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	12/02/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure a resident's comprehensive plan of care was followed and supervision was provided which resulted in unwitnessed falls for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B sustaining multiple injuries, including, but not limited to a fractured femur, hip, and multiple lacerations, some requiring sutures. Findings include:During a telephone interview, on 12/2/25 at 12:10 p.m., a family member indicated Resident B had five (5) falls in the last six months. Resident B had glass removed from her eye and face and sutures placed during the last fall. She was left alone in her room, and she was not supposed to be because of other falls. In September 2025, she was alone in her bathroom and fell. In November 2025, she was alone in her room and fell. During a telephone interview, on 12/2/25 at 1:48 p.m., a family member indicated she was concerned with Resident B's frequent falls and being left alone in her room. After talking with management, she was told Resident B's frequent falls were due to being alone in her room and she would not be left by herself. She was left in her room by herself by a staff member and had another fall. During an observation, on 12/2/25 at 2:49 p.m., Resident B had purplish/red colored scattered bruises under both her eyes and on her right forehead. She had a laceration above her right eye with seven sutures. She had a laceration under her right eye on her right cheekbone with two sutures. The clinical record for Resident B was reviewed on 12/1/25 at 2:30 p.m. The diagnoses included, but were not limited to, dementia, periprosthetic fracture around an internal prosthetic of the left hip joint, repeated falls, major depressive disorder, and cognitive communitive deficit.A care plan, dated 11/27/23, indicated Resident B was at risk for falls. The long-term goal was Resident B would remain free from falls with major injury. The clinical record for Resident B indicated she had five (5) falls in six (6) months and an injury with every fall. The injuries ranged from skin tears, bruises, lacerations, a fractured left hip and a periprosthetic fracture around an internal prosthetic left hip joint.1. A nursing progress note, dated 5/13/25 at 9:48 p.m., indicated Resident B had an unwitnessed fall, at 8:25 p.m., and sustained a skin tear to her left upper arm. She was observed on the floor in her room. She hit her head. The new intervention placed was to rearrange her room, to place Dycem to her chair, to apply moisturizer to keep her skin supple, and to encourage her to wear long sleeve shirts.A progress note, dated 5/13/25 at 10:07 p.m., indicated Resident B was observed lying face down with her left arm under her body and her legs extended out. Her wheelchair was positioned behind her. Resident B received a hematoma to her forehead, a skin tear to her left upper arm, and a bruise to her left knee. Resident B indicated she leaned over to get something off the floor and fell. 2. A progress note, dated 6/27/25 at 7:30 p.m., indicated Resident B had an unwitnessed fall. The resident was found on the floor in front of her wheelchair in the prone position. She was assessed and blood was coming from a laceration to her forehead. Resident B indicated she was using her grabber tool to pick up an item off the floor and fell over. The resident was asked to use her call light and to allow staff to assist her with picking up items from the floor.A facility incident report, dated 6/28/25 at 1:15 a.m., indicated Resident B had an unwitnessed fall in her room, on 6/27/25 at 7:30 p.m. She sustained a laceration during the fall. An intradisciplinary team note, dated 7/3/25 at 9:54 p.m., indicated Resident B was found on the floor, on 6/27/25 at 7:30 p.m. She was severely cognitively impaired. She indicated she was attempting to get something off the floor with her grabbing tool when she fell over. She had a laceration to the middle of her forehead. The intervention placed was to have a physical and occupational therapy evaluation to determine appropriate assistive devices. 3. A facility incident report, dated 9/4/25 at 8:02 p.m., indicated Resident B had an unwitnessed fall in her bathroom, on 9/4/25 at 7:30 p.m. She complained of pain in her left hip. Prior to the fall, Resident B was transferring herself from her wheelchair to use the restroom and fell. An intradisciplinary team note, dated 9/8/25 at 2:55 p.m., indicated Resident B had an unwitnessed fall, on 9/4/25. The resident was found on her restroom floor and complained of left hip pain. She was attempting to self-transfer to the toilet. Resident B was severely cognitively impaired and displayed an increase in anxiety after the fall. The new intervention placed was Resident B was not to be left unattended in the bathroom by herself.A nursing progress note, dated 9/8/25 at 4:42 p.m., indicated the x-ray company confirmed a subacute fracture at the lateral aspect of the proximal femur with no displacement. A nursing progress note, dated 9/12/25 at 10:27 p.m., indicated Resident B arrived back at the facility by ambulance. She had suffered a fracture of her left femur. She was non-weight bearing. She screamed with movement and was very anxious. Fall precautions were put into place.4. A facility incident report, dated 11/6/25 at 6:41 p.m., indicated Resident B had an unwitnessed fall in