at 10:35 a.m., the pipes had been cleared of ice and reinsulated with new material, however, there were new droplets of freezing ice observed on the ceiling of the freezer, near the pipe and along the seal of the freezer wall. During an interview on 3/12/26 at 11:00 a.m., the Corporate Director of Plant Operation indicated, ice build up on freezer compressors was a common effect of the systems routine defrost process and staff should know to monitor and the unit to prevent ice build up. Kitchen staff were in the freezer on a daily basis and should have identified the ice build up to notify the facility Maintenance Director who could address the issues. On 3/12/26 at 12:49 p.m., the Administrator provided a copy of current facility policy titled, Storage Procedures, dated January 2025. The policy indicated, .Frozen food equipment is routinely cleaned and defrosted and free from garbage and other waste. Freezer doors should be opened as little as possible to prevent fluctuations of storage temperatures. 410 Indiana Administrative Code (IAC) 16.2-3.1-19(bb)