STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155824	A. BUILDING 00 B. WING	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF SOUTH BEND	52565 STATE ROAD 933 SOUTH BEND, IN 46637

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00448825 and IN00450672. This visit included a State Residential Licensure Survey. Complaint IN00448825 - No deficiencies related to the allegations are cited. Complaint IN00450672 - No deficiencies related to the allegations are cited. Survey dates: January 30, 31 and February 3, 4, 5 and 6, 2025. Facility number: 013302 Provider number: 155824 AIM number: 201281730 Census Bed Type: SNF/NF: 40 SNF: 14 Residential: 34 Total: 88 Census Payor Type: Medicare: 30 Medicaid: 14 Other: 11 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 2/14/2025	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of South Bend that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of South Bend. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0550 SS=E	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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Bldg. 00	Based on interview and record review, the facility failed to have a process for residents to file a grievance anonymously. This had the potential to affect 54 of 54 residents who resided in the facility. Finding includes: During a Resident Council meeting on 1/30/2025 at 10:29 A.M., 8 out of 8 residents did not know how to file a grievance anonymously. On 1/30/2025 at 11:01 A.M., the Executive Director (ED) indicated the facility used an application (app) to allow residents to file a grievance. The app to file a grievance was only accessible on facility computers and tablets. If a resident wanted to file a grievance, the resident had to tell a staff member so the staff member could open the app and give the resident the electronic device. The grievance app did allow, once accessed online, residents to submit anonymously. During an interview on 1/31/2025 at 2:21 P.M., the Life Enrichment Director (LED) indicated she helped residents file grievances. If a resident wanted to file a grievance, the LED opened the grievance app and gave the resident the device. She indicated if only one resident asked to file a grievance in a day, and the grievance was submitted anonymously, she would know who filed the grievance and the grievance was not anonymous. During an interview on 1/31/2025 at 2:30 P.M., the Social Services Director (SSD) indicated he helped residents file grievances by giving the resident a device that had access to the grievance app. If a resident asked to file a grievance, and the facility	F 0550	1 All residents had the potential to be affected by the alleged deficient practice of not having access to paper concern forms to submit a grievance anonymously. No adverse effects were noted from this alleged deficient practice. 2 Paper compliance forms have been placed in public area with writing utensils, with a locked box for residents and or families to submit anonymous grievance. 3 As a measure of ongoing compliance, the ED and or designee will educate residents on placement of paper concern forms and drop box for the purpose of turning in a grievance anonymously during resident council monthly x 6 months. 4 As a quality measure, the ED and/or designee will review findings with QAPI monthly x 6 months. The plan will be reviewed and updated as warranted.	03/07/2025

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	only received one grievance that day that was submitted anonymously, the SSD would know who filed the grievance and the grievance was not anonymous. On 1/31/2025 at 3:02 P.M., the ED supplied a policy dated, 12/16/2024, and titled, "Resident Concern Process". The ED identified the policy as the one currently used by the facility. The policy indicated, "... 14. Resident rights for filling a grievance:... Grievances or concerns can be filed verbally, in writing or anonymously...." Although the facility had an electronic system to allow residents to file anonymous grievances, the system required direct staff assistance to open the system, thus allowing staff to know whom had filed a grievance and potentially removing autonomy. 3.1-3(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observations, interviews and record review, the facility failed to proved Activities of Daily Living (ADLs) for a a dependent resident related to shaving for 1 of 4 residents reviewed for ADLs. (Resident 4) Finding includes: During an observation, on 1/31/2025 at 10:15 A.M., Resident 4 had multiple white hairs present on her chin that were approximately a half inch in length. During an observation, on 2/3/2025 at 1:40 P.M. Resident 4 still had multiple white hairs present on her chin over the length of a half an inch.	F 0677	1 One of four residents were affected by the alleged deficient practice of activities of daily living for a dependent resident related to her not being shaved. 2 Resident was immediately assisted with being shaved. 3 As a measure of ongoing compliance, the DHS and or designee will audit five residents weekly for the assistance of ADL's on dependent residents x 4 weeks, then bi-weekly x 4 weeks, then monthly x 4 months. 4 As a quality measure, the ED and/or designee will review	03/07/2025

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	During an observation, on 2/4/2025 at 1:55 P.M., Resident 4 had multiple white hairs on her chin over the length of a half an inch. The clinical record of Resident 4 was reviewed on 2/3/2025 at 12:50 P.M. The resident's diagnoses included, but were no limited to: emphysema, traumatic pneumothorax, wedge compression fracture of thoracic vertebrae, acute on chronic heart failure, paroxysmal atrial fibrillation, pleural effusion, left bundle branch block, presence of automatic cardiac defibrillator, depression and dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 11/21/2024, indicated Resident 4 was severely cognitively impaired and required supervision with oral hygiene, toileting, showering and bathing, upper body dressing and personal hygiene. A current Care Plan, revised 1/30/2025, indicated the resident required staff assistance to complete ADL tasks completely and safely. Interventions included, but were not limited to: offer facial shaving on shower days, as needed, or as requested and to notify nursing of refusals. The medical record for Resident 4 indicated the resident had received showers on the following dates: 2/3/2025, 1/30/2025, 1/27/2025, 1/26/2025, 1/22/2025, 1/20/2025, 1/16/2025, 1/13/2025, 1/9/2025, 1/6/2025 and 1/2/2025. The progress notes did not include any documentation of Resident 4 refusing to have her face shaved. During an interview, on 2/4/2025 at 1:56 P.M.,		findings with QAPI monthly x 6 months. The plan will be reviewed and updated as warranted.	

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	CNA 8 indicated shaving for residents should be provided every day. CNA indicated facial shaving should be provided to both male and female residents if the resident has facial hair unless their preference was to have facial hair. CNA 8 was not aware of any female residents who preferred to have facial hair. During an interview, on 2/4/2025 at 2:13 P.M., CNA 9 indicated the residents were given a shower two times a week according to a provided shower schedule. CNA 9 indicated she shaved the male residents' faces with every shower and if needed, she shaved the female residents' faces during shower days, too. During an interview, on 2/4/2025 at 3:07 P.M., LPN 10 indicated Resident 4 had visible chin hairs and should have been shaved. On 2/5/2025 at 8:30 A.M., the DON provided a paper titled, "Lesson #11 Activities of Daily Living (Oral Care, Grooming, Nail Care)," undated and indicated this paper was currently used by the facility as a policy. The policy indicated "...be able to explain the importance of...grooming, including hair and facial hair... " 3.1-38 (a)(2)(A)-(E)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to serve food in a sanitary manner for 1 of 3 dining rooms observed. This had the potential to affect 9 of 9 residents ate in the dining room. Finding includes:	F 0812	1 All residents have the potential to be affected by failing to serve food in a sanitary manner by serving a plate with a thumb touching the top of the plate. 2 Dietary deficiency was corrected after identification.	03/07/2025

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	During an observation and interview, on 1/30/2025 at 11:29 A.M., Dietary Aide 4 carried two different residents' plates with her thumb on the eating surface of plate. The dietary aide indicated the residents' plates should have been carried from the bottom surface. During an observation, on 1/30/2025 at 12:05 P.M., Dietary Aides 5 and 6 were observed touching the eating surface of two different residents' plates with their thumbs while serving meals. During an interview, on 1/30/2025 at 12:10 P.M., the Director of Food Service indicated the food servers should have handled the plates from the bottom and not have touched the eating surface of the plate. On 1/30/2025 at 12:48 P.M., the Executive Director (ED) provided a policy titled, "Food Production Guidelines - Sanitation and Safety", dated 2009 and indicated the policy was the one currently used by the facility. The policy indicated " ...plates...are handled so hands do not touch the areas where the food or mouth will be placed..." 3.1-21(i)(3)		Dietary staff educated on proper food handling, sanitation and safety. 3 As a measure of ongoing compliance, the Director of Food Services (DFS) and or designee will audit one meal a day 5 days a week for 4 weeks, then bi-weekly x 4 weeks, then monthly x 4 months. 4 As a quality measure, the ED and/or designee will review findings with QAPI monthly x 6 months. The plan will be reviewed and updated as warranted.	
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services Based on observation, interview, and record review the facility failed to ensure coordination of Hospice care and documentation of care provided was maintained in the facility for 1 of 1 residents reviewed for Hospice care. (Resident 21) Finding includes: A record review was completed for Resident 21 on	F 0849	1 Resident 21 was affected by the alleged deficient practice of resident's hospice binder being up to date with hospice documentation. No adverse effects were noted from this alleged deficient practice. 2 All hospice binders are all current and up to date with	03/07/2025

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	2/3/2025 at 8:57 A.M. Diagnoses included, but were not limited to: diabetes mellitus with neuropathy and senile degeneration of the brain. A Physician order, dated 1/9/2025, indicated Resident 21 had been admitted to Hospice. During a review of the Hospice communication book on 2/5/2025 at 11:30 A.M., for Resident 21, the following sections of the binder were blank: comprehensive care plan, physician orders, medication list, narcotic count and visit notes. During an interview on 2/5/2025 at 1:00 P.M., the DON indicated the Hospice book for Resident 21 was missing the medication list, physician orders, comprehensive care plans, narcotic count and assessments. She indicated the book should have had those documents. On 2/6/2025 at 8:50 A.M., the Clinical Support Nurse indicated the facility did not have a policy for maintaining a Hospice book for communication between the facility and the Hospice team. On 1/30/2025 a contract for Hospice services was provided by the Administrator. The contract for Hospice services was a requested and provided. The contract, dated 10/4/2021 included the following "...1.03 Information/Documentation provided to Facility on admission and on-going: * most recent hospice plan of care; *Hospice medication information specific to each patient; * Hospice physician and attending physician orders specific to each patient; *copies of clinical notes after each visit. 1.04 Coordination/Continuity of Care: *Communicating with Facility representatives and other Hospice to ensure quality of care for the patient/family. *Maintain communication with facility staff, patient/family		hospice documentation. 3 As a measure of ongoing compliance, the Director of Health Services (DHS), Executive Director (ED) and or designee will audit hospice binders weekly x 4 weeks, bi-weekly for 4 weeks, then monthly x 4 months. 4 As a quality measure, the ED and/or designee will review findings with QAPI monthly x 6 months. The plan will be reviewed and updated as warranted.	

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	and physician with appropriate documentation. 1.07 Hospice RN Case Manger will coordinate and supervise all services provided to the hospice patient residing within the Facility, through written communication, to ensure the patient/family needs are met 24 hours a day. The communication will be documented on nurse visit notes. 2. Responsibilities of Facility: 2.07 Maintain an accurate medical record that includes all services and events provided. All services will be furnished according to agreement. Required documentation provided by Hospice will be included in a designated area/section. Facility will ensure that these forms are not removed. Facility will provide a copy of patients's medical record to Hospice, if requested after discharge....."			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review the facility failed to follow standard precautions during the performance of routine testing of blood glucose and the administration of insulin for 1 of 1 reviewed for infection control. (Resident 21) Finding includes: During an observation of a medication administration pass on 2/4/2025 at 11:06 A.M., LPN 3 gathered her supplies from the medication cart and entered Resident 21's room. LPN 3 then donned gloves and proceeded to take the Resident's blood sugar. When she had completed the task, she exited the room with her gloves on, disposed of the supplies and removed the gloves, donned new gloves and cleaned the glucometer. Next, she removed those gloves, opened up the computer and prepared the insulin. LPN 3 then	F 0880	1 One resident was affected by alleged deficient practice of hand hygiene/hand washing during blood glucose check and insulin administration. The resident was assessed and no adverse reactions noted. 2 Staff was educated and re-educated on proper hand hygiene. 3 As a measure of ongoing compliance, the DHS and or designee will observe two residents who require blood glucose checks with insulin administration weekly x 4 weeks, bi-weekly x 4 weeks and then monthly x 4 months. 4 As a quality measure, the ED and/or designee will review	03/07/2025

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	entered Resident 21's room, donned gloves and administered the insulin. At no point did LPN 3 wash her hands or use alcohol based hand rub. During an interview on 2/4/2025 at 11:12 A.M., LPN 3 indicated she should have used alcohol-based hand rub before and after taking the blood sugar and prior to the administration of the insulin. On 2/4/2025 at 11:47 A.M., the Regional Clinical Support provided, "Specific Medication Administration Procedures and Blood Sugar Monitoring", and indicated the procedures are the one currently used by the facility. The procedures included the following ... 2. Perform hand hygiene and done (Sic) gloves. And for medication administration from a syringe to sanitize hands with approved sanitizer and remove and discard gloves. Clean hands by washing or using sanitizer....." On 2/5/2025 at 8:20 A.M., the Administrator provided a policy titled, "Guidelines for Handwashing/Hand Hygiene," revised 2/9/17, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Health Care Workers (HCW) shall use hand hygiene at times such as: c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc....." 3.1-18(l)		findings with QAPI monthly x 6 months. The plan will be reviewed and updated as warranted.	