STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbrooke of Carmel	12315 Pennsylvania Street 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 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 pain assessments were completed prior to and after the administration of narcotic pain medication for 2 of 3 residents reviewed for quality of care. (Resident B and C)Findings include:1. The clinical record for Resident B was reviewed on 9/12/25 at 3:00 p. m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, malignant melanoma of the skin, anxiety disorder, and chronic degeneration of the lumbar region.A physician's order, dated 3/17/25, indicated to administer Oxycodone (a narcotic pain medication) 5 mg (milligrams) once a day as needed for pain. The Electronic Medication Administration Record (EMAR) indicated a pain assessment was to be completed prior to administering the medication and to follow-up on the effectiveness of the medication after it was administered.A pain assessment was not documented on the EMAR prior to or after the medication was administered on the following dates and times:a. On 7/18/25 at 12:00 a.m.b. On 7/23/25 at 12:25 a.m.c. On 7/24/25 at 12:00 a.m.d. On 7/27/25 at 8:00 p.m.e. On 8/5/25 12:00 a.m.f. On 8/6/25 at 9:00 p.m.g On 8/19/25 at 9:30 p.m. 2. The clinical record for Resident C was reviewed on 9/12/25 at 3:15 p.m. The diagnoses included, but were not limited to, dysarthria following cerebral infarction, stiffness of the right shoulder, type II diabetes mellitus with diabetic neuropathy, and major depressive disorder.A physician's order, dated 5/31/24, indicated to administer Oxycodone 5-325 mg as needed every six hours for moderate to severe pain. The Electronic Medication Administration Record (EMAR) indicated a pain assessment was to be completed prior to administering the medication and to follow-up on the effectiveness of the medication after it was administered.A pain assessment was not documented on the EMAR prior to or after the medication was administered on the following dates and times:a. On 8/15/25 at 1:15 a.m.b. On 8/19/25 at 11:00 p.m. During an interview, on 9/12/25 at 12:40 p.m., Resident B indicated she had not asked for pain medication over the last few weeks, except for one day last week for pain in her shoulder.During an interview, on 9/12/25 at 2:11 p.m., Resident C denied asking for pain medication over the last few weeks. Resident C's daughter was present during the interview and indicated her Resident C would not have asked for the strong pain medication, she preferred Tylenol if she needed something for pain. During an interview, on 9/12/25 at 3:34 p.m., the Executive Director indicated LPN 2 should have completed a pain assessment prior to administering narcotic pain meds to Resident B and C. LPN 2 should have also completed a follow-up pain assessment after the administration of the narcotic pain medication to assess how effective the pain medication was for each resident.This Citation was related to Intake 2598338.3.1-37(a)

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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure narcotic pain medications were documented as administered on the medication administration record for 2 of 3 residents reviewed for controlled medications. (Resident B and C) The deficient practice was corrected on 8/22/25, prior to the start of the survey, and was therefore past noncompliance.Findings include:A facility reported incident, dated 9/4/25, indicated there was an irregularity noted in the narcotic sign out sheets for Residents B and C. When both residents were interviewed, they indicated they had not requested the as needed narcotics which were signed out on 8/19/25 and 8/20/25.1. The clinical record for Resident B was reviewed on 9/12/25 at 3:00 p.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, malignant melanoma of the skin, anxiety disorder, and chronic degeneration of the lumbar region.A physician's order, dated 3/17/25, indicated to administer Oxycodone (a narcotic pain medication) 5 mg (milligrams) once a day as needed for pain. Resident B's narcotic count sheet indicated Oxycodone was given on the following dates and times, but there was no signature on the electronic medication administration record (EMAR) to indicate the resident had received the medication.a. On 7/18/25 at 12:00 a.m.b. On 7/23/25 at 12:25 a.m.c. On 7/24/25 at 12:00 a.m.d. On 7/27/25 at 8:00 p.m.e. On 8/5/25 12:00 a.m.f. On 8/6/25 at 9:00 p.m.g On 8/19/25 at 9:30 p.m. 2. The clinical record for Resident C was reviewed on 9/12/25 at 3:15 p.m. The diagnoses included, but were not limited to, dysarthria following cerebral infarction, stiffness of the right shoulder, type II diabetes mellitus with diabetic neuropathy, and major depressive disorder.A physician's order, dated 5/31/24, indicated to administer Oxycodone 5-325 mg as needed every six hours for moderate to severe pain. Resident C's narcotic count sheet indicated Oxycodone was given on the following dates and times, but there was no signature on the EMAR to indicate the resident had received the medication. a. On 8/15/25 at 1:15 a.m.b. On 8/19/25 at 11:00 p.m. During an interview, on 9/12/25 at 12:40 p.m., Resident B indicated she had not asked for pain medication over the last few weeks, except for one day last week for pain in her shoulder.During an interview, on 9/12/25 at 2:11 p.m., Resident C denied asking for pain medication over the last few weeks. Resident C's daughter was present during the interview and indicated her Resident C would not have asked for the strong pain medication, she preferred Tylenol if she needed something for pain. During an interview, on 9/12/25 at 3:34 p.m., the Executive Director indicated LPN 2 should have documented the narcotics she administered to Resident B and C on the EMAR's as well as the narcotic sign out sheets.A current facility policy, titled The 6 Rights of Medication Administration, undated and provided by the Executive Administrator on 9/12/25 at 2:00 p.m., indicated .Right Documentation: Record the administration of a medication after you give it to your individual. Follow your agency policy for proper documentation.The deficient practice was corrected by 8/22/25, after the facility implemented a plan which included a thorough investigation, staff and resident interviews, staff education and narcotic medication audits.This citation relates to Intake 2598338.3. 1-25(b)(3)