

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155806		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025	
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF WABASH				STREET ADDRESS, CITY, STATE, ZIP CODE 20 JOHN KISSINGER DRIVE WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Preoccupancy Survey for the Removal of two borrow lights, walls and casework, removal of two sections of non-load bearing wall within the dining room, repaired finishes, new Class 1 flooring in the dining room and relocation of fire alarm and electrical devices was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 01/08/25</p> <p>Facility Number: 012993 Provider Number: 155806 AIM Number: 201208210</p> <p>At this Preoccupancy survey, Wellbrooke of Wabash was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, carbon dioxide detector by gas fire places, and hard wired smoke detectors in all the resident sleeping rooms. Due to the lack of a two hour separation (which was determined by facility construction prints and physical inspection) between assisted living and health care, the entire facility was surveyed. The facility has a capacity of 70 health care beds with a census of 57.</p>			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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K 000	Continued From page 1 All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/09/25	K 000			